Primary Care in a modern world

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@fatherofhan

Declaration of interests

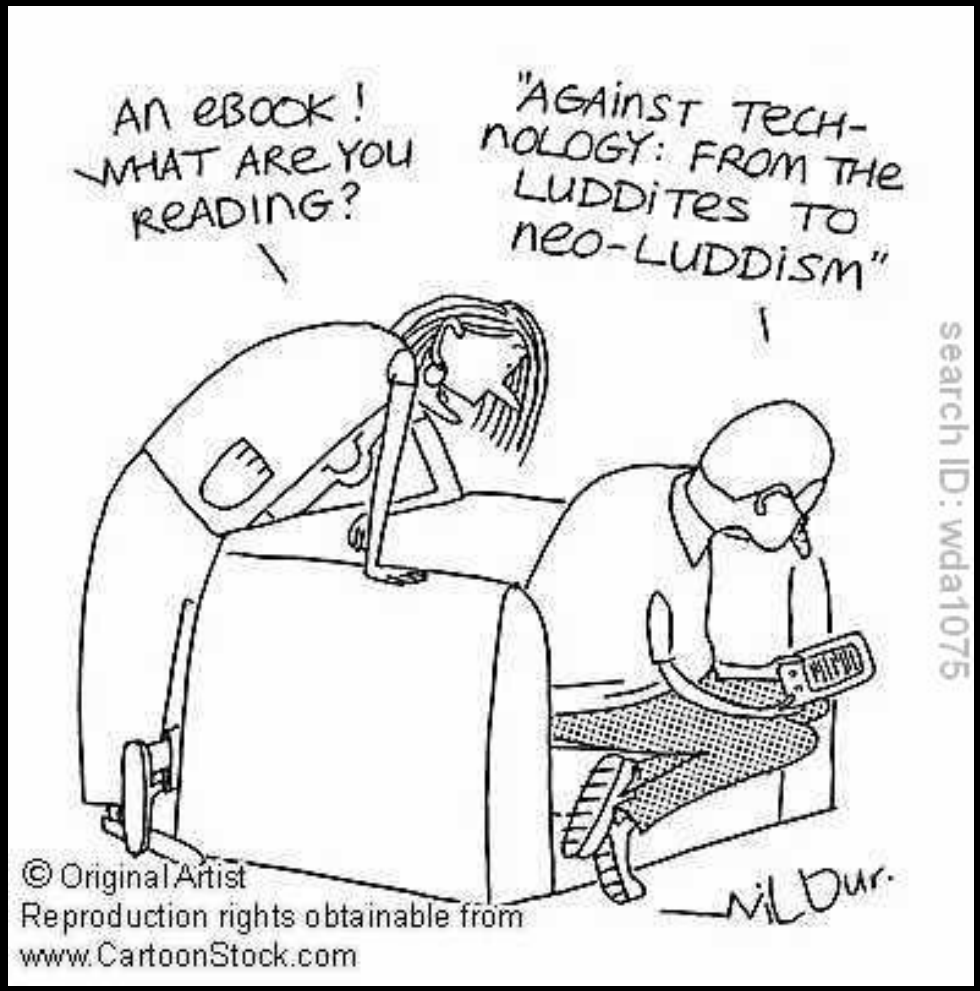
- The Westcliffe Partnership has received funding from: Abbott, Bayer, Boehringer-Ingelheim, Bristol Myers Squibb, Dawn, INRStar, Medtronic, Oberoi Consulting, Pfizer, Roche, Sanofi-Aventis, Servier.

- An advisor to: Anticoagulation Europe, Arrhythmia Alliance, Heart Valve Voice, National Stroke Association, Syncope Trust

- A trustee of Thrombosis UK and AF Association

What I want to talk about

- Looking forward
- Looking backwards
- What is general practice
- Drivers of change
- Futures and non-future
- Observations on general practice now
- Possible futures for general practice
- Questions for the future…The List!


