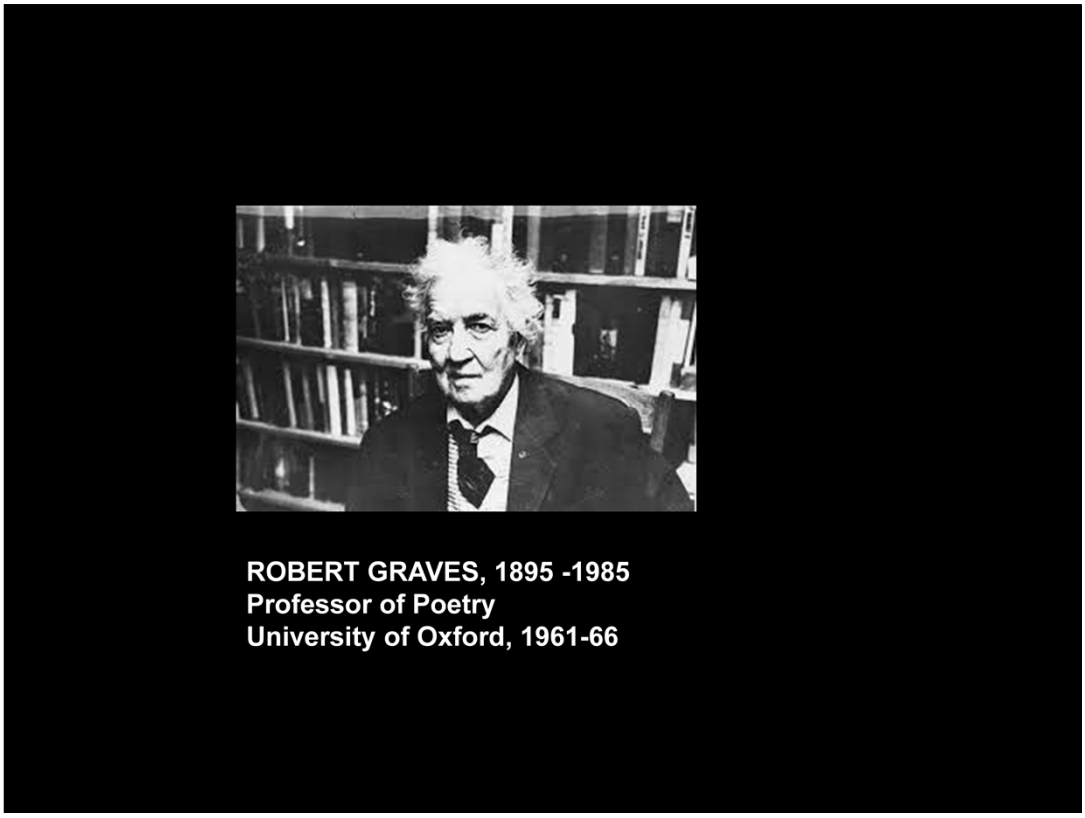
RE-IMAGINING THE NHS

LEARNING FROM GENERAL PRACTICE AT THE DEEP END

Presentation by Professor Graham Watt

Glasgow Centre for Population Health, 8th December 2016

Thank you for this invitation. I'm going to cover a lot of ground. When you see this green star, I'll be saying something that I think particularly important. Of course you will be your own judge of that.



SLIDE 1

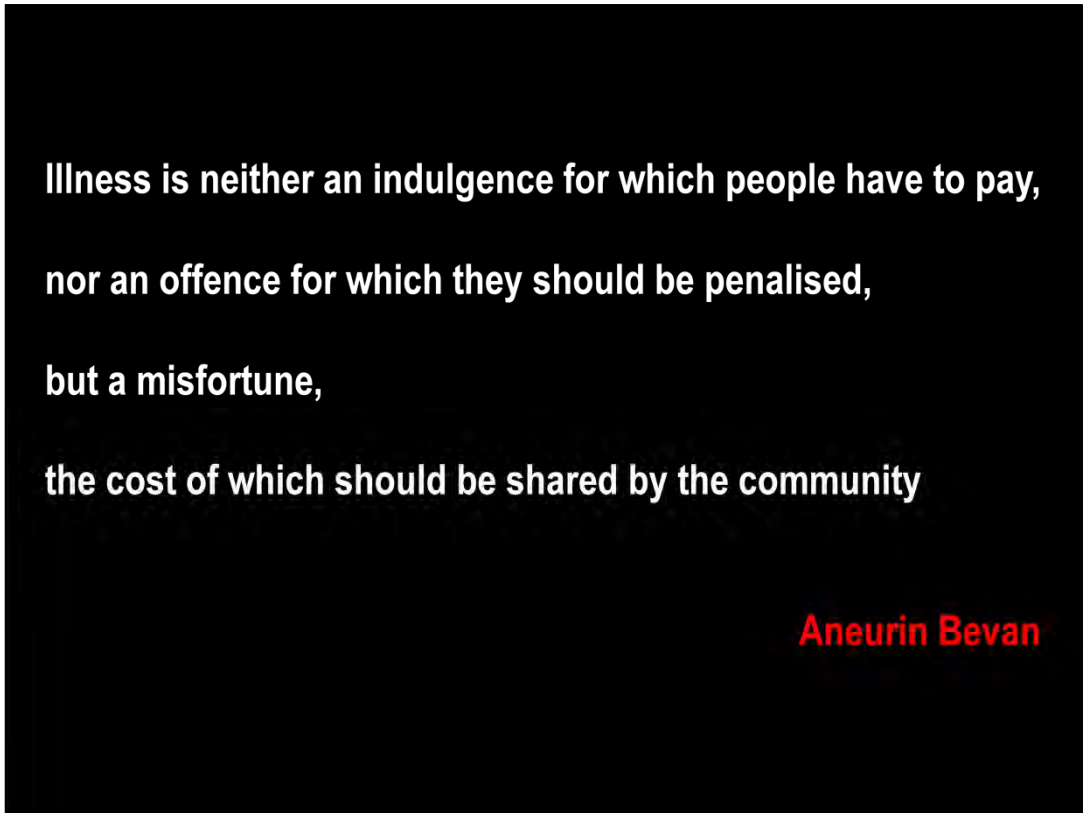
Robert Graves was Professor of Poetry at Oxford. On his passport, under occupation, he put professor rather than poet, saying that this avoided trouble and guaranteed “dull respect.”

SLIDE 2

Graves was a First World War poet, who survived four years in the trenches. By that time he said in his autobiography *Goodbye to all that*, the front line troops had only contempt for the priests and chaplains who tried to put a gloss or higher purpose on futility. The soldier's experience of cruel fate and blind chance had left them with only one remaining value – loyalty to colleagues, they were in it together.

SLIDE 3

Not an original sentiment, and easier to approve in principle than to demonstrate in practice.



SLIDE 4

But demonstrate it our parents and grandparents did, after World War 2, in the creation of the National Health Service, following Bevan's call that illness should neither be an indulgence for which people have to pay, nor an offence for which they should be penalised, but a misfortune the cost of which should be shared by the community

SLIDE 5

Bevan wrote only one book, but its title *In Place of Fear* succinctly captures what the NHS was set up to do – to remove the fear of the consequences of illness.

SLIDE 6

That fear is still with us. Few things bring people out into the streets – anger at an illegal war, joy at a local football team winning a cup, and the fear caused by any plan to close a hospital, but in the latter case, it's an irrational, misinformed fear. Hospitals are the last resort. They are very expensive. They shouldn't be the first point of contact. We should make less use of them, but that means policies that reduce, delay or avoid our need for hospital care.

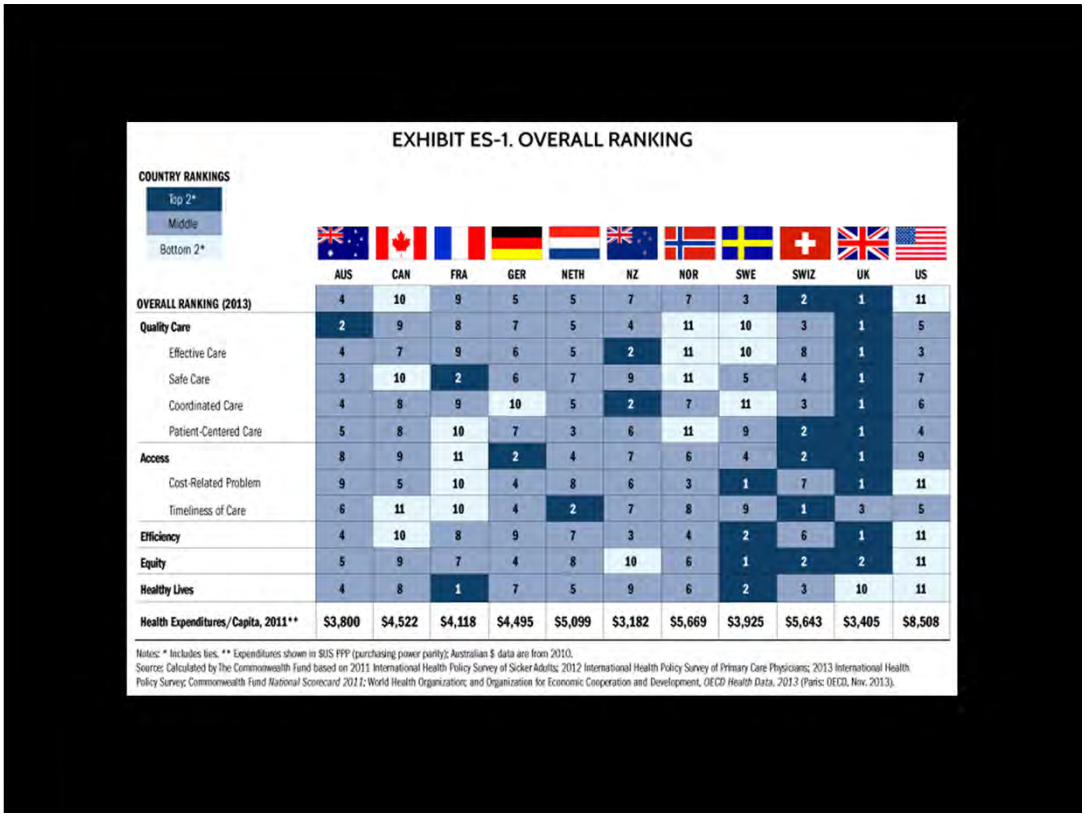


EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS
Top 2*
Middle
Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011*; World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

SLIDE 7

I'll come to that, but first I want to deal with two possible distractions.

Distraction 1 - let us be clear that the NHS has not failed. In this independent review of 11 rich countries, by the Commonwealth Foundation in New York (nothing to do with the British Commonwealth), the NHS ranked first on almost every quality indicator, the US coming last. Yet The NHS spends second least on health care per head, while the US spends most, by a country mile. The NHS is under pressure, but the pressure comes from underfunding, not the lack of US style corporate health care.

SLIDE 8

As the vultures gather, as they always do, because health care can be a lucrative business if you hoodwink the worried well and exclude people who can't pay, we may need to decide, as our parents and grandparents did, whether health care is a commercial business to make profits, a public utility keeping customers satisfied or a social institution, based on mutuality and trust.

SLIDE 9

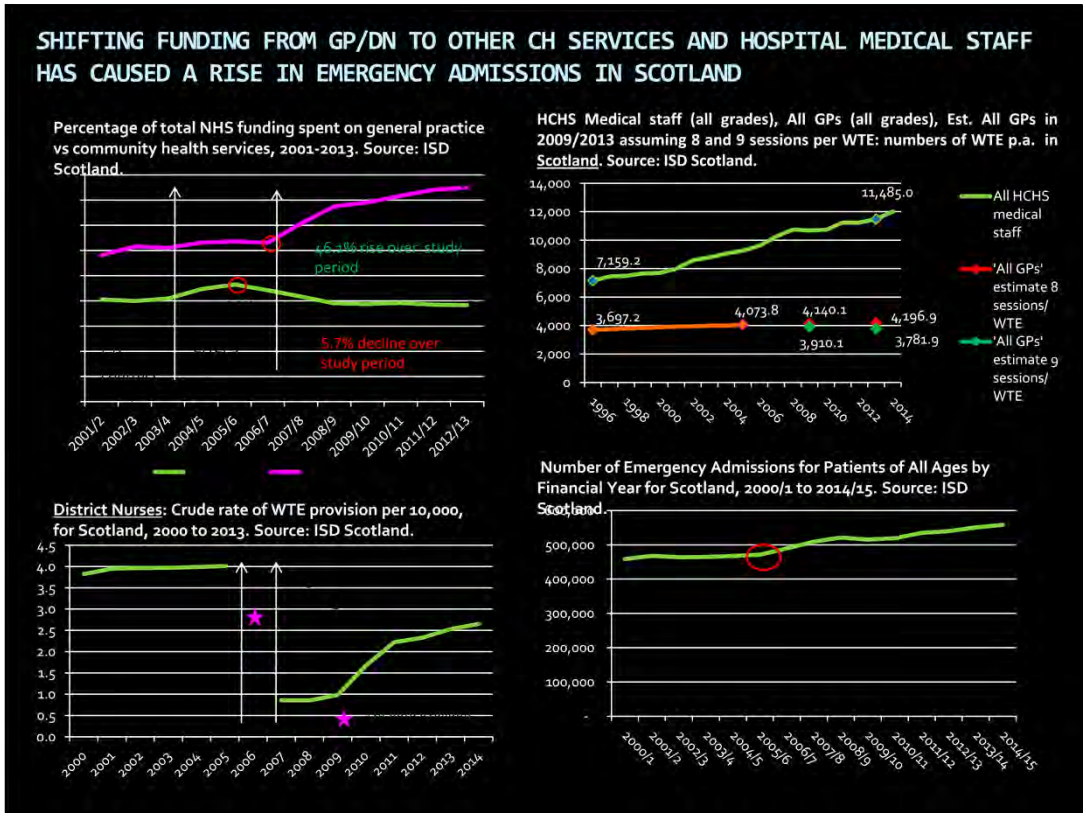
It's complicated because the NHS, and our experience of it, involves many different things for ourselves and our families – dealing with emergencies, both large and small; providing access to specialist diagnosis and treatment; getting a good start in life; dying in comfort and with dignity; and increasingly, living long and well with long term conditions.

SLIDE 10

Distraction Two is the false promise of genetic-based, so-called, precision medicine. I don't doubt that this can do fantastic things for selected patients, but we are a long way from having the epidemiological information needed to tell us whether these interventions can improve public health.

SLIDE 11

To put it simply, in Willy Wonka and the Chocolate Factory, there were only 5 golden tickets. How many golden tickets will precision medicine provide?



SLIDE 12

To set the scene for the first part of my talk, here are data from Dr Helene Irvine, who seems to have become a one person, alternative, Information Services Division for NHS Scotland.

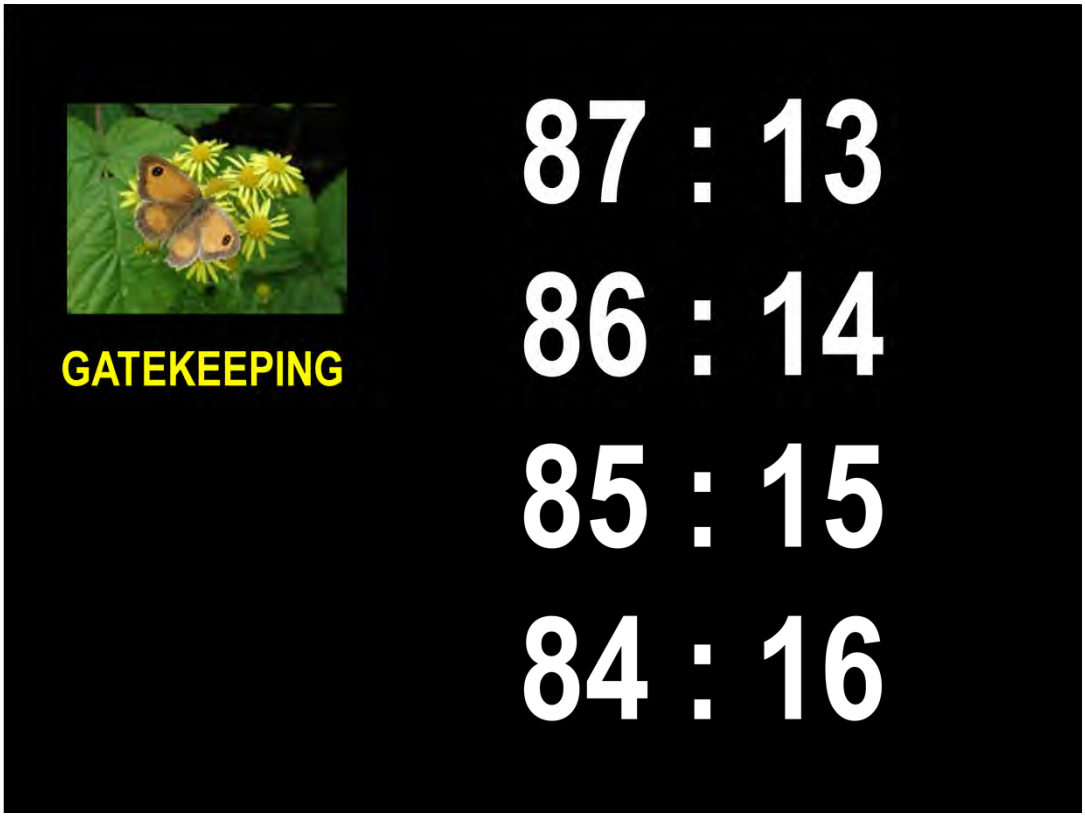
TOP LEFT, while general practice funding (in blue) fell by a sixth in the last ten years, funding for community health services (in pink) increased 46%.

