Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

Inquiry into primary care

RCP Wales response

About us

The Royal College of Physicians (RCP) aims to improve patient care and reduce illness, in the UK and across the globe. We are patient centred and clinically led. Our 33,000 members worldwide, including 1,200 in Wales, work in hospitals and the community across 30 different medical specialties, diagnosing and treating millions of patients with a huge range of medical conditions.

Amdanom ni

Mae Coleg Brenhinol y Meddygon yn amcanu at wella gofal cleifion a lleihau salwch, yn y DU ac yn fyd-eang. Rydym yn sefydliad sy'n canolbwyntio ar y claf ac sy'n cael ei arwain yn glinigol. Mae ein 33,000 o aelodau o gwmpas y byd, gan gynnwys 1,200 yng Nghymru, yn gweithio mewn ysbytai a chymunedau mewn 30 o wahanol feysydd meddygol arbenigol, gan ddiagnosio a thrin miliynau o gleifion sydd ag amrywiaeth enfawr o gyflyrau meddygol.

For more information, please contact:

Lowri Jackson
RCP senior policy and public affairs adviser for Wales
[redacted]
[redacted]

Royal College of Physicians (Wales)
Baltic House, Mount Stuart Square
Cardiff CF10 5FH
[redacted]
www.rcplondon.ac.uk/wales

Health, Social Care and Sport Committee
National Assembly for Wales
Cardiff CF99 1NA

SeneddHealth@assembly.wales

From the RCP vice president for Wales
O'r is-lywydd yr RCP dros Gymru
Dr Gareth Llewelyn FRCP
[redacted]

From the RCP registrar
O'r cofrestrydd yr RCP
Dr Andrew Goddard FRCP
[redacted]

3 February 2017

Inquiry into primary care

1. Thank you for the opportunity to respond to the Health, Social Care and Sport Committee inquiry into primary care. If you would find it helpful, we would be very happy to organise oral evidence on this inquiry to the Health, Social Care and Sport Committee from consultant physicians, trainee doctors or members of our patient carer network.

2. In the future, much more specialised care should be delivered in or close to the community. Physicians and specialist medical teams should expect to spend part of their time working in the community, providing care integrated with primary, community and social care services with a particular focus on optimising the care of patients with long-term conditions and preventing crises. Primary care should no longer be synonymous with general practice – community healthcare must include a wide variety of different professions, specialties and therapies.

   > ***For many specialties and for general physicians, there is an increasing need to devote sessions to working in the community, thereby forming part of a team … There are established examples of physicians working in this integrated fashion, crossing from the inpatient to the community arena, usually for patients with complex chronic conditions. Examples include community geriatricians, palliative care consultants, and integrated respiratory and diabetic physicians … [They] work closely with GPs and other health professionals working across acute and community settings. The sharing of information and joint working between and with GPs and social care is crucial.***[1]

3. Furthermore, people who live in nursing or residential care and often have multiple morbidities and complex medical needs should have access to enhanced primary care from GPs and to community services. There is also evidence to suggest that their care is improved by involvement of geriatric medicine physicians. This can be particularly effective when the community geriatric medicine team is linked to the acute services and care plans are shared between teams. These specialist teams can also have an important role in providing skills to the staff who work in care homes. This may reduce the need for admissions.

[1] Future Hospital Commission. *Future hospital: caring for medical patients.* A report from the Future Hospital Commission to the Royal College of Physicians. London: Royal College of Physicians, 2013, p59

4. The RCP believes that we need to move away from a workforce model in which we invest in either primary or secondary care, and towards more integrated team working – the hospital without walls – where specialists hold more of their clinics in the community, and GPs spend part of their time working with colleagues at the front door of the hospital. A whole system approach across primary, community, secondary and social care is now required to deal with the impact of the growing pressure on unscheduled care.

