Royal College of General Practitioners

DHSC Major conditions strategy: call for evidence – RCGP submission

Questions

Cardiovascular Disease

1. In your opinion, which of these areas would you like to see prioritised for CVD?
(Select up to 3)

Areas for priority	Selection
Preventing the onset of CVD through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention)	1
Stopping or delaying the progression of CVD through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention)	3
Getting more people diagnosed quicker	
Improving treatment provided by urgent and emergency care	
Improving non-urgent and long-term treatment and care to support the management of CVD	2

[SELECTION ONLY - NO TEXT]

2. How can we successfully identify, engage and treat groups at high risk of developing CVD through delivery of services that target clinical risk factors (atrial fibrillation, high blood pressure and high cholesterol)? (Please do not exceed 500 words)

The current model for targeting CVD prevention is demonstrably ineffective and the strategies must change. The public needs to understand what the NHS can do, given its scarce resources and increasing waiting times, and what they can do for themselves to prevent or reduce the impact of disease once it happens should be a priority.

Empowering people to self-care and understand the risks of a sedentary lifestyle, obesity and cardiovascular risk factors is important. Too often in primary care medication is sought as a fix, when lifestyle changes could be equally beneficial e.g. weight loss for type-2 diabetes. To really make a difference, we need to spread these messages at home, at school, in the workplace and beyond. We can no longer expect the NHS to be the only part of the system that considers primary prevention with public health messaging. Prevention is better than treating the effects of a disease.

All primary care, including dentistry, pharmacy and others, should be alert to those presenting to them and be able to identify those at risk. With the crisis in the workforce of general practice and increasing demand for care we need to consider alternative ways to reach the whole population. As of April 2023, there are 27,231 fully qualified full-time equivalent GPs in England, 3.2% less than in December 2019 (and 7.3% less than in 2015). Therefore, GPs have less time to proactively target populations at a higher risk of CVD and this limits the ability of general practice to address the needs of its population.

Engaging communities to take care of their own health is also important. For groups at a high risk of developing CVD, Core20plus5 targets those who are least engaged with our healthcare systems and at the highest risk of developing CVD that goes untreated. However, many have limited access, face stigma when accessing, or choose not to access health care provision. Therefore, innovation is key to ensure those who most need healthcare are able to access it and we must engage with communities and ensure that everyone has access to prevention tools.

Use of digital and wearable technology can also identify those at risk within the community but needs to be funded appropriately with results integrated into clinical systems for it to have a benefit. And whilst digital innovation is key, it is also imperative to consider those in the population who do not have access to digital technology, do not want to use digital technology or have poor broadband which limits the use of technology.

We need clarity around local guidelines and pathways. NHS waiting lists are growing and more patients are being treated in an under-resourced primary care. Patients should receive the right care at the right time, and this must be communicated and clear to all involved. So many patients end up lost in the NHS system being bounced between different services that it creates a negative experience which can lead to less engagement in health and therefore poorer patient outcomes.

Chronic Respiratory Diseases

3. In your opinion, which of these areas would you like to see prioritised for CRD?
(Select up to 3)

Areas for priority	Selection
Preventing the onset of CRDs through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention)	1
Stopping or delaying the progression of CRDs through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention)	3

Getting more people diagnosed quicker	
Improving treatment provided by urgent and emergency care	
Improving non-urgent and long-term treatment and care to support the management of CRD	2

[SELECTION ONLY - NO TEXT]

Dementia

4. In your opinion, which of these areas would you like to see prioritised for dementia?
(Select up to 3)

Areas for priority	Selection
Preventing the onset of dementia through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention)	1
Delaying the progression of dementia through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention)	3
Getting more people diagnosed quicker	
Improving treatment provided by urgent and emergency care	
Improving non-urgent and long-term treatment and care to support the management of dementia	2

[SELECTION ONLY - NO TEXT]

Musculoskeletal conditions

5. In your opinion, which of these areas would you like to see prioritised for MSK?
(Select up to 3)

Areas for priority	Selection
Preventing the onset of MSK through population-wide action on risk factors and wider influences on health (sometimes referred to as primary prevention)	1
Stopping or delaying the progression of MSK through clinical interventions for individuals at high risk (sometimes referred to as secondary prevention)	3
Getting more people diagnosed quicker	
Improving treatment provided by urgent and emergency care	
Improving non-urgent and long-term treatment and care to support the management of MSK	2

[SELECTION ONLY - NO TEXT]