TOP RIGHT, while GP numbers (in orange) have largely flat-lined, medical staffing in hospital and community services (in blue) increased 60%.

BOTTOM LEFT, district nursing was slashed in the noughties, then rallied but is still 40% below its previous capacity.

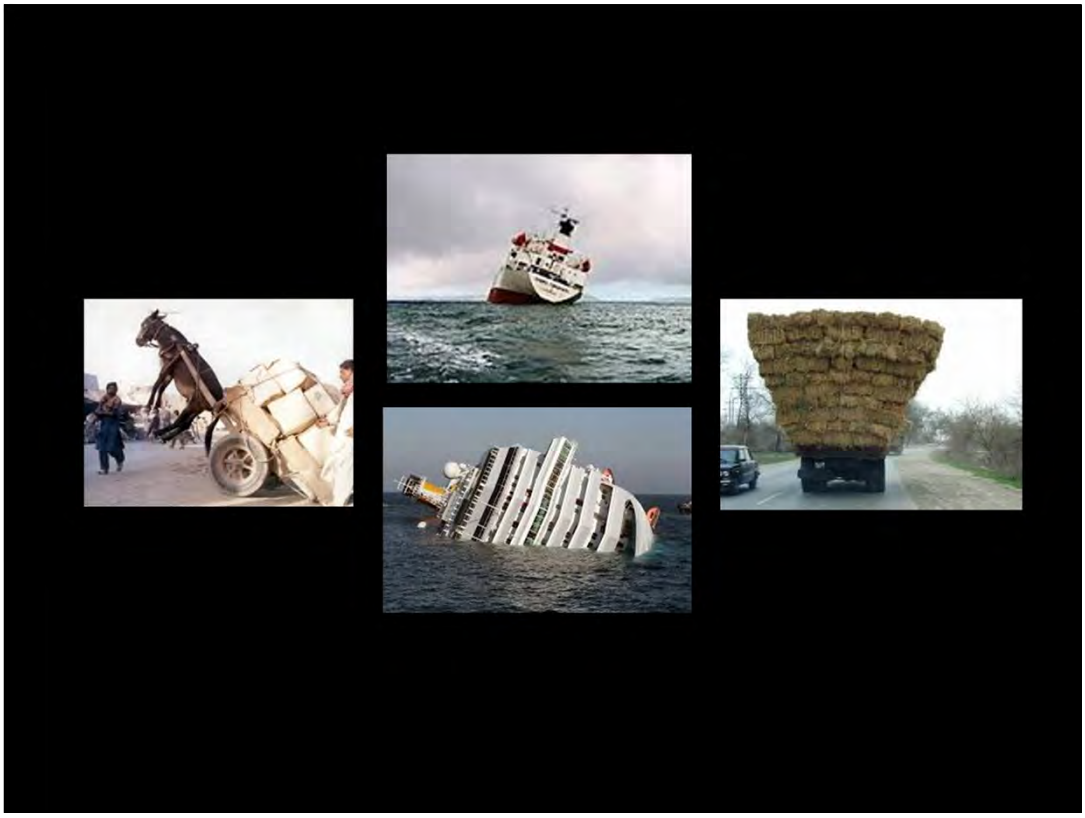
BOTTOM RIGHT, the consequences, since 2005, an acceleration of emergency hospital admissions, which has not stopped, and is not fully explained by the ageing population.

There are many possible explanations, including the weakening of district nursing, the council tax freeze and its knock on effects on community care, but also, the weakening of general practice.



SLIDE 13

If the balance of care shifts from 87% in the community and 13% in hospitals, to 84% in the community and 16% in hospitals, the difference is imperceptible in the community, but overwhelming in hospitals. The answer to that problem is not more hospital resources. Unbelievably, as recently as September, the Scottish Government was suggesting that hospital pressures could be addressed by getting GPs to work in hospitals.



SLIDE 14

When a vehicle or organisation becomes unbalanced or lopsided, the danger is that it will capsize. The challenge facing us is to correct that imbalance before it is too late.

SLIDE 15

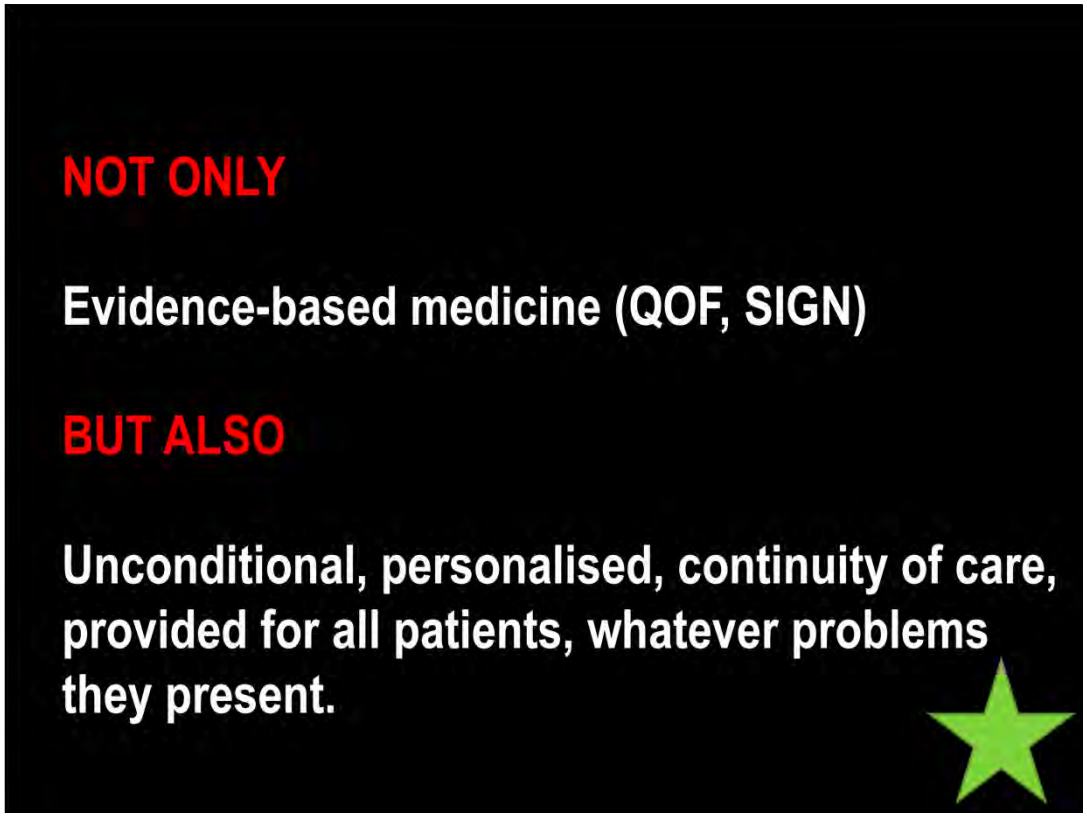
It is the gatekeeping role keeps the NHS afloat, or in balance, keeping most care in the community. For emergency services, there isn't an actual gate, only a gateway that patients can go through at any time to Out of Hours, A&E or an acute hospital bed. What keeps patients in the community is satisfaction with the care they receive, and the avoidance of complications. What does that involve?

SLIDE 16

As Barbara Starfield pointed out, the main contribution of health care is to reduce the severity of established conditions and delay their progression, thereby preventing, postponing or lessening complications.

SLIDE 17

Of course, there are social determinants of health which operate outside the NHS, which need to be addressed, to prevent health inequalities in the long term, but this is an important neglected social determinant of health which operates in the short term.

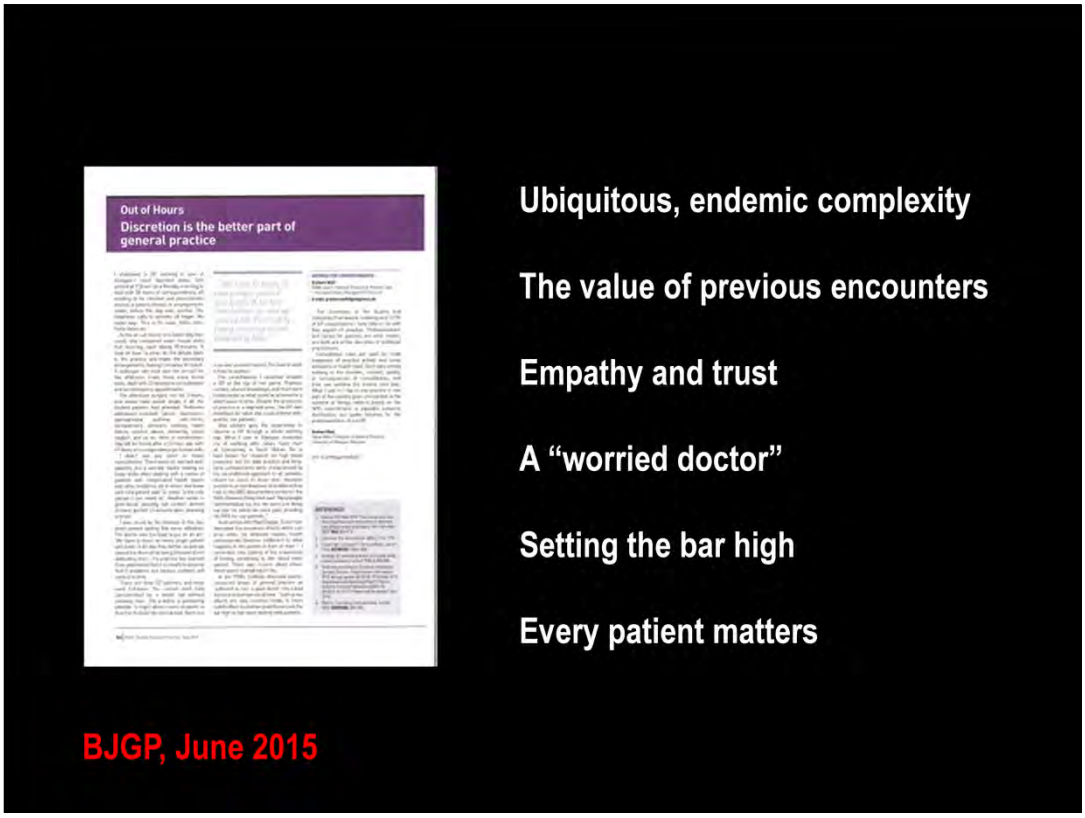


SLIDE 18

That's achieved partly via the delivery of evidence-based medicine, but also, and equally important, via unconditional, personalised continuity of care for all patients, whatever condition of combination of conditions they have.

SLIDE 19

Decisions are only sometimes informed by evidence; usually they are based on experience; always, they are underpinned by values. Yes, we should produce evidence whenever we can, but we also have to draw on experience and to appreciate and express the values.



SLIDE 20

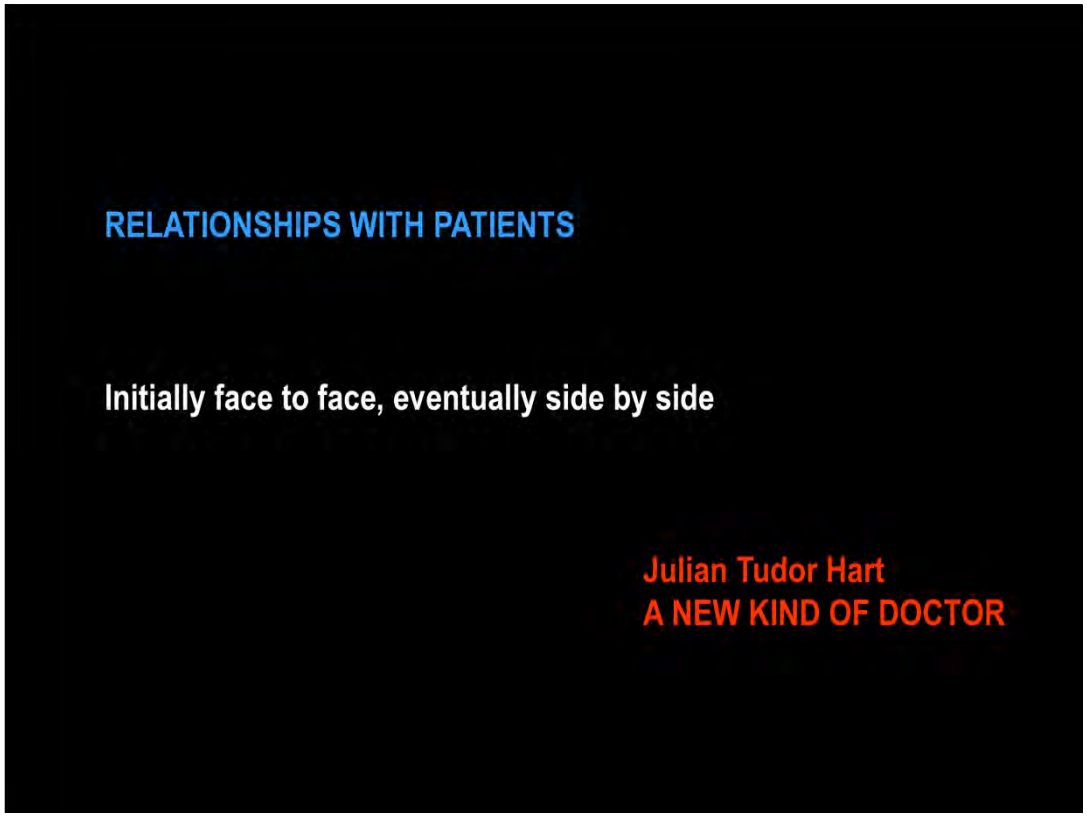
I spent a day shadowing a GP in Scotland’s most deprived general practice. I saw endemic multimorbidity and social complexity; the importance of previous encounters and shared knowledge, for anything much to be achieved in a short consultation; the value of empathy and trust; I didn’t see any worried well patients, but I did see a worried doctor, taking it upon herself to anticipate problems and take avoiding action; she set the bar high; every patient mattered.

SLIDE 21

That was just one day in the life of a GP. At Govan Health Centre in Glasgow, these three GPs have over 60 year's experience of one community between them. What might they have achieved in thousands of days, throughout their professional lifetimes? When they retire (and one has retired) it's the equivalent of the Wall Street crash. Capital built up over years, in terms of knowledge, experience and trust, disappears.

SLIDE 22

In life, as in the film, nothing very much happens in brief encounters. It's the serial encounter that matters, all the contacts strung together, with starts, stops, re-starts, diversions, events, successes, failures, but underlying it all, consistent direction.

