

Designing health care for the people who need it

Professor Chris Salisbury

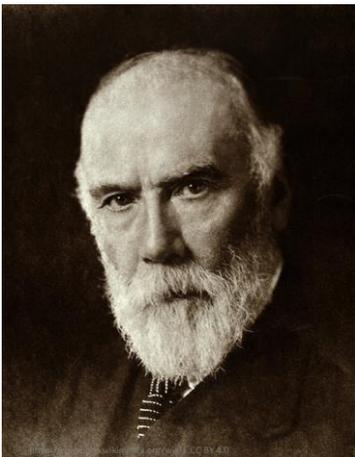
James Mackenzie lecture RCGP 23 November 2018

Introduction

Thank you. It's a great honour to be invited to give this lecture. I've read many of the previous Mackenzie lectures, which was a fascinating experience. I can't help mentioning the MacKenzie lecture given by our President, Mayur Lukhani, entitled the Uber GP.¹ He's clearly a man ahead of his time, given that his lecture was in 2010 and Uber wasn't launched until the following year.

So thank you. What I hope to do is to think about what exactly we are trying to do, as GPs, what are we there for; maybe to ruffle a few feathers; but also to remind you why what you do is so important.

James Mackenzie: the need for observation of patients in general practice



James Mackenzie was born in 1853. He went to medical school in Edinburgh and then went into general practice, which seems to have been a bit of a shock.

To quote from his biographer:²

He had come from Edinburgh reasonably confident ... – now it seemed he could not carry out even the simplest medical task, that of finding out what was wrong with his patients. He arrived in Burnley labouring under the misapprehension that every man, woman and child would be suffering from some easily identified ailment and their signs and symptoms would fall neatly into separate categories.

Have you had that bewildering experience? That sense of disconnection between what we expect - clearly defined problems where symptom leads to diagnosis which leads to treatment - and our experience of what we actually find in front of us, which is messy complex difficult problems, what Donald Schon memorably called the 'swampy lowlands'.³

The swampy lowlands, where situations are confusing messes incapable of technical solution and usually involve problems of greatest human concern

(Schön 1983)

James MacKenzie came to believe that the only way to really understand people and their illnesses was through carefully observing them in their natural environment, which meant in general practice rather than in hospital. A sort of

David Attenborough approach. He went on to become one of the founding fathers of epidemiology as well as general practice. But that determination to understand what actually goes on in general practice is the basis of my lecture as well.

Overview of lecture

I'm going to talk about who are the patients who most use and need health care, and what type of care do they need? I'm going to base this on the fundamental principle that health care should be provided in relation to need. So if general practice doesn't meet the needs of the people with the biggest health problems it is failing. I'm going to highlight the fact that the number of people with complex multiple health problems, or multimorbidity, is growing rapidly, and they're the main users of health care. But many recent developments in primary care have been designed to improve care for people with relatively simple problems. Some of these ideas have been introduced because general practice seems to be failing, but their introduction makes failure more likely because they undermine the key principles on which general practice is based. So the question is - are these principles no longer relevant? Or are they needed more than ever, but perhaps played out in new ways?



Who uses primary care?

I stopped seeing patients last year. These seven patients I saw in one of my last afternoon surgeries.

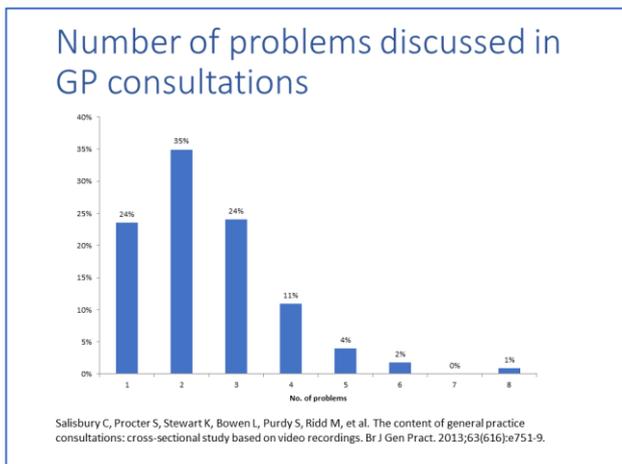
F, in her 60s	Cyst on nose. Cancerphobic
F, 60s	Neck and back pain. Difficulty working. Already seen a colleague and a physio with same problem within the last month.
M, 6Y	Flagged on computer as 'vulnerable child in care'. Persistent cough ? asthma
F, 12Y	Eczema. Behavioural problems. Won't eat. (Very inconsistent parenting observed)
M, 70s	Multimorbidity ++. Deaf. Asian origin with limited English. Under care of three different hospital specialties. Came to discuss recent admission for collapse ? cause.
F, 7Y	Persistent unusual lump in neck. Urgent referral to paediatrics.
F, 90s	Looking after her through bereavement, having looked after her husband when he died.

None of this is simple. There are layers of complexity in each of these consultations, it just depends how far you are willing to get involved.

Let's just think about that man with multimorbidity. I glanced at his records as he walked down the corridor to consult me, and saw that he was on 15 different regular medications. In my previous

consultation with him I had dealt with otitis externa, low back pain, seborrheic dermatitis and poor diabetic control all in one consultation.

So these are not simple problems. Perhaps you think that I've chosen the juicy ones to tell you about. No – some details have been changed to protect anonymity, but this is a genuine list of patients. Its the reality of modern general practice.



In one of my projects, and very much in the spirit of James Mackenzie, we video-recorded 229 general practice consultations with 30 different GPs.⁴ I wanted to know - is it just me who finds that most patients seem to come in with a list of problems?