Tackling the risk factors of ill health

6. Do you have any suggestions on how we can support people to tackle these risk factors?

- [✓ Yes]
- No

[SELECTION ONLY - NO TEXT]

7. How can we support people to tackle these risk factors? (Please do not exceed 500 words)

You might consider suggestions on how we could:

- *make changes at a local level to improve the food offer and support people to achieve or maintain a healthy weight and eat a healthy diet*
- *identify and support inactive people to be more physically active*
- *support people to quit smoking, including through increasing referrals to stop smoking support and uptake of tobacco dependency treatment*
- *support people who want to drink less alcohol to do so*

Risk factors are present throughout life. Personal and environmental risk factor modification needs to start early and continue throughout the life course. Waiting until people reach adulthood and are able to access services for themselves is too late.

A cross governmental department approach should be considered with health, work and education all included. Intervention should look to address:

- Prenatal information to parents on the effects of their lifestyle on their unborn child
- Perinatal and postnatal services to provide information on what effects long term health e.g. smoking, diet, exercise. Providing access to the tools people need to live healthy lives is also crucial is ensuring these risk factors are addressed. There should be support provided to children under the age of four, especially in ‘at risk’ households where adverse childhood experiences (ACE) have affected the parents and there is risk of generational perpetuation of ACEs, and subsequent uptake of smoking, alcohol and drug use to cope with trauma.
- At school, teaching children about the harms of smoking and alcohol, alongside cookery classes to understand nutrition can help to tackle these issues from an early age.
- Community power: there should be a focus on the empowerment of communities to find their own solutions for their unique populations and support strategies to improve mental and physical health and wellbeing. Those in their community are best placed to know the most effective ways to target risk factors that affect them, and so should actively lead the work ensuring interventions are accessible to all those who will use them, particularly focusing on reading literacy levels and language translation.

- Exercise: increasing the amount of aerobic exercise in schools is key to helping reduce the obesity problem in our children and young people. The proliferation of outdoor gyms in public parks was a good step towards making exercise more accessible, and apps like couch to 5k worked effectively to support those with less confidence to embrace a healthier lifestyle.
- Key social focus areas that would help to tackle risk factors include addressing homelessness, the effect of rapidly increasing food prices and high energy bills.
- Commercially: encourage supermarket and commercial providers to provide healthy food in all areas. Avoiding high sugar promotions and encouraging promotions on healthy food instead.

From a general practice perspective, more work could be done in terms of prevention and reduction of health inequalities, if funding was more fairly distributed. The RCGP Fit for the Future report set out a vision for the future of general practice as 'community hubs', where a range of wellbeing and community services are available to address patients' broader psychosocial needs and help build resilient communities.

Supporting those with conditions

8. How can we better support local areas to diagnose more people at an earlier stage?

You might consider suggestions to increase capacity available for diagnostic testing or identify people who need a diagnosis sooner.

Rather than focus on individual conditions, the RCGP calls for government to prioritise the care for those living with multiple long-term conditions.

A. Suggestions for multiple conditions:

1. A focus throughout public health, social, education and healthcare on multiple long-term conditions at every stage of life would increase the emphasis and knowledge base of all.
2. A change in the training at an undergraduate and post graduate level across all health care settings to identify multiple long-term conditions at an early stage rather than focus on individual diseases or body systems.
3. Public awareness and knowledge must be improved to ensure people are aware of the early signs/ symptoms of all conditions listed and that some diseases, e.g. hypertension, often have no visible signs. Once knowledge has increased, empowering communities to lead their own revolution in identification of early disease is of paramount importance. Every community is different and what works in inner city London will not be as successful in the Lake District and vice versa.
4. Empowering all health care partners and systems to look for early signs and symptoms of long-term conditions. For example, outpatient departments in hospitals would routinely weigh people and measure blood pressure/ perform urine dipstick analysis in the past. Opportunities to feel a pulse and identify atrial fibrillation, detect silent diabetes with random urine tests or hypertension with

random BP measurements are now lost as they no longer undertake these basic checks in many areas. Ensuring that the whole of the health system was responsible for prevention and identification of early disease would be a welcome step.

5. The RCGP Fit for the Future vision details the need for more diagnostic testing, currently delivered in hospitals, being provided closer to home in community settings. This will include not only the diagnostic hubs currently being set up, but also access to a greater range of data sources and AI to support diagnostic decision making.
6. Joined up clinical notes throughout the primary and secondary care system or handheld electronic patient notes would make it easier to share information across systems and allow specialist and generalists to be aware of the information across disease boundaries.