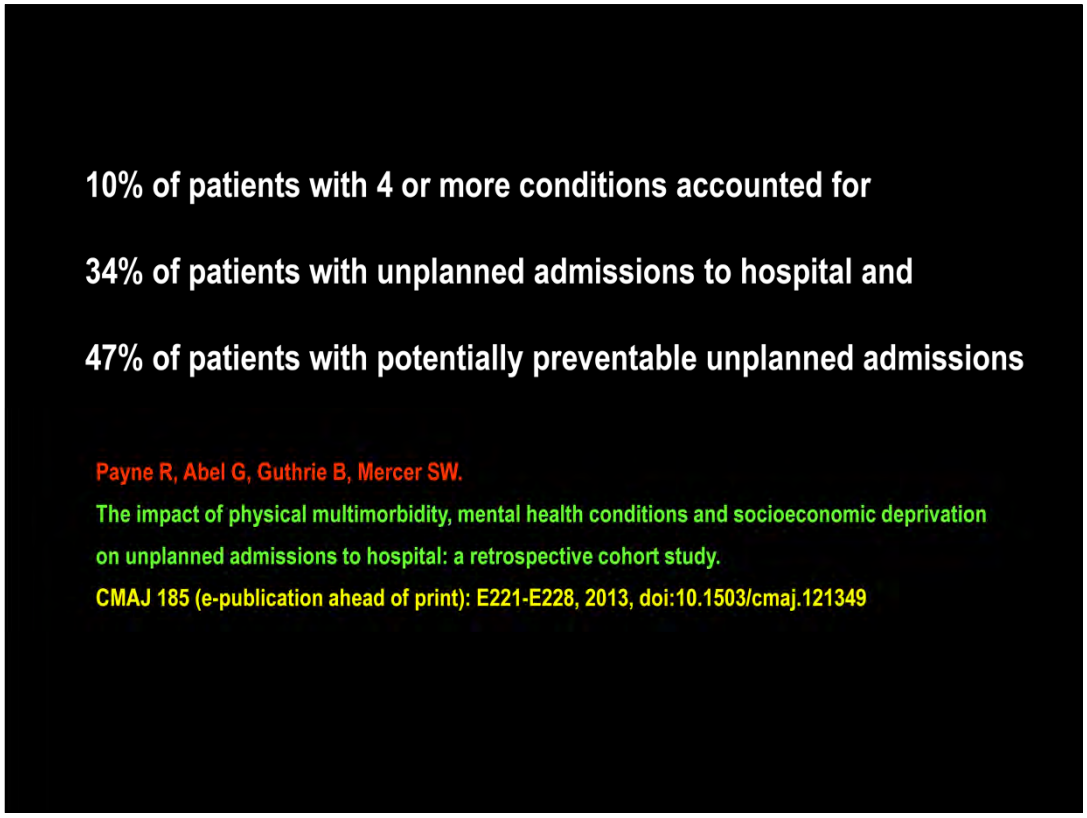


SLIDE 23

As Tudor Hart put it, initially face to face, eventually side by side. In deprived areas, self-help and self-management are destinations not starting points. What the “unworried unwell” need, at least to begin with, is a worried doctor, to steer the course, facilitate access and anticipate hazards.

SLIDE 24

In Tales of the Arabian Nights, Scheherezade had to make up a new story every day. Her life depended on it. That's also the business of general practice, making up thousands of stories, building knowledge and confidence, helping patients live long and well, avoiding the complications of their conditions.

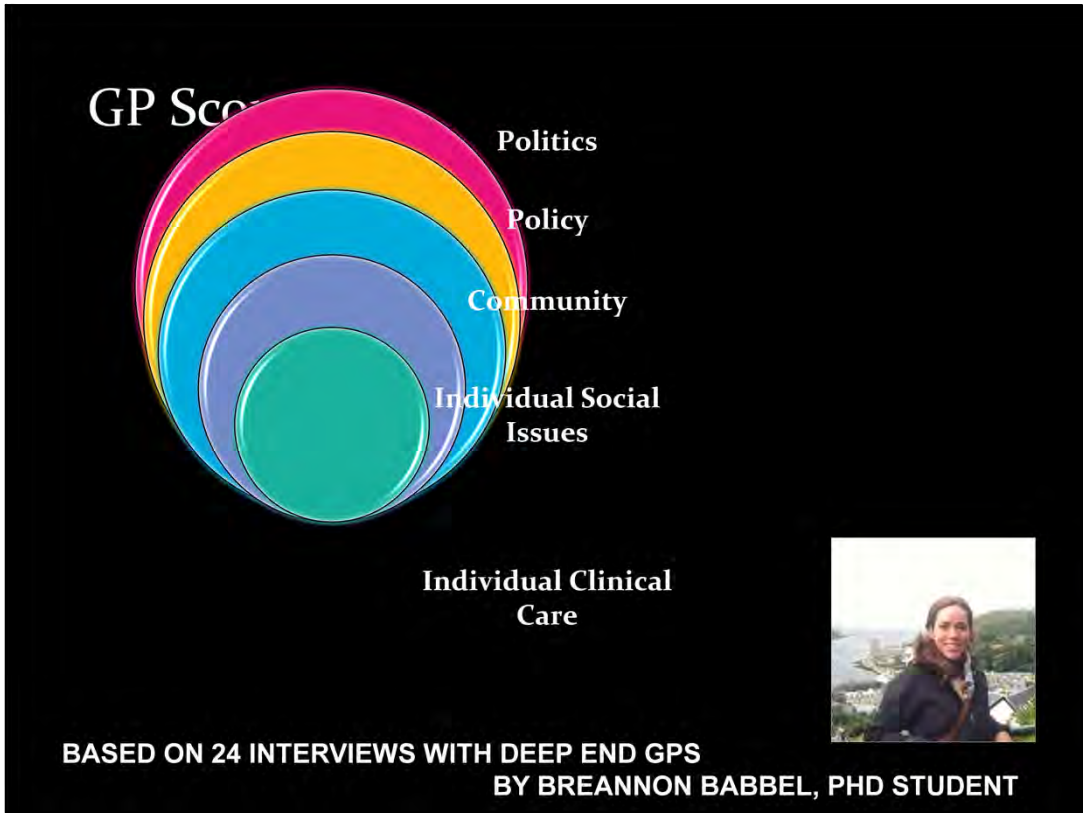


SLIDE 25

Not every patient needs this, but the 10% of patients in Scotland with 4 or more conditions, who account for a third of all unplanned admissions to hospital, and a half of all potentially preventable unplanned conditions, certainly do.

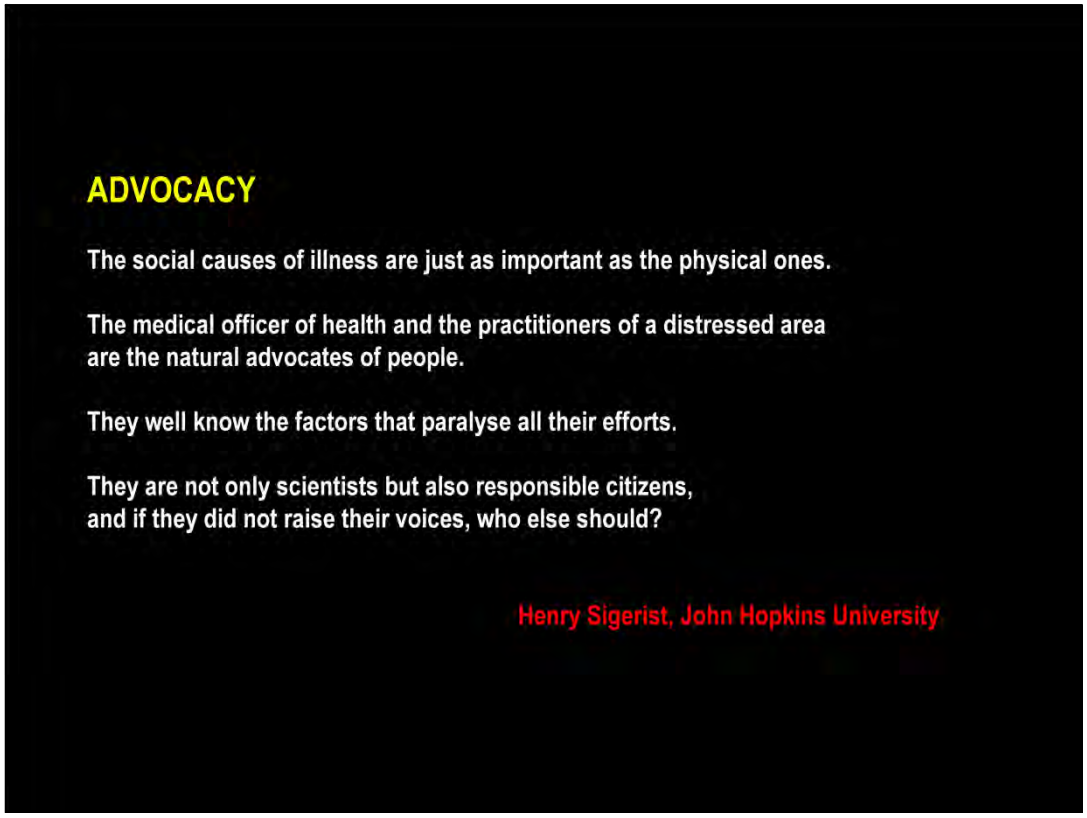
So far, I've said nothing about re-imagining the NHS. It needs to be rescued first, from its current calamity after a decade of preferential investment in specialist services, weakening general practice and its ability to keep patients in the community. The problems of GP recruitment and retention are symptoms of this massive own goal.

But I do now want to look ahead.



SLIDE 26

My PhD student, Breannon Babbel from Oregon, interviewed 24 GPs working in very deprived areas to ask them what they thought their role could be. Some saw no further than the conventional medical model; others broadened the consultation to include social issues; others looked outside their practice to the local community; while others took advocacy positions, trying to influence local and national policies, engaging with managers and politicians. All of that is possible, but only if GPs have the interest, time and support, enabling them to do it.



SLIDE 27

Take advocacy. As Sigerist put it, “The practitioners of a distressed are the natural advocates of people. They well know the factors that paralyse all their efforts. They are not only scientists but also responsible citizens, and if they did not raise their voices, who else should?”

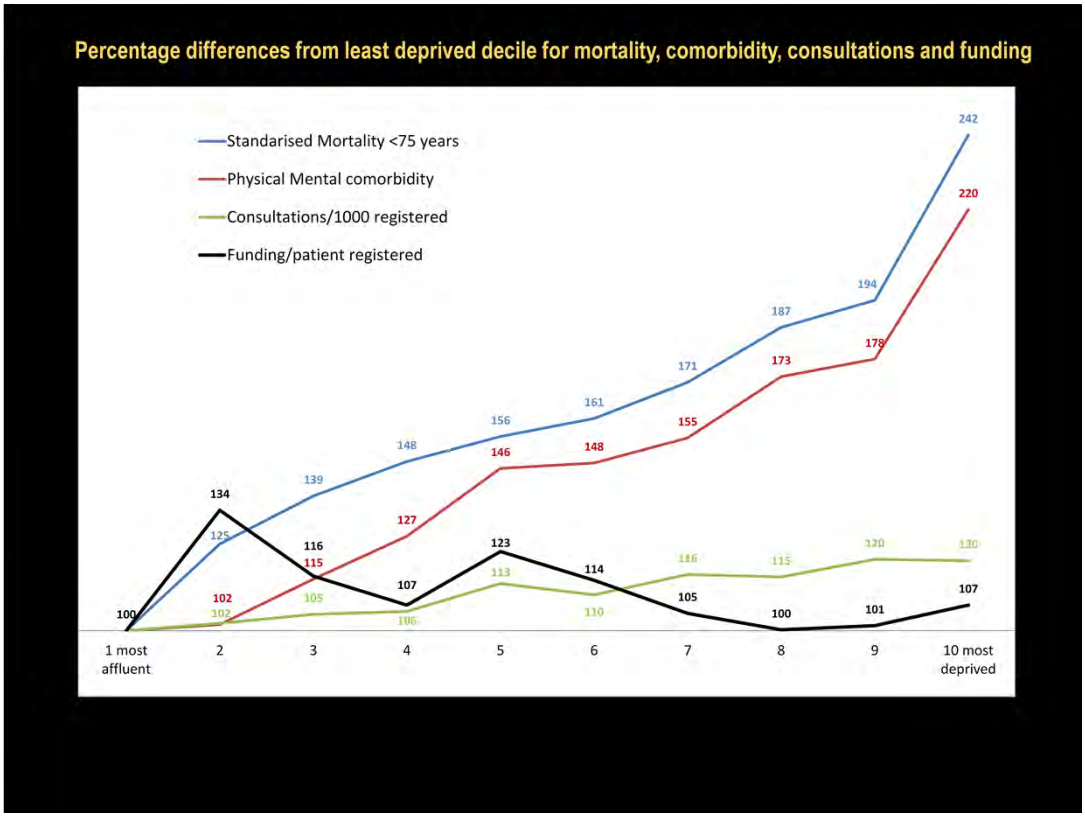
SLIDE 28

…… a role exemplified by several Deep End Reports on the havoc being wrought by changes to the welfare benefit system. Based on the recent experience of practitioners and patients, these reports had huge authority, and travelled fast.

My daughter, Nuala Watt, has cerebral palsy, a PhD, gets DLA and sometimes ESA, is also involved in advocacy. She says to the DWP, "Please stop calling me a customer. If I was a customer, I would take my custom elsewhere and write terrible reviews on the Internet".

SLIDE 29

However, welfare benefit changes are not the main focus of our advocacy. The elephant in the room is that if general practice makes a difference, but is delivered inequitably, the NHS will itself widen inequalities in health. Can such a thing be true?



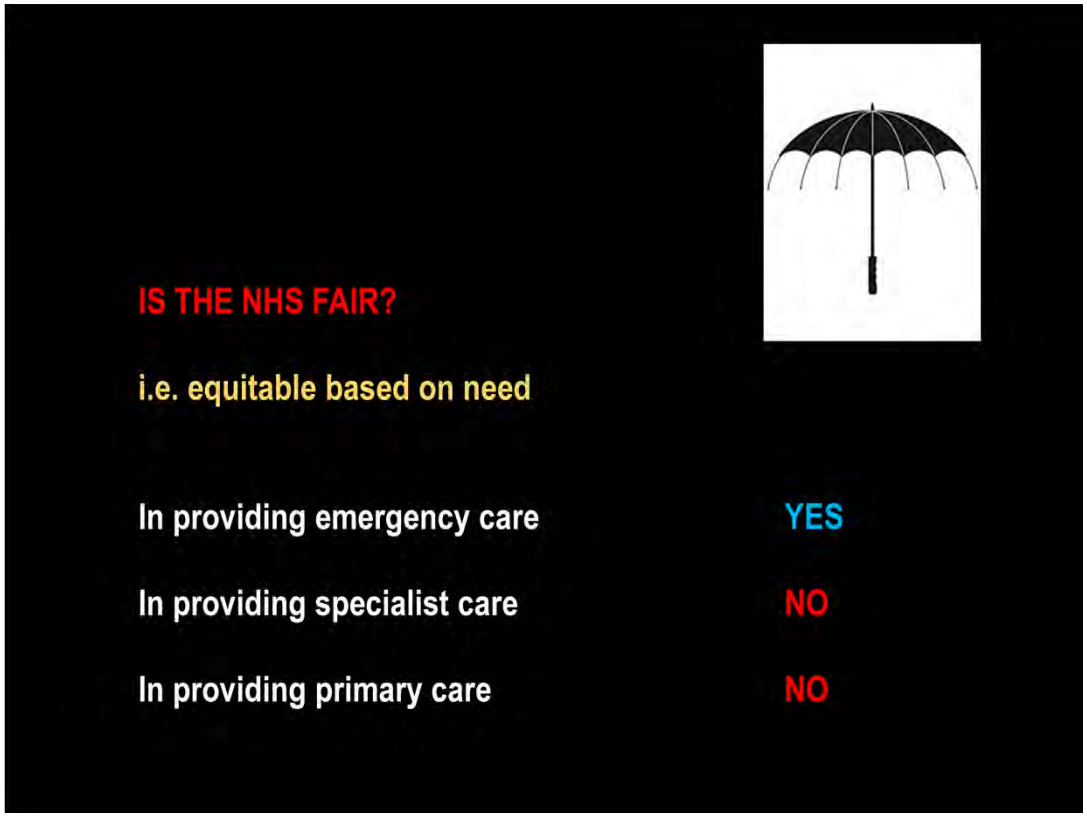
SLIDE 30

The figure divides the Scottish population into tenths, richest on the left, poorest on the right. Premature mortality in blue and complex multimorbidity in red more than double in prevalence across the spectrum, while general practice funding per patient, in black, is broadly flat. We have horizontal equity in terms of access, but not vertical equity in terms of needs-based care. The consequences in the bottom right hand side of the slide include: GP consultations that involve more problems, but are shorter and achieve less. Unmet need accrues. Inequalities in health widen. Because general practice is less able to cope, patients are more likely to use emergency services. Hospitals feel the pressure.