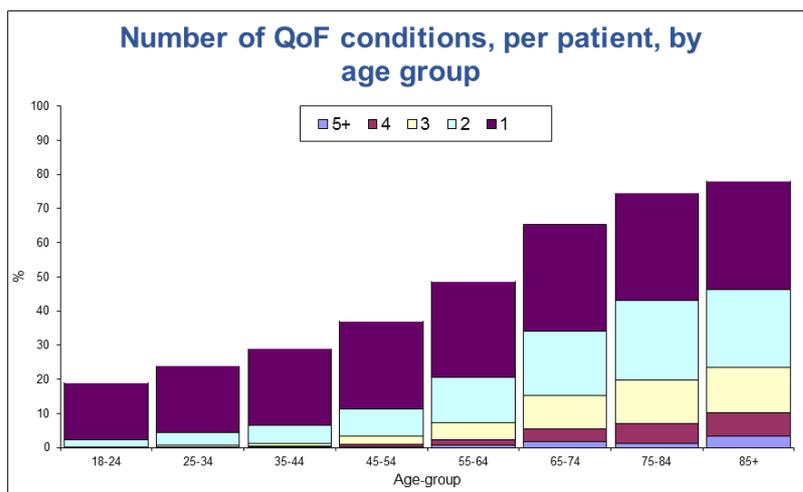
We analysed each consultation and found that only ¼ of consultations involved one problem, while over 40% involved at least 3 different problems.⁴

This issue of needing to address multiple problems in one consultation really came to my attention after the introduction of the quality and outcomes framework, the QOF, when GPs had to perform against targets for specific diseases. It felt as if almost every patient had several ongoing problems. So, like MacKenzie, I wanted to study this, to analyse what was happening.

Of course I had an advantage over Mackenzie, because I had a computer and access to anonymised computerised medical records from 100,000 people registered with 182 different general practices.

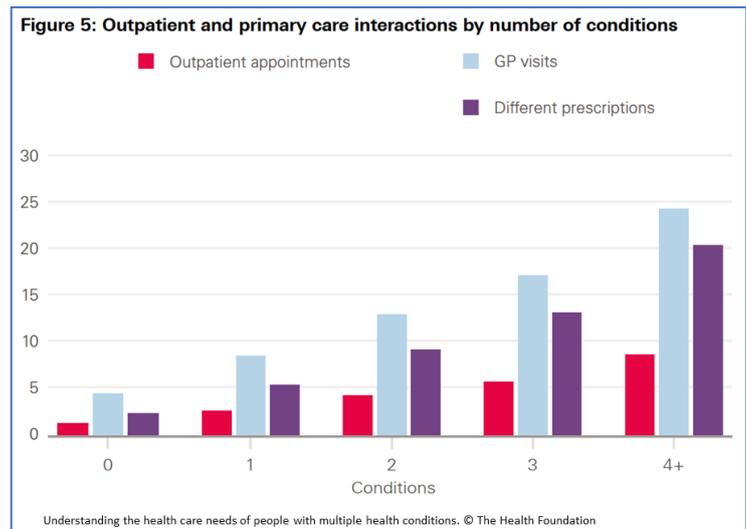
Multimorbidity

What we found was that 41% of adult patients had one of the conditions included in the QOF framework while 16% had more than one.⁵ And although these patients with multimorbidity made up only 16% of the population, they took up a third of all GP consultations in my study.



Salisbury C, Johnson LR, Purdy S, Valderas JM, Montgomery AA. Epidemiology and impact of multimorbidity in primary care: a retrospective cohort study. Br J Gen Pract. 2011;61(582):e12-e21.

A report published just last week by the Health Foundation shows numbers of GP and outpatient consultations over 2 years, according to the number of long term conditions.⁶ The average patient with four or more condition went to their GP 24 times – about once a month. These are the people who fill up your surgery appointments every day. No wonder you get to know them well. And its not just general practice. People with multimorbidity fill more than half of hospital beds, and account for more than half of all NHS expenditure.



Its not surprising that people with multimorbidity are big users of health care, since they have a lot wrong with them. They have poor quality of life, and worse life expectancy. When people have several physical health problems they often have mental health problems from anxiety and depression as well.⁷

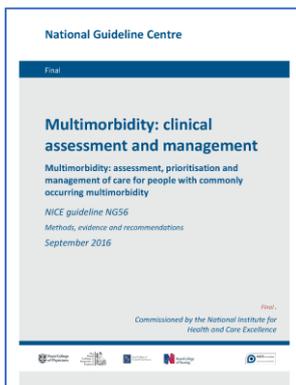
Just as an aside, Bruce Guthrie, a great colleague who did similar research in Scotland, tried to explain to his teenage daughter what he did at work. And she responded in the way that only a teenage daughter can: “Let me get this right, she said. So you’ve shown that people who’ve got lots of serious diseases, feel more ill, go to the doctor more often, and die earlier. And they pay you for this??”

I recently led a trial of a new approach to managing multimorbidity, the 3D trial.⁸ We recruited people who each had three or more types of major long-term condition. We collected a lot of information about them both before as well as after the trial, and we asked their GPs about their care as well.⁹

- Before the trial, two thirds described their health as only fair or poor.
- A third of them had anxiety or depression.
- 96% of the GPs said that continuity of care was important in the care of patients with multimorbidity and 75% of patients said they had a preferred GP.
- But the level of continuity these patients actually received was very low.
- Most GPs said it was important to give patients with multimorbidity a care plan.
- 90% of patients said they didn’t have a care plan.

- When asked if their care was joined up, 23% of patients said rarely or never.
- Most strikingly, when asked whether in the last 6 months they have discussed the problems that were most important to them in managing their own health, more than a third of patients said 'rarely' or 'not at all'.

So these are the patients with the highest needs, who should be the top priority for the health service – but there are real problems with their care.



Since we did our work showing the importance of multimorbidity back in 2010, the whole topic has become very big news, with major reports from NICE,¹⁰ our own RCGP,¹¹ and many other organisations.¹²⁻¹⁴ The reason is obvious. Half the population aged over 65 have multimorbidity. And over the next twenty years the number of people aged over 65 living with complex multimorbidity is going to more than double.¹⁵ More than a third of these patients will have dementia or mental health problems. This will swamp the capacity of the NHS unless we think about health care in a new way.

What kind of care do the biggest users of health care need?

So if we want to design health care for the people who most need it, the focus needs to be on people with multimorbidity.

What kind of health care do they need? Like everyone else, they need treatment for simple illnesses, like when they get an infection. But they also need well-organised chronic disease management to help them stay healthy. And given the scale of the problem, this can't just depend on doctors and nurses. So a key priority is to help patients to manage their illnesses themselves. And they need an advocate in the system. Health care is very complicated, especially if you have 5 chronic diseases, attend 3 different specialist clinics and take 15 types of tablets each day. You need someone to help you navigate the system and to help you sort out the mess when it goes wrong - which it does all too often. You get lost to follow-up, or you get two appointments from different people in different places for the same problem.