AN eBOOK! WHAT ARE YOU READING?
"AGAINST TECHNOLOGY: FROM THE LUDDITES TO NEO-LUDDISM"
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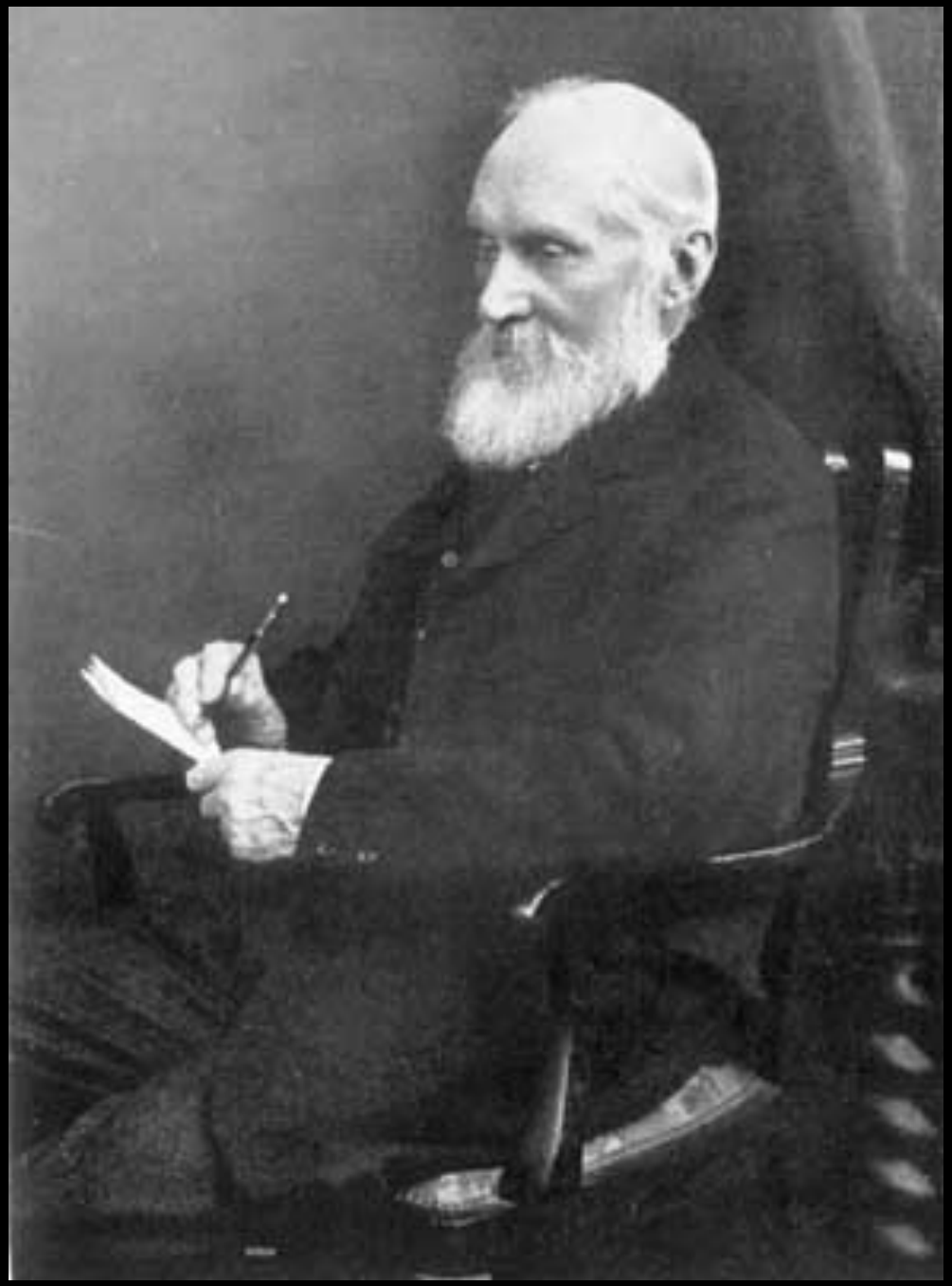
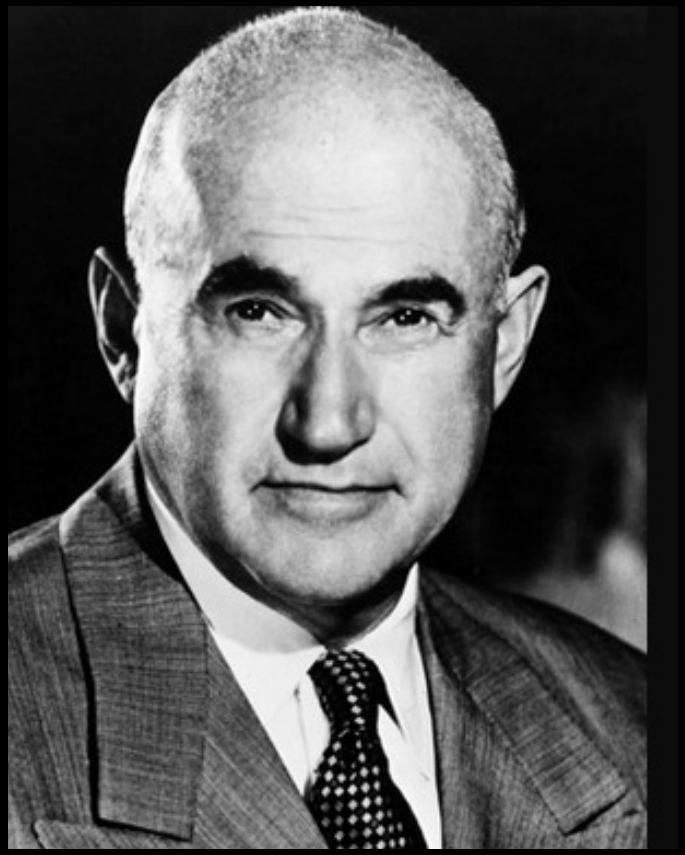