5. The RCP has led the call for Wales to lead the way by developing new integrated workforce models in rural communities. Medical education and training should equip doctors with the expertise to manage older patients with complex needs, including frailty and dementia, and to lead and coordinate the 'whole care' of patients in hospital and the community. Many physicians already work between hospital and community clinics; NHS Wales and GP clusters should build on these pockets of good practice and take a planned approach to establish specialty care in the community.

Case study: Delivering specialist diabetes care in the community

Managing a chronic disease such as type 2 diabetes requires the input of a multidisciplinary team across primary and secondary care. Historical models of care for diabetes have separated primary and secondary care elements and have led to the fragmentation of care, duplication of workload and long waits for senior specialist advice.

In Cardiff, which has a total of just over 23,000 people registered with diabetes, we have moved towards a more seamless diabetes service. We started with a small pilot study and began implementing the full model of care in 2010. Each of the 69 GP practices in the health board is allocated a diabetes consultant who visits the practice twice a year for case notes review, dissemination of best practice guidelines and face-to-face dialogue with GPs and their practice nurse.

There are eight full-time equivalent diabetes consultants and two academic diabetes consultants. Each consultant mentors 6–8 practices depending on the list size. In addition, GPs can request advice from their supporting consultant via an electronic system (similar to email but with robust audit) with a 5 day maximum response time for medication and management queries. Requests for advice are automatically routed to the appropriate consultant. This ensures that GPs have access to timely senior advice and develop a rapport with their consultant without the patient having to wait to be seen in an outpatient clinic. Secondary care outpatient referrals are triaged electronically to the appropriate consultant via the Welsh Clinical Communications Gateway (WCCG). The consultant can approve and book the referral into a clinic or request additional information. The latter opens a dialogue that may resolve the query. In addition, we have developed local type 2 diabetes prescribing guidelines which guide treatment choice and highlight cost differences between classes of treatment. The guidelines are intended to support primary care prescribing and draw attention to more cost effective prescribing where possible.

Over the first 2 years of implementation, new referrals to secondary care clinics fell by 35%. As a consequence, the waiting time for outpatient appointments fell from just under 6 months to between 4 and 6 weeks depending on the clinic. An audit of primary care found greater confidence overall in managing diabetes but especially in initiating non-insulin injectables, combining therapies and dose titration of oral and injected treatments. Practice staff find the electronic access to senior consultant advice within a working week particularly helpful. Advice offered for an individual patient will frequently be applied to other similar clinical scenarios leading to a ripple training effect.

More recently, we have demonstrated improved glycated haemoglobin (HbA1c) results in patients who have been discussed either during visits or electronically, and hope that this will lead to a fall in HbA1c across primary care due to greater confidence and ability to manage diabetes. We have also started to see new prescriptions for analogue insulin plateau and start to fall, while human insulin prescriptions are starting to rise with the potential for cost savings. This is an area we'd like to develop over the next 2 years.

So far, these changes have been made in a cost-neutral environment by asking primary and secondary care colleagues to work together in a different way. The model continues to evolve and we are recruiting community diabetes specialist nurses to support practices. We hope to fund these posts through more cost-effective use of human insulin where appropriate and reviewing the stop criteria for medications that are no longer effective. We also believe that this model could be helpful in supporting primary care to manage other chronic diseases. Its success depends on developing close, sustainable links with primary care. I am grateful to my colleagues in primary and secondary care for the hard work that has gone into establishing and sustaining this innovative model of care.

Dr Lindsay George
Clinical lead for diabetes, University Hospital Llandough
Cardiff and Vale University Health Board

6. The role of the community physician should be developed. Wales should actively promote itself as a place to develop highly specialist skills in rural and community-based medicine. We know from our own research that geography is important to trainees, and that most trainees would like to gain a consultant post where they have undertaken specialist training. Developing a rural training pathway for general medicine which splits time between the hospital and the community could boost medical recruitment in Wales in the future. Wales has a real opportunity to lead the way on innovative community health service design.