The charity National Voices recently asked patients what they wanted from integrated health care in future.¹⁶ Patients said they wanted to know that the people caring for them knew them as a person, they wanted clinicians to know about all of their relevant conditions and to have knowledge of local support services. Importantly, they wanted a single trusted point of liaison who could advise them on the next steps and help them co-ordinate the help they need.



How does general practice provide this?

Fortunately we have, in general practice, a system which can, when it works well, do all of these things. There are several foundational principles that make this possible. My argument is that these principles are absolutely inter-dependent. The strength of the whole structure depends on all the components.



McKenzie being from Scotland, I thought this picture was apt. The Forth Bridge is often used as a metaphor for things that take forever and once they are done you have to start again – which sounds like NHS re-organisation. But in my case, the point I'm trying to make is that all those girders hold each other up, and without any one of them the whole structure risks collapse.

You'll be very familiar with these girders, these key principles:¹⁷

- General practice is local and accessible (I'm not saying this is necessarily how it is, but how it should be)
- It is generalist and comprehensive. Most people can go there for most of their problems most of the time. If you've got multimorbidity, you don't have to go to a different appointment and a different specialist for each condition. That means what while you're there, there's an opportunity to deal with several things at once. And the doctor can take the opportunity to talk to you about giving up smoking, or having a flu vaccination.
- It's person-centred not disease-centred. It doesn't start or end at the beginning or end of a specific illness. Seeing the same professional over time builds trust, which makes it more likely that people will follow your advice to stop smoking or to have a flu jab. I can't count the number of times over my career that policy makers and interest groups have said 'GPs are well placed to do that', whether its advice about obesity, or safe sex, or screening for depression. A couple of weeks ago it was loneliness. And of course in many ways they are right. GPs are well placed but only because people trust them, a trust built through repeated

General practice:

- Accessible
- Generalist, Comprehensive
- Personal
- Co-ordinating
- Responsible for a defined population

contacts over time. And we know that a personal trusting relationship is particularly important to people with multimorbidity.

- General practice has a co-ordinating and gate-keeper role as the route to almost all other services, and by holding the central record of what has happened to the patient. This increases the efficiency of the whole system.
- Finally, GPs work have a responsibility for a defined local population. They are responsible for people whether or not they turn up at the practice. This includes the housebound, the person with learning difficulties, and the people who maybe don't look after themselves as well as they might. Thanks to their registered list of patients, GPs can pro-actively seek out and arrange care for people who need it.

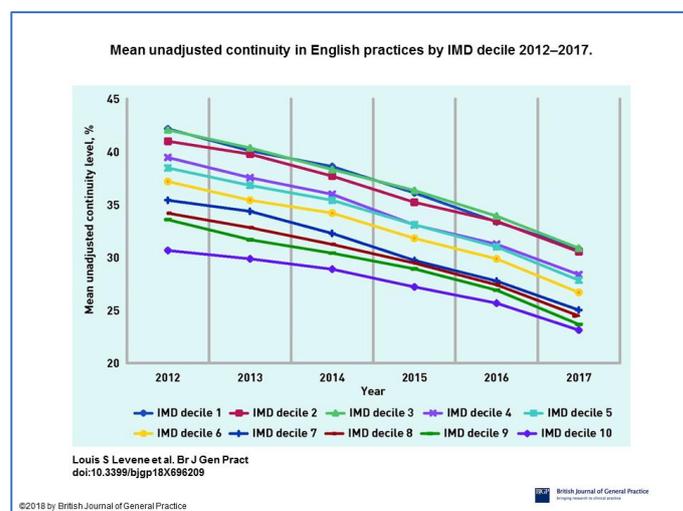
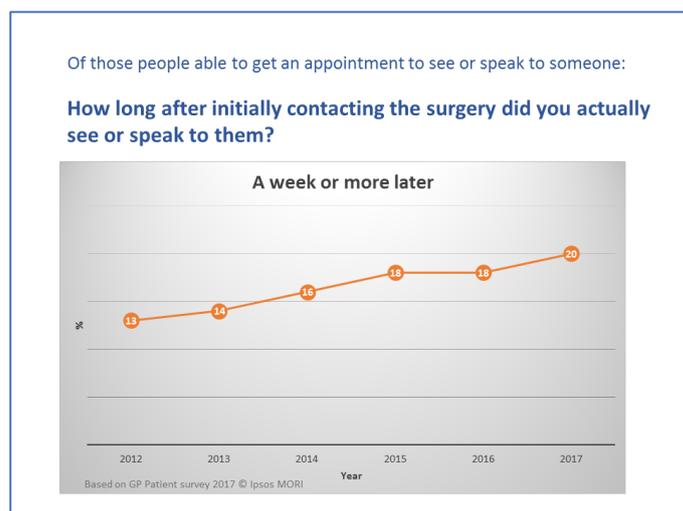
The GP Forward view¹⁸ captures the essence of general practice very succinctly:

*The GP is an expert medical generalist and must be properly valued as the provider of holistic, person-centred care for undifferentiated illness, across time within a continuous relationship.*¹⁸

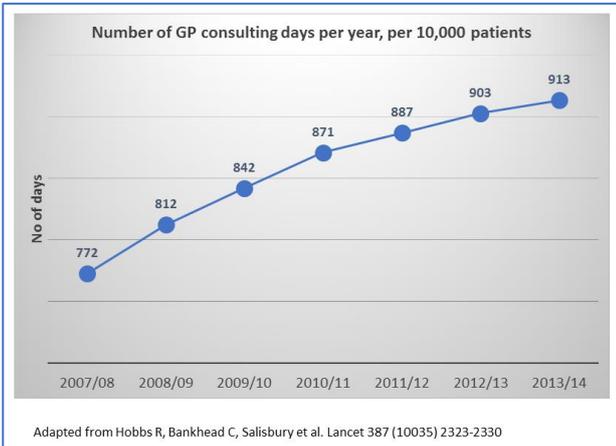
Is general practice fulfilling its functions?

But you know all this, and that all sounds great. So how are we doing?