This is separate from the recent problem of underfunding that Helene Irvine describes. It is an endemic historical problem that affects deprived areas, most of which are in Glasgow.

SLIDE 31

Tudor Hart's Inverse Care Law described how the availability of good medical care tends to vary inversely with the need for it in the population served. But it's not a law, it's a man-made policy that restricts care in relation to need. And it's not about bad care in poor areas. Rather, it's the difference between what practices can do, and could do, if they were better resourced.



SLIDE 32

People think that because the NHS deals with emergencies in an equitable way, it does so for everything, but that's not the case with access to specialists, nor with ordinary general practice. I've yet to see this acknowledged in a Scottish Government report on health inequalities, a report of a Director of Public Health or CMO, or with one exception a report from the Glasgow Centre of Population Health. But it is quintessentially a Glasgow problem.

Why don't people see it as a problem requiring urgent attention? Why do other issues get priority? I think there may be three reasons. First, because it doesn't produce noise, from patients who have learned not to expect more (the CMO's call for Realistic Medicine doesn't apply here), from professional bodies serving other interests, or from politicians supposedly representing affected communities. Second, because despite all the bluster, conceit and self-congratulation, we are a conservative society, most comfortable in how things are. Third, because many people do not know or cannot imagine how general practice makes a difference.

The Herald

FOUNDED ON MONDAY JANUARY 27, 1783

GPs at the Deep End

Give care services more resources

Our health service should be at its best where it is needed most

SCOTLAND has an admirable record of providing comprehensive health care which is free at the point of use, and has been steadfast in protecting its NHS from the ravages of market competition, which continue to threaten the NHS in England.

However, as the continuing statistics on health inequality show, NHS Scotland has still to address the inverse care law, whereby the availability of good medical care tends to vary inversely with the need for it in the population served.

While NHS resource distribution formulae and general practitioner contracts have recognised for a long time the increased health problems, multiple morbidity and needs for care of elderly populations, they have been much less effective in providing resources to meet the increased health problems, multiple morbidity and social complexity of younger patients living in very deprived areas.

As general practitioners working in the 100 most deprived general practices in Scotland, we are the front line of the NHS in Scotland as it battles with health inequality. We are in daily contact with large numbers of patients, with unrivalled levels of continuity and coverage, and have substantial experience and knowledge of the health problems of people living in Scotland's poorest communities, including vulnerable children, and those struggling with mental health and addiction problems, in addition to physical ailments.

The inverse care law in Scotland is not a matter of good medical care in affluent areas and bad medical care in deprived areas. It is the difference between what general practice and primary care can currently achieve, in meeting the needs of patients in very deprived areas, and what could be achieved if the service were better resourced to address levels of need.

The major issue which must be addressed, and whose solution requires political action, is the shortage of time within consultations to address a patient's needs in very deprived areas. Although other measures are needed, without this essential building block, the NHS will continue to fail in its attempts to narrow health inequalities.

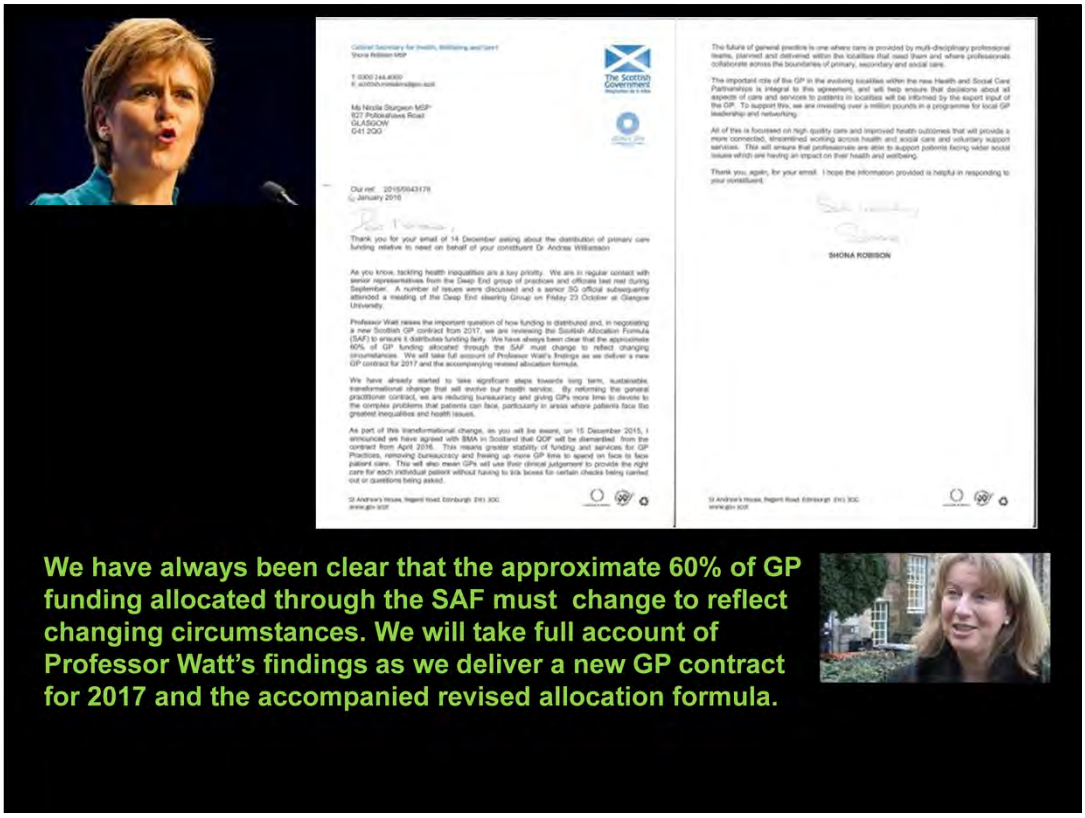
Longer consultations are needed to work with patients on their problems, to take a preventive approach and to instigate links to other services.

The NHS has many challenges to face, but should be at its best where it is needed most. We call on political parties contesting the forthcoming election to commit themselves to eliminating the inverse care law in Scotland. Their first step should be to provide general practices in the front line with additional time for patient consultations.

Members of the Deep End Steering Group: Georgina Brown, GP, Springburn Health Centre; John Budd, GP, Edinburgh Homeless Practice; Peter Cawston, GP, Drumchapel Health Centre; Margaret Craig, GP, Possil and Springburn; Susan Langridge, GP, Possilpark Health Centre; Stewart Mercer, Professor of Primary Care Research, University of Glasgow; Catriona Morton, GP, Craigmillar Health Centre; Anne Mullin, GP, Govan Health Centre; Jim O'Neill, GP, Lightburn Medical Centre; Euan Paterson, GP, Govan Health Centre; Petra Sambale, GP, Keppoch Medical Centre; Graham Watt, Professor of General Practice, University of Glasgow; Andrea Williamson, GP, Glasgow Homeless Health Services.

SLIDE 33

The NHS needs to be at its best where it is needed most; otherwise health inequalities will widen. Everyone can agree with that, but as Julian Tudor Hart also said, “intellectual opposition to injustice is only the beginning of social understanding”.



SLIDE 34

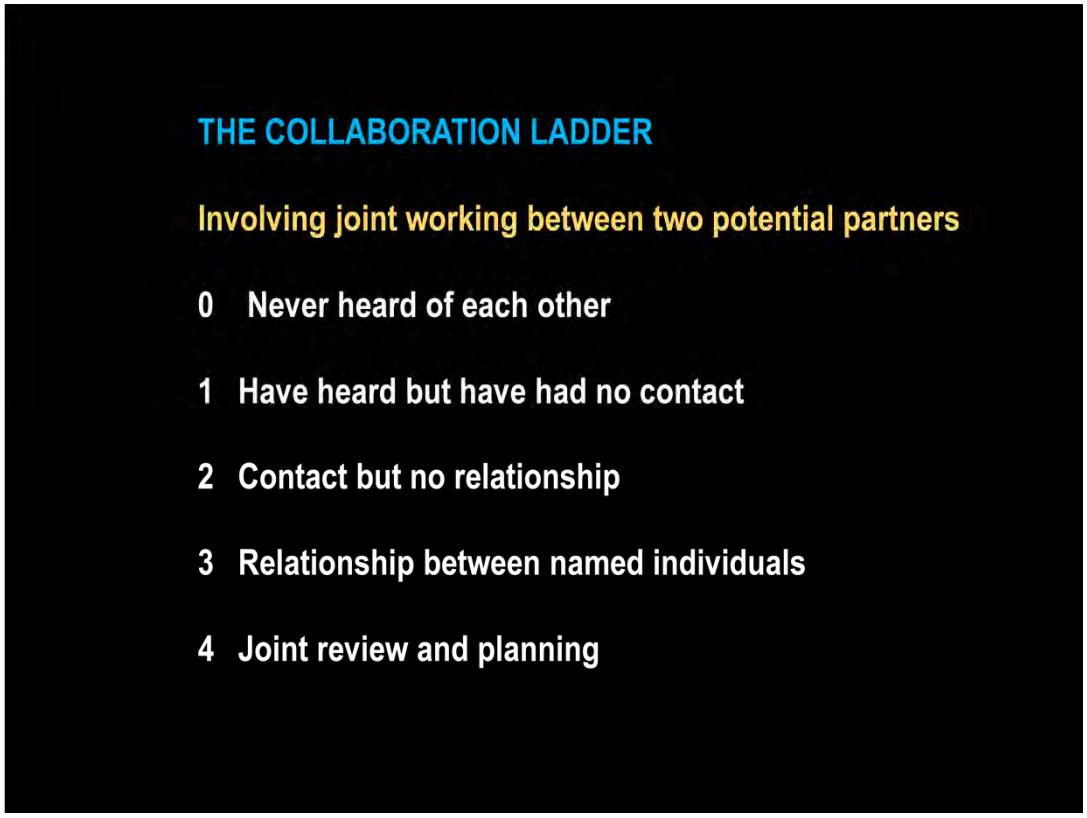
When the research paper with the figure I've showed you was published just over a year ago, First Minister Nicola Sturgeon and Cabinet Secretary for Health Shona Robison both said they expect the needs of deprived areas to be addressed via the new, revised, GP contract. We shall see. I'll say no more about this for now.

SLIDE 35

It used to be that a single-handed GP knew everything and did everything, like Dr Ciriani here at Kremmling, Colorado, but no more

SLIDE 36

The intrinsic features of general practice – patient contact, population coverage, continuity, flexibility, long term relationships and trust – are essential, they make general practice the natural hub of local health systems. No other part of public service has these characteristics in such large measure. But although essential, they are not sufficient. Links are needed to a host of other resources and services.



SLIDE 37

Two professionals might work in the same community. On the Collaboration Ladder, zero means they have never heard of each other; 1 they have heard of each other but have never met; 2, they've met but that's it; 3, they work together haphazardly; 4, they sit round a table to review and plan joint work. Very little use has been made of these metrics.

SLIDE 38

Local health systems can be resource poor but people rich – think of Cuba (whatever you think about that country, its achievements in health and education have been huge), or resource rich and people poor – think of the US. Who knows how our local health systems measure up on this scale?

SLIDE 39

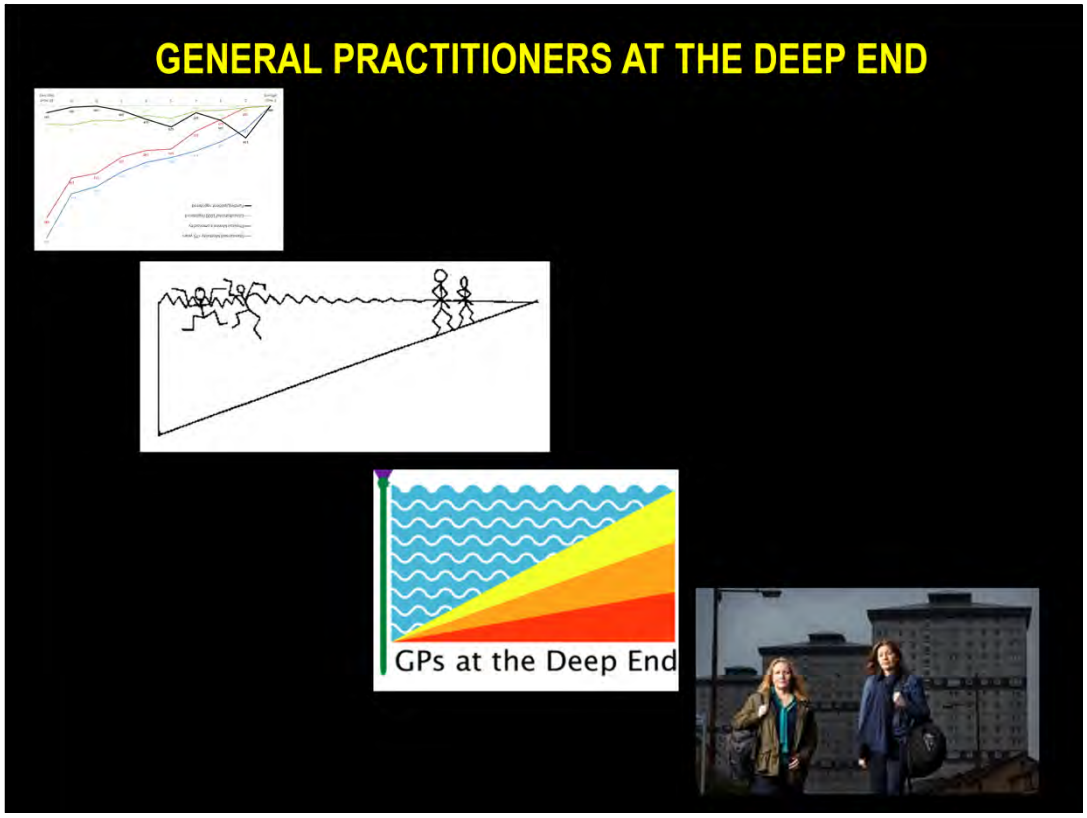
Remember the day almost 50 years ago when Celtic not only became the first British team to win the European Cup, but did so with 11 players, none of whom had been born more than 30 miles from Glasgow.

When Alex Ferguson's Aberdeen team beat Real Madrid to win the European Cup Winner's Cup in 1983, they were the last team to win a European competition with players all from the same country.

The purpose of these examples is not to argue against immigration. It is to show that local people can do extraordinary things, if they work together and believe in what they are doing. Neither Jock Stein nor Alex Ferguson scored goals, defended well or saved penalties, but they knew how to get others to do that.

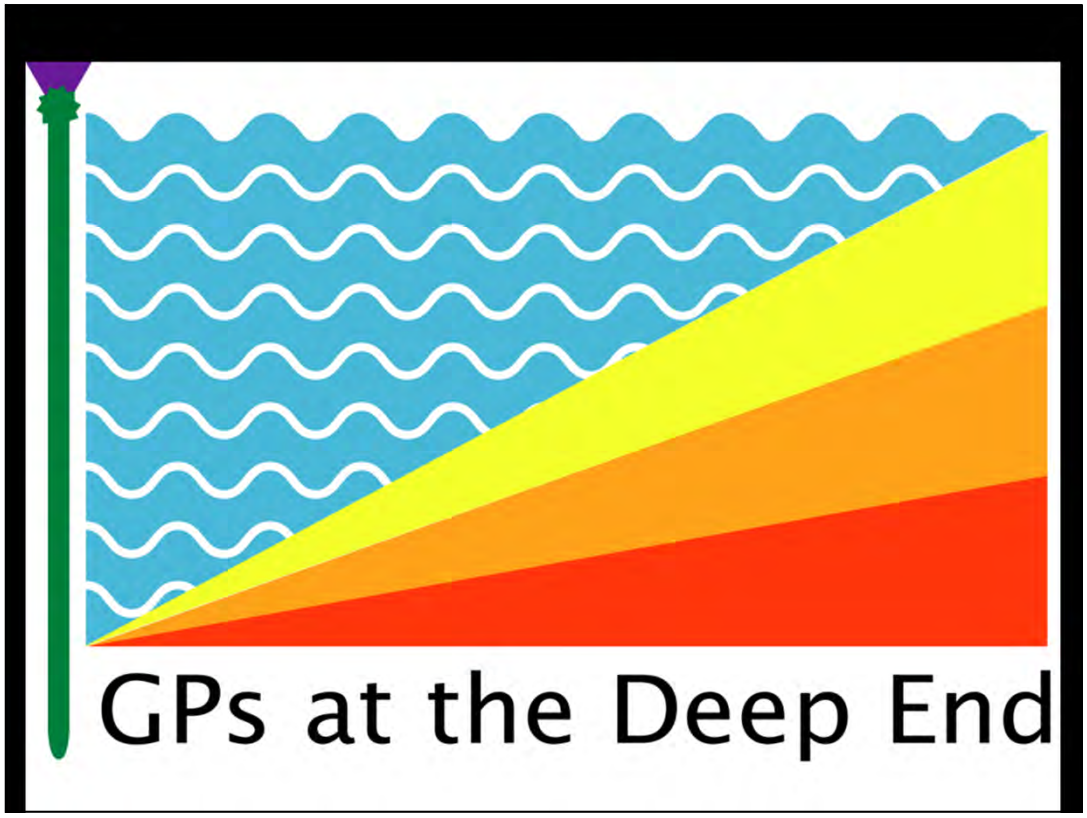
SLIDE 40

So I close the first half of my talk with the need for a building programme, not with bricks and mortar, but with relationships, building patient stories on the one hand, building better relationships with colleagues and services on the other.