Predictions of Lord Kelvin
president of the Royal Society, 1890-95

- "Radio has no future"
- "Heavier than air flying machines are impossible"
- "X rays will prove to be a hoax”

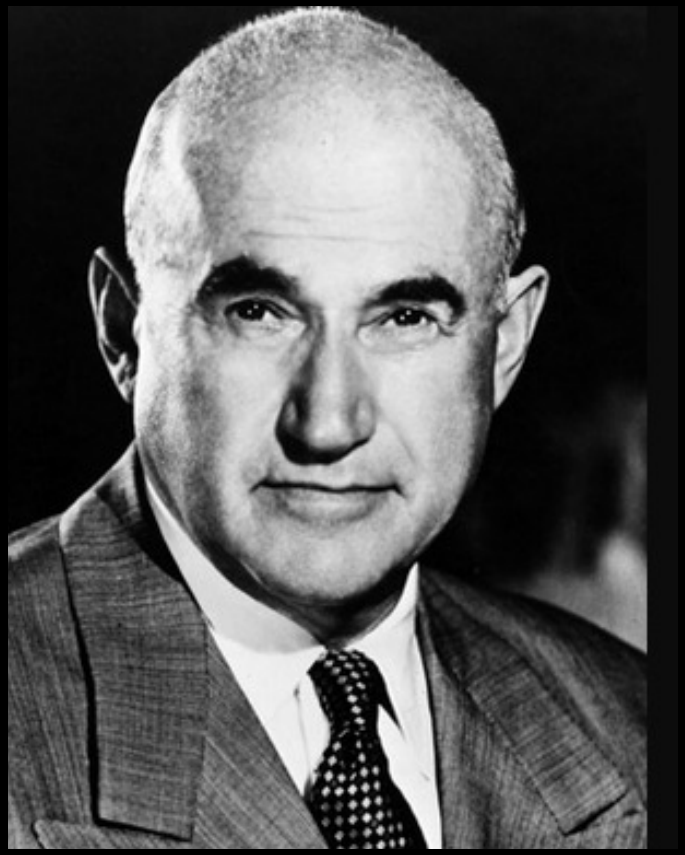
Dangers of predicting the future



I never make predictions, especially about the future.