- Accessibility. I'm guessing that some of you will think I've spent too long in an academic ivory tower if I think general practice is accessible. According to the national GP patient survey, the number of people who waited at least a week to see or speak to a doctor increased from 13% in 2012 to 20% in 2017.¹⁹
- What about personal relationships and continuity of care? This feels even more like fantasy land. Continuity of care has declined fast over the last decade, and is almost non-existent in many UK general practices. This shows how continuity is declining in all socio-economic groups.²⁰
- With regard to person-centred care, I've mentioned the evidence from our 3D study showing how people with multimorbidity say they often don't get a chance to talk about what's most important to them.⁹ Patients complain that we're too busy ticking things off on our computers.



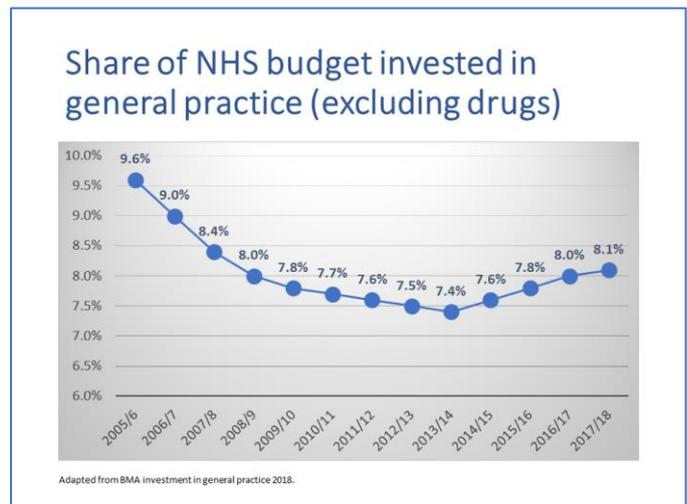
- And not surprisingly, satisfaction with general practice is dropping. We're very proud of the fact that for 35 years general practice has achieved higher levels of satisfaction than any other public service. That is, until this year. In the last decade, satisfaction with general practice has dropped by 15 percentage points, and its now lower than satisfaction with hospital outpatient departments.²¹



Now there is of course a backdrop to this story. With Richard Hobbs and a team of researchers in Oxford I've been studying changes in GP workload, based on a dataset of 100 million anonymous GP-patient consultations. We've found that both the number and length of GP consultations have increased. When you put these things together this led to a 16% increase in workload over the 7 years between 2007 and 2014.²²

Meanwhile, investment in general practice as a proportion of NHS expenditure went down consistently until 2014. It's increased a bit since then, but still a measly 8% of NHS expenditure.²³

So is it any surprise that GPs are retiring early and fewer young doctors are willing to replace them? Despite the promise in the GP Forward View to increase the number of GPs by 5000 by 2020,¹⁸ the number has actually dropped by almost 1800.²⁴



I've been involved in a study led by John Campbell's team in Exeter in which we asked GPs about why they're leaving the profession early and what can be done to keep them.²⁵ Over and over again we heard from GPs who felt that it was becoming impossible for them to do a good job, because of the demands placed on them.

I was just working at such a pace and I knew I was making myself ill.

But just as important as the workload was the sense that what they did wasn't valued:

I think most people, if you ask them why they do jobs, it's a complex mixture... people always focus on incomes and things but, the more detailed the analysis is, it always comes back to things like being appreciated, feeling valued.

Conceptual failure or implementation failure?

So, what's going wrong? Is the idealised model of personal generalist care no longer sustainable?

I do research trials on interventions – new ways of doing things – and often they don't work out as you expected. This always leads to the question - Was it conceptual failure or was it implementation failure? Was the whole idea misconceived? Or maybe the idea was fine, but it never actually got implemented.

This question of conceptual failure or implementation failure is key, because I think many recent policy initiatives in general practice have confused the two. I think the problem is implementation failure – we haven't been able to deliver on our principles. But some of the solutions that have been introduced imply conceptual failure – that we need a different model. Some of the recent innovations in primary care aren't ways to strengthen generalist patient-centred care.²⁶ Instead they ignore and chip away at the fundamental concepts which hold the whole thing up.

It's like allowing the girders on the Forth Bridge to rust away.

This starts with disease-focused rather than patient-centred care. Since the QOF, we've standardised disease management using protocols and care pathways and computerised checklists. GPs began to treat people as commodities that needed to be batched, processed and treated in a particular way, whether or not it was what they wanted or needed.

And what about the concept of a simple, single point of contact and continuity of care? People couldn't get an appointment quickly, so we introduced 48 hour access targets and telephone triage schemes. Because of the shortage of appointments in general practice, parallel services were set up, like walk-in centres

or primary care access hubs so that patients could get seen somewhere else instead. I did a talk at a CCG the other day about multimorbidity, and someone said what we should do is set up a special area-wide multimorbidity service. That is a typical well-meaning management reaction – identify a problem and set up a specific solution for it, separate from general practice, ignoring the fact that this is exactly what general practice is there for.

The GP Forward view¹⁸ talks about our role in providing holistic, person-centred care across time within a continuous relationship. That sounds great, but how is it borne out in some of the solutions proposed in that same report? How is that supported by a policy which strongly promotes electronic consultations with a different unknown doctor every time?

Problems with seeking a different concept rather than improving implementation

Why does this matter? Isn't it fine if we say that old concepts of general practice work for some people, but we need a different concept for a new era? I'd argue that innovations which don't

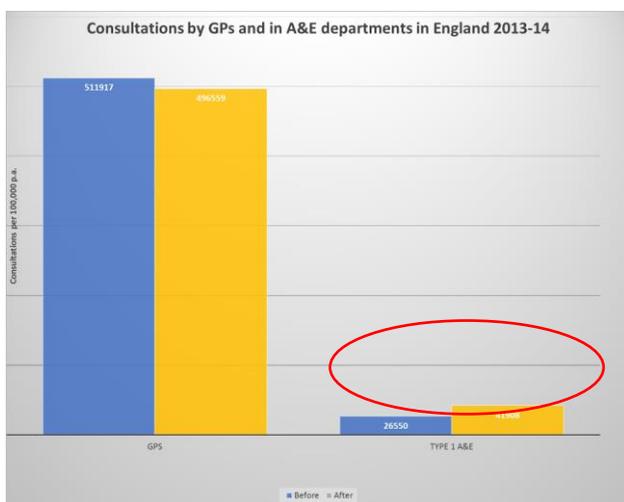


recognise the fundamental principles on which general practice is based lead to a number of problems.