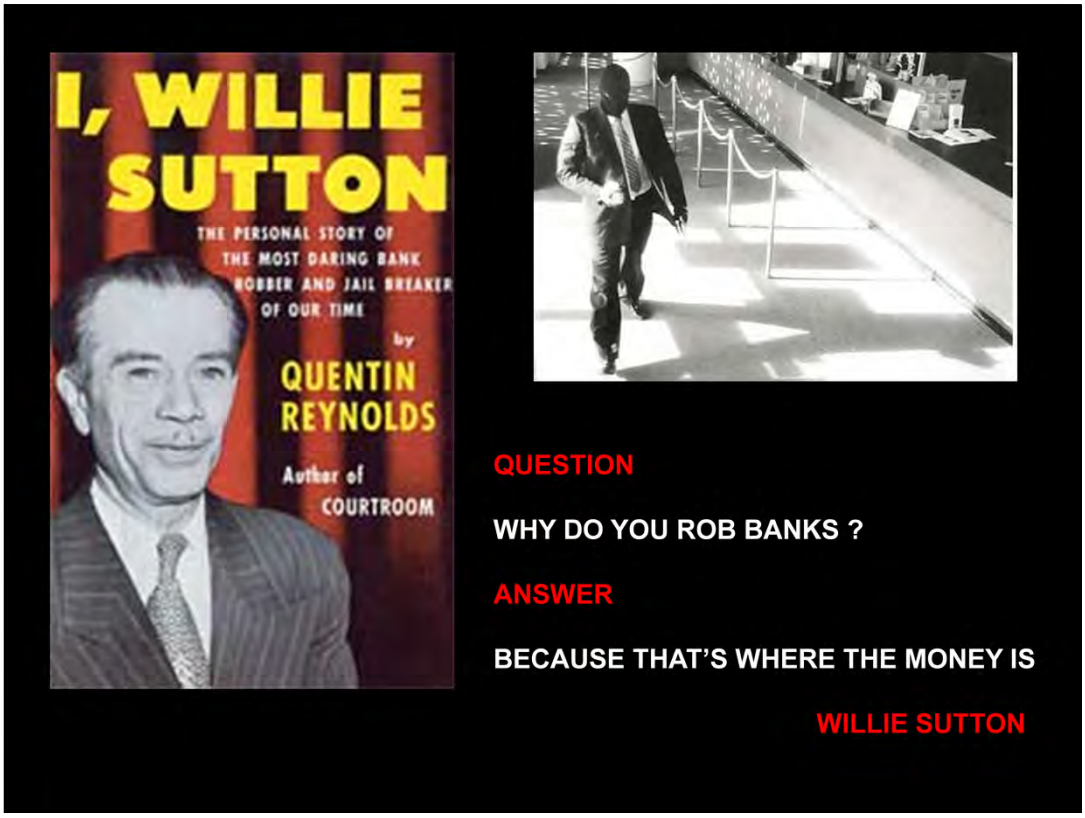
SLIDE 41

Turn the figure upside down, it becomes a swimming pool, with a deep and shallow end, hence General Practitioners at the Deep End, and here are an intrepid pair of Deep End GPs in Possilpark, Glasgow.



SLIDE 42

The logo shows the swimming pool, the steep gradient of need, the flat slope of resource, a sunrise or a sunset, a thistle and a spurtle, that's a traditional kitchen stirring implement. The whole thing is a flag, for rallying under.

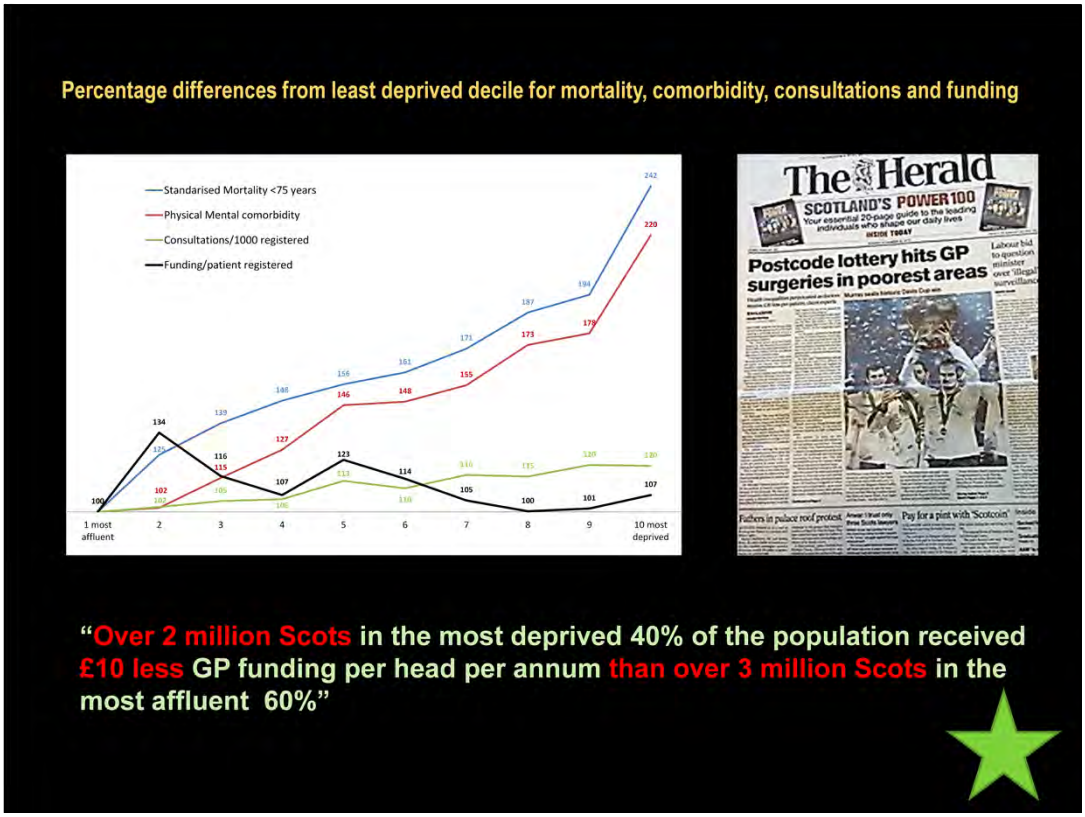


SLIDE 43

When asked why he robbed banks, Willie Sutton replied, “Because that’s where the money is”. Why the Deep End? Because that’s where the deprivation is.

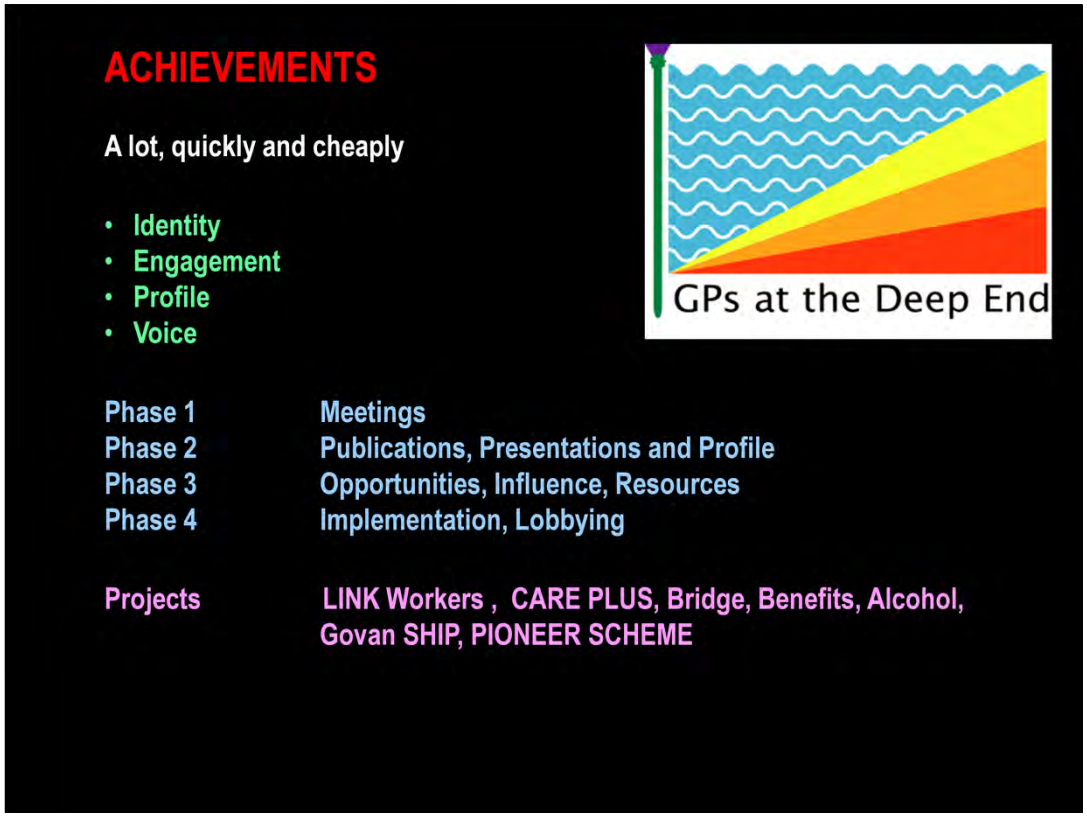
SLIDE 44

Not pocket deprivation, the small numbers of deprived patients to be found in most practices, but the blanket deprivation that dominates everything a practice does.



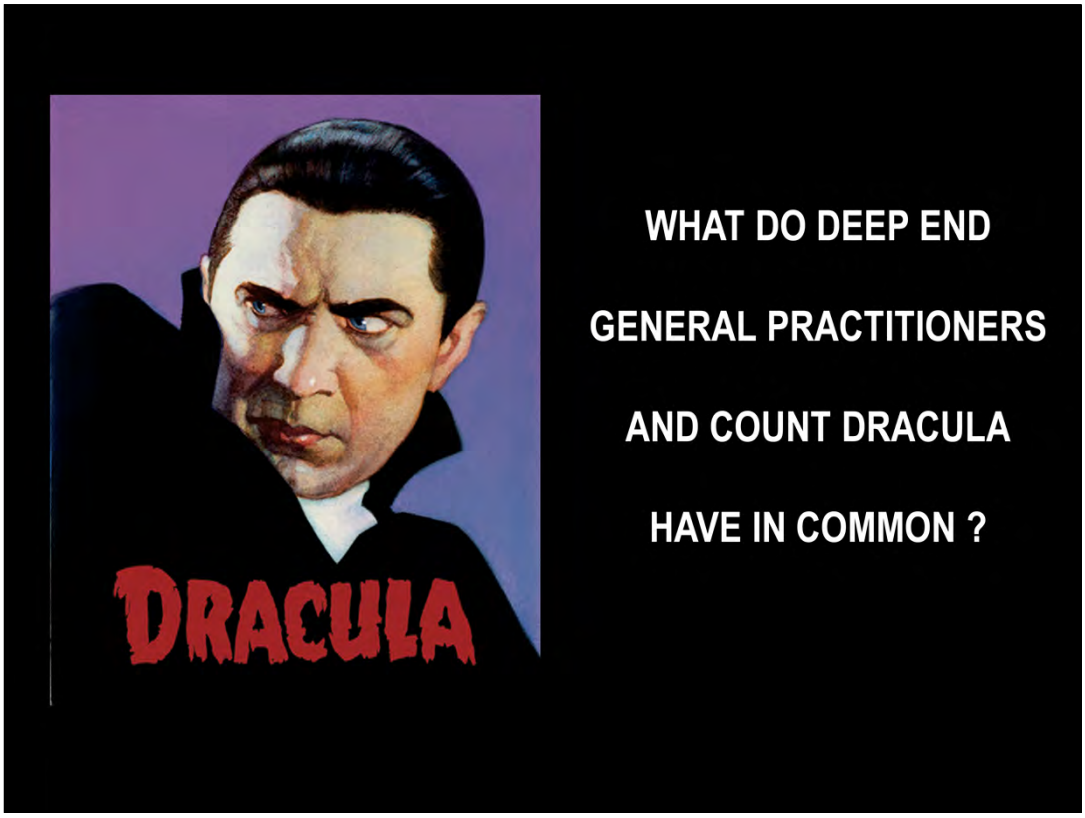
SLIDE 45

Bear in mind that the Inverse Care Law applies not just in the Deep End. In Scotland, over 2 million Scots, the most deprived 40%, get £10 les GP funding per head per annum than over 3 million Scots, the most affluent 60%. That needs a pro rata funding formula. Patients in Deep End practices would benefit most, but not exclusively.



SLIDE 46

In 20-09, the 100 most deprived general practices in Scotland had never been convened or consulted by anybody. Now they have identity, profile, voice, impact and increasingly, shared activity.

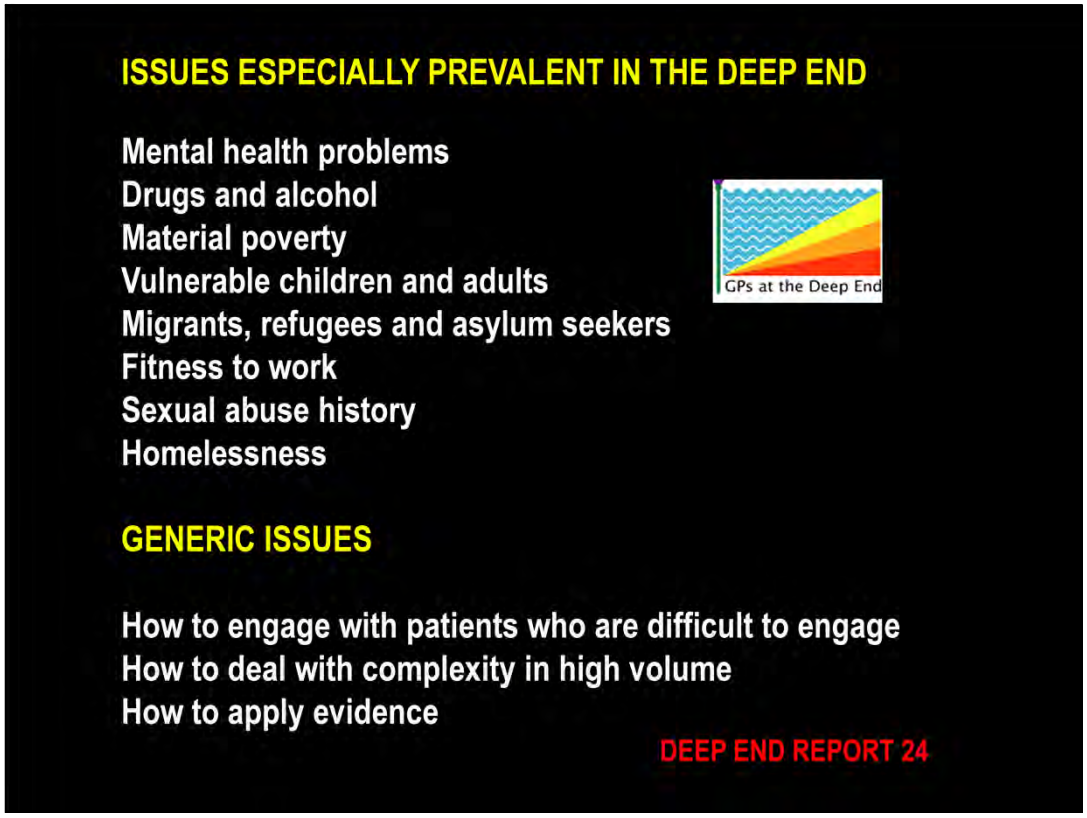


SLIDE 47

What do Deep End practitioners and Count Dracula have in common? They only come out at night, being occupied during the day. At the beginning we needed a locum budget that got colleagues out of practice, so we could capture their views and experience. The GCPH gave us that budget.

