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Joint Statement April 2006

Making the best use of doctors' skills – a balanced partnership

A Joint Statement from the Royal College of General Practitioners and the Royal College of Physicians on how specialists and generalists can work together for the benefit of patients in the NHS

The Royal College of Physicians and the Royal College of General Practitioners believe that new models of healthcare must be developed to meet the aspirations and needs of patients in the new and modern NHS and that doctors working together across traditional organisational boundaries are central to such new models. Service provision should move away from the needs of organisations to the needs of patients. The Colleges believe that specialists and generalists working in strong collaborative arrangements offer a major and unrivalled opportunity to improve the quality and safety of patient care and to reduce health inequalities. Such arrangements are essential to deliver NHS initiatives outlined in the new health and social care White Paper, such as the Care Closer to Home programme and better management of long-term conditions. Current reform of postgraduate medical education and training also gives an opportunity to develop innovative training to support such collaborative arrangements.

Introduction

The new health and social care White Paper, *Our health, our care, our say*,¹ proposes a major reshaping of the NHS by shifting appropriate care out of acute hospitals and into the community. It is proposed to transfer 5% of acute sector budget into the community over the next decade. Specific initiatives include a programme of Care Close to Home in six specialties, aggressive management of long-term conditions and the targeting of health inequalities. The new policies pose a formidable implementation challenge for local health communities. In addition to the White Paper, there is a further context: the future of the medical workforce.² Major reform of education and training through Modernising Medical Careers (MMC) has led to an important debate about the needs of patients and the service in the future, and the role of doctors within this.

Both drivers – care in the community and MMC – require a rethinking of the role of consultants and general practitioners and it is timely to explore new models of healthcare to meet the aspirations and needs of patients. Change on this scale is likely to challenge expectations, existing organisations and the established ways of working of doctors.

The purpose of this statement is to explore the key issues and advance some principles that would support a much needed strengthening of the interface between primary and secondary care. We start with the premise ▷

that service provision should move away from the needs of organisations to the needs of patients. We believe that there is a significant opportunity to improve patient care that needs to be exploited by clinicians and that any transition needs to take place in a planned and supported way involving users of the service. Our most important message is that doctors must be enabled to work together across traditional organisational boundaries to meet the aspirations and needs of patients.

There are four key issues to consider:

- How can specialists and generalists work together for the benefit of patients in the NHS?
- How can care be organised such that patients see the right doctor at the right time and in the right setting?
- How can the quality and safety of care be assured, including tackling health inequalities?
- How to provide and train the workforce of the future.

Professional partnerships of doctors working in primary and secondary care

We are used to the concept of the multidisciplinary team in both hospitals and GP practices. In hospital there are many areas of good collaborative practice, for example cardiac surgery and cardiology, renal transplantation and nephrology, gastroenterology and gastrointestinal surgery. Now we need partnerships across the previously sacrosanct boundaries of primary and secondary care.

The language of primary and secondary care is becoming increasingly redundant. For example, services traditionally provided in hospital (such as minor surgery or dermatology) could be, and are being delivered in general practice. And GPs are often co-located in accident & emergency departments and work in consultant clinics. We therefore prefer the use of the terms 'generalist' and 'specialist'.

The partnership between generalists and specialists needs to be focused within the community and not within the hospital and must encompass service, education, research and audit. In our model, clinicians will champion and lead local health economies. Groups of doctors and related healthcare professionals should be responsible for the healthcare of a geographically defined population. This discrete geographical management and organisation would lend itself to the setting of locality quality measures.

Our model is more than just geographical co-location; the more important issue is stronger clinical interaction between specialists and generalists

with clear and effective arrangements for clinical leadership and team working. In addition to specialists and generalists, primary healthcare teams could include nurses, modern matrons, pharmacists, therapists and all the other members of the broader, but integrated multidisciplinary team. The ways to ensure patients have access to the best and most appropriate treatment will vary from one place to another. However, clear accountability is and remains important for clinical care and responsibility. Regardless of team involvement, there should be clear identification of the clinician with overall responsibility for the care of any particular patient.