First, they are often promoted with much hype, sometimes driven by commercial interests, particularly in the case of digital interventions, and not based on any evidence of benefit. And its all too easy to ignore the possibility that they could cause harm or at least unintended consequences. For example, despite the enthusiasm for e-consultations, the research on this suggests that they are at least as likely to increase GP workload as to reduce it.²⁷⁻²⁹

Second, there is the issue of opportunity cost. In many cases, new models of care are considerably more expensive than the general practice they are designed to replace. I've mentioned NHS walk-in centres, which I've done a lot of research on. They were meant to take pressure off hard-pressed GPs. But in our research we found that a walk-in centre consultation was about 50% more expensive than a consultation in general practice.³⁰ Telehealth monitoring of people with chronic disease, which was supposed to be more efficient, was actually much more expensive.³¹ According to the National Audit Office, a consultation in a GP access hub is at least 50% more expensive than a normal consultation.³² It's like going out to dinner at an expensive restaurant to save on your supermarket food bill.

Third, some of these innovations have failed to take account of the phenomenon of supply-induced demand.³³ In the Esteem trial, another project led by John Campbell, we showed that introducing telephone triage led to 33% increase in total GP-patient contacts.³⁴ People change their expectations and behaviour according to the options available.



I'm currently involved in an evaluation of a scheme to put GPs in A&E departments, because of the idea that many of the people attending ED could be managed in general practice instead. That's probably true, but GPs see vastly more patients than do A&E departments. So if putting a GP in the A&E department means that just 3% of patients attending general practice decide to go to A&E instead that will massively increase the number of people attending A&E and make the original problem worse.

Fourth, segmenting care into different models or services for each disease leads to a patient with multimorbidity having different specialist nurses or doctors for each of their problems. This leads to duplication of effort but also to gaps in care. What happens when you have a problem which doesn't fit into one of these segmented services and a generalist service no longer exists because most of its functions have been carved off to other services?

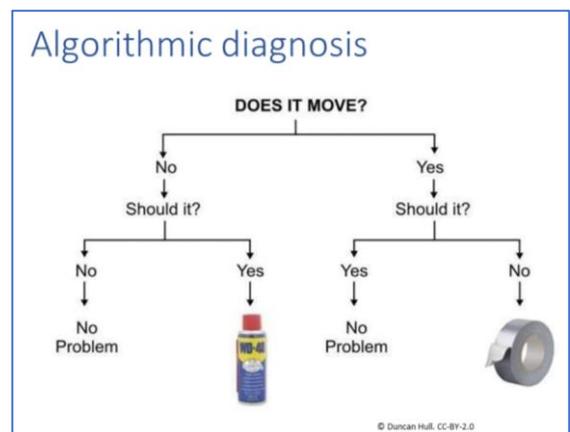


A similar argument applies to the enthusiasm for skill-mix – the idea that nurses, pharmacists, physicians associates should do much of the work that GPs used to do. Don't get me wrong – I'm entirely in favour of a wider range of professionals working in general practice. But we need to think very carefully about the appropriate role of these different groups so that they support rather than undermine generalist patient-centred care. Too many people involved can quickly undermine continuity and co-ordination and also be inefficient.

The fundamental misunderstanding that general practice is simple

I think the problem with many of these solutions is that they are based on a fundamental misunderstanding. They are based on the assumption that most consultations are for simple transactions and well-defined problems which can be handled by almost anyone with a bit of training, or better still by a computer algorithm without needing a human at all.

This flies in the face of the evidence that most consultations are for people with complex health problems. It reminds me of the bemusement James MacKenzie felt when he first went into general practice and found that hardly any of the patients he met had the simple, easily classified problems he expected.²



Of course some people have simple problems – particularly young fit people who hardly ever see a doctor. In my research on walk-in centres we've shown how they were used by a younger and generally healthier population than those who use general practice.³⁵ More recently, we've shown how online consultations are much more likely to be used by people between the ages of 18 and 40. So we are investing in initiatives targeted at people with the fewest health needs, which drains resources from services for people with the greatest needs. So it's an issue of efficiency, but it's also an issue of equity.

What's more, an emphasis on simple transactions undermines the key role of general practice in meeting the needs of a registered population. In his Mackenzie lecture in 1989, Julian Tudor Hart talked about the collision between reactive and proactive care.

He wrote *"If we are serious about controlling hypertension, or any chronic condition in which needs correlate poorly with symptoms, we must move decisively from our traditional role as shopkeepers passively responding to sick customers, to becoming active guardians of the health of registered populations."*³⁶

I want to emphasise that phrase ‘active guardians’. People don’t talk about GPs as shopkeepers any more. The model of the corner shop doesn’t seem appropriate in our large, modern, highly computerised surgeries, and as we merge into bigger and bigger organisations which are less and less personal. We are trying to replace the corner shop with Amazon. But I think that Tudor Hart would say that as active guardians we should be foodbanks at least as much as we should be online retailers. Our first priority is to the people with the greatest need, not necessarily the people demanding the quickest response.

Consequences of undermining the principles that underpin general practice

So, instead of strengthening general practice, some initiatives have instead undermined the key foundations that general practice depends on.

They have often been designed as an alternative, to ‘get around’ the perceived problems of general practice. But this undermines the reason for the existence of general practice.

If general practice is no longer **a single entry-point to the NHS**, then we lose the advantage of a simple system which patients understand and which enables good use of more expensive hospital care. One of the main reasons for the increasing use of A&E departments for primary care problems is because people are totally confused about how to get health care. But they know where the hospital is and that its always open.

If we lose **continuity of care** we lose that sense of understanding of context that allows GPs to work effectively as patients advocates and we lose the trust that makes their advice so powerful.

If we lose **generalism**, we won’t have ‘right patient, right place, right time’ – that favourite phrase of health service policy makers. We will have too many patients receiving the wrong care in the wrong place at the wrong time.

