



Royal College of
General Practitioners

PREPARING THE FUTURE GP: THE EVIDENCE FOR ENHANCING CLINICAL SKILLS





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1.1: WHY IMPROVED CARE FOR CHILDREN AND YOUNG PEOPLE IS A TRAINING PRIORITY

IN THE UK THERE ARE APPROXIMATELY¹:

- 12 million children and young people aged 18 and younger
- 6 million young people aged under 10
- 600,000 live births a year
- 1 million children with mental health disorders
- 400,000 children and young people in need
- 320,000 disabled children and young people
- 60,000 looked-after children and young people.

The vast majority of NHS healthcare for children and young people is delivered via their general practice teams in the context of their parents and families. Children aged 4 years and under visit their GP on average six times each year and school-age children visit their GP between 2–3 times each year². All GPs therefore need high-quality training in leading, coordinating and delivering care for children and young people.

Non-GP-based models for delivering community-based child services have been postulated by some commentators but cost-modeling has not shown them to be financially viable in the UK³. Strengthening and developing primary care to deliver more high-quality modern child healthcare therefore remains critical to the improvement of health outcomes for children and young people in the UK.

To deliver effective and safe care for children and young people, the modern GP needs a range of highly-developed clinical, generalist and leadership skills. To develop these skills requires exposure to high-quality educational experiences in both the specialist and primary care settings.

The large proportion of children receiving urgent physical and mental health care outside general practice, in combination with the relatively low prevalence of serious illness in the community, means that that some specific aspects of child healthcare training are best delivered outside primary care. For example, a specialist paediatric placement can provide

1 <http://www.statistics.gov.uk/hub/index.html>.

2 Stephenson T. Paediatric primary care in Europe: variation between countries. *Arch Dis Child* 2010;95:767-768; doi:10.1136/adc.2010.184788.

3 *Improving Health Services for Children in North Sefton*. Accessed via: www.nhssefton.nhs.uk/Library/Publications/corporate_publication/Childrens%20Report%20_final.pdf.

trainees with exposure to large numbers of sick children in a safe, supervised environment within a relatively short period of time.

Despite this clear advantage, approximately 50% of GP trainees do not currently have an opportunity to experience acute childhood illness in a specialist-based training placement during the current three-year GP training programme⁴.

'We have been calling for better training for a long time. While the trainees completing training are technically competent they are not as confident as they could be and exposure to more sick children during their training would help.'

Professor Steve Field, Chair of NHS Futures Committee⁵

To address this issue it is important that trainees have training in the care of acutely sick children and that this takes place in an appropriately supervised and safe environment.

Although hospital-based paediatric placements result in exposure to a range of acute paediatric problems, this is often not sufficient to train GP trainees adequately in the wide range of common and long-term health issues encountered in the community context because the types and prevalence of conditions encountered in the primary and secondary care working environments are different. Children present to their GPs with different problems compared to specialist settings and hence it is important that the future trainee has exposure to both. For example, whereas 98% of GP trainees in the West Midlands who had completed a 4–6-month paediatric specialty placement reported that they had confidence in managing a child presenting with diarrhoea and vomiting, only 64% reported confidence in managing a child with failure to thrive, only 56% felt confident in managing a child with recurrent abdominal pain, and just 19% felt able to manage a child presenting with behavioural problems as very few had encountered these problems in their secondary care posts⁶.

There is a growing body of evidence that the current three-year GP specialty training programme is no longer adequate to meet the needs of today's children and young people. An extension and enhancement of training is required to improve child health in the UK.

CHALLENGE 1: SPOTTING THE SICK CHILD

Although the trainees who undertake hospital-based paediatric placements gain exposure to a range of acute problems, GPs also need to have exposure to the range of problems presenting in community settings. The GP must be able to identify a potentially serious problem quickly and efficiently amongst the 'background noise' of children presenting with self-limiting illnesses.

Children and young people deserve consistently reliable and high-quality access to urgent care, delivered by clinicians trained in the appropriate skills for assessment, diagnosis, treatment and continuing care. The recent report *Why Children Die*⁷ found failure to recognise severity of illness was one of the key avoidable factors in the national audit of child deaths. Specifically, failures were identified in understanding the importance of

4 *Education and Training – Next Stage. A report from the NHS Future Forum.* Accessed via: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_132025.pdf.

5 RCGP Child Health Strategy 2010–2015. Accessed via: http://www.rcgp.org.uk/pdf/CIRC_RCGP_Child_Health_Strategy_2010_2015_FINAL.pdf.

6 Walker V, Wall DW, Goodyear HM. Paediatric training for GP VTS trainees: are we meeting the requirement? *Education in Primary Care* (2009);20(1): 28–33.

7 Confidential Enquiry into Maternal and Child Health. *Why Children Die: A pilot study* (2008). Accessed via: http://www.injuryobservatory.net/documents/why_children_die1.pdf.

history, clinical examination, interpretation of physical signs, recognition of complications, clinical supervision and prompt referral and treatment. One of the five recommendations in the RCPCH's *Facing the Future: Standards for Paediatric Services* (amended March 2011) is to increase the number of GP trainees supporting acute paediatric services⁸.

Despite this clear requirement, a significant proportion of doctors entering general practice today receive less clinical exposure to sick children than previously due to changes in the specialisation of paediatric care, the delivery of acute care and reconfiguration of out-of-hours services; this is particularly an issue for those patients under four years old and for those with disability and complex needs. The impact of this change has been evidenced by the identified 'bulge' in children's attendance in emergency departments in the evenings⁹ and the increase in recorded GP referrals and admissions out-of-hours¹⁰.

All doctors working in primary care need adequately supervised exposure to sick children in order to develop and maintain the skills required to adequately recognise the sick child, assess, diagnose and manage them safely and effectively.

CHALLENGE 2: IMPROVING SAFEGUARDING

The key primary care issue described in Standard 5 of the National Service Framework for Children, Young People and Maternity Services is: 'All agencies must work to prevent children suffering harm and to promote their welfare, provide them with services they require to address their identified needs and safeguard children who are being or likely to be harmed'¹¹. The Victoria Climbié Inquiry¹² and other recent high profile cases (such as that of Baby Peter)¹³ have further highlighted the importance of safeguarding children and raised the political profile of the issue in society.

In 2009, the National Institute for Health and Clinical Excellence (NICE) published guidelines on *When to Suspect Child Maltreatment*¹⁴ highlighting the unique responsibilities of GPs in the early recognition and intervention for children and young people who may not otherwise reach their potential or may suffer harm. The role of the GP in safeguarding is wide-ranging: recognition of patterns of neglect, referring in a timely and appropriate manner to secondary health care colleagues or social care, responding to inter-agency requests, supporting families and giving context at case conferences.

However, 53% of trainees report that they were not confident to manage a child presenting with suspected physical abuse (with 37% being unconfident in diagnosis) and 70% of trainees report that they are not confident to manage a child presenting with suspected

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- 8 RCPCH. *Facing the Future: Standards for Paediatric Services* (April 2011). Accessed via: http://www.rcpch.ac.uk/sites/default/files/RCPCH_Facing_the_Future:_Standards_for_Paediatric_Service_April_2011V2.pdf.
 - 9 RCPCH. *Modelling the Future: A consultation on the future of children's health services* (2007). Accessed via: <http://www.rcpch.ac.uk/sites/default/files/MtF%2025.09.07.pdf>.
 - 10 Kennedy I. *Getting it Right for Children and Young People: Overcoming cultural barriers in the NHS so as to meet their needs* (2010). Accessed via: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_119446.pdf.
 - 11 Department of Health and Department for Education and Skills. *National Service Framework for Children, Young People and Maternity Services* (2004). Accessed via: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_409052.pdf.
 - 12 House of Commons Health Committee. *The Victoria Climbié Inquiry Report* (2003). Accessed via: <http://www.publications.parliament.uk/pa/cm200203/cmselect/cmhealth/570/570.pdf>.
 - 13 Local Safeguarding Children Board Haringey. *Serious Case Review: Baby Peter* (2009). Accessed via: http://www.haringeylscb.org/executive_summary_peter_final.pdf.
 - 14 NICE. *When to Suspect Child Maltreatment* (2009). Accessed via: <http://www.nice.org.uk/nicemedia/live/12183/44954/44954.pdf>.

sexual abuse (with 56% being unconfident in diagnosis) even after doing a specialist paediatric placement¹⁵.

As general practice is by far the largest provider of healthcare for children in the NHS, this reinforces the need for high quality, team-based safeguarding training in the primary care setting. The authors of the above study concluded that GP training, as currently delivered, was not meeting the outcomes set out by the RCGP curriculum and the Royal College of Paediatrics and Child Health. They noted that an integrated training curriculum and an extended period of training from three to five years would enable GPs to gain the required experience and confidence to be proficient in dealing with children.

GPs must also engage more effectively with vulnerable groups such as 'looked-after-children', children whose parents abuse drugs or alcohol, and children of asylum seekers or migrants who have particularly poor outcomes in health.

CHALLENGE 3: IMPROVING CARE FOR CHILDREN WITH LONG-TERM CONDITIONS

The proportion of children with chronic ill health and disability has increased in recent years, partly due to the success of neonatal intensive care and paediatric treatment of life-limiting conditions (e.g. cystic fibrosis). Infants and children suffer from a number of chronic conditions (e.g. asthma, eczema and arthritis) for which they rely heavily on the skills of GPs and their teams.

Increased numbers of chronically disabled children are looked after at home¹⁶. These patients are often complex with multiple diagnoses; failure to manage their needs can have poor outcomes stretching into adult life¹⁷. Many have high readmission rates to secondary care, whereas they would prefer to be cared for in primary care; they also may have medical equipment with which those in primary care are not familiar. Those requiring specialist treatment or investigations from primary care need to make lots of trips to hospital for different appointments. Integration of these services closer to home will have a profound benefit for these patients and families. However, few primary care organisations have children or young people's involvement in patient partnership groups and the needs of young carers are also often inadequately addressed¹⁸.

General practice is at the hub of a wider system of care and must take responsibility for co-ordination and signposting to services both within and beyond health care. GPs must also develop the skills to actively co-ordinate the transition period when a young person with long-term illness or disability is transferred into adult services. A clear transfer age should be set, with the GP being involved in care planning two years before transition occurs.

15 Walker V, Wall DW, Goodyear HM. Paediatric training for GP VTS trainees: are we meeting the requirement? *Educ Prim Care* (2009) Jan;20(1):28-33.

16 Kennedy I. *Getting it Right for Children and Young People: Overcoming cultural barriers in the NHS so as to meet their needs* (2010). Accessed via: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_119446.pdf.

17 Mercer S. Personal communication (2011).

18 RCGP/The Princess Royal Trust For Carers. *Supporting Carers Action Guide* (2011). Accessed via: www.rcgp.org.uk/professional_development/continuing_professional_dev/carers.aspx.

CHALLENGE 4: IMPROVING END-OF-LIFE CARE FOR CHILDREN AND YOUNG PEOPLE

There are 23,500 children and young people in the UK who have been diagnosed with health conditions for which there is no reasonable hope of cure. Half of these children have substantial palliative care needs and 3,000 will die each year. Around 100,000 close family members will be affected, many of whom provide 24 hour complex care and support for their child¹⁹.

There is a continuing trend to shift health care to 'as close to home as possible'. This will require GPs to play a greater role in providing end-of-life care and also in the scripting of advance care plans in children with life-limiting conditions. At present GPs often demonstrate a lack of awareness of these processes as there is rarely opportunity to experience them directly within the current training programme.

Following a child death, a GP has a statutory duty to take part in the multi-agency investigation that follows²⁰. Such contribution involves completing required datasets and attending or leading multi-professional case review meetings. The GP also plays a central role in providing support to the bereaved parents and family.

CHALLENGE 5: SUPPORTING HEALTHY CHILDHOOD DEVELOPMENT

We know that a child's experience in early life – and even before birth – has a crucial impact on life chances.

It is estimated that:

- 705,000 children in the UK live with a dependent alcohol drinker²¹ – this brings with it the potential consequences of social deprivation and the physical impact through foetal alcohol spectrum
- 335,000 children live with a dependent drug user²²
- 30–50% of adult mental health users are parents.

The 2001 census identified 175,000 young carers²³. However a recent BBC poll of secondary school children found that 8% of secondary school children had moderate or high levels of care responsibilities. This translates to a figure of approximately 700,000 young carers across the UK²⁴. The true figure may be even higher, as this figure only relates to children of secondary school age. Data collected in 2003 from projects supporting young carers suggested that 71% of young carers were between the ages of 11 and 18. The remainder were aged 5–10 years²⁵. This implies that the true figure for the number of young carers in the UK may be nearer 1 million. Young carers may come from any family background,

19 RCGP Child Health Strategy 2010–2015. Accessed via: http://www.rcgp.org.uk/pdf/CIRC_RCGP_Child_Health_Strategy_2010_2015_FINAL.pdf.

20 HM Government. *Working Together to Safeguard Children* (2010). Accessed via: <https://www.education.gov.uk/publications/eOrderingDownload/00305-2010DOM-EN.pdf>.

21 Manning V, Best DW, Faulkner N, Titherington E. New estimates of the number of children living with substance misusing parents: results from UK national household surveys. *BMC Public Health* (2009);9:377-389. Accessed via: www.biomedcentral.com/1471-2458/9/377.

22 *Ibid.*

23 Doran T, Drever F, Whitehead M. Health of young and elderly informal carers: analysis of UK census data. *British Medical Journal* (2003);327:1388. Accessed via: www.bmj.com/content/327/7428/1388.full.pdf.

24 BBC Press release. "Hidden Army" of young carers could be four times as high as official figures (16.11.2010). Accessed via: www.bbc.co.uk/pressoffice/pressreleases/stories/2010/11_november/16/carers.shtml.

25 Dearden C, Becker S. *Young Carers in the UK – The 2004 report*. Carers UK and The Children's Society. Accessed via: www.carersuk.org/Professionals/ResearchLibrary/Profileofcaring/1207234991.

but only 4% of adults with care needs who are looked after by their children are in paid employment.

Access to community-based pre-natal care and healthy life-style advice to support parents is therefore key to improving longer-term health outcomes. The role of fathers in contributing to their child's development and wellbeing should not be overlooked. Parents need information to help them make informed decisions about the needs of their children and efforts should be made to ensure that consistent advice and information is given to parents across different care settings.

In 2010–11, over a fifth (22.6%) of children aged 4–5 years in England were overweight or obese. By Year 6, this rate was one in three (33.4%)²⁶. It is a health priority that GPs work with secondary care colleagues to develop more effective pathways for making effective family interventions for the prevention and management of obesity.

CHALLENGE 6: DEVELOPING YOUTH-FRIENDLY SERVICES

It is widely recognised that feedback from patients is essential to improving the quality of healthcare services and to ensure effective engagement. However, feedback from young people on their experiences and Patient Recorded Experience Measures (PREMs) are rarely recorded. There is a need for improved communication and listening skills by healthcare professionals providing healthcare to children, together with more effective inter-professional communication.