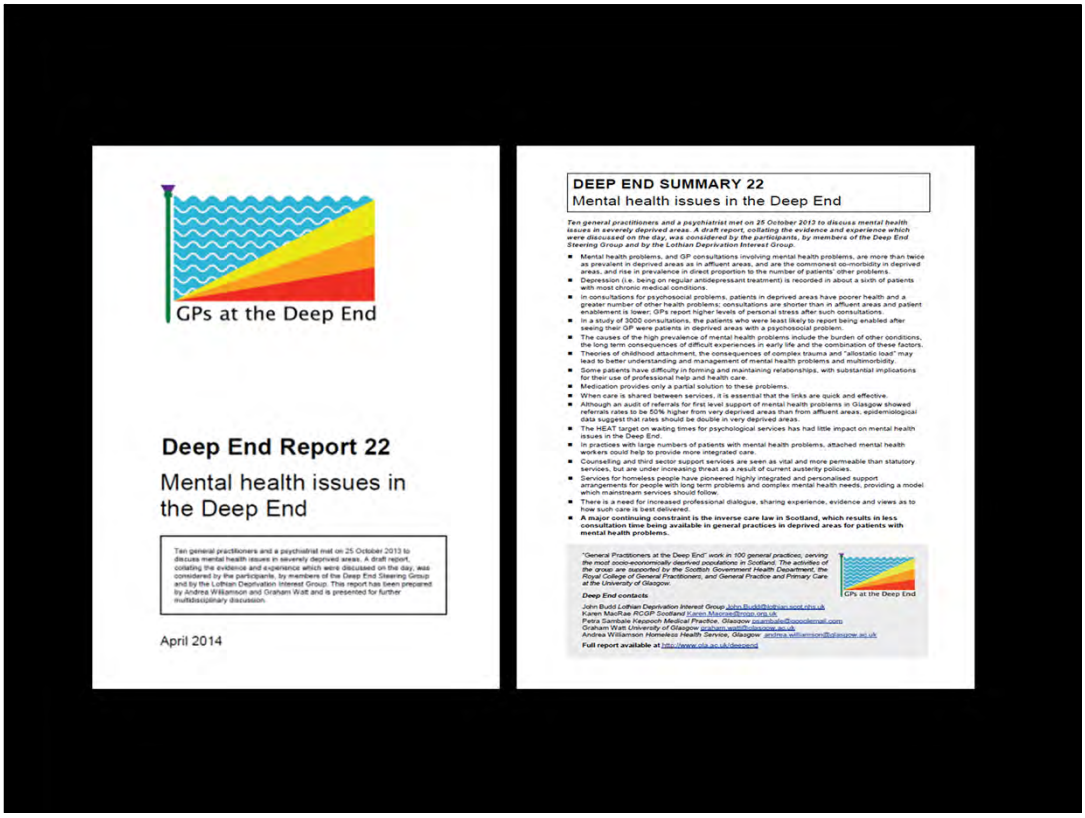
SLIDE 48

Which led to nearly 30 reports, all in short and long forms, available on our website, capturing GPs' experience and views on a range of topics, in language that is jargon-free and easily understood.



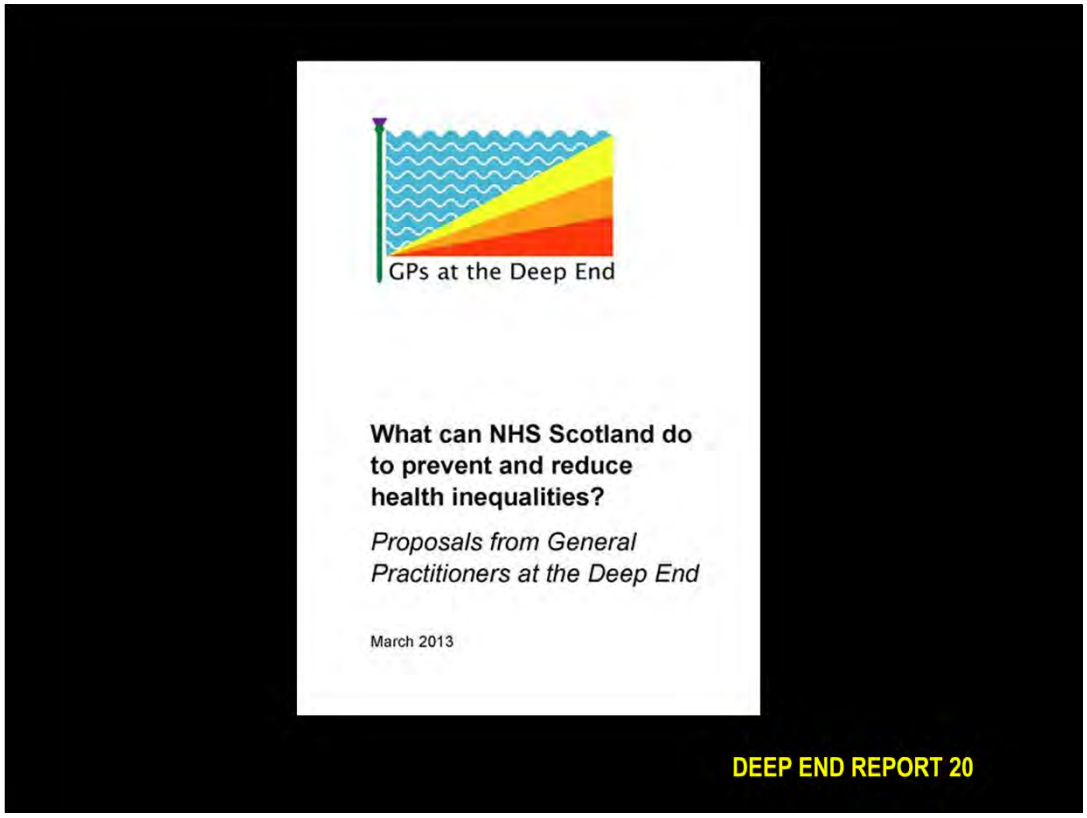
SLIDE 49

For example, this report on Continuing Professional Development needs identified the usual list of topics that occur most often in Deep End practice, but also generic issues, such as how to engage with patients who are difficult to engage, how to deal with complexity in high volume and how to apply evidence when so little of it is based on the types of patients you see in practice.



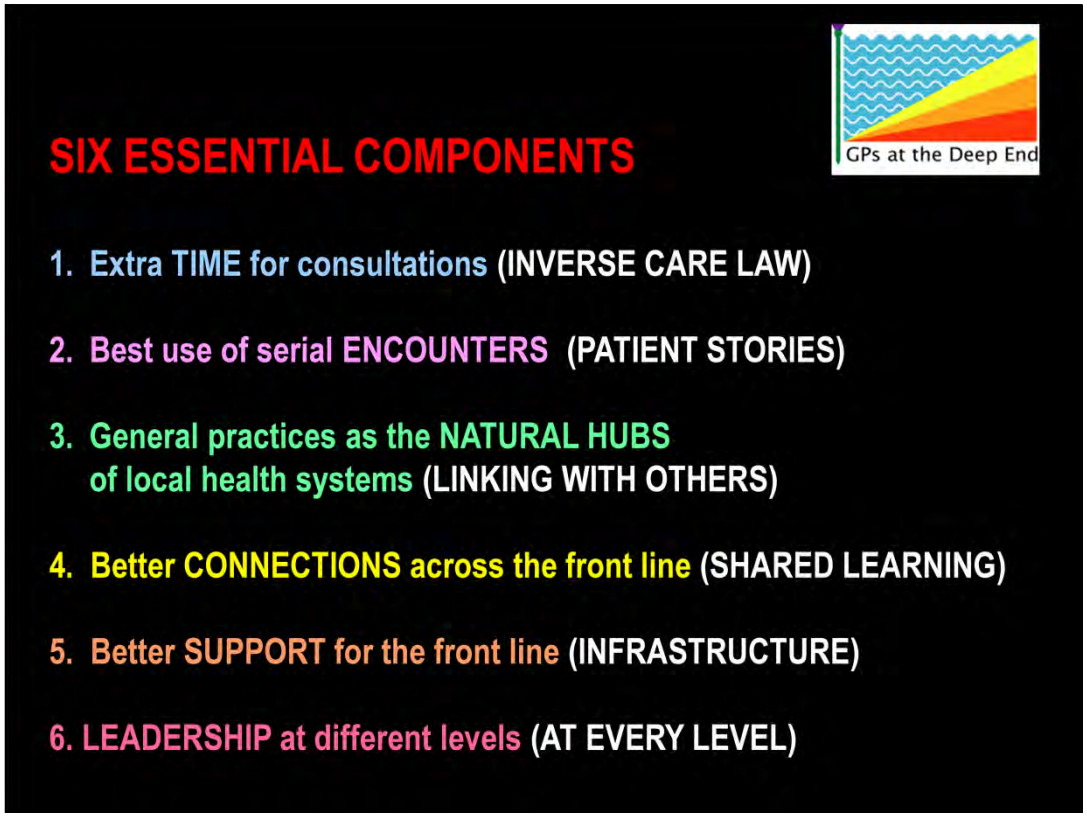
SLIDE 50

This report on mental health issues complimented out local mental health services but pointed out that they leave a lot for general practice to do, with patients who don't meet referral criteria, are not good at accessing services, have other health problems or who are not made better by the protocols on offer.



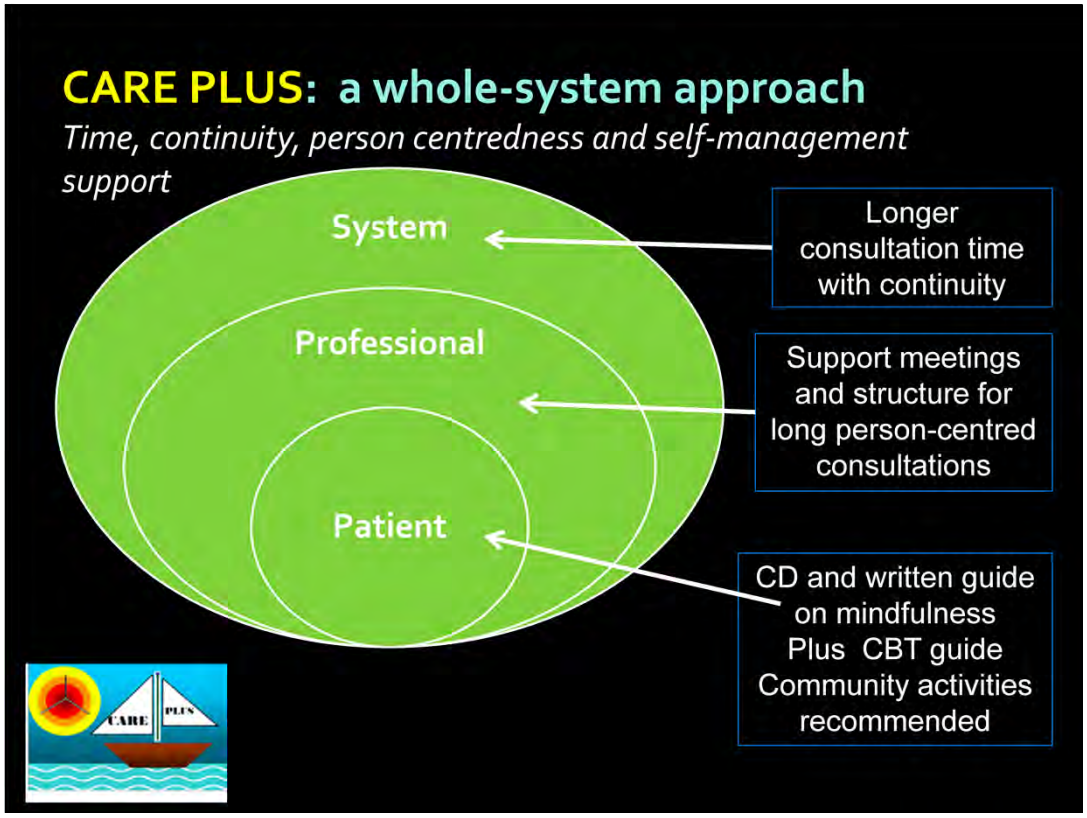
SLIDE 51

The Deep End Manifesto was published in 2013, in Report No 20.



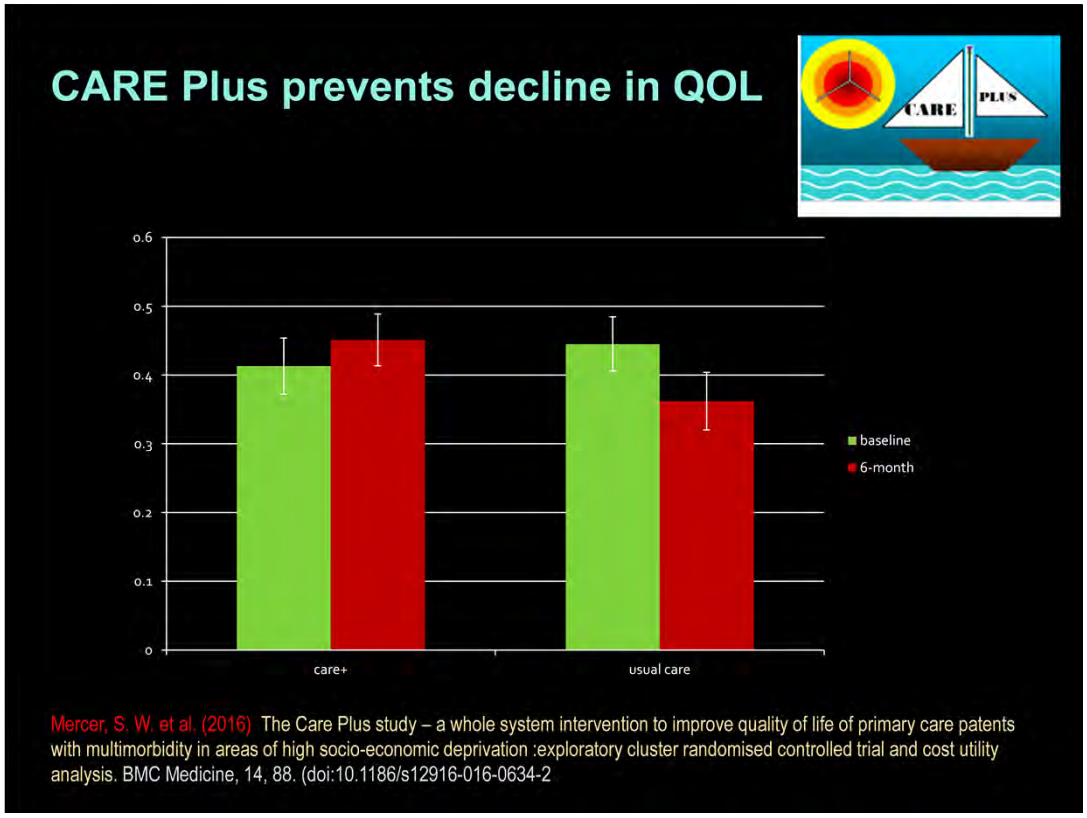
SLIDE 52

It argued for: extra time, to address the inverse care law; better use of serial encounters, to build patient narratives; general practice as the natural hub of local health systems; better connections across the front line, for shared learning; better support from central organisations; and stronger leadership at every level, sharing power, resource and responsibility. I'm going to describe four projects, giving expression to these aims.



SLIDE 53

The recently published CARE Plus Study involved 152 patients in 8 Deep End Practices in a RCT of extra consultation time for complex patients, plus support for practitioners and patients. About an hour extra per patient per year, spent mostly on a long initial consultation.