If we lose the **clear accountability** between a doctor and a patient that comes from the registered list of patients, we will end up with lots of choice and a great service for those with simple problems, and a second-class safety net for the old, the ill and the vulnerable.³⁷

If the core purpose of general practice is undermined through initiatives which don’t take account of what makes it work, it loses its reason for existence. I tried to think of an analogy for this.

I have this picture in my head – I wonder what brought this to mind? Are you thinking ‘showstopper’?



Yes, you could leave out the chocolate filling and buy a bar of dairy milk instead. And yes you could eat some strawberries from a punnet.

But what you would be left rather misses the whole point.

Loss of raison d'être is key reason for shortage of GPs

I think it is this sense of lack of purpose and value that is at the heart of why fewer people are choosing careers in general practice. It isn't just the pressure of work, although that is part of it. It is because doctors find it almost impossible to provide the kind of high quality care that they want to provide.²⁵

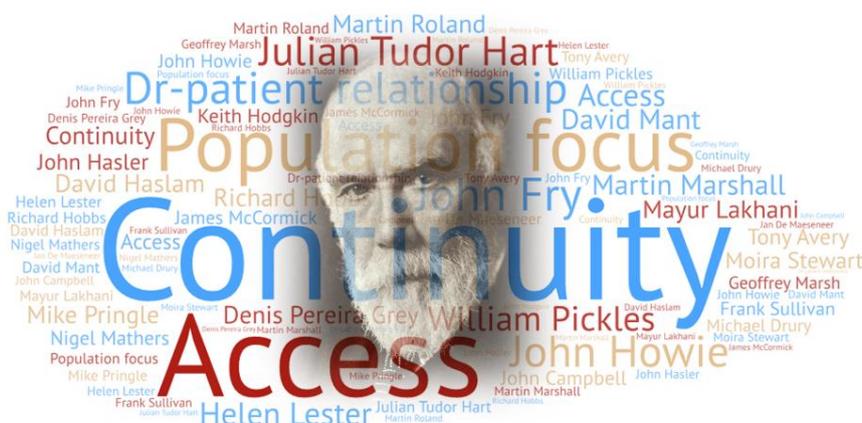
There have been a number of attempts to improve recruitment and retention in general practice.

But I don't think the answer is in incentive schemes, or golden hellos, or support systems to help doctors cope with a job that feels impossible. Instead, the real solution is to recognise what general practice at its best is there to do, and to make it possible for GPs to do that job to the best of their ability, and in a sustainable career structure. Under the right circumstances, there are few jobs as rewarding as general practice, so let people do it well and the recruitment problem would solve itself. Make it into a telephone call centre, or like a warehouse for Amazon, and even fewer doctors will want to work there.



These arguments are not new – why have they not been accepted?

In reading the James MacKenzie lectures, one thing that struck me was how many of the lecturers over the last 30 years have said the same things: the need for a population focus, the importance of continuity, the doctor-patient relationship. So why do we need to keep saying these things, and why does no-one seem to listen?



I think part of the reason is that people don't see the rhetoric reflected in reality – its not their personal experience. This is a challenge to us all. We may talk about the values of the accessible, generalist, personal care, but sometimes we don't live up to them. Are we really doing all we can to be accessible? A recent report found that almost a fifth of practices are closed before 3pm on at least one weekday each week.³² And how can we claim to be person centred if we put up signs like this, which say you can only discuss one problem at a time? And many practices have just given up on any attempt to provide continuity of care? If we are going to make claims about the role of general practice, we have to do our best to live up to our claims. If we lose sight of what makes us valuable and unique, what we are there for, we will no longer have a reason to exist.



And another part of the problem is that there is so little hard evidence about what actually goes on in general practice. One of the reasons that waiting times in Emergency departments get so much attention is because a report about this lands on ministers' desks every week, whereas no-one has any idea what goes on in general practice. It is a scandal that we don't even know have any reliable timely data about how many people go to general practice or what they go for. John Fry, another previous MacKenzie lecturer, had better evidence about this 50 years ago than we do now.

Designing health care for the people who need it

So how can we design health care for the people who need it? We need initiatives which reinforce rather than undermine general practice.

We need to start with the patients with the greatest needs at the forefront of our minds when we think about how we provide health care. Whenever someone suggests a new idea in general practice think about how its going to work for 80 year old Mrs Smith with dementia, diabetes and very dodgy knees and you won't go far wrong.



Instead of efficient but impersonal care, we need person-centred care. I recently published a trial of a new approach to managing patients with multimorbidity called the 3D approach,⁸ which involved improving continuity of care, focusing on problems that affected patient's quality of life rather than just disease control, and replacing separate disease-focused reviews with a whole person review every months.

We have to be able to offer longer consultations to people with complex problems. It's not a new thought, but it can't be ducked. In our study of GP workload published in the Lancet we found that the average consultation in England still only lasts 9 minutes.²² In Australia its 15 mins, Canada 16 minutes and 22 minutes in Sweden.³⁸

We have to be willing to innovate to improve access to care – if we aren't accessible we lose one of the most important reasons for our existence. Practices are exploring ways of using different forms of communication to improve access.²⁹ We're getting better at using online systems to share information with patients and to book appointments. We should explore using technology like video-consultations. But these things can all be done in ways which reinforce a co-ordinating, personal service from general practice, or they can be done in ways which undermine this.

If we are designing a system for people with multiple complex problems, patients need someone with a clear responsibility for co-ordinating their care. We're entering an era when diagnosis will become easier thanks to artificial intelligence, and health information is more easily available to patients, both of which we should welcome. But what patients with complex problems will need is someone to help them make sense of all that information and to help them when decisions are difficult and trade-offs have to be made. That means there will be a greater need for wise generalist doctors and nurses, not just specialist nurses for each disease.

We need simplicity based on a single point of contact. We need to provide as many services as possible in one place, from people who know each other, talk to each other and share one record system.

Yes we need skill mix and a wider network of staff, but working in teams in one building. We shouldn't under-estimate the power of informal communication and a shared team mission, which can't be replaced by endless electronic referral forms between different professionals.

So I think that means we need services that are small and local rather than large and impersonal. Yes, we need federations or other arrangements in which groups of practices work together. But I think these larger organisations should provide back-room functions, policies, shared facilities, quality control, IT and so on, not undermine personal generalist care on a human scale.