7. It is becoming increasingly clear that the community-based health and social care workforce will need to change and diversify in the future. Primary care should include more specialty clinics in the community which work with advanced nurse practitioners, specialist nurses and physician associates, for example. Optometry and podiatry services should be more widely commissioned in primary care, nursing shortages should be addressed, and innovative models of staffing involving allied health professionals such as occupational therapists and physiotherapists should be promoted. Pharmacists must play a bigger role in treating more complex patients with long-term conditions. Paramedics must be an integral part of these teams, helping to assess patients at an early stage of their treatment journey. This needs to be approached in an organised and structured manner, and the funding must be planned carefully, particularly for nursing posts and physician associate training courses.

8. Ideally, a formal evaluation of the current pilot bursary scheme for physician associates should be carried out as soon as possible. A successful evaluation should demonstrate improved access to care for patients and should measure patient, student and junior doctor experience. However, waiting until the first cohort of trainees from this pilot scheme have graduated means that we will not be able to evaluate this scheme until at least 2018, if not the year after. We recommend that the Welsh Government consider evaluating the impact of existing physician associates in other parts of Wales – especially those working in primary care – to find out more about their effect on patient care and any potential improvements to trainee experience.

9. Health boards and GP clusters should embrace innovation in order to improve communication with patients and between healthcare professionals and to improve quality of care and the

patient experience. People increasingly expect to interact with health services using personal technology such as smartphones and tablets; where appropriate, patients and clinicians should be able to use telehealth and telemedicine, particularly in remote and rural areas.

10. Telemedicine needs to be further embedded into everyday practice. Clinicians must continue to challenge resistance to change. The RCP Future Hospital development site in north Wales – CARe delivered with Telemedicine to support Rural Elderly and Frail patients (CARTREF) – is a telemedicine project that aims to improve access to care for frail older patients in rural Wales. The project allows patients to have follow-up hospital appointments by video clinics and means that patients and relatives can see specialists without travelling. The team can demonstrate patient satisfaction rates of 80%. This is just one of many examples of innovative clinical telemedicine and the future hospital workforce in Wales; best practice must be shared more consistently and rolled out in a structured way.

11. There are also some potential short-term wins. For example, moving the Quality Outcomes Framework census date to the end of the summer would help to ensure that at a peak time for unscheduled pressure, scheduled appointments would be freed up.

12. The Welsh Government and NHS Wales must ensure that lessons learned from the many GP cluster plans are written up, evaluated and if appropriate, rolled out more widely. GP clusters must also be encouraged to focus on unscheduled care rather than scheduled care from next year. We acknowledge that the problems in unscheduled care are far trickier to solve, and they have understandably not been the focus of GP clusters so far. However, the system must operate in a far more joined up fashion if we are to prevent unnecessary hospital admissions.

13. The RCP has long advocated standardised electronic patient records, which can save clinician time and improve patient safety. We have called for the electronic communication of referrals, outpatient letters and discharge summaries between primary and secondary care, using structured documents taken from structured records. The failure to develop these effective communication systems can lead to delays or impaired clinical decision-making. Access to health records and alternatives to admission *must* be available seven days a week.

14. We believe that patients should also be able to book appointments, receive reminders and check test results online. They should be able to record and upload their own findings, such as weight or glucose levels. Hospital records should be integrated into a summary patient record that conforms to national standards and contributes to a single comprehensive summary of the hospital records.

More information

15. More information about our policy and research work in Wales can be found on our website. **We would be delighted to provide oral evidence to the Committee or further written evidence if that would be helpful.** For more information, please contact Lowri Jackson, RCP senior policy and public affairs adviser for Wales, at [redacted]

With best wishes,

Dr Gareth Llewelyn
RCP vice president for Wales
Is-lywydd yr RCP dros Gymru

Dr Andrew Goddard
RCP registrar
Cofrestrydd yr RCP

Annex 1

https://www.rcplondon.ac.uk/projects/outputs/patient-care-unified-approach

Annex 2

https://www.rcplondon.ac.uk/projects/outputs/teams-without-walls-value-medical-innovation-and-leadership