SLIDE 54

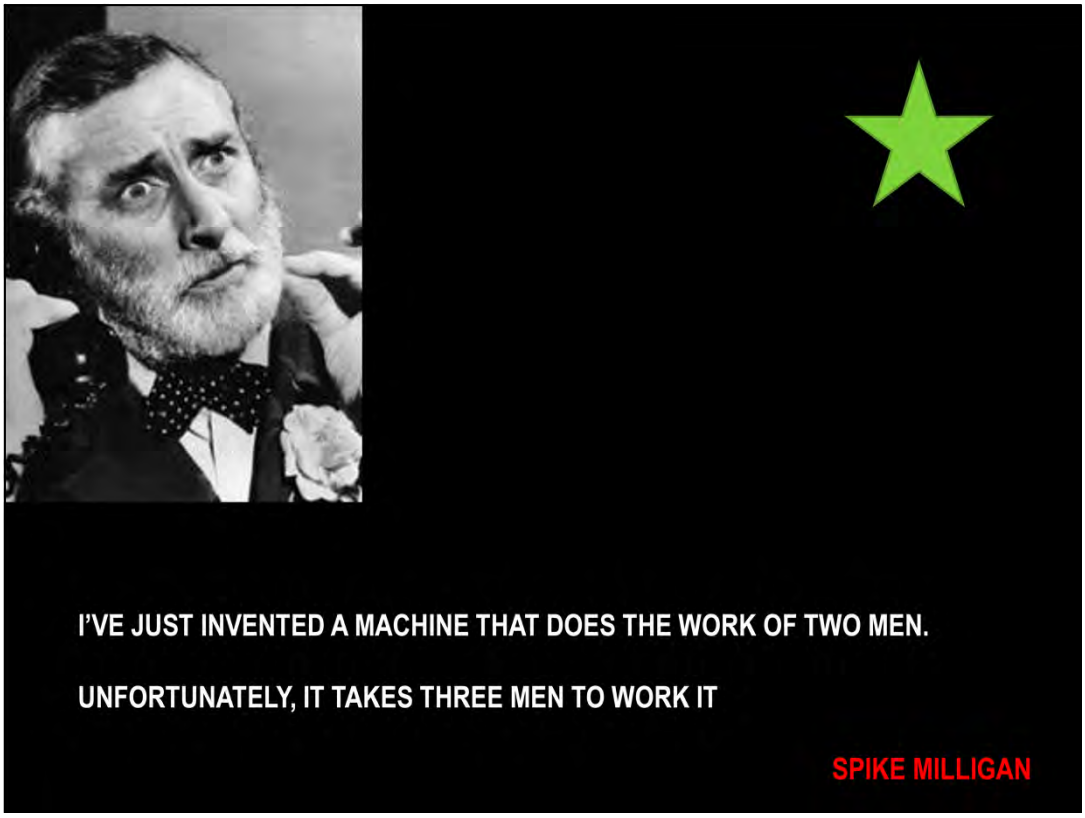
After 6 months and a year, Quality of Life was higher in the intervention group, on the left, not so much because it improved in this group, but because it got worse in those not getting the intervention, on the right. The intervention slowed decline. That's a crucial observation.

SLIDE 55

And it was a cost-effective use of NHS resources, coming well below the NICE threshold. If this were a drug or technology, it would be funded, and sail into policy and practice.

SLIDE 56

The Link Worker Programme has embedded a full-time community links practitioner in 7 Deep End practices. They do several things: connecting with community resources, helping patients who need help to access community resources, one to one serial encounters. But when link workers help patients floundering between dysfunctional and fragmented health care arrangements, a bigger issue is being addressed.

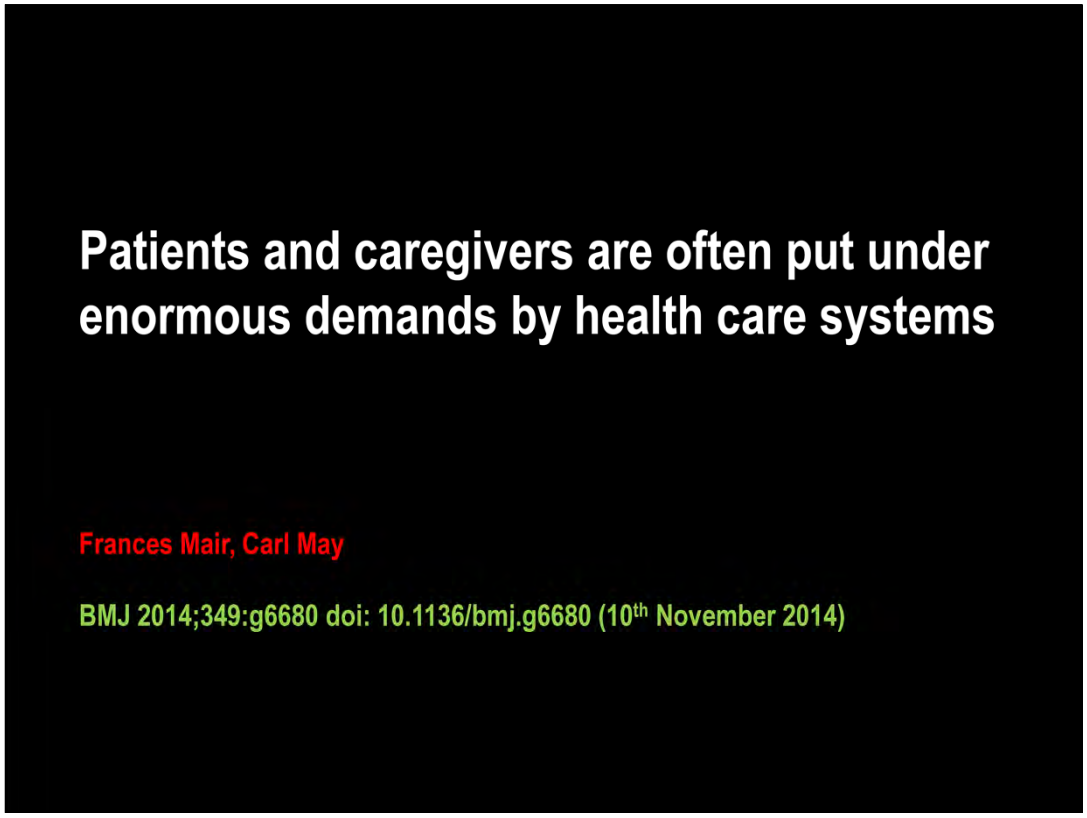


SLIDE 57

Spike Milligan described a machine that did the work of two men, but took three men to work it. Modern health care in a nutshell.

SLIDE 58

There are too many hubs, or centres in the NHS doing a particular thing, with referral criteria, waiting lists to control demand, evidence-based protocols to deliver, and discharge back to practice when they're done. All that may be done well, but leaves a lot for general practice to do, with patients who don't fit the criteria, are not good at accessing unfamiliar services, have other conditions or who are not made better by the treatment.



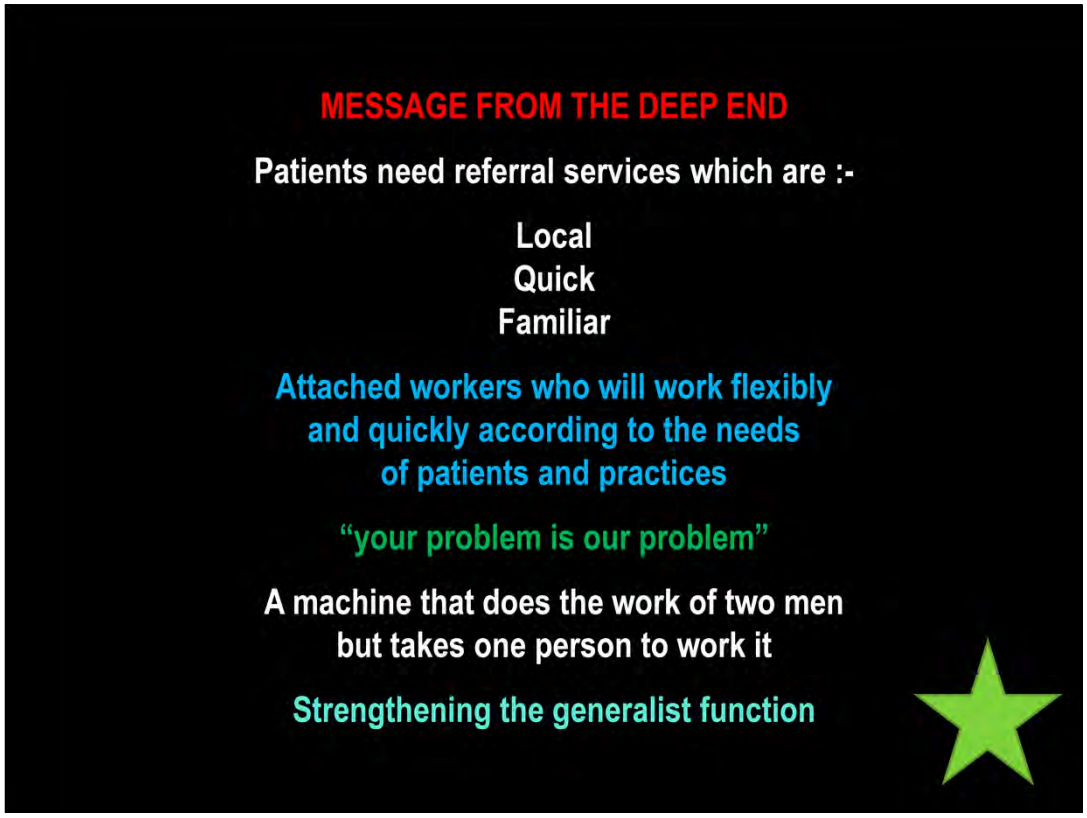
SLIDE 59

When patients with multiple problems, which above a certain age is most people, 10-15 years earlier in deprived areas, when they have to attend multiple clinics, life is made more difficult through what's been called the "treatment burden". What's convenient for professionals and services is often burdensome for patients. Everyone practises "patient-centred medicine", but somehow the patient isn't at the centre.

George Bernard Shaw describe all professions as conspiracies against the laity, not because they meet in secret to conspire against patients, but because of their tendency and ability to arrange things as it suits them.

SLIDE 60

For some patients, healthcare is like a pinball machine



SLIDE 61

Link workers often help patients engage with the services they need. In doing so, they support rather than challenge dysfunctional, fragmented systems.

In the Deep End, patients need referral services that are quick, local, and familiar; preferably via attached workers who can work flexibly according to the needs of patients and practices, not external criteria. Accepting that "Your problem is our problem, and we shall start to deal with it today".

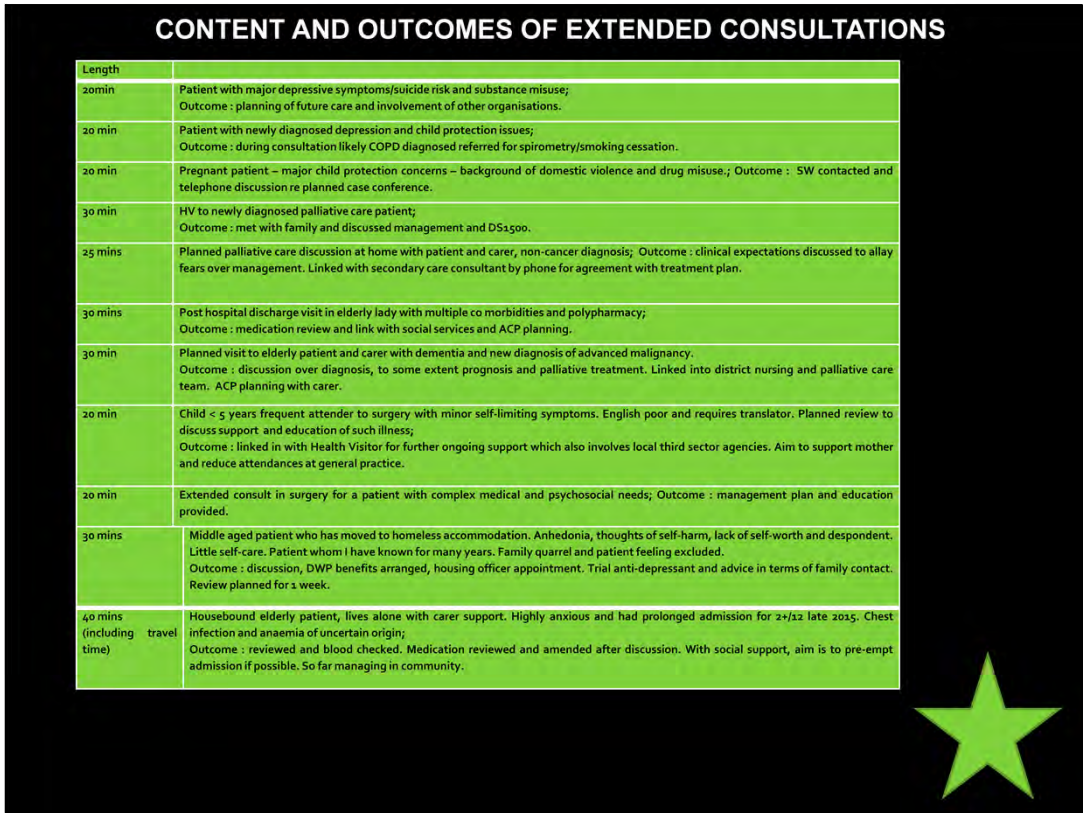
The health care equivalent of machines that do the work of two men, but need only one person to work them, are small local teams of doctors and nurses, working as generalists, unconditionally, knowing their patients well. The future is insufficiently imagined if it does not address this challenge.

SLIDE 62

The Govan SHIP Project (standing for Social and Health Integration Partnership, but based near shipyards that built the Queen Mary) adds clinical capacity (about 10%) to 4 Deep End practices via permanent locums, releasing a protected session per week for all 15 GPs. There are two attached social workers, 2 attached link workers and support for monthly multidisciplinary team meetings in each practice. With increased clinical capacity, it is perhaps the only place in Scotland that is addressing the inverse care law directly.

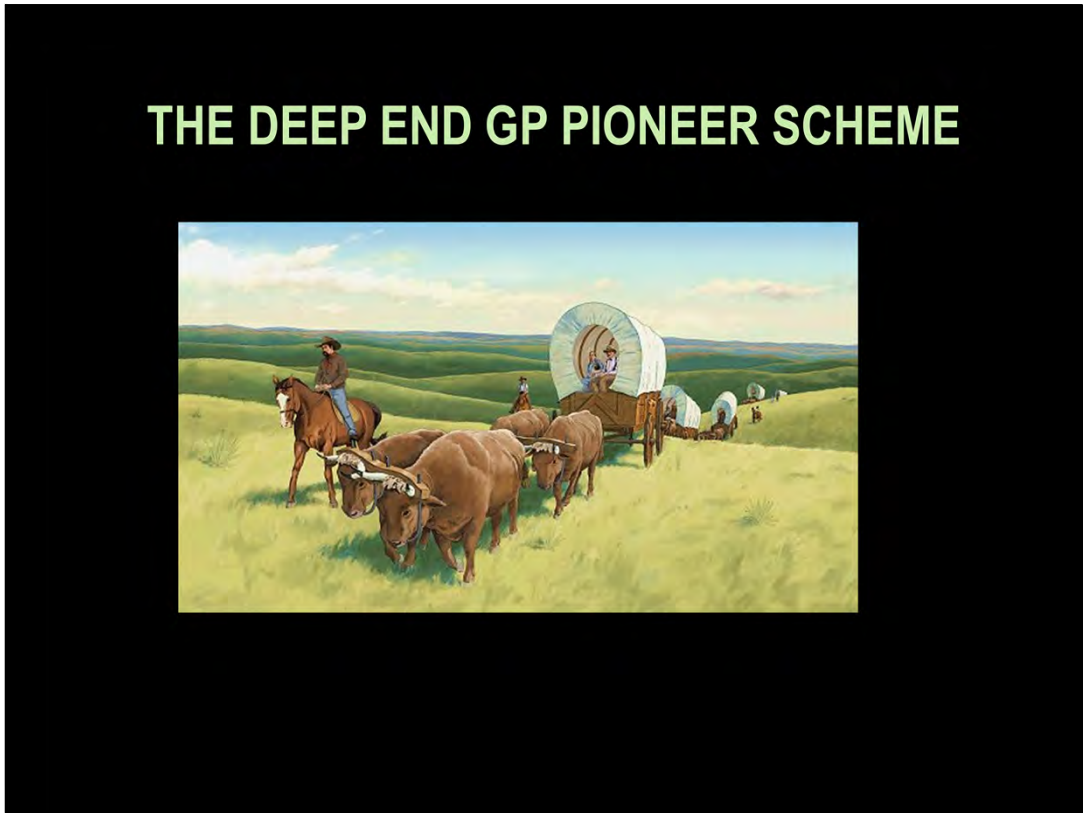
SLIDE 63

This audit described what the 15 GPs did with their protected sessions during two weeks in February. 136 documented activities, of which 76 were extended consultations, in the surgery or at home, and 14 were case note reviews without the patient being present.