And we need data. As GPs we are sitting on a gold mine of data and it could be used to understand population needs; to help us manage individual patients using expert systems; and to make visible the pressures on us and the importance of what we do. Which means we have to find solutions to GP's concerns about sharing anonymous data.



The need for sustainable careers for GPs

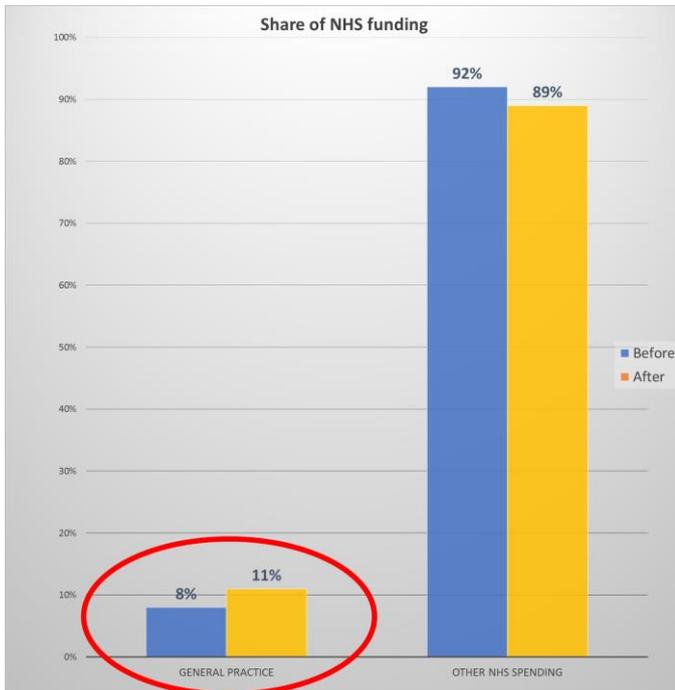
And to implement all this, we need sustainable careers for GPs. Many people will respond to what I've said by thinking that's all very well, but we can't offer the kind of care you're describing because we don't have the doctors. But I'd argue that there quite a lot of GPs out there – they are just choosing not to work as much as they

could because of the current environment. And a lot more people who would like to be GPs if they didn't think it would be so stressful and so unsupported. We have to ask difficult questions about why so many GPs try to squeeze a whole working week into 3 exhausting 12 hour days of intense patient contact, with no time to think. How is that the way to a healthy and sustainable career? I think we should stop talking about portfolio careers, as if you are only being a proper GP when you are seeing patients and everything else you do is something 'other'. Instead we need to model a new normal, where periods of direct patient contact are interspersed with programmed time for learning new skills, developing services, management, teaching or even research. Where you meet up with your colleagues each day to discuss patients, to learn together, to share ideas. Where you finish each day with a sense of achievement, a sense of having helped people, and with energy and enthusiasm for the next day. This isn't a portfolio career, this should be a normal professional GP career.

Misplaced nostalgia?

I suspect some of you are thinking that when I talk about continuity of care and person-centred care, and a primary care team that all works together, I'm harking back with rose-tinted spectacles to a past form of general practice that never really existed. I don't believe that's the case. For a start, we may have rehearsed the fine rhetoric but that doesn't mean we've ever really put it into practice. I certainly don't think general practice was perfect in the past. When have we ever been very accessible? Were we ever really patient-centred? Have we looked after the housebound proactively? But nor do I believe that this mean the model has failed and needs to be thrown out and replaced with something else. I think the model makes complete sense but has never been properly tried. Its implementation failure not conceptual failure.

Or unrealistic without more resources?



And others of you will point out that much of what I've said would only be possible with more resources. That's true but its also a completely realistic aim.

Just as a 3% shift in the number of people going from general practice to A&E would have a big impact on the A&E department, a similarly small 3% shift in resources from hospitals to general practice would have a massive impact on resources in primary care.²³

The choice

So we face a choice. We continue along the line that continuity of care is no longer relevant, that we should provide a range of fragmented services in order to ensure the fastest possible access and the greatest possible consumer choice (but only to people who are able to travel to centralised services and have the wherewithal to exercise choice). I believe the end result will be fewer GPs, paradoxically longer waits for care, much higher costs for the health service and an inevitable drift towards patients seeking primary care from emergency departments. In fact why shouldn't they, because general practice won't look very different from an emergency department. Most importantly, there will be better care for those with the fewest health needs and worse care for those who most need it.

Alternatively we promote, support, develop and invest in comprehensive primary care. We don't accept a gradual decline by hanging on to outdated ideas, but we embrace innovation. But innovations that are designed to support the foundational primary care principles of accessibility, generalism, personal care, and co-ordination of care for a defined population. These ideas haven't failed, they've just never been fully implemented.

Thank you

With many thanks to:

Patients and staff at Horfield Health Centre, Grovelands Medical Centre and the Merrywood Practice for inspiring my ideas about what makes good general practice. The many academic colleagues who have worked with me on numerous interesting and challenging projects. And my family who have supported me throughout.