Sam Goldwyn Mayer

Dangers of predicting the future



A hospital is no
place for a sick person

Sam Goldwyn Mayer

Looking to the future: a common mistake

- Making predictions rather than attaching probabilities to possibilities
- Simply extrapolating current trends
- Thinking of only one future
- People consistently overestimate the effect of short term change and underestimate the effect of long term change.

Ian Morrison
Emeritus president of the Institute for the future

Why bother with the future?

- "If you think that you can run an organisation in the next 10 years as you've run it in the past 10 years you're out of your mind."

CEO, Coca Cola

Why bother with the future?

- **“The future belongs to the unreasonable ones, the ones who look forward not backward, who are certain only of uncertainty, and who have the ability and the confidence to think completely differently.”**

Charles Handy quoting Bernard Shaw

So if not forward…

…backwards

So if not forward…

…backwards

General Practice in the Seventeenth and Eighteenth Centuries

During the 17th century, Scotland was an extremely poor country. The southern and more wealthy part had been wasted by the English Wars in the middle of the 16th century, by the plague, and by the internal political troubles associated with the period of the Reformation. About the middle of the 17th century, the country was still further impoverished by the Civil Wars, the efforts made in 1650 on behalf of Prince Charles, and the great fines subsequently imposed by Cromwell. The 17th century accordingly was one which showed only a very gradual development in medicine. Opportunities for medical education were few, and means of transport were extremely bad and slow, so that it was difficult for medical practitioners to travel any great distance to see patients, except in the case of the wealthy, or, indeed, to subsist at all in country places. With the exception of a few roads between the principal towns, there were no routes over which wheeled vehicles could pass, and such roads as existed were of very poor quality. Communication in country districts was carried out entirely on foot or horseback. Even carts were not introduced till late in the 17th century, and merchandise was transported on rough sledges or by horse panniers. Horse litters also had been used from early times by wealthy and sickly people.

History of Scottish Medicine to 1860
John D. Comrie (1927)

So if not forward…

…backwards

As an example of the sparseness of medical practitioners in country districts, it is said that there was only one medical man on the main road for fifty miles north of Aberdeen at the beginning of the 18th century, Dr. Beattie, in the Garioch. "In his later days he used to be seen visiting patients mounted on a shaggy pony. His professional dress was a greatcoat, so frayed by time and weather that its original colour was undiscernible, and he wore a yellow wig." [3]

In the absence of local medical practitioners, it was necessary that the clergyman and the Laird should know something about medicine, and they had often picked up some rudiments of this during their College course. In the case of the wealthy, physicians and surgeons were frequently brought from a long distance to attend during an illness, while the great nobles and the Highland chiefs had their private medical attendants, who could give assistance to the poor retainers of their patrons.

History of Scottish Medicine to 1860
John D. Comrie (1927)

Well...may be not so far back

Development of General Practice

- **History of General Practice**

- **Pre 1949**-Prior to NHS
  - Single-handed, fee-paying, some government payments

- **1949 – 1966** Early years NHS – "Independent Contractor Status"
  - Single-handed, working from own home, sub-standard premises
  - Minimum support staff. No appointments, a lot of visiting
  - Lack of Post-graduate training

- **1966 - 1990** 1966 Charter - "Golden Years" – the Red Book
  - **Introduced better pay, seniority, practice allowances**
  - Reimbursement of staff salaries, premises improvement schemes
  - Swing towards appointments, less visiting (22% in 1971, 10% in 1994)
  - Establishment of RCGP, development of VTS

Development of General Practice

- **History of General Practice**

- **1990- 1999** 1990 New Contract
  - Targets – smears and immunisations
  - Accountability – fundholding, prescribing budgets
  - Increased computerisation. Part-time options, assistants. Out-of-hours services

- **After 1999 Primary care groups, Primary care trusts - ? salaried service**
  - PMS Pilots – opting out of the Red Book
  - New Primary Care Services – NHS Direct, Walk-in Centres

Development of General Practice

- **History of General Practice**

- **Structure of GP Pay -** NHS 85%, Private 15%
- **NHS**
  - **Basic work** **20% Basic Practice Allowance**
    50% Capitation Payments
    15% Item of Service (imms, maternity, minor ops, contraception)
    5% Targets – Smears and childhood vaccinations
    10% Miscellaneous (training grant, premises, committees)
  - Staff Reimbursements – 75-80% of salaries covered by staff budget
  - **Private** Medicals, reports, drug trials

What is Primary Care?