General practices must provide health services at a time that young people can access them discretely and easily. Services must be designed to enable young people to talk about issues regarding their emotional, physical and sexual health, such as drugs and alcohol, relationship problems and peer pressure, abortion counseling and referral and smoking cessation. There also needs to be access to contraception and sexual health advice and testing.

There is a lack of recognition and appropriate management of mental health issues in young people, including the provision of local treatment which is integrated in primary care. GPs need the skills to manage common childhood and adolescent behavioural and mental health problems and to reduce their adverse impacts on long-term health.

CHALLENGE 7: IMPROVING ORGANISATIONAL ASPECTS OF HEALTHCARE

The introduction of clinically-led commissioning in England provides an opportunity for GPs to be involved in designing services for children and young people. To do this GPs will need to develop a greater understanding of the role and expertise of other child health and public health professionals and the skills to work effectively with them in shared team leadership roles. The commissioning of children's services needs to start with pre-conceptual care to make an impact. Working in partnership with adult mental health, drug and alcohol misuse services, youth offending teams and adult medicine services will be essential. Multi-morbidity starts in childhood²⁷.

Within their practices, GPs need to be trained on the practical measures that can improve accessibility to children and young people. For example, they need to ensure that

26 UK Government National Child Measurement Programme (NCMP) for England, 2010/11 school year. Accessed via: www.ic.nhs.uk.

27 Mercer S. Personal communication (2011).

appointment booking systems reduce the amount of time children and young people are away from school and take into account the particular needs of disabled children and young people who find it hard to wait to be seen (e.g. via double appointment times or ring-fencing the first or last appointments).

A significant number of medication administration errors involve children²⁸ – in particular, dosing errors. GPs need the skills to set up and use electronic records and administration systems that help prevent error and facilitate appropriate age medication dosage in the various points of contact – including the practice, the OOH clinic and on home visiting. There is under-reporting of patient safety incidents involving children in primary care and a need for clinical systems that allow prompt recording and discussion of these issues. GPs also need to understand the role of information systems that can provide data to enable identification of children at high risk – for example those that do not attend hospital appointments or have frequent hospital Emergency Department attendances. Improved data collection is required for health checks for young people with a learning disability and health checks on looked after children. Effective recall systems in primary care are required for hard-to-reach groups (e.g. annual flu immunisations for young adults with asthma).

28 National Patient Safety Agency. *Review of Patient Safety for Children and Young People*. National Patient Safety Agency, 2009. Accessed via: www.nrls.npsa.nhs.uk/resources/?EntryId45=59864.

1.2: WHY IMPROVED CARE FOR PEOPLE WITH MENTAL HEALTH PROBLEMS IS A TRAINING PRIORITY

'GP surgeries need to be welcoming places for people with mental health problems. All primary care staff have a key role in looking after the physical as well as mental health of people with a mental illness.'

HM Government, *No Health Without Mental Health*, 2011²⁹

IN THE UK:

- At least one in four people will experience a mental health problem at some point in life and one in six adults has a mental health problem at any one time³⁰
- One in ten children aged between 5 and 16 years have a mental health problem, and many continue to have mental health problems into adulthood³¹
- Half of those with lifetime mental health problems first experience symptoms by the age of 14^{32, 33} and three-quarters before their mid-20s³⁴
- Self-harming in young people is not uncommon (10–13% of 15–16-year-olds have self-harmed)³⁵
- Almost half of all adults will experience at least one episode of depression during their lifetime³⁶
- One in ten new mothers experiences postnatal depression³⁷
- About one in 100 people have a severe mental health problem³⁸

29 HM Government. *No Health Without Mental Health* (2011). Accessed via: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf.

30 McManus S, Meltzer H, Brugha T et al. *Adult Psychiatric Morbidity in England, 2007: Results of a household survey*. Leeds: NHS Information Centre for Health and Social care, 2009. Accessed via: [http://www.ic.nhs.uk/webfiles/publications/mental_health/other_mental_health_publications/Adult_psychiatric_morbidity/APM/2007\(FINAL\)_Standard.pdf](http://www.ic.nhs.uk/webfiles/publications/mental_health/other_mental_health_publications/Adult_psychiatric_morbidity/APM/2007(FINAL)_Standard.pdf).

31 Green H, McGinnity A, Meltzer H et al. *Mental Health of Children and Young People in Great Britain, 2004*. Basingstoke: Palgrave Macmillan, 2005.

32 Kim-Cohen J, Caspi A, Moffitt T et al. Prior juvenile diagnoses in adults with mental disorder. *Archives of General Psychiatry* (2003);60: 709-717.

33 Kessler R, Berglund P, Demler O et al. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry* (2005);62:593-602.

34 Kessler R and Wang P. The descriptive epidemiology of commonly occurring mental disorders in the United States. *Annual Review of Public Health* (2007);29:115-129.

35 Hawton K, Rodham K, Evans E and Weatherall R. Deliberate self harm in adolescents: self report survey in schools in England (2002). *British Medical Journal* 325: 1207-1211.

36 Andrews G, Poulton R and Scoog I. Lifetime risk of depression: restricted to a minority or waiting for most? *British Journal of Psychiatry* (2005);187:495-496.

37 Gavin N, Gaynes B, Lohr K et al. Perinatal depression: a systematic review of prevalence and incidence. *Obstetrics and Gynaecology* (2005);106:1071-1083.

38 HM Government. *ibid*.

- In 2011, there were 820,000 people living with dementia in the UK³⁹ and this is set to increase to over a million by 2021⁴⁰; the financial cost of dementia in the UK is currently £23 billion each year⁴¹.
- Some 60% of adults living in hostels have a personality disorder⁴².
- Some 90% of all prisoners are estimated to have a diagnosable mental health problem (including personality disorder) and/or a substance misuse problem⁴³
- The aggregate economic and social costs of mental health problems in England in 2009/10 was estimated to be £105.2 billion⁴⁴.

Mental wellbeing is associated with a range of better outcomes for people of all ages and backgrounds. These include⁴⁵:

- improved physical health and life expectancy
- reduced risk of mental health problems and suicide
- reduced health risk behaviours such as smoking and substance misuse
- better educational achievement and increased skills
- improved employment rates and productivity
- reduced anti-social behaviour and criminality; and
- higher levels of social interaction and participation.

The converse is true for people with mental ill-health.

Half of all people with a long-term mental health problem (excluding dementia) will have experienced symptoms by the age of 14, and three-quarters by their mid-20s^{46, 47}. There are also indications that behavioural and emotional problems are becoming more common in young people¹². The UK has one of the highest rates of teenage self-harm in Europe⁴⁸. This may herald an increase in mental ill-health in the adult population in the years to come.

As mental health problems disproportionately affect younger people, their impact on educational achievement and work is considerable. In England, a person dies every two hours as a result of a suicide attempt^{49, 50}. These are potentially preventable deaths and contact in primary care is often an opportunity to intervene. For the first time in 2011, mental health issues became the most common causes of long-term absenteeism from

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- 39 Alzheimer's Research/University of Oxford. *Dementia 2010*. Accessed via: <http://www.dementia2010.org/reports/Dementia2010Full.pdf>.
- 40 House of Commons all Party Parliamentary Group on Dementia. *The £20 billion question: an inquiry into improving lives through cost effective dementia services* (2011). Accessed via: <http://www.insidehousing.co.uk/Journals/1/Files/2011/7/12/Dementia.pdf>.
- 41 Alzheimer's Research/University of Oxford. *Dementia 2010*. Accessed via: <http://www.dementia2010.org/reports/Dementia2010Full.pdf>.
- 42 Rees S. *Mental Ill Health in the Adult Single Homeless Population: A review of the literature*. London: Crisis and Public Health Resource Unit, 2009.
- 43 HM Government. *No Health Without Mental Health* (2011). Accessed via: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf.
- 44 Centre for Mental Health. The economic and social health costs of mental health problems in 2009/10. Accessed via: www.centreformentalhealth.org.uk/pdfs/Economic_and_social_costs_2010.pdf.
- 45 HM Government. *No Health Without Mental Health* (2011). Accessed via: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf.
- 46 Kim-Cohen J, Caspi A, Moffitt T et al. Prior juvenile diagnoses in adults with mental disorder. *Archives of General Psychiatry* (2003); 60: 709-717.
- 47 Kessler R, Berglund P, Demler O et al. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry* (2005); 62:593-602.
- 48 Cole-King A, Green G, Wadman S, Peake-Jones G, Gask L. Therapeutic assessment of patients following self-harm. *InnovAiT* (2011) 4(5): 278-287.
- 49 National Mental Health Development Unit. *Suicide Prevention Activity* (2011). Accessed via: <http://www.suicideprevention.org.uk/>.
- 50 Department of Health. *National Suicide Prevention Strategy* (2002). Accessed via: <http://www.nmhd.org.uk/silo/files/national-suicide-prevention-strategy-for-england.pdf>.

work⁵¹. Furthermore, parents' mental ill-health can impact on the health and well-being of their children, thus creating a cycle of inequality across generations¹². Good mental healthcare has the potential to substantially reduce work absenteeism and improve educational potential.

Depression is the most common mental illness in the elderly, with depression affecting an estimated 15% of the elderly community-dwelling population⁵². In this age group, depression is associated with increased morbidity and mortality, poor quality of life and increased social dependence. The National Service Framework for Older People highlights detection and management of depression in the over 65s as a priority.

The prevalence of psychological problems manifesting as physical symptoms is high and results in considerable morbidity for patients and cost for the NHS and wider economy. This is addressed in Supporting Evidence document 2, Outcome 2.3.

Dementia affects 820,000 people in the UK, and it is becoming an increasingly common problem as our population ages. It currently costs the UK economy £23 billion p.a, more than cancer (£12 billion p.a.) and heart disease (£8 billion p.a.) combined⁵³. Costs of dementia are likely to rise as the prevalence of dementia increases and it is important that GPs have strategies for effective care and develop and commission new care pathways to optimise care delivery.

'The UK's dementia crisis is worse than we feared ... dementia is the greatest medical challenge of the 21st century.'

Rebecca Wood, Chief Executive, Alzheimer's Research Trust²⁰

CHALLENGE 1: PROMOTION OF MENTAL WELL-BEING AND IMPROVED RESILIENCE

No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages⁵⁴ was published in 2011 as part of the Government's Mental Health Strategy. This document sets out six objectives. The first, 'More people will have good mental health', is about promotion of mental well-being and aims to reduce the number of people with mental health problems by 'starting well, developing well, working well, living well and ageing well'.

In its 2004 report on this topic, the WHO makes the case that goals and traditions of public health and health promotion can be applied just as usefully in the field of mental health as in heart health, infectious disease control and smoking cessation⁵⁵. This is not the job of the GP alone, but is an inter-agency goal spanning health and social care, employment, housing and economic policy.

Promoting well-being is something that applies to any age group:

- A good start in life and positive parenting promote good mental health, well-being and resilience to adversity throughout life
- Poorer mental health is associated particularly in adolescents with health risk behaviours such as high alcohol intake, smoking and illicit drug use; strengthening

51 CIPD. Absence management 2011. Accessed via: [http://www.cipd.co.uk/binaries/5632%20Annual%20AbMan%20SR%20\(WEB\).pdf](http://www.cipd.co.uk/binaries/5632%20Annual%20AbMan%20SR%20(WEB).pdf)

52 Alexopoulos G. Depression in the elderly. *Lancet* (2005); 365: 1961-1970.

53 Alzheimer's Research/University of Oxford. *Dementia 2010*. Accessed via: <http://www.dementia2010.org/reports/Dementia2010Full.pdf>.

54 HM Government. *No Health Without Mental Health* (2011). Accessed via: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf.

55 WHO. *Promoting Mental Health* (2004). Accessed via: http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf.

young people's ability to take control of their lives and taking measures to increase self-esteem and resilience is protective

- In adulthood, employment is good for mental health; unemployment or even threat of job loss is associated with poorer mental health
- For the elderly, reduction in social isolation is associated with improved well-being
- For all age groups, access to green spaces is associated with better mental health.

Mental health promotion is also cost effective. In one study looking at mental health promotion for children in Wales, intervention with a pre-school parenting programme cost between £1350–£6000 per child but saved £75,000 per child over the child's lifetime⁵⁶. Another study looked at debt and found that provision of debt counselling produced sizeable health and social care savings that outweighed the cost of the counselling over a two-year period⁵⁷.

CHALLENGE 2: EARLIER RECOGNITION OF PSYCHOTIC ILLNESS

The benefits of early identification of mental health problems and prompt intervention are highlighted within the second objective within *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages*⁵⁸.

In England alone every year, 6,900 young people aged between 15–35 years experience a first episode of psychosis. Psychosis carries a 10% lifetime risk of suicide, usually within the first 5 years of diagnosis and most commonly at the time of first relapse⁵⁹. Up to 88% of people diagnosed with a psychotic illness cannot find permanent employment and become socially excluded⁶⁰.

There is overwhelming evidence of benefit from early intervention in people presenting with psychosis up to the age of 35 years. If caught very early in the prodromal phase of the illness, it is possible to delay or even prevent the onset of a disabling psychosis⁶¹. Overall, early intervention services produce clinically significant benefits compared to standard care with relation to relapse rates, rehospitalisation, symptom severity, satisfaction, quality of life and access and engagement with services⁶². Suicide risk is halved⁶³ and over 50% of those who are referred to early intervention programmes at first diagnosis will secure a

56 Friedli L, Parsonage M. *Promoting Mental Health and Preventing Mental Illness: The economic case for investment in Wales*. Accessed via: http://www.centreformentalhealth.org.uk/pdfs/Promoting_mental_health_Wales.pdf.

57 Knapp M, McDaid D, Parsonage M. *Mental Health Promotion and Mental Illness Prevention: The economic case* (2011). LSE/PSSRU. Accessed via: <http://www.iris-initiative.org.uk/silo/files/mental-health-promotion-and-prevention-the-economic-case.pdf>.

58 HM Government. *No Health Without Mental Health* (2011). Accessed via: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf.

59 Wiersma D, Nienhuis FJ, Sloof CJ, Giel R. Natural course of schizophrenic disorders: a 15 year follow up of a Danish incidence cohort. *Schizophrenia Bulletin* (1998); 24(1):75-85. Accessed via: <http://schizophreniabulletin.oxfordjournals.org/content/24/1/75.full.pdf>.

60 Perkins R, Rinaldi M. Unemployment rates among patients with long-term mental health problems: a decade of rising unemployment. *Psychological Bulletin* (2002); 26:295-298.

61 Morrison AP, French P, Walford L et al. Cognitive therapy for the prevention of psychosis in people at ultra-high risk: a randomised controlled trial. *British Journal of Psychiatry* (2004); 185:291-7.