B. Suggestions for CVD:

Easy access to diagnostic equipment for the general public that can detect diabetes, hypertension or atrial fibrillation. Some local areas around the country have trialled the use of at home monitoring or self-checking facilities of key indicator symptoms of CVD such as blood pressure or blood glucose levels. These have been stationed in places that are easily accessible to people and won't cause them to need to take time out of their day, for example, when queuing in supermarkets.

C. Suggestions for chronic respiratory diseases:

National initiatives to use cigarette packets to provide signposting to smoking cessation services and information on how to get support for smoking related diseases would improve earlier diagnosis of chronic respiratory conditions. The repeated exposure to this messaging is more likely to encourage people to use it and take the initiative to seek the help they may need.

D. Suggestions for MSK:

Utilise advertising campaigns which signpost to local initiatives or support for those with suspected or developing MSK issues in places where people are sedentary, such as pubs or public transport, to allow them to reflect on symptoms they may be experiencing. It is also useful to explain to people how long they should be experiencing MSK issues for in order to seek help.

E. Suggestions for dementia:

Using the evidence we have for other disease and their prevention is key as we await more dementia research. For example, diet changes that are used to improve CVD have also been shown to improve brain heath. This public health messaging needs to be shared at an early stage. If children were taught at school that a good diet can prevent them getting dementia and other diseases it would begin the conversation at the early stage that is needed to make an impact as people age. Public awareness advertising campaigns which educate on how to prevent dementia and what the symptoms of dementia are at an earlier stage should also be shared. Messages should be clear and understandable, but also come with reassurances that it is important to be checked as their symptoms may not be caused by dementia, but that it is better to find out earlier in order to get the right support and live well with dementia.

9. How can we better support and provide treatment for people after a diagnosis?
You might consider suggestions that help people to manage and live well with their conditions, with support from both medical and non-medical settings.

A. Suggestions for multiple conditions:

Care for people living with multiple long-term conditions is not joined up, but rather fragmented by the system to target each of their conditions. This can lead not only to ineffective treatment for these people as a whole but can create an extremely negative experience of their care which can exacerbate their conditions, particularly mental health conditions. Services tend to focus too much on symptoms and conditions and fail to consider the needs of the patient which leads to complex, uncoordinated and unintegrated care. To start to improve this, the RCGP is calling for a focus on multiple long-term conditions and recommends:

1. Appointment of a national clinical lead for multiple long term conditions to lead change in the NHS. Without national leadership leading the change long term conditions as a whole will not be considered in the same way individual disease processes are. Leadership needs to come from the top and within the DHSC in the way we have for women's health.
2. Appointment within each ICS of a lead for multiple long-term conditions to link to the national lead and implement change locally to integrate pathways of care horizontally across specialisms, aiming to move away from the silo care of disease that happens at the current time.
3. To learn from the experience of long Covid and to consider a funded and fully resourced expansion of the integrated multi-disciplinary meetings, often held virtually. These horizontally (across specialisms) and vertically (across primary and secondary care) integrated care pathways aim to reduce the burden on the patient and the secondary care services. This will ensure services consider the person as a whole, taking into account every long-term condition and move away from siloed individual disease treatment towards coordination of care. For example, with medication, the specialists consider which one medication can help with all of the long-term conditions rather than 3 specialists prescribing 3 different medications. Rehabilitation can be coordinated with a single person providing rehab, rather than separate rehab for each condition.
4. An updated NICE guideline on multimorbidity, to be called multiple long-term conditions, and for NICE to add to the scope of every new guideline what the impact of a disease specific recommendations will be on the wider person who has more than one long-term condition. Only if national guidance changes to include the treatment of disease in a horizontally integrated way, will the NHS treatment for patients improve.
5. Improve the shared electronic records across social, primary and secondary care to ensure we look holistically at a person, no matter where they present in the NHS.
6. Improve self-care support and empower people to self-care. Self-management is an essential part of the healthcare plan for these patients and when done

effectively, can lead to improved health outcomes. However, the personal management of multiple conditions can be challenging due to more medications, uncoordinated healthcare appointments and a system that is under strain. It also appears these strategies are less effective for people living in more deprived communities as they may lack the access or support in order to effectively undertake any plan drawn up for them. Self-supported care should receive greater consideration for those managing multiple conditions and commissioners and healthcare leaders should be encouraged to consider how self-care, self-supported care and social prescribing can be enhanced for people living with multiple long-term conditions.