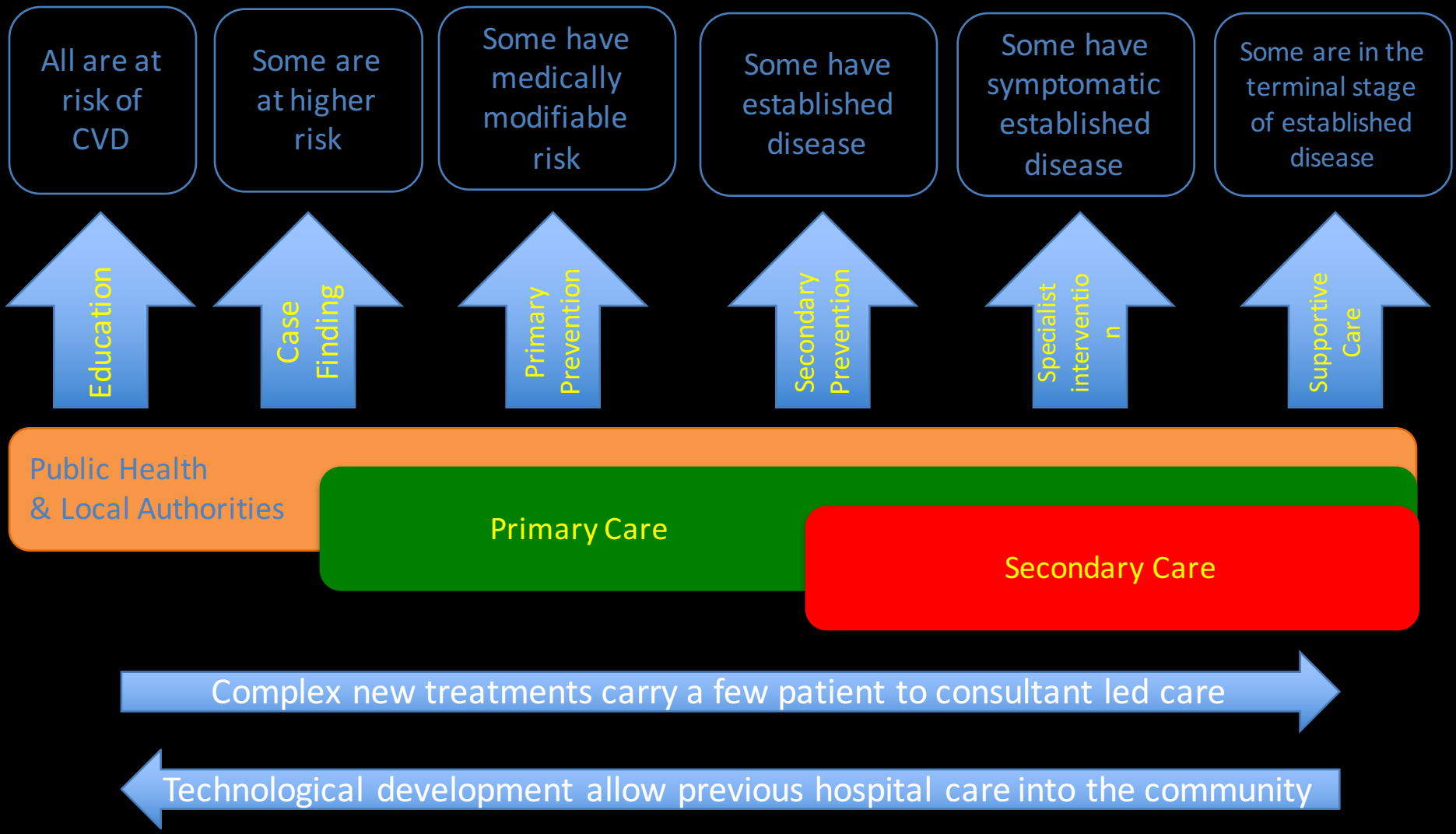
What is Primary Care

We know that strong primary care has the potential to impact positively on all elements of the health and social care system. Evidence shows the importance of a robust system of primary care for health economies[1] and that if you want high-quality health systems and healthy populations you require strong and effective primary care services[2].

1 Starfield B. Is primary care essential? Lancet 1994;344:1129-33.

2 Contribution of Primary Care to Health Systems and Health. Milbank Quarterly, September 2005. Starfield, Barbara; Shi, Leiyu; Macinko, James

What is Primary Care-CVD



What is general practice?

What is general practice?

‘A general practitioner is a medical practitioner who **treats acute** and **chronic illnesses** and provides **preventative care** and **health education** to patients’

‘ A general practice refers to the team, including the GP who deliver services to the practice population’.

Who is in your general practice team?

- **GP's**
- **Healthcare assistant**
- **Reception staff**
- **Trainees**
- **Locum staff**

- District nurses
- Health visitors
- Pharmacist
- Podiatrist
- Mental health team
- Social worker
- Specialist nurses e.g. heart failure, respiratory
- Physiotherapists
- Occupational therapists
- Medicine for the Elderly consultant

What is General Medical Services (GMS)?

Describes services provided by general practice across the UK, who work as **independent contractors**

The GMS as a contractual framework…

OTHER NON GMS

Activity e.g. carers health checks

ENHANCED SERVICES

'Range of services aimed at improving care and choice for patients, supporting local service delivery or specific services to meet practice population needs' e.g. minor injuries

QUALITY & OUTCOMES FRAMEWORK

'Rewards practices for the provision of quality care

Helps to standardise improvements in the delivery of medical services

ADDITIONAL SERVICES

'Range of services practice have 1st refusal for delivery e.g contraception

CORE SERVICES

'The care of those who are, or believe themselves to be unwell'

Some points of note

- Patient now registered with practice not a named GP