62 NICE. *Schizophrenia* (update) (2009). Accessed via: <http://www.nice.org.uk/nicemedia/live/11786/43607/43607.pdf>.

63 Power P. Suicide prevention in first episode psychosis. In: *Psychological Interventions in Early Psychosis*. Editors: McGorry P, Gleeson J. Wiley, 2004.

job⁶⁴. Furthermore, early intervention reduces health service costs by around a third, largely because of reduction in in-patient admissions⁶⁵.

However, for early intervention to be effective, young people with new-onset psychosis must be identified and referred promptly to specialist early intervention services. The first appearance of symptoms can be bewildering to an individual and GPs are often the first point of contact with a health professional. Early symptoms may be non-specific and difficult to define or uncover. They may include⁶⁶:

- poor sleep
- panic
- mood changes
- social withdrawal and isolation
- loss of job
- broken relationships; and
- early psychotic thinking such as suspicion, mistrust or perceptual changes.

GPs require additional enhanced training in the detection of early psychosis in order for timely detection and referral to specialist early intervention services to be improved.

CHALLENGE 3: IMPROVED DETECTION AND MANAGEMENT OF COMMON MENTAL DISORDERS

Reducing the prevalence of common mental disorders (CMDs) such as depression and anxiety is a major public health challenge. CMDs can result in physical impairment and problems with social functioning and are a significant source of distress to individuals and those around them. If left untreated, CMDs are more likely to lead to long-term disability and premature mortality; depression increases the risk of mortality by 50%⁶⁷ and doubles the risk of coronary heart disease in adults⁶⁸. If identified, these patients with CMD can often be successfully treated, reducing the risk of long term disability and premature mortality.

One in five women and one in eight men have a CMD at any time⁶⁹. Although usually less disabling than major psychiatric disorders such as psychosis, the greater prevalence of CMD means that the cumulative cost to society is great⁷⁰. For the first time in 2011, mental health issues became the most common causes of long-term absenteeism from work⁷¹ and it is estimated that anxiety and depression account for one in five work absences⁷².

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- 64 Killackey E, Jackson HJ, McGorry PD. Vocational intervention in first episode psychosis: a randomised controlled trial of individual placement and support versus treatment as usual. *British Journal of Psychiatry* (2008); 193:114-120.
- 65 Knapp M, McDaid D, Parsonage M. *Mental Health Promotion and Mental Illness Prevention: The economic case* (2011). LSE/PSSRU. Accessed via: <http://www.iris-initiative.org.uk/silo/files/mental-health-promotion-and-prevention-the-economic-case.pdf>.
- 66 Iris initiative. *GP Guidance and Psychosis: what you need to know* (2010). Accessed via: <http://www.iris-initiative.org.uk/silo/files/pc-guidance-about-early-detection-of-psychosis.pdf>.
- 67 Mykletun A, Bjerkeset O, Overland S et al. Levels of anxiety and depression as predictors of mortality: the HUNT study. *British Journal of Psychiatry* (2009);195:118-125.
- 68 Hemingway H and Marmot M. Evidence based cardiology. Psychosocial factors in the aetiology and prognosis of coronary heart disease: systematic review of prospective cohort studies. *British Medical Journal* (1999); 318:1460-1467.
- 69 McManus S, Meltzer H, Brugha T et al. *Adult Psychiatric Morbidity in England, 2007: Results of a household survey*. Leeds: NHS Information Centre for Health and Social Care, 2009. Accessed via: [http://www.ic.nhs.uk/webfiles/publications/mental%20health/other%20mental%20health%20publications/Adult%20psychiatric%20morbidity%2007/APMS%2007%20\(FINAL\)%20Standard.pdf](http://www.ic.nhs.uk/webfiles/publications/mental%20health/other%20mental%20health%20publications/Adult%20psychiatric%20morbidity%2007/APMS%2007%20(FINAL)%20Standard.pdf).
- 70 NICE. *Depression in Adults* (update) (2010). Accessed via: <http://www.nice.org.uk/nicemedia/live/12329/45896/45896.pdf>.
- 71 CIPD. *Absence Management 2011*. Accessed via: [http://www.cipd.co.uk/binaries/5632%20Annual%20AbMan%20SR%20\(WEB\).pdf](http://www.cipd.co.uk/binaries/5632%20Annual%20AbMan%20SR%20(WEB).pdf).
- 72 Das-Munshi J, Goldberg D, Bebbington PE, Bhugra DK, Brugha TS, Dewey ME et al. Public health significance of mixed anxiety and depression: beyond current classification. *British Journal of Psychiatry* (2008); 192(3):171-177.

The second objective of *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages*⁷³ highlights the benefits of early identification of common mental disorders and prompt intervention. It also states that people with common mental health disorders should be offered appropriate information and a choice of high-quality interventions based on evidence or good practice, including psychological therapies.

Most patients with common mental health disorders are managed entirely within the primary care environment. Screening for common mental health disorders in primary care for those with chronic disease has been highlighted by targets within the Quality and Outcomes Framework (QOF) Clinical Indicator Depression 1⁷⁴. Standard 7 of the National Service Framework for Older People sets a target to promote good mental health in the elderly and to treat and support older people with depression⁷⁵, and NICE has produced guidance for GPs about identification of common mental disorders in the primary care setting⁷⁶ and management of anxiety⁷⁷ and depression³⁹ in general practice.

However, both anxiety and depression often remain undiagnosed and thus not treated. This is particularly true for older people and those in residential care⁴⁴. There are a number of reasons for under-diagnosis, including failure to present to healthcare professionals because of the stigma attached to mental illness or fear of treatment; presentation with somatic symptoms; and communication or cultural difficulties⁴⁵.

At present, more than 50% of depressed people who see their GP will not have a diagnosis of depression made⁴⁵. GPs are very variable in their ability to diagnose CMDs with some recognising virtually all, and others recognising very few. Communication skills are key to accurate diagnosis. Enhanced GP training will ensure that GPs have the consultation skills to detect CMDs in the community, the knowledge to target those at high risk of CMDs with screening questionnaires, and the professional experience to treat such patients successfully within the primary care and community setting, thus improving both short and longer term outcomes.

CHALLENGE 4: IMPROVED PHYSICAL HEALTH CARE FOR PEOPLE WITH MENTAL ILLNESS

The third objective within *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages*⁷⁸ is that fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health.

Those with severe mental illness also have physical health problems. People with psychotic illness die on average 16–25 years sooner than the general population⁴⁷. They are less likely to benefit from screening and public health programmes and have higher rates of

73 HM Government. *No Health Without Mental Health* (2011). Accessed via: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf.

74 NHS Employers/BMA. Quality and outcomes framework guidance for GMS contract 2011/12. Accessed via: http://www.nhsemployers.org/SiteCollectionDocuments/QOFguidanceGMScontract_2011_12_FL%2013042011.pdf.

75 Department of Health. *National Service Framework for Older People* (2002). Accessed via: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4071283.pdf.

76 NICE. *Common Mental Disorders: Identification and pathways to care* (2011). Accessed via: <http://guidance.nice.org.uk/CG123/Guidance/pdf/English>.

77 NICE. *Generalised Anxiety Disorder and Panic Disorder* (2011). Accessed via: <http://www.nice.org.uk/nicemedia/live/13314/52667/52667.pdf>.

78 HM Government. *No Health Without Mental Health* (2011). Accessed via: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf.

respiratory, cardiovascular and infectious disease and diabetes⁷⁹. Obesity is also more prevalent and adults with mental health problems, including those who misuse alcohol or drugs, smoke 42% of all the tobacco used in England⁸⁰. Increased smoking is responsible for most of the excess mortality.

The presence of a physical illness can complicate the assessment of depression and some symptoms, such as fatigue, are common to both mental and physical disorders⁸¹. Severe depression affects a much higher proportion of those with chronic physical illnesses⁸² and learning disability⁸³. Depression is reported to affect:

- 30% of people with epilepsy
- 30–50% of adults with learning disability
- 40% of people after a stroke
- 50% of people following myocardial infarction or coronary arterial disease
- 50% with type two diabetes mellitus
- 50% of people with cancer; and
- up to 80% of those diagnosed with rheumatoid arthritis.

Depression in those with chronic medical illnesses is increasingly recognised to adversely affect the prognosis of the medical illness. Associations include:

- 50% increase in risk of mortality⁸⁴
- doubling of the risk of coronary heart disease⁸⁵
- poorer glycaemic control in diabetics and more end-organ complications
- higher obesity rates; and
- increased disability caused by chronic back pain.

People with depression are also more likely to smoke and live sedentary lifestyles, and are less likely to adhere to medication regimes, including oral hypoglycaemics, antihypertensives and lipid-lowering medications.

79 de Hert M, Dekker JM, Wood d et al. *Cardiovascular Disease and Diabetes in People with Severe Mental Illness*. Position statement from the European Psychiatric Association (2009). Accessed via: <http://www.easd.org/easdwebfiles/statements/EPA.pdf>.

80 McManus S, Meltzer H, Campion J. *Cigarette Smoking and Mental Health in England*. Data from the Adult Psychiatric Morbidity Survey (2010). National Centre for Social Research. Accessed via: www.natcen.ac.uk/media/601275/smoking_and_mental_health_-_final_report_revised%20and%20final.pdf.

81 NICE. *Depression in Adults with a Chronic Physical Health Problem: Treatment and management* (2009). Accessed via: <http://www.nice.org.uk/nicemedia/live/12327/45909/45909.pdf>.

82 Clarke DM, Currie KC. Depression, anxiety and their relationship with chronic diseases: a review of the epidemiology, risk and treatment evidence. *Medical Journal of Australia* (2009);190(7): S54-S60. Accessed via: www.mja.com.au/public/issues/190_07_060409/cla10974_fm.pdf.

83 Smiley E. Epidemiology of mental health problems in adults with learning disability: an update. *Advances in Psychiatric Treatment* (2005);11: 214-222.

84 Mykletun A, Bjerkeset O, Overland S et al. Levels of anxiety and depression as predictors of mortality: the HUNT study. *British Journal of Psychiatry* (2009);195:118-125.

85 Hemingway H and Marmot M. Evidence based cardiology. Psychosocial factors in the aetiology and prognosis of coronary heart disease: systematic review of prospective cohort studies. *British Medical Journal* (1999); 318: 1460-1467.

In addition, depression affects how patients perceive their symptoms and their medical illness. Those with depression are more likely to suffer and report pain associated with chronic physical illnesses⁸⁶. Reporting of symptoms associated with poor glycaemic control in those with diabetes and co-morbid depression is more closely related to the severity of their depression than to their glycosylated haemoglobin levels⁸⁷, and in those with treatment-resistant epilepsy it is presence of depression not frequency of seizures that predicts quality of life⁸⁸. Morbidity and mortality are increased as are healthcare costs in those with chronic physical illnesses complicated by depression, therefore it is vitally important to manage depression as quickly and effectively as possible.

However, GPs receive very little formal training about the interactions between physical and mental health. Enhanced GP training will develop the GP's ability to manage multiple co-morbidities in the same individual, including combinations of physical and mental health problems, thus improving quality of care, managing medication and using resources better and optimising health outcomes.

CHALLENGE 5: MITIGATION OF SELF-HARM AND SUICIDE

Suicidal thoughts, non-fatal suicide attempts and self-harm are associated with high levels of distress both for those engaging in them and for those around them. Risk of suicide is increased further for those who repeatedly self-harm and the continued use of weak analgesics to self-poison is a particularly strong indicator of future suicide⁸⁹. Around 17% of people have thought about committing suicide at some point in life; 6% have attempted suicide and 5% have self-harmed⁹⁰. Every year in England, 4,400 people die as a result of suicide⁹¹.

The 2011 *Consultation on Prevention of Suicide in England*⁹² aims to update and build on the *National Suicide Prevention Strategy for England* published in 2002⁹³. It examines factors that put individuals at high risk of suicide in order to implement preventive strategies and identifies six areas for action (Box 1.2.1). Similar initiatives are in place in Wales⁹⁴, Scotland⁹⁵ and Northern Ireland⁹⁶.

86 Bair MJ, Robinson RL, Katon W, Kroenke K. Depression and pain comorbidity. *Archives of Internal Medicine* (2003); 163: 2433-2445. Accessed via: <http://archinte.ama-assn.org/cgi/reprint/163/20/2433>.

87 Lin EHB, Katon W, Von Korff et al. Relationship of depression and diabetes self-care, medication adherence and preventative care. *Diabetes Care* (2004); 27(9): 2154-2160. Accessed via: <http://care.diabetesjournals.org/content/27/9/2154.full.pdf+html>.

88 Boylan LS, Flint LA, Labovitz DL, Jackson SC, Starner K, Devinsky O. Depression but not seizure frequency predicts quality of life in treatment-resistant epilepsy. *Neurology* (2004); 63(5): 942-943.

89 Qina P, Jepsena P, Nørgårda B, Agerbo E, Mortensena PB, Vilstrup H, Sørensen HT. Hospital admission for non-fatal poisoning with weak analgesics and risk for subsequent suicide: a population study. *Psychological Medicine* (2009); 39(11): 1867-73.

90 McManus S, Meltzer H, Brugha T et al. *Adult Psychiatric Morbidity in England, 2007: Results of a household survey*. Leeds: NHS Information Centre for Health and Social care, 2009. Accessed via: [http://www.ic.nhs.uk/webfiles/publications/mental%20health/other%20mental%20health%20publications/Adult%20psychiatric%20morbidity%2007/APMS%2007%20\(FINAL\)%20Standard.pdf](http://www.ic.nhs.uk/webfiles/publications/mental%20health/other%20mental%20health%20publications/Adult%20psychiatric%20morbidity%2007/APMS%2007%20(FINAL)%20Standard.pdf).

91 HM Government. *Consultation on Preventing Suicide in England* (2011). Accessed via: http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128463.pdf.

92 *Ibid*.

93 Department of Health. *National Suicide Prevention Strategy for England* (2002) Accessed via: http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4019548.pdf.

94 Welsh Assembly. *A National Action Plan to Reduce Suicide and Self-harm in Wales 2008-2013*. Accessed via: http://wales.gov.uk/consultation/dhss/talktome/actionplane.pdf;jsessionid=q8z2T1DTnPyZGQ1qxZPfy4pvB1w9vmpvlgdrDyDJ0FCW_hcyM4JG!-2045186729?lang=en.

95 The Scottish Government. *Choose life: A National strategy and action plan to prevent suicide in Scotland* (2006). Accessed via: <http://www.scotland.gov.uk/Resource/Doc/46932/0013932.pdf>.

96 Northern Ireland Department of Health, Social Services and Public Safety. *Protect Life: A shared vision* (2006). Accessed via: http://www.dhsspsni.gov.uk/phnisuicidepreventionstrategy_action_plan-3.pdf.