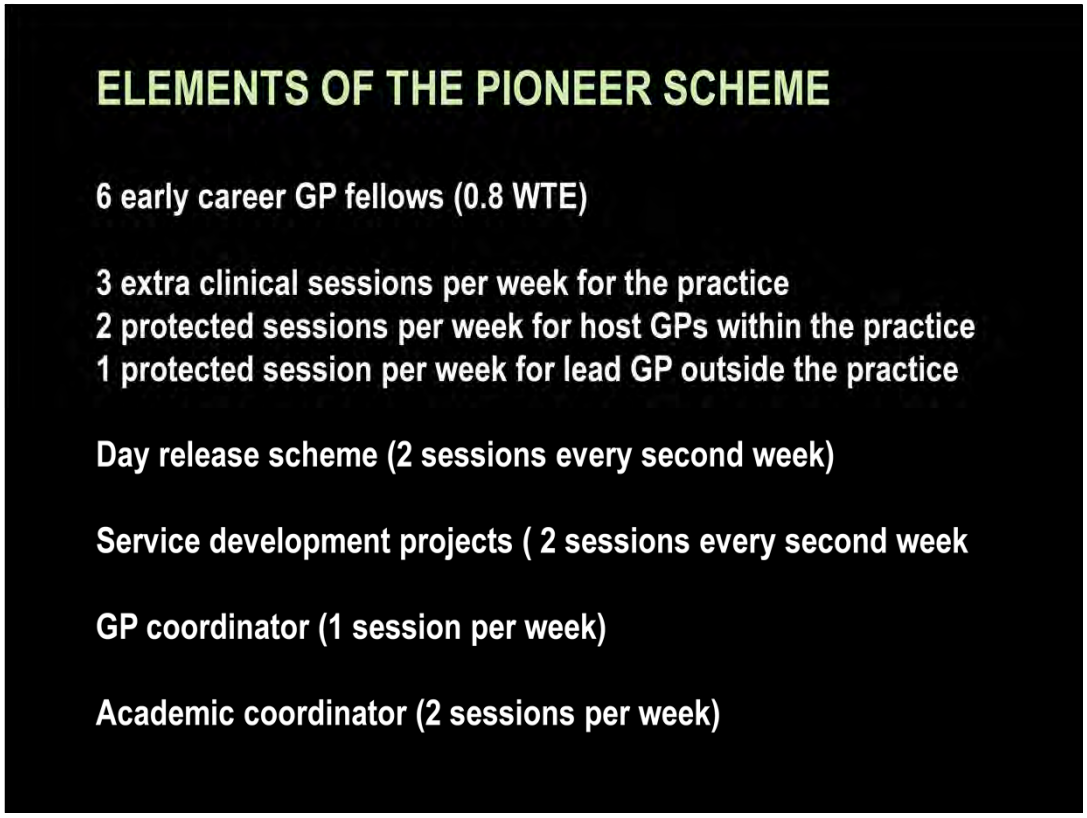
SLIDE 64

Here is a sample of the extended consultations, all for complicated combinations of medical, psychological and social problems. In one sense they are all different; in another, they are all the same, requiring unconditional, personalised, coordinated, continuity of care. This work, driving integrated care based on a re-assessment of patients' problems needs clinical generalists, not nurses or pharmacists working in circumscribed areas. Every case is a demonstration of unmet need, or uncoordinated care, the consequences of the inverse care law, that added clinical capacity can address. Deep End report 29 is on the web and I commend it to you.



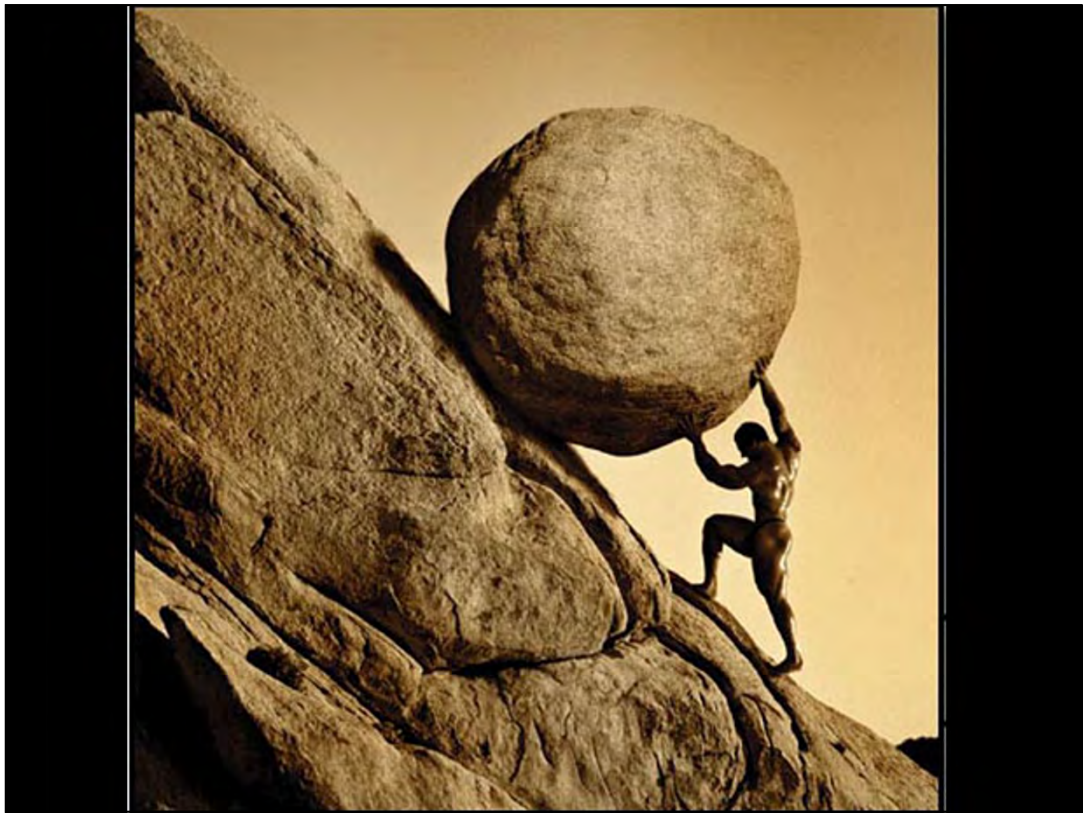
SLIDE 65

We are excited by the new Deep End GP Pioneer Scheme.



SLIDE 66

6 early Career GPs have been appointed, and attached to 6 Deep End practices in Glasgow. Their 8 sessions per week comprise three extra clinical sessions for the practice (about 10% extra), 3 protected sessions per week for host GPs to use as they wish; and 2 protected sessions per week for the Fellows to attend a day release programme, addressing their own learning needs as Deep End GPs and, in doing so, producing learning materials and activities for others to use. Fellows and lead GPs will work together a programme of service developments. It is a huge opportunity for GP-led, primary care transformation, addressing GP recruitment, retention and new ways of working.



SLIDE 67

These are challenging times. With the underfunding of general practice, staying in the same place is hard work. The ball could easily roll downhill, never to return.

SLIDE 68

The Government has launched a programme to boost the recruitment and retention of GPs. They would do well to recognise that the three essential ingredients of professional satisfaction are autonomy (the ability to make decisions, to fashion the future), mastery (that's the feeling of being valued for what you do and doing it well) and purpose (the sense of having a clear shared direction). In a small way, the Deep End Project is trying to achieve that.

SLIDE 69

The heart of the Deep End Project has been the steering group, an informal group of 10 to 16 GP colleagues, meeting every six weeks or so, in their own evening time. We don't usually have food and wine, but after 50 meetings, it seemed reasonable to celebrate. We've now moved to day time meetings with locum funding for clinical backfill. If it hadn't been for the steering group, the Deep End Project would have been just another short term initiative, trying to change general practice from the outside. Instead, we have a thriving academic/service partnership, based on mutuality and respect.

SLIDE 70

It’s been a good start, in a modest way (only a fifth of the 100 practices are involved in the projects I’ve described), bolstering the role of general practice, improving the prospects for recruitment and retention, not only imagining the future, but finding ways to get there.

SLIDE 71

Some final, closing remarks. Be in no doubt, if we do not change direction, we shall arrive where we are heading. The risks are real.

SLIDE 72

There are five building challenges.

First, as I hope I have made loud and clear, we need to bolster and develop the local generalist function, to deal unconditionally with multimorbidity. Metaphorically that means machines that do the work of two people but which can be worked by one.

Second, we need to build and measure social capital within local health systems, the sum of all working relationships, based on where they are in the collaboration ladder.

Third, the ultimate yardstick of integrated care is the random sample of patient experience, not just satisfaction with single episodes, but whether individual aspirations and goals are being met, acquiring the knowledge and confidence to live well with their conditions.

Fourth, to build public understanding, support and engagement in what we are trying to do (not in an abstract way, or via small numbers of patient representatives on official organisations but, for example, via the experience of the relatives of elderly people). So that instead of public outrage at proposals to change hospital services, we have public support for arrangements in the community, reducing, delaying or even avoiding the need to be admitted to hospital.

Fifth, this cannot be achieved by a centrally managed organisation that sees itself as a public utility, keeping its customers satisfied. Our goal should be a social institution, based on mutuality and trust, for which everyone is responsible.

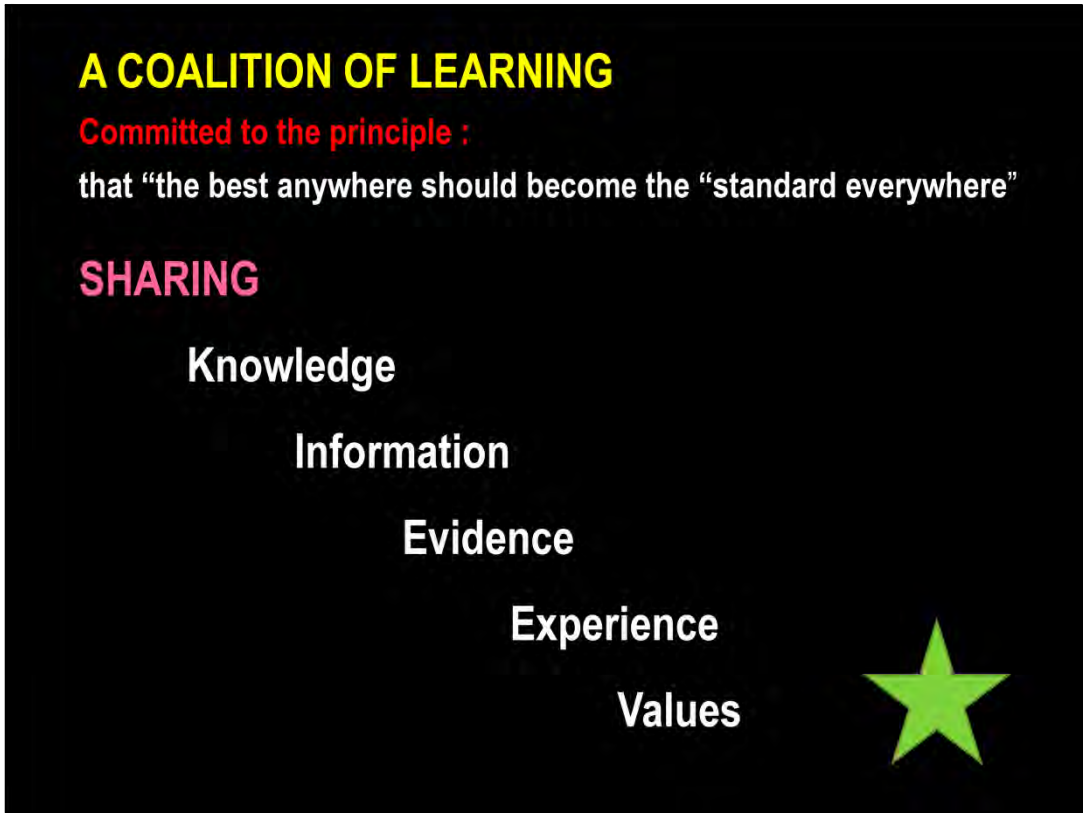
SLIDE 73

To do this, we shall need help from powerful people (they control resources) and clever people (often not as clever as they think), but mostly this work can only be done locally, by streetwise people, who have contact and relationships with local communities.

SLIDE 74

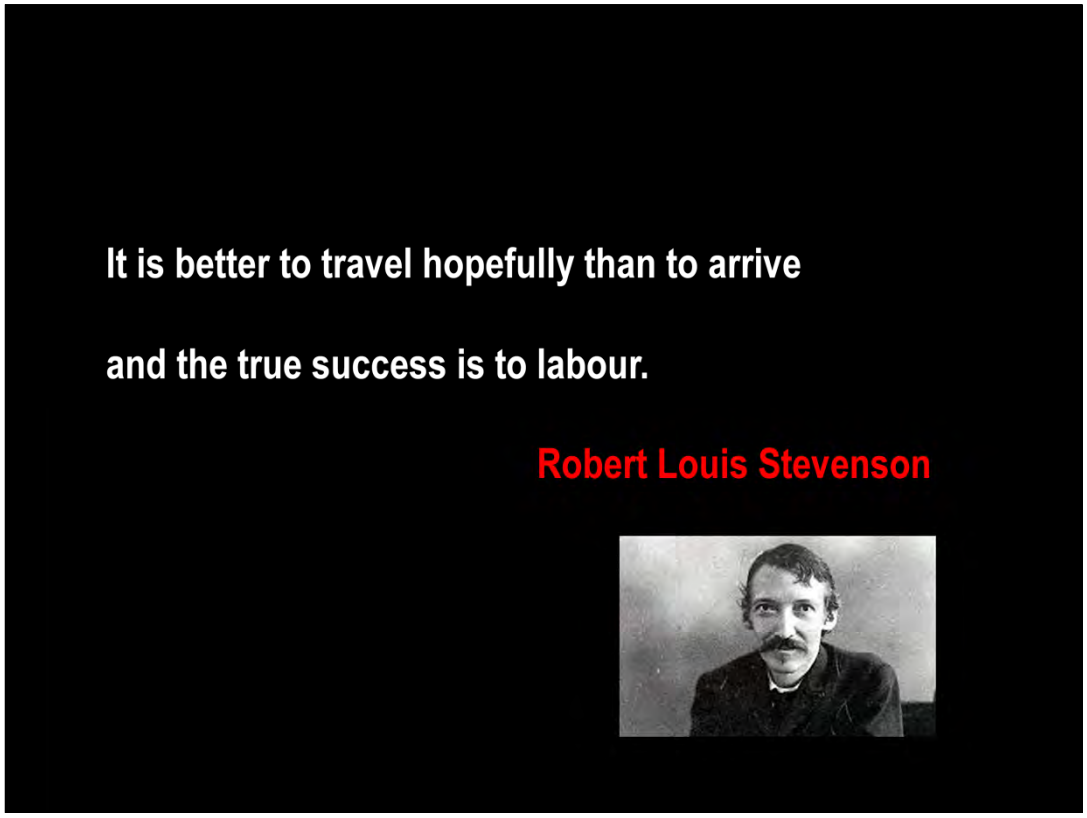
In the Deep End, we learned from the Bridge Project, attempting to link practice’s knowledge of elderly patients to community resources for social and physical activity, there is no blueprint that can be rolled out. Each locality needs to find its own solutions, by trial and error.

It’s not, as Spock used to say to Captain Kirk, that human behaviour is illogical. It’s that the logic is only apparent in local terms. You can review where local teams have got to, but you cannot tell them how to get there.



SLIDE 75

A recipe for chaos, unless everyone is connected, voluntarily, in a coalition of learning, sharing experience, knowledge, information, evidence and values so that the "best anywhere" becomes the "standard everywhere". We need infrastructure to support that process. It will need imagination to provide it, not just the practical arrangements but also a culture of mutual responsibility and shared learning. As the GCPH considers its next programme of work, perhaps there is a role for it here.



SLIDE 76

We may not know the destination, but we do know the direction of travel. As Robert Louis Stevenson put it, “It is better to travel hopefully than to arrive, and the true success is to labour”.

Thank you for listening