- GP's opt out of out of hours delivery
- Core hours are Monday to Friday, 8am until 6.30pm (Except key public holidays)
- Home visiting. 'The contractor must attend a patient outside practice premises if the patients medical condition is such that, in the reasonable opinion of the contractor, it is necessary to do so'

Some points of note (continued)

- ‘The contractor is obliged to provide a consultation to patients aged 75 or over who request it if the patient has not had a consultation within the last 12 months’

- ‘All contractors must produce a practice leaflet including information about clinical staff, details on registration, services available, health board contact details, appointment system, disability access, methods for obtaining repeat prescriptions, how to make complaints, actions that may be taken where patient is violent or aggressive

Some points of note (continued)

New registration

If a practices list is ‘open’ they must accept any application to join their list unless they have fair reasons for not doing so.

Such reasons may include:

- History of violence or relatives of violent patients
- Previous removal from practice list

Patient lives outside boundary is no longer a reason for exclusion

Some points of note (continued)

PULSE
At the heart of general practice since 1960

OPINION
Jeremy Hunt talking perfect sense? Oh hang on Copperfield

18,000-practice set to close as GP partners hand back contract

15 September 2016 | By Michelle Madsen

A practice in Oxfordshire with a list of 17,948 patients could be set to close after failing to recruit enough GPs to remain open.

Partners at the Horsefair Surgery in Banbury said in a letter to patients that it had given notice to NHS England to terminate its GMS contract after several of its GPs left due to retirement or ill health.

As a result, one branch is closing from 3 October 'for the forseeable future', while the partners will continue to run its other surgery until a new provider is found.

MOST POPULAR MOST COMMENTED


1 Red Cross deployed to cope with NHS 'humanitarian crisis'


2 GPs in A&E and care homes can cut unnecessary attendances, says Hunt

3 NHS to spend £15m on training

Why bother with the future?