Box 1.2.1: Six key areas for action to prevent suicide

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by a suicide
5. Support the media in delivering sensible and sensitive approaches to suicide and suicidal behaviour
6. Support research.

GPs are vitally important to the success of any suicide prevention strategy: while only 25% of those who die by suicide are known to specialist mental health services, the majority of the remaining 75% are in contact with front-line services, including primary care. Around one in four of those aged under 35 who go on to die from suicide have been in contact with their GP in the previous month. This figure rises to 60% in those aged over 55⁹⁷. Furthermore, 63% of men and 58% of women who attempt suicide and 42% of men and 53% of women who self-harm, seek help afterwards⁹⁸ – many from GPs in primary care.

Most people (97%) who have had contact with health services in the month before their death are not rated as at high or even moderate risk by a GP⁹⁹. Enhanced training will provide skills training to enable more accurate suicide risk assessment by GPs and promote closer liaison between primary and secondary care services to implement the 12-points to a safer service identified by the National Suicide Prevention Unit¹⁰⁰ and meet National Suicide Prevention targets.

CHALLENGE 6: IMPROVED DETECTION AND MANAGEMENT OF DEMENTIA

There are currently 821,884 people suffering from dementia in the UK, representing 1.3% of the UK population. It is estimated that dementia costs the nation at least £23 billion every year in health and social care costs, loss of productivity and informal care costs¹⁰¹. As dementia predominantly affects older people, prevalence and thus also cost is increasing as our population ages.

'Providing people with dementia and their carers the best life possible is a growing challenge, and is one that is becoming increasingly costly for the NHS. Research shows that early intervention in cases of dementia is cost-effective and can improve quality of life for people with dementia and their families.'

Department of Health, 2007¹⁰²

97 Luoma JB, Martin CE & Pearson J L. Contact with mental health and primary care providers before suicide: a review of the evidence. *American Journal of Psychiatry* (2002):159: 909-916.

98 McManus S, Meltzer H, Brugha T et al. *Adult Psychiatric Morbidity in England, 2007: Results of a household survey*. Leeds: NHS Information Centre for Health and Social Care, 2009. Accessed via: [http://www.ic.nhs.uk/webfiles/publications/mental%20health/other%20mental%20health%20publications/Adult%20psychiatric%20morbidity%2007/APMS%2007%20\(FINAL\)%20Standard.pdf](http://www.ic.nhs.uk/webfiles/publications/mental%20health/other%20mental%20health%20publications/Adult%20psychiatric%20morbidity%2007/APMS%2007%20(FINAL)%20Standard.pdf).

99 Pearson A, Saini P, Da Cruz d, Miles C, While D, Swinson N et al. Primary care contact prior to suicide in individuals with mental illness. *British Journal of General Practice* (2009); 59(568):825-32.

100 National Suicide Prevention Unit. *Twelve Points to a Safer Service* (2011). Accessed via: <http://www.medicine.manchester.ac.uk/mentalhealth/research/suicide/prevention/nci/about/keyfindings/saferservice>.

101 Alzheimer's Research Trust/University of Oxford. *Dementia 2010*. Accessed via: <http://www.dementia2010.org/reports/Dementia2010Full.pdf>.

102 Department of Health. *The NHS in England: The operating framework for 2008/09* (2007). Accessed via: http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081271.pdf.

The GP and primary care team have a central role to play at all stages of disease – from diagnosis to palliative care. Early identification of dementia is important to enable people suffering from dementia to make choices whilst they retain the capacity to do so and also to allow treatment to preserve cognitive function. Diagnosis early in the course of dementia with appropriate support is cost effective as it improves quality of life and reduces residential care placements¹⁰³. Objective 2 of *Living Well with Dementia: A National Dementia Strategy*¹⁰⁴ aims for all people with dementia to have access to a pathway of care that delivers:

- a rapid and competent specialist assessment
- an accurate diagnosis sensitively communicated to people with dementia and their carers; and
- treatment, care and support provided as needed following diagnosis.

Although the diagnosis of dementia should be made by a specialist service, the GP primary care team has a crucial role in identifying people with early symptoms or signs of cognitive impairment suggestive of dementia, excluding other possible causes of symptoms and referring on promptly for specialist assessment¹⁰⁵. However, diagnosis is often currently made late when a crisis arises, thus resulting in preventable distress for the individuals involved and greater costs to health and social care services. The 2011 House of Commons Report *The £20 Billion Question: An inquiry into improving lives through cost effective dementia services*¹⁰⁶ makes a case for lengthening GP training to allow time for improved coverage of dementia within the GP curriculum and enable GPs to recognise dementia earlier.

For people with an established diagnosis of dementia, GPs provide ongoing care in the community. Depending on the stage of the illness, this may involve:

- Ongoing prescription of disease-modifying drugs
- Management of non-cognitive symptoms of dementia
- Management of other co-morbid conditions
- Liaison with other health and social services
- Advocacy
- Assessment of mental capacity
- Palliative care; and
- Carer support.

Non-cognitive symptoms (also known as behavioural and psychological symptoms) of dementia are particularly distressing for carers. They are the most common reason for breakdown of the home care giving situation. In the past non-cognitive symptoms were widely managed using sedating neuroleptic medications. In 2009, the Department of Health published a report into the use of neuroleptic medication for non-cognitive symptoms in patients with dementia¹⁰⁷. It found that:

- at that time atypical antipsychotics were the most common pharmacological treatment of non-cognitive symptoms in the UK, despite NICE guidance to

103 Department of Health. *Living Well with Dementia: A National Dementia Strategy* (2009). Accessed via: http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_094051.pdf.

104 *Ibid.*

105 NICE. *Dementia: Supporting People with Dementia in Health and Social Care* (2011 update). Accessed via: <http://guidance.nice.org.uk/nicemedia/live/10998/30320/30320.pdf>.

106 House of Commons all Party Parliamentary Group on Dementia. *The £20 Billion Question: An inquiry into improving lives through cost effective dementia services* (2011). Accessed via: <http://www.insidehousing.co.uk/Journals/1/Files/2011/7/12/Dementia.pdf>.

107 Bannerjee S. *Report on the Prescribing of Anti-psychotic Drugs to People with Dementia*. Department of Health (2009). Accessed via: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108303.

- prescribe only if essential¹⁰⁸ and even though the only drug with a relevant licence was risperidone (which is only licensed for short-term use)
- a large number of people with dementia were being treated with anti-psychotic medication, when only a proportion of them 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 that 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 disappointing¹⁰⁹. This may be partly because GPs are not trained in appropriate alternative strategies for management.

Enhanced GP training will equip GPs with the necessary skills to diagnose dementia at an early stage. It will also provide GPs with strategies (both non-pharmacological and pharmacological) with which to manage non-cognitive symptoms of dementia. This will include recognition of side effects of medication (see Outcome 1.5, Challenge 4). Improved knowledge and understanding of dementia will enable better liaison between primary and secondary care to manage people with dementia, and care pathways to be developed and commissioned to keep costs to a minimum whilst maximising quality of life and dignity for both those with dementia and their carers.

CHALLENGE 7: MORE INTEGRATED SUPPORT FOR PEOPLE WITH MENTAL HEALTH ISSUES AND THEIR CARERS

Evidence for the physical, emotional, social and financial consequences of being a carer and the support required are summarised in Supporting Evidence document 1, Outcome 1.5. Evidence for the benefits of integrated care are summarised in Supporting Evidence document 2, Outcome 2.3.

Personalised support for carers and those receiving care is essential to maintain people with mental health problems in the community. The introduction of clinically-led commissioning in England provides an opportunity for integrating health and social care, but to do this GPs will need to develop through enhanced training a greater understanding of the role and expertise of other professionals and the skills to work effectively with them in shared team leadership roles.

108 NICE. *Dementia: Supporting people with Dementia in Health and Social Care* (2011 update). Accessed via: <http://guidance.nice.org.uk/nicemedia/live/10998/30320/30320.pdf>.

109 Burstow P. Speech at the National Dementia Congress 2nd November 2011. Press release. Accessed via: http://alzheimers.org.uk/site/scripts/press_article.php?pressReleaseID=725.

1.3: WHY IMPROVED CARE FOR PEOPLE WHO MISUSE ALCOHOL OR DRUGS IS A TRAINING PRIORITY

There are clear advantages for managing the majority of people with alcohol and drug problems in primary care:

- 78% of the population visit their GP at least once a year, thus providing huge potential for opportunistic intervention at ‘teachable moments’
- The stigma associated with attending a specialist service can be avoided
- Intervention occurs in the context of ongoing relationship with the patient and family; advice from GPs, practice nurses and other practice team members is likely to be respected
- Many users have long-term conditions which are now managed in a systematic way in primary care
- Shared-care management is more cost-effective than care provided in acute/ specialist settings and GPs can co-ordinate and encourage collaboration between sectors
- The role of the GP and the practice team is important in delivering brief interventions, leading on quality innovation and prevention activities (such as acute hospital liaison) and, with support of specialist services, supporting people to detoxify and maintain abstinence and recovery.

For individual patients it is now clear that brief interventions for alcohol misuse are effective in primary care as well as more specialist detoxification and rehabilitation. Each community should have access to a comprehensive range of evidence-based interventions to address the community needs. As primary care interventions can take a more ‘whole person approach’, enhanced GP competence in this area will make a significant difference in helping the people who are least likely to be able to access help due to their circumstances.

For opioid dependence, there is a lot of evidence that opioid substitution therapy significantly reduces morbidity and mortality and is often a vital step towards abstinence.

These statements are backed by numerous NICE guidelines for best practice in this area^{110, 106, 107, 108}.

110 NICE Clinical Guideline 100. *Alcohol-use Disorders: Diagnosis and clinical management of alcohol-related physical complications*. June 2010.

Patients report preferring being treated in primary care as it means they do not have to congregate with large numbers of other people with similar problems, it helps to normalise their life, access is usually more local and costs less for travel/time out of work. Established data on the benefit to cost ratio of treatment shows that GPs could deliver a greater proportion of the care that people with alcohol/drug problems need, at a lower cost and in a way that is more accessible to patients.

GPs of the future need to be able to support individuals to reintegrate back into society by linking with local treatment services and by establishing mechanisms of joint working with the wide range of services that can support someone to get a job or housing. More opportunities for effective treatment in GP settings will ensure greater emphasis on prevention, more opportunities to make the connection between drug taking and blood-borne viruses, nicotine and other adverse lifestyle factors such as poor diet and poor sexual health.

In general, new GPs have little experience or training in treating people with drug and/or alcohol problems unless their trainers have had a particular interest in the field. New GPs can feel out of their depth in dealing with these issues and then either fail to identify or respond to the problem or find themselves inappropriately drawn in and overwhelmed.

The recently published NICE guidance suite will form the basis of the learning in an enhanced curriculum alongside opportunities to rotate into community and primary care alcohol treatment and recovery services.

Whilst the evidence base for screening and brief intervention (SBI) is strong¹¹¹, enhanced GP training is needed to address major deficiencies in primary care in being able to confidently and consistently offer targeted SBI and also feel confident to offer additional capacity in respect of community alcohol detoxification and recovery.

GPs also need to understand the core principles of harm reduction as well as recovery oriented drug treatment. Substitute prescribing continues to have a role to play in the treatment of heroin dependence, both in stabilising drug use and supporting detoxification.

The rationale for providing SBI in primary care is to support **early intervention** and **secondary prevention**; that is, preventing medical and social harms but also more severe dependence. It has the potential to make a significant contribution to the public health agenda by broadening the base of interventions against alcohol-related harm, as well as reducing the use of healthcare resources and promoting cost-effectiveness.

¹¹¹ NICE Clinical Guideline 115. *Alcohol-use Disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence*. February 2011.

CHALLENGE 1: IDENTIFYING HARMFUL ALCOHOL AND DRUG USE IN ADULTS AND YOUNG PEOPLE

Alcohol is consumed by 87% of the population in England. However, over 10 million adults (23% of all adults and 32% of men) are drinking alcohol in a way that is potentially or actually harmful to their health or well being¹¹². Every GP sees around 364 heavy drinkers every year and many more who are at risk of harmful drinking¹¹³. Over one million adults are alcohol dependent, equating to 3.6% of the population, but only 6% of alcohol dependent adults receive treatment each year. Deaths from alcoholic liver disease have shown a sharp increase in recent years with a rise of 41% between 1999 and 2005¹¹⁴. Alcohol dependence and harmful alcohol use are recognised as mental health disorders by the World Health Organization (WHO, 1992) and are a major cause of disease and injury, with only tobacco use and high blood pressure being higher risk factors for disease. In 2009 there were 8,664 deaths as a direct result of alcohol¹¹⁵.

In 2009–10 there were over one million alcohol-related admissions each year in England. Alarming, this is more than twice as many as in 2002–3¹¹⁶. Alcohol-related harm to health costs the NHS in England £2.7 billion per year in hospital admissions, A&E attendances and primary care appointments at 2007 prices¹¹⁷. There are approximately 320,000 heroin and/or crack cocaine users in England, of which around 170,000 are in treatment in any one year. Offenders who use heroin, cocaine or crack cocaine are estimated to commit between a third and a half of all acquisitive crime¹¹⁸.

Whilst drug dependence can affect anyone, we know that those in our society with a background of childhood abuse, neglect, trauma or poverty are disproportionately likely to be affected. As family doctors, GPs need to be aware of these factors, recognise those who are at high risk and respond appropriately.

Enhanced training in the identification of harmful alcohol and drug use in primary care will result in greater prevention, early identification and harm minimisation, with enormous benefits to the health and wellbeing of the UK population and additional benefits for the economy¹¹⁹.

The UK has amongst the highest rates of young people's cannabis use and binge drinking in Europe. There are some 13,000 hospital admissions linked to young people's drinking each year¹²⁰. Early drug and alcohol use is related to a host of educational, health or social problems. General practices must provide health services at a time that young people can access them discretely and easily. Primary care services must be designed to enable young people to talk about issues regarding drugs and alcohol and to provide appropriately tailored management and support for those with alcohol and drug-related problems.

112 Fuller E, Jotangia D & Farrell M. Alcohol misuse and dependence. In: *Adult Psychiatric Morbidity in England, 2007. Results of a Household Survey* (eds S McManus, H Meltzer, T Brugha, et al.). Leeds: NHS Information Centre for Health and Social Care, 2009.

113 Accessed via: www.erpho.org.uk/Download/Public/14668/1/AlcoholHarmReductionStrategy.pdf.

114 Office for National Statistics. *Alcohol-related Deaths in the United Kingdom, 2000–2009*. 2011. Accessed via www.statistics.gov.uk/pdfdir/alc0111.pdf [date accessed 16.02.2011].

115 *Ibid.*

116 National Statistics Office. *Statistics on Alcohol: England, 2011*. Accessed via: <http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/alcohol/statistics-on-alcohol-england-2011-%5Bns%5D>.