The Royal College of Physicians (RCP) and the Royal College of General Practitioners (RCGP) believe that the public will be better served by models of care that allow patients to see the right doctor, at the right time and in the right setting. Specialists and generalists, who come together in community settings, offer an attractive model for improving patient care.

KEY MESSAGE: The Colleges believe that specialists and generalists working in strong collaborative arrangements offer a major and unrivalled opportunity to improve patient care.

Organisation of care – the patient journey: accessible and high quality care in convenient settings

The right doctor, at the right time and in the right setting

Too often, patients need to travel to see a specialist because the specialist works in a hospital. For some patients the journey is easy and for others it can be difficult. There is an additional health inequality issue in that poorer people are less likely to own a car and have greater dependency on public transport. It should surprise no one that, when asked, people express a preference to receive the care they need in local and convenient settings. However, whilst many specialist services can be delivered outside hospital, the convenience for the patient must not be at the expense of quality. There may be situations where there may be no other solution for patients but to visit hospitals, especially where patients need to have access to specialised equipment or procedure, team-based care, or to rare skills that are most effectively sited in units designed for a sizable population. In order to maintain acute medicine services, those consultants in specialties that also deliver care of acutely ill patients will need to spend sufficient time in and around hospitals. With continuing technological advances, innovative ways of providing advice to

patients should be sought, including, but not restricted to, examples such as telephone consultations between specialist and generalist, or telemedicine consultations.

Most of the work in chronic disease management,³ prevention of disease and non-life-threatening illnesses should be based in the community, with rapid access to diagnostics provided in the community. Patients should only be admitted to hospital if it is clear that they need the expertise of the hospital specialist services,⁴ and discharge arrangements should ensure rapid discharge as soon as appropriate. Care of acute and severe illness in the community could be revolutionised by changing some current inpatient provision to community-based care and treatment. Both chronic and acute care could be delivered in a wide range of settings, as appropriate to the individual circumstances of the patient. Furthermore, such initiatives could reduce the number of inappropriate hospital admissions through the concerted development of intermediate care with better skillmix and support from geriatric medicine specialists in the community.

The development of these models will require high quality commissioning from GP practices and primary care trusts. Merely moving outpatients to the community is unlikely to be cost effective.⁵ In addition, to tackle fragmentation of care, it is essential to coordinate and integrate care. Commissioning must not become a tussle between specialists and generalists; instead the focus should be on the development of care pathways. Specialists need to see appropriate patients, and generalists need to work patients up to the required level – such a way of working is supported by practice-based commissioning and payment by results. Having clear standards that involve clinicians and users in service redesign and using care pathways is essential to make practice-based commissioning work.

KEY MESSAGE: Moving care into the community should not be at the expense of quality and safety of care. It should be done in a managed and supported way. Most care, including that for mental health, can be given in the community; hospitals should be for acutely ill patients or where a specialised procedure or treatment is required.

Assuring the quality and safety of care in new models and reducing health inequalities

Traditionally the measurement and reporting of quality is sector based. In the new NHS, the assessment of quality should be centred on the patient journey and

aimed at improving the patient experience. The primary care model is based on Quality Outcome Frameworks (QOFs)⁶ and the secondary sector on waiting lists and activity targets. We should explore the use of QOFs, expanded to fit the local health economy, with measures for the defined community, rather than separate measures for hospital or general practice. We call for the development and use of such outcome measures for the assessment of quality in local health economies.

KEY MESSAGE: The use of quality and outcome frameworks for measurement of quality across local health economies and interfaces should be explored.

As professional boundaries become increasingly blurred, it is essential that doctors work within their defined and verified areas of competence to ensure the quality and safety of patient care. Practitioners with special interests must be accredited using explicit standards and process. General practitioners with a special interest could be a valuable asset working together in teams, but there is a need to ensure national standards of clinical practice, training and assessments.