The point is not to predict the future but to prepare for it and to shape it

Drivers of change in health care

- The information age
- Globalisation
- Cost containment
- Ageing of society
- Managerialism
- Increasing public accountability
- Political posturing and promises

Drivers of change in health care

- Rise of sophisticated consumers
- 24/7 society
- Science and technology
- Ethical issues to the fore
- Changing boundaries between health and health care
- Environment

Drivers of change in health care

- Chronic disease replacing acute episodes of disease
- Growing gap between rich and poor
- Growing gap between educated and uneducated
- Growing gap between technology haves and have nots
- Death of distance
- Collapse of socialism
  - "There is no such thing as society" M. Thatcher
- Postmodernism

Examples of future scenarios for information and health

Three possible futures: Free market

- Information technology develops fast in a global market
- Governments have minimal control
- People have a huge choice of technologies and information sources on health
- People are suspicious of government sponsored services
- There are many “truths”

The GP in the Free Market

- Patients shop around, collapse of “the list”
- GPs compete with specialists, complementary practitioners, cyberdocs, and all sorts of healers
- What’s your competitive advantage?
- Many patients “know” more than you do
- Technology runs your life
- Most consultations are e-consultations

Three possible futures: Social world

- A top down, regulated world
- People are overwhelmed by information so turn to trusted institutions--like the NHS
- Experts are important
- Information is standardised
- Public interest is more important than privacy

The GP in the social world

- A trusted figure
- Central to the community and the state
- Uniform information used by all
- Evidence based information
- Tight management of GPs
- Rationing of healthcare is accepted

The ”expert”

“I think people in this country,” declared Vote Leave’s **Michael Gove**, “have had enough of experts.” His fellow Brexiteers were quick to back him up. “There is only one expert that matters,” said Labour MP Gisela Stuart, also of Vote Leave, “and that’s you, the voter.”

The ”expert”

“It is a common misconception that doctors know about medicine, simply because they’ve studied it for up to 16 years.

“Yet, mere centuries ago, these same people were routinely prescribing leeches, and performing amputations without anaesthetic. Wrong then, wrong now.

“The decent, ordinary patients of Britain have had enough of the medical elite lecturing them about how many tablets to take, and ordering them to open wide and say, ‘Ahhh.’ Day after day, we’re fed scare stories about how eating too much will make you fat, and how smoking causes lung cancer. It’s pure scaremongering, and I think this type of negativity is turning patients off.

“Quite frankly, it’s time to take back control of the operating theatre, and start performing our own keyhole surgery.”

So if not forward…

…backwards

An interesting proprietary remedy, introduced early in the 17th century, was Anderson's Scots Pills. Dr. Patrick Anderson, who practised at Edinburgh, London and Paris, speaks in a little book, which he wrote on their virtues, of having got the receipt in Venice about 1603. Their main constituent was aloes, and they were widely used for headache, stomach troubles, constipation, rheumatism, etc. Indeed, several men who were early principals and regents in the Town's College, wrote elegant Latin verses on their usefulness. These pills were widely used for 300 years, and were still on sale in the year 1910.[4]

History of Scottish Medicine to 1860
John D. Comrie (1927)

Three possible futures: Anti-technology

- People react against technology as against genetically modified foods
- Legislation restricts technological innovation
- Privacy is highly valued
- Internet access is a community not an individual resource
- There are no mobile phones

The GP in the Anti-technology

- A local sage with a long beard (women too)
- Central to the community
- The state is unimportant
- The GP almost alone has access to the internet and the information it contains--”the mysteries”
- EBM is bunk; crystals are more important

General practice can never be Anti-technology

- **“Let’s create a ‘virtual Dr Brown’ online. He was a family doctor when I was a kid in Glasgow, 30 years ago. He fixed everything, knew all about you and your family, made you feel good. I can’t see why we can’t create such a doc online, and we can make sure he’s more up to date. And with sensors in his patients’ bodies and homes he’ll know more about their physiology.”**