117 Department of Health. *Health Improvement Analytical Team. The cost of alcohol harm to the NHS in England*. An update to the Cabinet Office (2003) study. London: Department of Health, 2008.

118 British Crime Survey 2009–10. Accessed via: <http://www.esds.ac.uk/findingData/snDescription.asp?sn=6627>.

119 Cochrane Reviews. Effectiveness of brief alcohol interventions in primary care populations (2007). Accessed via: www2.cochrane.org/reviews/en/ab004148.html.

120 HM Government. *Drug Strategy 2010: Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug free life*. HM Government, 2010.

One-third of the adult treatment (drug or alcohol) population have parental responsibility for a child. The risks to children are significant when living in an environment of alcohol/drug misuse and helping these families can change the lives of affected children by reducing potential neglect or abuse. The children of those dependent on drugs have to cope with the impact on their own lives and some may end up in state care or with subsequently reduced life chances.

The document *Hidden Harm* highlights all of these issues¹²¹.

CHALLENGE 2: PROVISION OF BRIEF INTERVENTIONS AND EXTENDED BRIEF INTERVENTIONS FOR HARMFUL DRINKERS

Few GPs have been trained to do screening and brief interventions (SBI) for alcohol, although there is plenty of evidence that it is both cost-effective and clinically effective¹²².

Screening should be targeted rather than universal and patients who have a positive screen should be offered simple structured advice. If resources permit, brief counselling would benefit harmful drinkers and more 'interested' patients, while patients with significant alcohol dependence should be referred for more intensive intervention.

The rationale for SBI is to prevent the medical and social harms but also more severe dependence. It has the potential to make a significant contribution to the public health agenda by broadening the base of interventions against alcohol-related harm, as well as reducing the use of healthcare resources and promoting cost-effectiveness.

There are clear advantages for locating brief interventions in primary healthcare, notably:

- 78% of population visit a GP at least once a year
- stigma can be avoided
- intervention is possible at 'teachable moments'
- intervention can be in the context of an ongoing relationship with patient and family; and
- advice from GPs, practice nurses and other PHC staff is likely to be respected.

Whilst the evidence base for SBI is strong, there are serious deficiencies in primary care being able to confidently and consistently offer targeted SBI due to lack of training. Also, GPs need opportunities to gain the skills required to offer additional capacity in respect to community-based alcohol detoxification and recovery schemes. The recently published NICE guidance suite would form the basis of the learning in an enhanced training programme, as well as the competences set out in the RCGP's Management of Alcohol Misuse certification programme for primary care.

121 Home Office. *Hidden Harm* – full report. London: Home Office. 2011.

122 NICE Clinical Guideline 115. *Alcohol-use Disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence*. February 2011.

CHALLENGE 3: MANAGING THE HEALTH IMPACTS OF ALCOHOL AND DRUG MISUSE

Most organs in the body are affected by the toxic effects of alcohol, resulting in more than 60 different alcohol-related diseases.¹²³ The risks of developing these diseases are related to the amount of alcohol consumed over time, with different diseases having different levels of risk. As generalists, GPs need to skills to recognise and investigate these alcohol-related conditions at an early stage.

Heavy chronic alcohol consumption increases the risk of mental health disorders including depression, anxiety, psychosis and alcohol dependence, and also increases the risk of suicide. Both acute and chronic heavy drinking can lead to a wide range of social problems, including domestic violence and marital breakdown, child abuse and neglect, absenteeism and job loss. All of these are challenging problems which a GP must learn to coordinate and manage effectively.

GPs of the future need to be able to support individuals to reintegrate back into society by linking up local treatment services and by establishing mechanisms of joint working with the wide range of services that can support someone to get a job or housing. More opportunities for effective training in these issues will ensure greater emphasis on prevention more opportunities to make the connection between drug taking and blood-borne viruses, nicotine and other poor lifestyle factors such as poor diet and poor sexual health.

Polysubstance abuse is increasingly the norm amongst drug misusers. This commonly involves misusing alcohol as well as different drugs. There is emerging evidence that young people in particular are mixing new legal 'chemical highs' with alcohol and other drugs. Managing polysubstance use requires GPs to gain a good understanding of the risks and management issues that apply with different kinds of substances, their use in combination and to apply a comprehensive care approach to the management of complex alcohol and drug misuse cases.

For older drug users on treatment for other health conditions, GPs must gain a greater understanding of the interactions between prescribed drugs and other substances and alcohol, and ways of reducing the ongoing risks to the patient's health.

CHALLENGE 4: DEVELOPING AND IMPROVING ACCESS TO LOCAL ALCOHOL AND DRUG SERVICES

There is a need for improved services and greater access to local, evidence-based interventions for patients who misuse alcohol and drugs¹²⁴. Effective alcohol and drug treatment enables users to turn round their lives and brings benefits not only to themselves but also to their families and society. Treatment gives individuals the opportunity to overcome their dependency and achieve abstinence, while reducing the health risks to communities.

There is a growing body of evidence that treatment of drug misuse can be very effective in preventing wider damage to the community – such as high volume acquisitive crime.¹²⁵

123 NICE Clinical Guideline 100. *Alcohol-use Disorders: Diagnosis and clinical management of alcohol-related physical complications*. June 2010.

124 NICE Clinical Guideline 115. *Alcohol-use Disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence*. February 2011

125 HM Government. Drug Strategy 2010. *Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug free life*. HM Government. 2010.

Together with initiatives like needle exchange schemes, primary care-based interventions can reduce the harms caused by dependence such as the spread of blood-borne viruses like HIV.

People with drug and/or alcohol problems form a significant number of the primary care population and have high morbidity and mortality rates. Alcohol and/or drug problems cut across the whole spectrum of primary care and are associated with (but often not recognised in) many common physical and mental illnesses.

GPs are in a unique and significant position to help these people effectively in a holistic and evidence-based way.¹²⁶ This involves their role as clinicians but also as leaders within their practices, responsible for ensuring their whole team is working competently and is sufficiently trained.

There is an increased move to decommission traditional psychiatry-led services for treatment in the community – this means that there are more opportunities for primary care to take a major role in these services either in partnership or as providers – for example through enhanced services schemes.

Interventions in primary care have shown to be cost-effective¹²⁷ and are in many ways preferable to secondary care type approaches, and it is well known that these interventions can save the health service a significant amount of money in the overall health and social economy¹²⁸. Clinical commissioners must therefore have the knowledge and skills to base their decisions on evidence and commission a range of integrated services at the local level that can provide tailored packages of care and support.

This means that GPs must learn the complex skills required to gain a detailed understanding of the health data and diverse needs of their local community when evaluating and re-designing services, plus engage with specialists and with a group of patients that, by its nature, can be hard to engage.

Enhanced GP training will enable the delivery of more effective screening and brief interventions in primary care. It will enable GPs to play a lead role in quality innovation and prevention activities (such as acute hospital liaison) and, with support of specialist services, support people to detoxify and maintain abstinence. Through integration of specialist based and primary care based training experience, extending GP training will enable GP trainees to integrate and reinforce core clinical skills, address curriculum gaps and develop the more complex skills required to reduce risk of harm for alcohol and drug users, their families and children.

An additional extension to ST5 would enable GP trainees to develop the more sophisticated leadership and evaluation skills to address the organisational aspects of care in their practices and communities, to evaluate and redesign local alcohol and drug services, and to lead system-wide, integrated improvements in the provision of care for at-risk patients and families.

126 *Roles and Responsibilities of Doctors in the Provision of Treatment for Drug and Alcohol Misusers*. Accessed via: <http://www.rcpsych.ac.uk/files/pdfversion/cr131.pdf>.

127 Cochrane Reviews. Effectiveness of brief alcohol interventions in primary care populations (2007). Accessed via: www2.cochrane.org/reviews/en/ab004148.html.

128 Department of Health. *Mental Health Promotion and Mental Illness Prevention: The economic case* (2011). Accessed via: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_126085.

1.4: WHY IMPROVED ACUTE CARE AND REHABILITATION FOR PEOPLE WITH SERIOUS ILLNESS OR TRAUMA IS A TRAINING PRIORITY

IN THE UK:

- On average each person in the UK has 5.5 appointments every year with their GP¹²⁹; about one in three of those appointments is perceived as urgent by the patient or carer and requires a same day assessment¹³⁰
- Major trauma is a serious public health problem; it is the leading cause of death in all groups under 45 years of age and a significant cause of short- and long-term morbidity¹³¹.
- 41% of adult men and 43% of adult women report a long-term illness and this figure is increasing as our population ages¹³²; among both sexes the proportion of people reporting good health declines with age and 41% of men and 38% women aged 60–74 years report an ongoing disability¹³³.
- The prevalence of sickness absence from work within the UK is 3.4% and the proportion of these that are on long-term sickness absence is estimated at 34%¹³⁴; someone who has been off work sick for 6 months or longer has an 80% chance of being off work for 5 years¹³⁵.

Urgent care refers to the range of responses that the health and care services provide to people who need, or perceive that they need, urgent advice, care treatment or diagnosis. Since publication of the White Paper *Equity and Excellence: Liberating the NHS* was

129 Hippisley-Cox J, Fenty J, Heaps M. Trends in Consultation Rates in General Practice 1995 to 2006: Analysis of the QRESEARCH database (2007). Accessed via: www.ic.nhs.uk/webfiles/publications/gp/QRESEARCH%20Consultation%20Rates%20Report%20FINAL.pdf.

130 Primary Care Foundation. *Urgent care: A practical guide to transforming same day care in general practice* (2009). Accessed via: http://www.primarycarefoundation.co.uk/files/PrimaryCareFoundation/Downloading_Reports/Reports_and_Articles/Urgent_Care_Centres/Urgent_Care_May_09.pdf.

131 National Audit Office. *Major Trauma Care in England* (2010). Accessed via: http://www.nao.org.uk/publications/0910/major_trauma_care.aspx.

132 NHS Information Centre. *Health Survey for England 2009*. Accessed via: http://www.ic.nhs.uk/webfiles/publications/003_Health_Lifestyles/hse09report/HSE_09_Summary.pdf.

133 National Statistics (2010). *Health and Care: Health expectancy*. Accessed via: www.statistics.gov.uk/cci/nugget.asp?id=934

134 NICE. *Economic Analysis: Modelling the cost effectiveness of interventions, strategies, programmes and policies to reduce the number of employees on sickness absence*. London: NICE, 2008.

135 Waddell G, Burton AK. *Is Work Good for Your Health and Well-being?* (2006) Accessed via: <http://www.dwp.gov.uk/docs/hwwb-is-work-good-for-you.pdf>.

published in 2010¹³⁶, urgent care services have started to change in order to develop a coherent 24-hour urgent care service.

Although local arrangements differ, GPs play a key role in delivering urgent care in the community as the majority of patients with urgent care needs would prefer to consult their GP than any other service¹³⁷. Urgent 'same day' appointments currently account for approximately one in three GP consultations¹³⁸ so it is essential that all GPs have the skills and knowledge to manage patients with a perceived urgent care need. Effective GPs can manage patients with urgent care needs so that 'dangerous diagnoses' are not missed and A&E and acute hospital services are used efficiently.

To meet calls for increasing sophistication of pre-hospital emergency care, a new sub-specialty has been developed. For GPs, particularly those working in urgent care settings or with populations that are geographically remote from acute specialist services, expertise in this sub-specialty would clearly be beneficial. However, currently GP training does not allow them to meet the basic entry requirement for training. Changes in GP training should remedy this situation.

Major life-threatening or life-changing trauma is a significant cause of death and disability in the UK, particularly in the under-45 age group where it is the leading cause of death¹³⁹. Management of major trauma is a field that only a few specialised GPs such as British Association for Intermediate Care (BASICS) GPs become involved with. However, the GP does have an important role in the management of this group of patients when they return to the community. Effective GPs provide support for patients and their families/carers and ongoing rehabilitation once the patient returns home to ensure that the individual makes as full a recovery as possible.

The principles of rehabilitation in the community are also relevant to people with other long-term conditions residing in the community and/or those recovering from serious acute illness such as stroke or myocardial infarction. Effective GPs play a crucial role as part of the multidisciplinary team in co-ordinating care to improve clinical outcomes and quality of life, reduce hospital admissions and enable early return to work (where relevant).

Although urgent care services are currently undergoing change to provide a more coherent 24-hour service, there is still considerable room for improvement^{140, 141}. Rehabilitation in the community has been identified as needing considerable improvement in the major trauma care pathway¹⁴². GPs have an increasing role in commissioning services. Better training in urgent care and rehabilitation medicine in the community will improve GPs' ability to commission and implement improved services.

136 HM Government. *Equity and Excellence: Liberating the NHS* (2010). Accessed via: http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf.

137 Maguire S, Ranmal R, Komulainen S, Pearse S. To understand and improve the experience of parents and carers who need advice when a child has a fever (high temperature) (2010). Accessed via: <http://www.rcpch.ac.uk/sites/default/files/Fever%20Project%20Report.pdf>.

138 Primary Care Foundation. *Urgent care: A practical guide to transforming same day care in general practice* (2009). Accessed via: http://www.primarycarefoundation.co.uk/files/PrimaryCareFoundation/Downloading_Reports/Reports_and_Articles/Urgent_Care_Centres/Urgent_Care_May_09.pdf.

139 National Audit Office. *Major Trauma Care in England* (2010). Accessed via: http://www.nao.org.uk/publications/0910/major_trauma_care.aspx.

140 HM Government. *Equity and Excellence: Liberating the NHS* (2010). Accessed via: http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf.

141 Primary Care Foundation. *Urgent care: A practical guide to transforming same day care in general practice* (2009). Accessed via: http://www.primarycarefoundation.co.uk/files/PrimaryCareFoundation/Downloading_Reports/Reports_and_Articles/Urgent_Care_Centres/Urgent_Care_May_09.pdf.

142 Department of Health. *Regional Networks for Major Trauma*. NHS Clinical Advisory Groups report (2010).

CHALLENGE 1: PROVISION OF IMPROVED URGENT CARE

In 2010, the White Paper *Equity and Excellence: Liberating the NHS* was published¹⁴³. It included a commitment to develop a coherent 24-hour urgent care service. Urgent care is the range of responses that health and care services provide to people who require or who perceive the need for urgent advice, care, treatment or diagnosis¹⁴⁴. This service will include general practice services both within and out-of-hours. It will be supported (subject to pilot evaluation) by a single telephone number – 111 – helping patients to access all urgent care services. The aim behind this is to make it easier for patients to get the right care, in the right place, at the right time.

When a patient has a problem that is perceived as urgent, that patient should expect to be able to access a relevant professional who is suitably trained to be able to advise on the most appropriate response¹⁴⁵. This may be:

- an emergency ambulance
- an urgent face-to-face contact with either a community or hospital service
- a pre-booked appointment with a community-based service; or
- advice and self-care.