References

1. Lakhani M. The über-GP: an exploration of clinical excellence, leadership, and patient-centred care in general practice. *British Journal of General Practice* 2011; **61**(584): 218-20.
2. Mair A. Sir James Mackenzie, 1853-1925: General Practitioner. London: Royal College of General Practitioners; 1986.
3. Schon.D.A. Educating the Reflective Practitioner: Toward a New Design for Teaching and Learning in the Professions. San Francisco: Jossey Bass; 1990.
4. Salisbury C, Procter S, Stewart K, et al. The content of general practice consultations: cross-sectional study based on video recordings. *Br J Gen Pract* 2013; **63**(616): e751-9.
5. Salisbury C, Johnson LR, Purdy S, Valderas JM, Montgomery AA. Epidemiology and impact of multimorbidity in primary care: a retrospective cohort study. *Br J Gen Pract* 2011; **61**(582): e12-e21.
6. Stafford M, Steventon A, Thorlby R, Fisher R, Turton C, Deeny S. Understanding the health care needs of people with multiple health conditions. 2018.
<https://www.health.org.uk/sites/default/files/upload/publications/2018/Understanding%20the%20health%20care%20needs%20of%20people%20with%20multiple%20health%20conditions.pdf>.
7. Wallace E, Salisbury C, Guthrie B, Lewis C, Fahey T, Smith SM. Managing patients with multimorbidity in primary care. *BMJ* 2015; **350**: h176.
8. Salisbury C, Man MS, Bower P, et al. Management of multimorbidity using a patient-centred care model: a pragmatic cluster-randomised trial of the 3D approach. *Lancet* 2018; **392**(10141): 41-50.
9. Chaplin K, Bower P, Man MS, et al. Understanding usual care for patients with multimorbidity: baseline data from a cluster-randomised trial of the 3D intervention in primary care. *Bmj Open* 2018; **8**(8): e019845.
10. National Guideline Centre. Multimorbidity: clinical assessment and management. London: National Institute for Health and Care Excellence, 2016.
11. Baker MJ, H. Responding to the needs of patients with multimorbidity. A vision for general practice. London, England: Royal College of General Practitioners, 2016.
12. The Academy of Medical Sciences. Multimorbidity: a priority for global health research. London, 2018.
13. Muth C, van den Akker M, Blom JW, et al. The Ariadne principles: how to handle multimorbidity in primary care consultations. *BMC Medicine* 2014; **12**(1): 223.
14. American Geriatric Society Expert Panel. Patient-centered care for older adults with multiple chronic conditions: a stepwise approach from the American Geriatrics Society: American Geriatrics Society expert panel on the care of older adults with multimorbidity. *J Am Geriatr Soc* 2012; **60**(10): 1957-68.
15. Kingston A, Robinson L, Booth H, Knapp M, Jagger C, Project M. Projections of multimorbidity in the older population in England to 2035: estimates from the Population Ageing and Care Simulation (PACSim) model. *Age Ageing* 2018; **47**(3): 374-80.
16. National Voices. Integrated care: what do patients, service users and carers want? 2013.
<https://www.nationalvoices.org.uk/publications/our-publications/integrated-care-what-do-patients-service-users-and-carers-want>.
17. Starfield B. Is primary care essential? *The Lancet* 1994; **344**: 1129-33.
18. NHS England. General Practice Forward View. London, 2016.

19. GP patient survey Practice Report. 2016. <https://gp-patient.co.uk/practices-search> (accessed 14/03/2017).
20. Levene LS, Baker R, Walker N, Williams C, Wilson A, Bankart J. Predicting declines in perceived relationship continuity using practice deprivation scores: a longitudinal study in primary care. *Br J Gen Pract* 2018; **68**(671): e420-e6.
21. Robertson R, Appleby J, Evans H. Public satisfaction with the NHS and social care in 2017: Results and trends from the British Social Attitudes survey. 2018. <https://www.nuffieldtrust.org.uk/files/2018-02/nut-kf-bsa-2018-web.pdf>.
22. Hobbs FD, Bankhead C, Mukhtar T, et al. Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007-14. *Lancet* 2016; **387**(10035): 2323-30.
23. Investment in general practice in England. 2018. <https://www.bma.org.uk/-/media/files/pdfs/collective%20voice/influence/key%20negotiations/nhs%20funding/investment-in-general-practice-in-england.pdf?la=en>.
24. NHS Digital. NHS Workforce Statistics. 2018. <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics20/10/2018>).
25. Sansom A, Terry R, Fletcher E, et al. Why do GPs leave direct patient care and what might help to retain them? A qualitative study of GPs in South West England. *Bmj Open* 2018; **8**(1): e019849.
26. Rosen R. Divided we fall? . 2018. <https://www.nuffieldtrust.org.uk/research/divided-we-fall-getting-the-best-out-of-general-practice>.
27. Edwards HB, Marques E, Hollingworth W, et al. Use of a primary care online consultation system, by whom, when and why: evaluation of a pilot observational study in 36 general practices in South West England. *Bmj Open* 2017; **7**(11): e016901.
28. Banks J, Farr M, Salisbury C, et al. Use of an electronic consultation system in primary care: a qualitative interview study. *Br J Gen Pract* 2018; **68**(666): e1-e8.
29. Atherton H, Brant H, Ziebland S, et al. The potential of alternatives to face-to-face consultation in general practice, and the impact on different patient groups: a mixed-methods case study. *Health Services and Delivery Research* 2018; **June**.
30. Salisbury C, Chalder M, Manku-Scott T, et al. The National Evaluation of NHS Walk-in Centres: Final report. Bristol: University of Bristol, 2002.
31. Henderson C, Knapp M, Fernández J-L, et al. Cost effectiveness of telehealth for patients with long term conditions (Whole Systems Demonstrator telehealth questionnaire study): nested economic evaluation in a pragmatic, cluster randomised controlled trial. *BMJ* 2013; **346**: f1035.
32. National Audit Office. Improving patient access to general practice. 2017. <https://www.nao.org.uk/wp-content/uploads/2017/01/Improving-patient-access-general-practice.pdf>.
33. Rosen R. Meeting need or fuelling unnecessary demand? Understanding the impact of improved access to primary care. . 2014. <https://www.nuffieldtrust.org.uk/research/meeting-need-or-fuelling-unnecessary-demand-understanding-the-impact-of-improved-access-to-primary-care#partners>.
34. Campbell JL, Fletcher E, Britten N, et al. The clinical effectiveness and cost-effectiveness of telephone triage for managing same-day consultation requests in general practice: a cluster randomised controlled trial comparing general practitioner-led and nurse-led management systems with usual care (the ESTEEM trial). *Health Technol Assess* 2015; **19**(13): 1-212, vii-viii.

35. Salisbury C, Chalder MJE, Manku-Scott TK, Pope CJ, Moore L. What is the role of walk-in centres in the NHS? *Br Med J* 2002; **324 (7334)**: 399-402.
36. Hart JT. A new kind of doctor. *J R Soc Med* 1981; **74(12)**: 871-83.
37. Hart JT. James Mackenzie lecture 1989. Reactive and proactive care: a crisis. *The British journal of general practice : the journal of the Royal College of General Practitioners* 1990; **40(330)**: 4-9.
38. Irving G, Neves AL, Dambha-Miller H, et al. International variations in primary care physician consultation time: a systematic review of 67 countries. *Bmj Open* 2017; **7**(e017902).