B. Suggestions for CVD:

For patients with CVD, there needs to be far better information flow from hospital to general practice and community care so that they can be best supported. While the system is very much under strain, there should be more responsive appointment options for people who have flair ups or exacerbations in their conditions so that they can receive the correct care right away. Utilisation of group sessions to help people manage their health is also very effective as it allows those living with potentially severe conditions to have a community around them and build connections which can encourage them to learn and embrace a healthier lifestyle.

C. Suggestions for chronic respiratory diseases:

There needs to be improvement in the use of clear care plans that are fully supported, as well as the utilisation of group support sessions and the development of better health literacy. It is also important to signpost those diagnosed with a chronic respiratory disease to smoking cessation resources in order to try to prevent the worsening of their condition.

D. Suggestions for MSK:

Providing easily accessible and unintimidating exercise opportunities is a key support tool for post diagnosis. This should include ensuring people have access to physiotherapy which can be virtual or in person depending on need. Considering the use of personal trainers to expand the rehabilitation team as successfully shown by the Nuffield charity long Covid programme response, or digitising the rehabilitation offer as services have done with long Covid could ensure we can provide higher volumes of treatment with less staff resource.

E. Suggestions for dementia:

For those diagnosed with dementia, there needs to be targeted support for carers and clear explanations around what to expect, for both the person and their family. This should include ensuring that the person and their family are made aware of all the medical and support resources available to them and they understand what types of planning should be involved in the person's care. As the disease progresses, it is important to limit the number of professionals involved with the care to reduce confusion or alarm and that everyone involved is clear on their care plan.

10. How can we better enable health and social care teams to deliver person-centred and joined-up services?
You might consider suggestions to improve the skill mix and training of the health and social care workforce.

A. Suggestions for multiple conditions:
There is no national direction or agenda to better support people living with multiple long-term conditions. In 2021, the government published a white paper that proposed a system which enabled better integration across health and social care and established the ICS bodies that we have today. So far, many ICSs have been unable to break down the siloed disease management structures that have existed before and fully re-design their health systems to better support people rather than just diseases. Therefore, the DHSC should appoint a National Clinical Lead for multiple long-term conditions to have the responsibility of leading the charge for the horizontal integration of care across specialities and ensure that there is support for both physical and mental health conditions equally within the NHS. This role could have the potential to create a step change in how multiple long-term conditions are factored into service design and improve the patient experience.

Multi-disciplinary and multi-speciality teams should be at the heart of supporting patients with multiple long-term conditions. Taking learning from the COVID-19 pandemic and long Covid, services should be built on a foundation of fully integrated multiple specialities forming virtual MDTs, working with GP colleagues in order to better manage the many outpatient referrals of those with multiple long-term conditions. This model should harness a cross-speciality and cross-sector integrated care approach and stakeholders should proactively work together in order to promote better care of our primary care patients with multiple long-term conditions.

Finally, national clinical and commissioning guidance for primary care must reflect on the impact it has on those with other long-term conditions. All guidance should be developed in a way that ensures it includes the needs of people with multiple long-term conditions, aiming to move away from silos of disease and reduce the medication burden for those with multiple long-term conditions.

B. Suggestions for CVD:
There needs to be increased investment in education, rehabilitation and remote monitoring to empower people to manage their own health better and make their use of the healthcare system more efficient.

C. Suggestions for chronic respiratory diseases:
There needs to be improved awareness of management of chronic respiratory conditions and co-production of rescue plans which involve cross-disciplinary working. There needs to be health and social care key points of contact and clear delegation of responsibility for the person’s care.

D. Suggestions for MSK:

There needs to be a multidisciplinary team approach to the care of people with MSK conditions. These conditions can impact in many other body systems and the support these people require can be broad. For example, shared clinics between GPs, physiotherapists and other team members who help to manage MSK conditions could help to support people much more effectively.

E. Suggestions for dementia:
There needs to be a multidisciplinary team approach to the care of people diagnosed with dementia. The teams should specifically include, but not be limited to, GPs, occupational therapists, physiotherapists, nurses and social care workers to provide 360 support.

11. How can we make better use of research, data and digital technologies to improve outcomes for people with, or at risk of developing, the major conditions?

A. Suggestions for multiple conditions:
More research needs to take place regarding the impact multiple-long term conditions. Most healthcare research is single disease specific and does not account for other conditions which may co-exist. In fact, many patients with co-exiting conditions are excluded from research trials and therefore the interactions of various diseases are not effectively explored. NICE's multiple-long term conditions guideline has also flagged this as an area that requires more research and there is recognition in the healthcare community that, while we have effective structures for turning research into treatment for single diseases, there has been no thinking around how to integrate this where there exist multiple conditions.