At present, GPs in most areas provide urgent 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). The challenge for GP training of providing urgent care in the out of hours setting is explored in depth in Supporting Evidence document 3, Outcome 3.1.

In general, patients would prefer to seek advice from their GP if they have an urgent problem. In a recent study looking at parent preferences when seeking help for feverish children, 67% said that their preference was to seek initial advice from their GP¹⁴⁶. On average each person in the UK has 5.3 appointments every year with their GP¹⁴⁷; about one in three of those appointments is perceived as urgent by the patient or carer and requires a same day assessment¹⁴⁸.

As well as improving health outcomes and the experience of care for patients, improvements in urgent care provision by GPs in the community could substantially reduce Accident and Emergency Department attendance and emergency admissions to hospitals and thus result in considerable savings in healthcare costs. In one practice in Norfolk, an 'appropriate care at point of need' scheme providing urgent care resulted in a 16% reduction in hospital admissions¹⁴⁹.

143 HM Government. *Equity and Excellence: Liberating the NHS* (2010). Accessed via: http://www.dh.gov.uk/dr_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf.

144 Department of Health. *Direction of Travel for Urgent Care: A Discussion Document* (2006). Accessed via: http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/consultations/Liveconsultations/DH_4139428.

145 *Ibid.*

146 Maguire S, Ranmal R, Komulainen S, Pearse S. To understand and improve the experience of parents and carers who need advice when a child has a fever (high temperature) (2010). Accessed via: <http://www.rcpch.ac.uk/sites/default/files/Fever%20Project%20Report.pdf>.

147 NHS Information Centre. Trends in Consultation Rates in General Practice 1995 to 2008: Analysis of the QResearch@ database. Accessed via: http://www.ic.nhs.uk/webfiles/publications/gp/Trends_in_Consultation_Rates_in_General_Practice_1995_2008.pdf.

148 Primary Care Foundation. *Urgent Care: A practical guide to transforming same day care in general practice* (2009). Accessed via: http://www.primarycarefoundation.co.uk/files/PrimaryCareFoundation/Downloading_Reports/Reports_and_Articles/Urgent_Care_Centres/Urgent_Care_May_09.pdf.

149 *Ibid.*

To provide good quality urgent care services, GPs must be able to:

- Manage first contact with patients with a perceived urgent care need whether face-to-face or on the telephone across a variety of different general practice settings
- Provide a thorough face-to-face assessment as needed
- Recognise common patterns of acute illness and symptoms or signs that suggest 'dangerous diagnoses'
- Take appropriate, safe and effective action, for example acute referral to hospital, treatment in the community, self-help and provision of safety netting advice
- Work together effectively with other organisations providing urgent care, such as rapid response teams in the community, the ambulance service, A&E departments and acute surgical and medical services; and
- Be aware of the factors that may influence provision of good urgent care and work within the practice management and multidisciplinary healthcare team towards improving urgent care within the organisation that they work in; this may include use of new technologies such as telemedicine.

Although GPs in training currently do have exposure to patients requiring urgent assessment during their 18 months in general practice, complaints about GPs are rising; 60% of complaints concern missed diagnoses¹⁵⁰. Many of these patients will have presented for urgent, same-day care. Analysis of the 776 complaints about delayed or missed diagnosis received by the Medical Defence Union in the year up to April 2010¹⁵¹ reveals that the conditions most commonly involved are:

- Cancers (221 cases)
- Infections (72 cases)
- Fractures (54 cases)
- Myocardial infarction (26 cases)
- Meningitis (25 cases)
- Ectopic pregnancy (18 cases) and
- Thromboembolic disease (12 cases).

Enhanced GP training will provide increased emergency care training both within normal working hours and out-of-hours so that new GPs are competent and safe to manage patients presenting with urgent care needs across a variety of different general practice settings on completion of GP training. This training will also inform GPs to help them work with local commissioning groups to design, commission and implement improved urgent care services for the future.

150 Campbell D, Boseley S. *GP Negligence Claims: Alarming rise revealed* (2011). Guardian Newspaper. Accessed via: <http://www.guardian.co.uk/society/2011/jul/29/gps-missing-serious-illnesses?INTCMP=ILCNETTXT3487>.

151 *Ibid.*

CHALLENGE 2: OPPORTUNITIES FOR TRAINING FOR GPs TO EQUIP THEM FOR ENTRY INTO THE SUB-SPECIALTY OF PRE-HOSPITAL EMERGENCY CARE

To address urgent care needs, in many areas of the UK, 'urgent care centres' staffed by specialist nurses and GPs are being set up. Increasing expectation of more sophistication of out-of-hospital emergency care skills has led to the approval of a new subspecialty: pre-hospital emergency medicine. The RCGP was one of the lead Colleges involved in the creation of this sub-specialty.

Increased expertise in pre-hospital emergency care would be beneficial particularly for:

- those GPs working exclusively in urgent care centres
- traditional GPs working in remote rural areas
- BASICS GPs who are specially trained to provide skilled medical help at the site of an accident or other medical emergency (or in transit); and
- those GPs employed by the Armed Forces, on cruise ships or by activity or aid organisations.

However, despite clear advantages for a subset of GPs to be trained in this subspecialty, GP training does not currently equip GPs with sufficient emergency care skills to be eligible for entry into postgraduate training for it.

Enhanced GP training will provide opportunities for GPs in training who would like to pursue a career in pre-hospital emergency medicine to undertake basic training necessary for entry to training for this sub-specialty.

CHALLENGE 3: REHABILITATION FOLLOWING MAJOR TRAUMA

Major trauma is defined as 'multiple, serious injuries that could result in disability or death'¹⁵². It includes serious head injuries, severe gunshot wounds and road traffic accidents.

Major trauma is a serious public health problem; it is the leading cause of death in all groups under 45 years of age and a significant cause of short- and long-term morbidity. The National Audit Office estimates that there are at least 20,000 cases of major trauma each year in England, resulting in 5,400 deaths¹⁵³. The most common cause is road accidents.

Added to this there are significant numbers of armed forces veterans who have experienced trauma and injury or illness in the course of their duties around the globe; approximately 8% of the UK population are veterans so the average GP practice with 2000 patients can expect to have approximately 160 veterans on their list¹⁵⁴.

A recent report on the state of major trauma services in England has highlighted a number of deficiencies in the care pathway¹⁵⁵. Although GPs are not generally involved in first aid for trauma victims, acute treatment or initial in-hospital rehabilitation, they may be involved in the transition of people (both civilians and armed forces veterans) who have suffered major

152 Department of Health. *Regional Networks for Major Trauma*. NHS Clinical Advisory Groups report (2010).

153 National Audit Office. *Major Trauma Care in England* (2010). Accessed via: http://www.nao.org.uk/publications/0910/major_trauma_care.aspx.

154 RCGP. *Veterans Health in General Practice* (2011). e-Learning for Health. Accessed via: www.elearning.rcgp.org.uk.

155 Department of Health. *Regional Networks for Major Trauma*. NHS Clinical Advisory Groups report (2010).

trauma back into the community and ongoing rehabilitation and support for them and their families/carers.

However, this report notes a lack of connection between rehabilitation and primary and community-based services, which may result in poor care following discharge and in some cases lead to readmission¹⁵⁶. Following major trauma, rehabilitation is essential for patients to address the physical and psychosocial needs that result from their injuries and experiences. Without such input, they are unlikely to return to their maximum levels of function, which has significant implications for them, their carers and society as a whole¹⁵⁷. The NHS Clinical Advisory Groups report into trauma services in England acknowledges that this is the least well developed aspect of the trauma care pathway and recommends 'co-ordinated development of rehabilitation services and long-term support in the community, which can deliver comprehensive and effective rehabilitation to meet the needs of traumatically injured patients, irrespective of their age'¹⁵⁸.

Currently rehabilitation following trauma and support of armed forces veterans is not covered within the RCGP Curriculum for GP training. If GPs are to provide effective care for major trauma patients transferring back into the community and their families/carers, and assist in commissioning services to meet their needs, they need knowledge about the problems that patients may suffer following major trauma, the principles of rehabilitation and services available to support patients who have experienced major trauma and their families. Using this knowledge they must then work effectively as part of the multidisciplinary team. Enhanced GP training will extend the GP curriculum and the experience of trainees to encompass rehabilitation following major trauma to enable GPs to provide better patient care and commission effective support and rehabilitation services.

CHALLENGE 4: REHABILITATION FOLLOWING ILLNESS

Serious illness such as stroke, progressive neurological diseases and chronic lung disease can have profound effects on the functioning of individuals in society. At present 41% of adult men and 43% of adult women report a long-term illness and this figure is increasing as our population ages¹⁵⁹. Due to our ageing population, the number of people with a long-term condition is set to rise by 23% over the next 25 years¹⁶⁰. People with long-term conditions are also very intensive users of services; they account for 52% of GP appointments¹⁶¹, 65% of outpatient appointments¹⁶² and 77% of hospital bed days¹⁶³.

GPs are often the lead health professional for co-ordinating care for such patients. Traditionally, care in general practice has been reactive: providing solutions for problems as they arise. However, the principles of rehabilitation using a multidisciplinary team and holistic, proactive, problem-based approach with goal setting and regular reviews can be very effective in improving patient functioning. For example, a recent Cochrane review showed that exercise-based cardiac rehabilitation effectively increases quality of life, and

156 *Ibid.*

157 *Ibid.*

158 *Ibid.*

159 NHS Information Centre. *Health Survey for England 2009*. Accessed via: http://www.ic.nhs.uk/webfiles/publications/003_Health_Lifestyles/hse09report/HSE_09_Summary.pdf.

160 Department of Health. *Ten Things You Need to Know About Long-term Conditions* (2008). Accessed via: http://www.dh.gov.uk/en/Healthcare/Longtermconditions/DH_084294.

161 *Ibid.*

162 *Ibid.*

163 Department of Health Press Release. *Innovative care could help over 15 million people with long-term conditions* (2011). Accessed via: http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_128890.

reduces cardiovascular mortality and hospital admissions¹⁶⁴. Home-based schemes are as effective as centre-based schemes¹⁶⁵. A similar picture is seen for patients with chronic obstructive pulmonary disease who receive pulmonary rehabilitation. For these patients, rehabilitation relieves dyspnoea and fatigue, improves emotional function and enhances patients' sense of control over their condition¹⁶⁶.

Good interdisciplinary communication and co-ordination is essential and psychological and socio-cultural aspects are as important as medical aspects of care.

Enhanced GP training will ensure that all GPs in training have received adequate training in the principles and practice of rehabilitation in the community so that they can work together with patients and their families/carers within the multidisciplinary team to optimise their functioning in society and quality of life.

Enabling adult patients of working age to return to work is also an important part of rehabilitation. Most sickness absence, long-term incapacity for work and premature retirement on medical grounds is caused by less severe mental health, musculoskeletal and cardio-respiratory conditions. Returning to work promotes recovery, improves physical and mental health and well-being and reduces social exclusion and poverty¹⁶⁷. In contrast, long periods out of work can cause or contribute to:

- higher consultation, medication consumption and hospital admission rates
- 2–3 times increased risk of poor general health
- 2–3 times increased risk of mental health problems; and
- 20% excess mortality¹⁶⁸.

The longer anyone is off work, the lower their chances of getting back to work. The best time for effective rehabilitation is 1–6 months after the onset of the disabling condition¹⁶⁹. Earlier, most people recover spontaneously; later the obstacles to recovery become more complex and harder to overcome, and rehabilitation to normal functioning has a lower success rate. Timely application of rehabilitation principles, and planning and supporting return to work in partnership with patients, are important parts of good clinical management¹⁷⁰. Enhanced GP training will provide improved training to GPs to help them to enable patients to return to work earlier. The relationship between health and work is discussed further in Supporting Evidence document 2, Outcome 2.1.

164 Heran BS, Chen JMH, Ebrahim S, Moxham T, Oldridge N, Rees K, Thompson DR, Taylor RS. Exercise-based cardiac rehabilitation for coronary heart disease. *Cochrane Database of Systematic Reviews* (2011); Issue 7. Art. No.: CD001800. DOI: 10.1002/14651858.CD001800.pub2.

165 Taylor RS, Dalal H, Jolly K, Moxham T, Zawada A. Home-based versus centre-based cardiac rehabilitation. *Cochrane Database of Systematic Reviews* (2010); Issue 1. Art. No.: CD007130. DOI: 10.1002/14651858.CD007130.pub2.

166 Lacasse Y, Goldstein R, Lasserson TJ, Martin S. Pulmonary rehabilitation for chronic obstructive pulmonary disease. *Cochrane Database of Systematic Reviews* (2006); Issue 4. Art. No.: CD003793. DOI: 10.1002/14651858.CD003793.pub2.

167 Waddell G, Burton AK. *Is Work Good for Your Health and Well-being?* (2006) Accessed via: <http://www.dwp.gov.uk/docs/hwwb-is-work-good-for-you.pdf>.

168 *Ibid.*

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

170 *Ibid.*

CHALLENGE 5: SUPPORTING VETERANS AND THEIR FAMILIES

Approximately 8% of the UK population are veterans: those who have served in the British Armed Forces (Regular or Reserve), merchant seamen and also fishermen who have assisted in military operations. This means that a typical GP with 2,000 patients can expect to have approximately 160 veterans on their list¹⁷¹.

Many veterans have specific health needs related to their time in service¹⁷². A minority have been seriously injured. However, a far larger number experience more subtle ill effects such as loss of hearing, or joint pains resulting from previous trauma. Common mental health problems, for example depression or anxiety are more common among veterans, particularly amongst reservists who have been deployed^{173,174}. Research has indicated that deployment increases alcohol misuse rates in regular service personnel¹⁷⁵.

GPs are usually the first point of contact for most veterans when accessing healthcare. Despite this, of the 500 GPs surveyed across England and Wales by Ipsos Mori in an on-line questionnaire in 2009, 48% said they did not know very much about priority treatment for veterans and 33% admitted to knowing 'nothing at all'¹⁷⁶.

Equally, it is not easy to identify the families of service personnel, and so their needs may not be catered for. Families of servicemen are in an especially difficult position, inhabiting the environment in service yet needing access to NHS care. Families of veterans with long-term injury are often in particular need of support¹⁷⁷.

Military service should not result in disadvantage for veterans when they attempt to access healthcare. In fact, the Department of Health (England) directs the NHS to prioritise veterans' treatment for service-related conditions so as to prevent any overall disadvantage¹⁷⁸. This can only happen if the referring doctor informs the hospital of their patient's veteran status and requests that the referral is prioritised where possible. The same applies to the families of service men and women, who frequently lose their place on hospital waiting lists, due to the highly mobile nature of the job.