KEY MESSAGE: In new ways of working, it is essential that healthcare professionals work within their defined and verified areas of competence to ensure the quality and safety of patient care.

The central gate-keeping or navigation role of the general practitioner must be retained to ensure the most appropriate pathway for patients and use of resources.⁷

It is estimated that 17 million adults in the UK live with one or more chronic long-term conditions.⁸ The inverse care law continues to operate widely in the NHS. The targeting of health inequalities mentioned in the White Paper is welcomed and such problems can only be addressed by innovative, collaborative programmes shared between specialists and generalists. Only then will the NHS be able to meet its national targets, including the Public Service Agreement (PSA).⁹

KEY MESSAGE: Specialists and generalists working together can help tackle health inequalities.

Supplying and educating the future workforce

Patients are best served by an appropriate balance of generalist and specialist skills: the benefit to patients of adequate numbers of specialists is undermined if there are insufficient GPs, or vice versa. Furthermore, the GP workforce, as opposed to the specialist workforce, is

inversely correlated with deprivation in that the most deprived areas have fewest GPs per head of population.

The number of consultants has increased significantly over the last ten years. By contrast, the GP workforce has remained static, with small increases in the number of GPs being outweighed by the increasing move to part-time working chosen by many GPs, an increasing proportion of whom are female. It is clear that there should be a major expansion of the GP workforce.

What doctors will be doing in the future is being determined by the changing clinical needs of patients and the needs of the service. It is clear that care should be delivered by trained doctors. New ways of working in the future bring the opportunity for joint education and training both at specialist level and after Certificate of Completion of Training (CCT). This will inevitably require new training models – shared where appropriate – with trainees moving seamlessly between what are currently defined as primary and secondary care. There is urgency in reviewing the training programmes in some specialties, for example diabetes, where the reduction in hospital-based outpatient clinics could compromise the training of specialists.

Specialist training in these areas will need to be undertaken in both primary and secondary care, requiring the joint supervision of the RCP and the RCGP. The new competency-based assessments lend themselves to this approach and, provided that we determine the appropriate competencies for the identified specialties, this has the potential for exciting new training programmes. The opportunity will also exist for conversion of specialism in both directions provided the required selection criteria are met – the concept of transferable competencies is important.

KEY MESSAGE: Patients are best served by an appropriate balance of generalist and specialist skills. Reform of postgraduate medical education and training offer innovative opportunities for training and education.

The way forward

Both the RCP and the RCGP are committed to joint working. Our aims are to deliver better training and support for doctors and higher clinical standards. We wish to work more closely together for the benefit of patients. We are of the view that new ways of partnership working, and models of care between the branches of the medical profession are long overdue. The current model, with separation of primary and secondary care coupled with the budgetary dominance of the hospital, should be challenged.

We suggest a new partnership, the ‘balanced clinical partnership’ (BCP), in which primary and secondary care together develop and explore new ways of working and commissioning. The exact nature of the BCP needs further development and wider discussion but it would promote the managed development of care outside of hospital. We suggest that the impact of new models of care and new ways of working is carefully studied and limited to pilots until evidence confirms sustained improvements. The evaluation needs to include both an assessment of the quality of the care delivered, compared with existing models of care, and a cost comparison to ensure that the changes are not rolled out until there is clear evidence of cost effectiveness and value for money.

KEY MESSAGE: It is essential to evaluate pilots of new models of care, assessing the quality of care, and cost effectiveness, before roll-out across the NHS.

These tasks need to be taken forward at a national and local level. At the national level, the RCP and the RCGP in collaboration with the specialist societies have a key role to play in setting the agenda. Each specialty should reflect on the care they provide and what aspects of that care could be delivered in alternative settings. At a local level, we encourage physicians in primary and secondary care to work together in partnership to put these principles into practice, reflecting the needs of the local community.

References

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