Regarding digital technologies, the College is supportive of harnessing the benefits of digital technology and delivering more digital services to improve patient care. As stated in our Fit for the Future report, the RCGP envisions general practice using digital technology to deliver more proactive and preventative care. That can happen by remotely monitoring patients' conditions and adherence to medication and using home testing and wearable technology innovations. Linking wearables to smartphone apps and patient-held electronic records will empower patients to better manage their own care, check their current health status, and quickly alert them and their GPs when they are at risk.

To achieve that, upgrades in IT infrastructure and skills in primary care are necessary, as well as ensuring that IT systems across the NHS are interoperable. The College's "The future role of remote consultations & patient 'triage'" report has set some specific recommendations to consider, including ensuring GPs and their teams have access to the tools, training, guidance, and support in routinely using digital tools; improving digital patient triage platforms and processes; and producing guidance for patients to support the effective implementation of new digital tools and systems.

Finally, it will be critical to mindfully address the possible impact of the increased use of digital tools and remote consultations on health inequalities. Some patients, especially those in vulnerable situations (e.g. due to age or rurality), might not have access to IT or digital literacy, which can exacerbate health disparities.

B. Suggestions for CVD:

C. Suggestions for chronic respiratory diseases:

D. Suggestions for MSK:

E. Suggestions for dementia:
We need to invest more in research on dementia, especially relating to lifestyle measures that can prevent the disease, treatment to prevent disease progression and the interventions that can help people live well with dementia including psychological, creative health and social care.

12. How can we improve access to palliative and end of life care?

You might consider suggestions for how best to involve individuals in conversations about their future care.

There needs to be a step change in the way we approach death and dying in line with The Lancet commission for death and dying. Talking about death and dying needs to become normalised. Communities need to be encouraged to see death and dying as part of the natural life cycle and empowered to become involved. Death should be expected to be managed in the community unless the person specifically requests an alternative place / way they wish to die, with a 5-year plan put in place to reduce hospital deaths, transferring them to the community. With most people wanting to die at home, but in fact higher proportions dying in hospital, it is imperative that we normalise death once more.

Changing the narrative would then encourage more people to have advanced care discussions to ensure their preferences are taken into account for when life is coming to an end. Currently, in many places, this conversation comes too late, or is never had at all. We should empower people to plan for their death in the way we encourage them to plan for their retirement. This means increasing the number of conversations we all have regarding what is important to us in the last years, months, weeks and days of our lives.

With increasing pressure on our hospitals and the loss of dignity sometimes seen because of lack of privacy or long waits in A&E, it is important that the people receiving the care, as well as their carers and family are aware of all of the options available, and decisions made to ensure their choices can be effectively implemented. This must be fully resourced, with resources moving from secondary care into the community in order to realise this aim.

Cancer

13. How can we better support those with cancer? (Please do not exceed 500 words)

For those undergoing cancer treatment or living with cancer, it is important that wait times for treatment are brought down to the shortest time possible. There also needs to be more options available for treatment locations to allow people to receive their treatment closer to their home.

More investment needs to go into innovative treatments for cancer, and the NHS should actively support people with cancer to access clinical trials.

For cancer survivors, there must be a care pathway created to support the transition from secondary care back into the community and into primary care. Many people feel abandoned upon discharge from hospital care. Resources must follow the patients with onward community support funded to ensure care and support can continue.

Mental health

14. How can we better support those with mental ill health? (Please do not exceed 500 words)

Bringing mental health and physical health together is imperative to destigmatise mental health and ensure those with mental health conditions are treated as well as those with physical illnesses. The combining of services will also begin to address the interaction of physical and mental health where one often affects the other.

For those experiencing mental ill health, there needs to be an increase in the availability of evidence-based services such as cognitive behavioural therapy and dialectical behavioural therapy. Many times within primary care, if therapy was available without a long waiting time then antidepressants would not have to be prescribed. Sadly, because of long waits for therapy, people often return asking for medication to help whilst waiting for therapy. There should be a dedicated round the clock support line for mental health and clearly signposted points of contact to enable those experiencing mental ill health to receive support when they need it, and this is particularly important for people who have more limited access to healthcare, both geographically and systemically.

Training in mental health as a speciality should also be included earlier and more frequently in the clinical training of all health care professions in order to increase its exposure and ensure all clinicians have the right level of training to effectively manage those requiring mental health support. There should also be more guidance around supporting those with neurodiversity and learning disability with mental ill health and explanations around how presentation may differ, and assessment and management might need to be altered and adapted.