Enhanced GP training will enable future GPs to develop many of the key skills required to improve the care available to veterans. In addition to the improved rehabilitation skills for illness and injury set out in this outcome, GPs will be better placed to deal with mental health and substance misuse problems (see Outcomes 1.2, 1.3) as well as provide increased

171 RCGP online course: *Veterans Health in General Practice*. Accessed via: <http://elearning.rcgp.org.uk/course/info.php?id=87>.

172 RCGP. *Meeting the Healthcare Needs of Veterans – A guide for general practitioners* (2011). Accessed via: http://www.rcgp.org.uk/policy/key_rcgp_documents/healthcare_needs_of_Veterans.aspx.

173 Hotopf M, Hull L, Fear NT, Browne T, Horn O, Iversen A, Jones M, Murphy D, Bland D, Earnshaw M, Greenberg N, Hacker Hughes J, Tate AR, Dandeker C, Rona R, Wessely S. The health of UK military personnel who deployed to the 2003 Iraq war: a cohort study. *Lancet* (2006);367:1731–1741.

174 Fear NT et al. Mental health of the UK Armed Forces: what are the consequences of deployment to Iraq and Afghanistan? A cohort study. *Lancet* (2010); 13 May.

175 Iversen A C & Greenberg N. Mental health of regular and reserve military Veterans. *Advances in Psychiatric Treatment* (2009); 15: 100-106; doi: 10.1192/apt.bp.107.004713.

176 Ipsos MORI online questionnaire completed by 500 GPs across England and Wales. Fieldwork was conducted between 13–23 March 2009. Data weighted according to age, gender, region (Strategic Health Authorities in England, plus Wales), practice size and practice list size to reflect the profile of GPs in England and Wales. Accessed via: <http://www.britishtelegraph.org.uk/about-us/media-centre/news/campaigning/new-guidance-to-help-gps-support-Veterans%27-healthcare>.

177 Stephen J. Cozza, Jennifer M. Guimond, Jodi B. A. McKibben, Ryo S. Chun, Teresa L. Arata-Maiers, Brett Schneider, Alan Maiers, Carol S. Fullerton, Robert J. Ursano. Combat-injured service members and their families: The relationship of child distress and spouse-perceived family distress and disruption. *Journal of Traumatic Stress* (2010);23(1):112-115. International Society for Traumatic Stress Studies

178 Letter from Sir Liam Donaldson KB, Chief Medical Officer, 9 Feb 2010. Access to health services for military Veterans: priority treatment. Accessed via: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_111883.

support to family members who are acting as carers for those with long-term health conditions (see Outcome 1.5).

New GPs will also need to be made aware of the issues veterans face and the potential relevance of veteran status to a patient's current health problems. GPs must also learn about the resources which are available to help and support veterans, such as a 24-hour helpline for mental health issues, provided by Combat Stress, and a medical assessment programme based at St Thomas's Hospital in London. GPs also need to be able to work with other organisations that support veterans and their families, including the Royal British Legion, the Soldiers, Sailors and Airmen Families Association (SSAFA) and the Service Personnel and Veterans Agency (SPVA)¹⁷⁹.

¹⁷⁹ RCGP. *Meeting the Healthcare Needs of Veterans – A guide for general practitioners* (2011). Accessed via: http://www.rcgp.org.uk/policy/key_rcgp_documents/healthcare_needs_of_Veterans.aspx.

1.5: WHY IMPROVED CARE FOR OLDER PEOPLE AND THEIR CARERS IS A TRAINING PRIORITY

'Ageing, in all its complexity, is a central issue in human health and disease, and cannot be addressed as an afterthought.'

Lamb, 2002¹⁸⁰

IN THE UK:

- By 2010, a newborn girl could expect to live to 82 years and a newborn boy to 78¹⁸¹
- In 2010, 17% of the UK population was aged over 65 years. This is predicted to rise to 23% by 2035¹⁸²
- Increases in life expectancy since 1981 have outstripped increases in healthy, or disability-free, life expectancy, which means that we can now expect to live longer in poor health; amongst both sexes the proportion of people reporting good health declines with age and 41% of men and 38% women aged 60–74 years report an ongoing disability¹⁸³
- In general practice, the highest consultation rates occur in the age band 85–89 years for both sexes (males 14.0 consultations per person p.a, females 13.5 consultations per person-year)¹⁸⁴
- One in three NHS prescriptions is issued to a person over the age of 65, and 90% of these prescriptions are for repeat medications; adverse drug reactions are thought to account for 5–17% of hospital admissions in the over 75 age group¹⁸⁵
- It is estimated that by 2026, 1.7 million more adults in the UK will need social care¹⁸⁶

180 Lamb A. Medicine and ageing: an agenda for progress. *Clinical Medicine* (2002); 2(3):259-262.

181 National Statistics. *Statistical Bulletin: Older people's day* (2011). Accessed via: http://www.ons.gov.uk/ons/dcp171778_235000.pdf.

182 *Ibid.*

183 National Statistics. *Health and Care: Health expectancy* (2010). Accessed via: www.statistics.gov.uk/cci/nugget.asp?id=934.

184 NHS Information Centre/QResearch (2009). Trends in Consultation Rates in General Practice 1995/1996 to 2008/2009: Analysis of the QResearch® database. Accessed via: www.ic.nhs.uk/webfiles/publications/gp/Trends_in_Consultation_Rates_in_General_Practice_1995_96_to_2008_09.pdf.

185 Department of Health. *Medicines and Older People* (2001). Accessed via: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008020.

186 HM Government. *Shaping the Future of Care Together – Green Paper* (2009). Accessed via: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_102732.pdf.

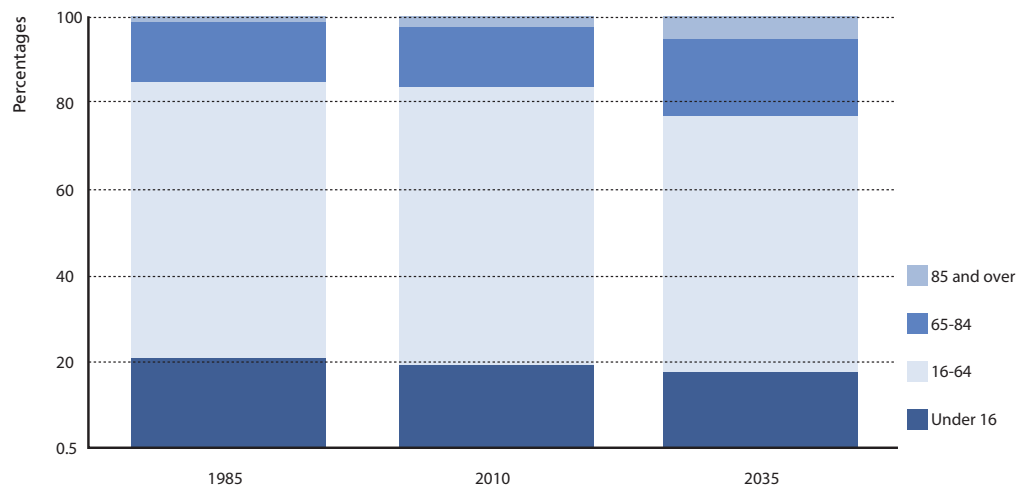
- Recent figures show that 12% of adults living in the UK are carers; 6% care for someone living in their own home; 6% for someone living elsewhere¹⁸⁷; the 1.2 million carers who provide care for more than 50 hours each week equate to a full-time workforce larger than the entire NHS and are estimated to save the UK economy at least £119 billion a year in care costs¹⁸⁸
- Unpaid, 'informal' carers suffer significant adverse physical and mental health consequences^{189,190}.

In common with other European countries, the UK has an ageing population. Over the past 25 years the number of people over the age of 65 increased by 1.7 million people¹⁹¹. This trend is likely to continue and by 2035, 23% of the population will be over the age of 65¹⁹².

The fastest population increase has been amongst those aged over 85. In 2008 there were 1.3 million people in this age group in the UK, and by 2033 the number of people over the age of 85 is likely to reach 3.2 million, accounting for 5% of the total population.

As well as older people living longer, the UK has seen a fall in birth rate over the past century. Falling fertility has resulted in fewer young people in the community, and hence an increase in the proportion of older people (Figure 1.5.1).

Figure 1.5.1: Population by age, UK, 1985, 2010, 2035



Reproduced from National Statistics. Statistical bulletin: *Older People's Day* (2011). Accessed via: http://www.ons.gov.uk/ons/dcp171778_235000.pdf.

187 NHS Information Centre for Health and Social Care. *Survey of Carers in Households 2009/2010* (2010). Accessed via: www.ic.nhs.uk/webfiles/publications/009_Social_Care/carersurvey0910/Survey_of_Carers_in_Households_2009_10_England.pdf.

188 University of Leeds/Carers UK. *Valuing Carers 2011: Calculating the value of carers' support* (2011). Accessed via: www.carersuk.org/professionals/resources/research-library/item/2123-valuing-carers-2011.

189 Pinquart M, Sorensen S. Associations of stressors and uplifts of caregiving with caregiver burden and depressive mood: a meta-analysis. *Journal of Gerontology Series B Psychological Sciences* (2003);58(2):P112-P128.

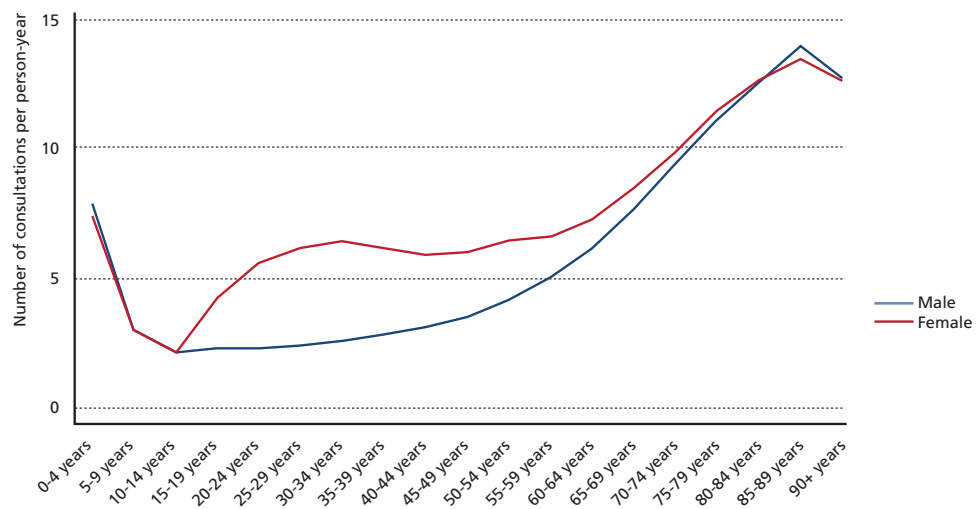
190 Pinquart M, Sorensen S. Differences between caregivers and noncaregivers in psychological health and physical health: a meta-analysis. *Psychology and Aging* (2003);18 (2):250-267.

191 National Statistics. *Statistical Bulletin: Older people's day* (2011). Accessed via: http://www.ons.gov.uk/ons/dcp171778_235000.pdf.

192 *Ibid.*

Within any two week period 19% of people aged over 75 see an NHS GP and 14% speak to a GP on the telephone (Figure 1.5.2)¹⁹³. An ageing population will bring increased demands on primary care and it is important that we, as GPs, have strategies for effective care of this important sector of our population.

Figure 1.5.2: Increase in consultation rate per person per year with age (England, 2008–9)



Reproduced from: NHS Information Centre/QResearch (2009)¹⁹⁴.

Older people are more likely to suffer from a number of diseases including dementia, osteoarthritis, osteoporosis, cancer, ischaemic heart disease, chronic respiratory disease and diabetes. The challenge presented by the increasing prevalence of dementia as our population ages is discussed further in Supporting Evidence document 1, Outcome 1.2.

These diseases may co-exist in the same person and impact upon each other. For example, an elderly lady with a history of smoking, chronic obstructive pulmonary disease (COPD) and increased breathlessness may have lung cancer, heart failure, an exacerbation of COPD, a combination of these or be breathless for a completely separate reason.

Older people’s needs are many and varied. They depend on age, and the conditions that the older person has. The GP is part of a multidisciplinary team, and support for older patients and their carers is an essential role of that team.

193 NHS Information Centre/QResearch (2009). Trends in Consultation Rates in General Practice 1995/1996 to 2008/2009: Analysis of the QResearch® database. Accessed via: www.ic.nhs.uk/webfiles/publications/gp/Trends_in_Consultation_Rates_in_General_Practice_1995_96_to_2008_09.pdf.

194 Trends in Consultation Rates in General Practice 1995/1996 to 2008/2009: Analysis of the QResearch® database. Accessed via: www.ic.nhs.uk/webfiles/publications/gp/Trends_in_Consultation_Rates_in_General_Practice_1995_96_to_2008_09.pdf.

The extent and nature of a GP's involvement in any particular case will depend on the patient's illnesses and also the roles of other professionals within the multidisciplinary team caring for that patient. It will also depend on the setting. For example, older people in residential care have very different support needs to those living in the community (see Supporting Evidence document 3, Outcome 3.1). Possible roles that a GP might have are listed in Box 1.5.1.

Box 1.5.1: Possible roles that a GP might have in supporting older people and their carers¹⁹⁵

- Keep in touch with the family and up-to-date with what is going on
- Provide support to the patient and other family members
- Provide chronic disease management in the surgery and via home visits as needed
- Provide general medical care, referring back to any specialist teams involved as needed
- Provide preventative care e.g. flu vaccination for patients and/or carers
- Ensure repeat prescriptions and prescriptions requested by specialist services are supplied promptly
- Co-ordinate care with other members of the primary care team and/or other services
- Provide continuity when care is passed from one secondary care team to another
- Give advice on any benefits or local services the family might find of assistance
- Provide ongoing support to family members if the patient dies.

All GPs therefore need high-quality training in leading, coordinating and delivering care for older people and their carers in the community.

A recent consultation by the British Geriatrics Society (BGS) endorsed the role of the GP in providing healthcare for older people in the community:

'The BGS believes that the traditional model of general practice in the UK is advantageous to older patients, and that a GP's commitment to a locality and knowledge of services for older people within that locality is important. Building up trust and strong relationship over time helps the patient to believe that the doctor will make the right decisions for them in the future and understand their health needs and preferences ... teamworking is a strength in general practice, including the very close working relationship between nurses and GPs, and this needs to be maintained or strengthened'¹⁹⁶.

¹⁹⁵ Simon C. Supporting older people and their carers in primary care. *InnovAiT* (2011);4(8):450-457.

¹⁹⁶ British Geriatric Society. *Striking a Balance – Consultation* (2010). Accessed via: www.bgs.org.uk/index.php?option=com_content&view=article&id=1150:gppartnershipconsultation&catid=14:consultations&Itemid=110.

CHALLENGE 1: MAINTAINING HEALTH AND PREVENTING DISEASE IN THE ELDERLY

The *National Service Framework for Older People* includes Standard 8, 'The promotion of health and active life in old age' with a view to extending healthy life expectancy¹⁹⁷. More recent initiatives such as the *Prevention Package for Older People*¹⁹⁸ and NICE guidance on *Mental Wellbeing and Older People*¹⁹⁹ reinforce the need for health promotion and preventive care in this age group. Prevention results in better outcomes for older people in terms of quality of life, and also more efficient use of health and social care resources²⁰⁰.

Although most GPs are currently exposed to the management of acutely unwell elderly people in the hospital setting in the course of their GP training, prevention of disease in the elderly is not covered during these placements. Although training in general practice does include prevention very generally, there is little time to look specifically at prevention in the elderly. All GPs at completion of their training should be able to:

- provide lifestyle advice to elderly people to prevent disease, including advice about weight, exercise, smoking cessation, alcohol moderation
- provide vaccination for older people to prevent pneumonia and complications of influenza, as well as travel-related illness
- provide advice to elderly people about National Screening Programmes that they are eligible to participate in
- use cardiovascular disease prevention strategies effectively for elderly people (for example, blood pressure and lipid management); and
- understand the need for additional preventive measures in high risk groups, such as those prone to falls or with osteoporosis, and understand the need for specialist services to support preventive measures in these areas.

CHALLENGE 2: RECOGNISING SERIOUS ILLNESS IN THE ELDERLY

A recent comparison of cancer survival rates from 1995–2007 in six developed Western countries across the world (Australia, Canada, Sweden, Norway, Denmark and the UK) showed that cancer survival was poor relative to other countries in the UK. This was particularly so for the over 65s²⁰¹. Cancer survival is often viewed as a key indicator of the effectiveness of a healthcare system.

One of the reasons for poor survival statistics for cancer in the UK that is consistently cited is late diagnosis. Late diagnosis impacts on cancer survival, but delayed diagnosis can also have a negative effect on quality of life, with the use of more toxic treatments when cancer is diagnosed at an advanced stage and an increase in psychological distress. Data from the National Patient Safety Agency published in 2009 suggest that those aged 55–75 years are most likely to experience delay in diagnosis. Two of the major reasons for delay in diagnosis

197 Department of Health. *National Service Framework for Older People* (2001). Accessed via: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4902624.

198 Department of Health. *Prevention Package for Older People* (2010). Accessed via: www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh_103146.

199 NICE. *Mental Wellbeing and Older People* (2008). Accessed via: <http://www.nice.org.uk/nicemedia/live/11999/42395/42395.pdf>.

200 Department of Health. *National Service Framework for Older People* (2001). Accessed via: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4902624.

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

were presentation with vague, non-specific symptoms, or misattribution of symptoms to other co-morbid diseases²⁰².

These statistics illustrate why diagnosis of serious disease can be difficult in older people. Diagnosis is complicated by:

- communication problems
- multiplicity of cause – a single symptom may be caused by different, concurrent processes. For example, breathlessness may result from chronic obstructive pulmonary disease, infection and heart failure – which may all co-exist in the same patient
- absent or non-specific symptoms or signs – symptoms may be absent despite disease, and signs harder to elicit; non-specific symptoms or signs, for example confusion, falls or being ‘off legs’, may be the only overt clues to underlying disease such as urinary tract infection, chest infection, myocardial infarction or stroke; and
- misattribution of symptoms to normal age-related changes resulting in potentially treatable conditions being missed.

These problems apply not only to diagnosis of cancer, but also to diagnosis of other serious conditions such as myocardial infarction and stroke. GPs require additional training in the management of complex elderly patients to enable serious illness to be detected sooner and thus managed more effectively.

CHALLENGE 3: MANAGING MULTIPLE MORBIDITIES

It is estimated that 65% of healthcare usage is by adults with more than one chronic health condition²⁰³. It is thought that this proportion will continue to increase as the UK population ages.

Evidence relating to the challenge of managing multiple morbidities is summarised in Supporting Evidence document 2, Outcome 2.3.

CHALLENGE 4: AVOIDING DRUG-RELATED PROBLEMS IN THE ELDERLY

Statement 9 of the National Service Framework (NSF) for Older People highlights the need or close supervision of medicines being prescribed for older people. It requires all people over 75 years to have their medicines reviewed at least annually and those taking four or more medicines to have a 6 monthly review²⁰⁴. This NSF standard has subsequently been incorporated as a quality standard within QOF (Medicines 11 and Medicines 12)²⁰⁵.

202 National Patient Safety Agency. *Delayed Diagnosis of Cancer: Thematic review* (2009).

203 Gerhard Anderson. Presentation to the OECD 50th Anniversary Conference (2011). Accessed via: www.oecd.org/document/t/17/0,3746,en_2649_37407_48127569_1_1_1_37407,00.html.

204 Department of Health. *National Service Framework for Older People* (2001). Chapter 5. Standard 9: Medicines and Older People. Accessed via: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_5033624.

205 NHS Employers/BMA. *Quality and Outcomes Framework Guidance for GMS Contract 2011/12*. p.26. Accessed via: www.nhsemployers.org/SiteCollectionDocuments/QOFguidanceGMScontract_2011_12_FL%2013042011.pdf.

Drug side effects are also more common as a result of altered pharmacodynamics and pharmacokinetics in the elderly. As people get older, their use of medicines also tends to increase; 80% of people over the age of 75 years take at least one medicine regularly and 36% take four or more medicines regularly²⁰⁶. Thus medication related problems are more common in this age group. These may take a number of forms:

- Adverse effects – it is estimated that between 5–17% of hospital admissions result from adverse drug effects²⁰⁷. More minor adverse effects increase morbidity and reduce quality of life.
- Underusage – some medications, such as statins or warfarin, are effective in older age groups yet may be underprescribed²⁰⁸.
- Overusage – it is easy to add new drugs for every new condition that a patient presents with. It is also important to remove drugs when no longer required. For example, it is estimated that long-term diuretic treatment can be stopped in around 50% of patients without adverse effects²⁰⁹.
- Poor concordance – it is estimated that up to 50% of medicines are not taken as prescribed by elderly patients²¹⁰. This may be due to a number of reasons including poor labelling, and fear of adverse effects.
- Inequivalence of repeat prescribing quantities – it is estimated that prescribing different amounts of drugs each month results in over-ordering and thus drug wastage²¹¹; and
- Drug errors – changes of medication in secondary care (either through out-patient departments or during hospital admissions) are not always carried through into general practice. These errors can result in inappropriate prescribing²¹².

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

The evidence for improved prescribing for people with chronic disease is discussed in Supporting Evidence document 2, Outcome 2.3.

CHALLENGE 5: DEVELOPING SERVICES APPROPRIATE FOR THE ELDERLY

It is widely recognised that feedback from patients is essential to improving the quality of healthcare services and to ensure effective engagement. Although older people generally are included in feedback mechanisms, particularly vulnerable groups of elderly patients are excluded, for example, the very elderly (over 80), those who are housebound with chronic disability, those with communication problems and those with cognitive deficit. There is a need for improved communication with older people in these vulnerable groups and their carers to ensure better service provision tailored to their needs.

206 Department of Health (2001). *Medicines and Older People*. Accessed via: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008020.

207 *Ibid.*

208 *Ibid.*

209 *Ibid.*

210 *Ibid.*

211 Department of Health (2001). *Medicines and Older People*. Accessed via: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008020.

212 *Ibid.*

General practices must provide health services in ways that older people can access them. For example an elderly person coming to the surgery for a routine chronic disease management check with a daughter who works full time, might be offered the first appointment to allow the daughter to get back to work with the minimum of delay. Similarly, an elderly lady who cares for her husband with dementia may be unable to leave him to attend the surgery for her own health needs, and might warrant a home visit even though she is fit enough to get to the GP surgery herself.

GPs also need to understand the role of new technology and information systems in optimising care of older people. For example, RISC software can provide data to enable identification of older people at high risk of hospital admission, enabling resources to be targeted to support those individuals better in primary care and thus reducing hospital admissions.

The introduction of clinically-led commissioning in England provides an opportunity for integrating health and social care, but to do this GPs will need to develop a greater understanding of the role and expertise of other elderly care and public health professionals and the skills to work effectively with them in shared team leadership roles.

CHALLENGE 6: INCLUDING CARERS IN CARE PLANNING

A carer is a person of any age, adult or child, who provides unpaid support to a partner, child, relative or friend who could not manage to live independently or whose health or wellbeing would deteriorate without this help. This could be due to frailty, disability or serious health condition, mental ill health or substance misuse²¹³.

There are approximately 6 million carers in the UK. Although there are slightly more women than men who are carers, and carers are most commonly aged 45–64, carers can be of all ages and from all parts of society. Carers are not always fit and healthy themselves and may have their own health needs. They may look after more than one person, for example a child with a disability and an elderly relative.

- 1.25 million carers in the UK do caring tasks for more than 50 hours per week
- An additional two million carers care for more than 20 hours per week
- 2.9 million carers combine paid employment with caring for somebody else²¹⁴
- 49% of current carers have been providing care for more than five years²¹⁵.

Carers are estimated to save the UK economy £119 billion a year in care costs. This is equivalent to £18,473 p.a. for every carer in the UK²¹⁶. At the time that this calculation was made this figure exceeded total government spending on the NHS, and was several times the spending on social services. Our society could not afford to provide the current level of community care without this willing army of unpaid support. Carers are therefore vital to both our society and our economy.

213 RCGP/The Princess Royal Trust For Carers. *Supporting Carers Action Guide* (2011). Accessed via: www.rcgp.org.uk/professional_development/continuing_professional_dev/carers.aspx.

214 These three statistics are taken from Census 2001.

215 NHS Information Centre for Health and Social Care. *Survey of Carers in Households 2009-10*. London: Health and Social Care Information Centre, 2010.

216 University of Leeds/Carers UK. *Valuing carers 2011: Calculating the value of carers' support* (2011). Accessed via: www.carersuk.org/professionals/resources/research-library/item/2123-valuing-carers-2011.

'NHS services must reflect the needs and preferences of patients and their families and their carers. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment.'

The NHS Constitution for England, 2009²¹⁷

Carers know the people that they care for better than anyone else. This knowledge can be extremely useful in planning patient care, and also in identification of problems that may require intervention. If care is planned without the input of carers an opportunity has been lost. Therefore, engagement and co-operation with carers is an essential part of good patient care.

Furthermore, co-operation is needed from carers to effectively implement any patient care plan. Involving carers when devising a care plan and listening to their views is likely to result in better co-operation and concordance.

Evidence for this comes from evaluations of four re-enablement programmes in England which found that involving and supporting carers can improve re-enablement of patients.²¹⁸ In the area of stroke care, one randomised controlled trial (RCT) found that personal care training for carers resulted in a higher proportion of patients who have had a stroke achieving independence at an earlier stage, and reduced need for physiotherapy and occupational therapy. There were also significant reductions in carer burden and improvements in mood and quality of life for carers and care recipients.²¹⁹

Although carers are regularly mentioned within the GP curriculum, there is no information or emphasis on including them as partners in care or the benefits that this can bring. Enhanced GP training would stress the importance of carers to the success of care in the community and demonstrate to GPs in training how involving carers in care planning can benefit both patients and health services alike.

CHALLENGE 7: SUPPORTING CARERS IN THEIR ROLES

Carers have been highlighted as a group experiencing comparatively poor health within *Healthy Lives, Healthy People: A strategy for public health in England (2010)*²²⁰. Research on populations of carers has consistently demonstrated that caring has a pronounced adverse effect on psychological health:

- 40% of carers have significant distress and depression levels²²¹
- informal carers providing more than 20 hours of care per week over extended periods have twice the risk of experiencing psychological distress over a two year period than non-carers; the risk for distress increases progressively with the amount of time devoted to caring each week and adverse effects of caring are evident beyond the end of caring episodes²²².

217 Department of Health. *The NHS Constitution* (2009). Accessed via: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613.

218 Department of Health. *Homecare Re-enablement Workstream, Care Services Efficiency Delivery Programme*, 2007. Pg 31.

219 Kalra L, Evans A, Perez I, Melbourn A, Patel A, Knapp M, Donaldson, N. Training carers of stroke patients: Randomised controlled trial. *BMJ* (2004);328:1099-1101.

220 HM Government. *Healthy Lives, Healthy People: A strategy for public health in England*. London: The Stationery Office, 2010.

221 Pinquart M, Sorensen S. Differences between caregivers and noncaregivers in psychological health and physical health: a meta-analysis. *Psychology and Aging* (2003);18(2):250-267.

222 Hirst M. Carer distress: a prospective, population-based study. *Social Science & Medicine* (2005);61:697-708.

Effects of caring on physical health are less clear but research studies do support a negative effect of caring on physical health. In particular:

- older carers who report 'strain' have a 63% higher likelihood of death in a four-year period than non-carers or carers not reporting strain²²³; and
- providing high levels of care is associated with a 23% higher risk of stroke²²⁴.

Recognised, Valued and Supported: Next steps for the carers' strategy was published in November 2010²²⁵. This document focuses on improving health and social care support for carers in England. Four areas have been prioritised, the first three of which GP practices can clearly influence:

- supporting early self-identification and involvement in local care planning and individual care planning
- personalised support for carers and those receiving care
- supporting carers to remain healthy; and
- enabling carers to fulfil their educational and employment potential.

Although many carers are in contact with multiple support agencies, 88% of carers have visited their GP in any year for concerns about their own health, as well as visiting for the person that they are caring for²²⁶. This is a far higher proportion of carers than has seen any other support professional. Carers expect the GP to know about available help and presume that if they are not informed about support, it does not exist²²⁷. Furthermore, carers view their GP as the person most able to make a difference to their situation²²⁸.

Therefore GPs have a crucial role to play for carers who need to access additional support. However, although there are many examples of excellent support for carers from GPs and other primary care team members, carers often feel that their needs for support have not been met and that GPs do not understand them^{229, 230}.

Evidence for the need for enhanced training for GP s to identify and support carers, and the effectiveness of enhancing GP training in achieving this is summarised in Supporting Evidence document 2, Outcome 2.3.

223 Schulz R & Beach S. Caregiving as a risk factor for mortality. *Journal of the American Medical Association* (1999); 282(23):2215-2219.

224 Haley WE, Roth DL, Howard G, Safford MM. Caregiving strain and estimated risk for stroke and coronary heart disease among spouse caregivers. *Stroke* (2010);41:331-336.

225 HM Government. *Recognised, Valued and Supported: Next steps for the carers' strategy*. Accessed via: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_122393.pdf.

226 Henwood M. *Ignored and Invisible? Carers experience of the NHS* (1998). Carers National Association.

227 *Ibid.*

228 *Ibid.*

229 *Ibid.*

230 Warner L, Wexler S. Eight hours a day and taken for granted (1998). Princess Royal Trust for Carers. Accessed via: <http://static.carers.org/files/taken-for-granted-1.pdf>.

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