Ian Morrison
Emeritus president of the Institute for the future

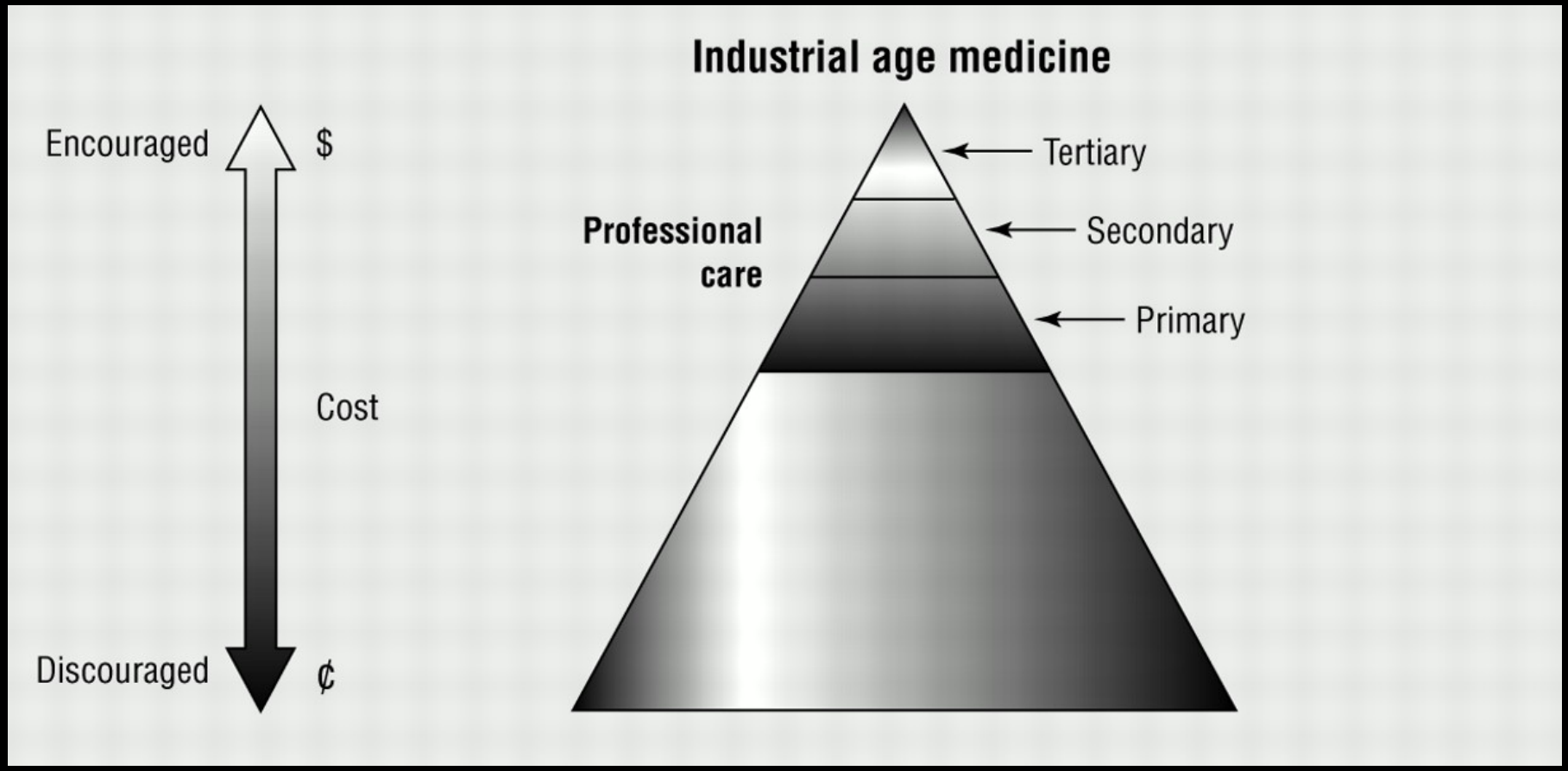
Why are GPs so fed up?

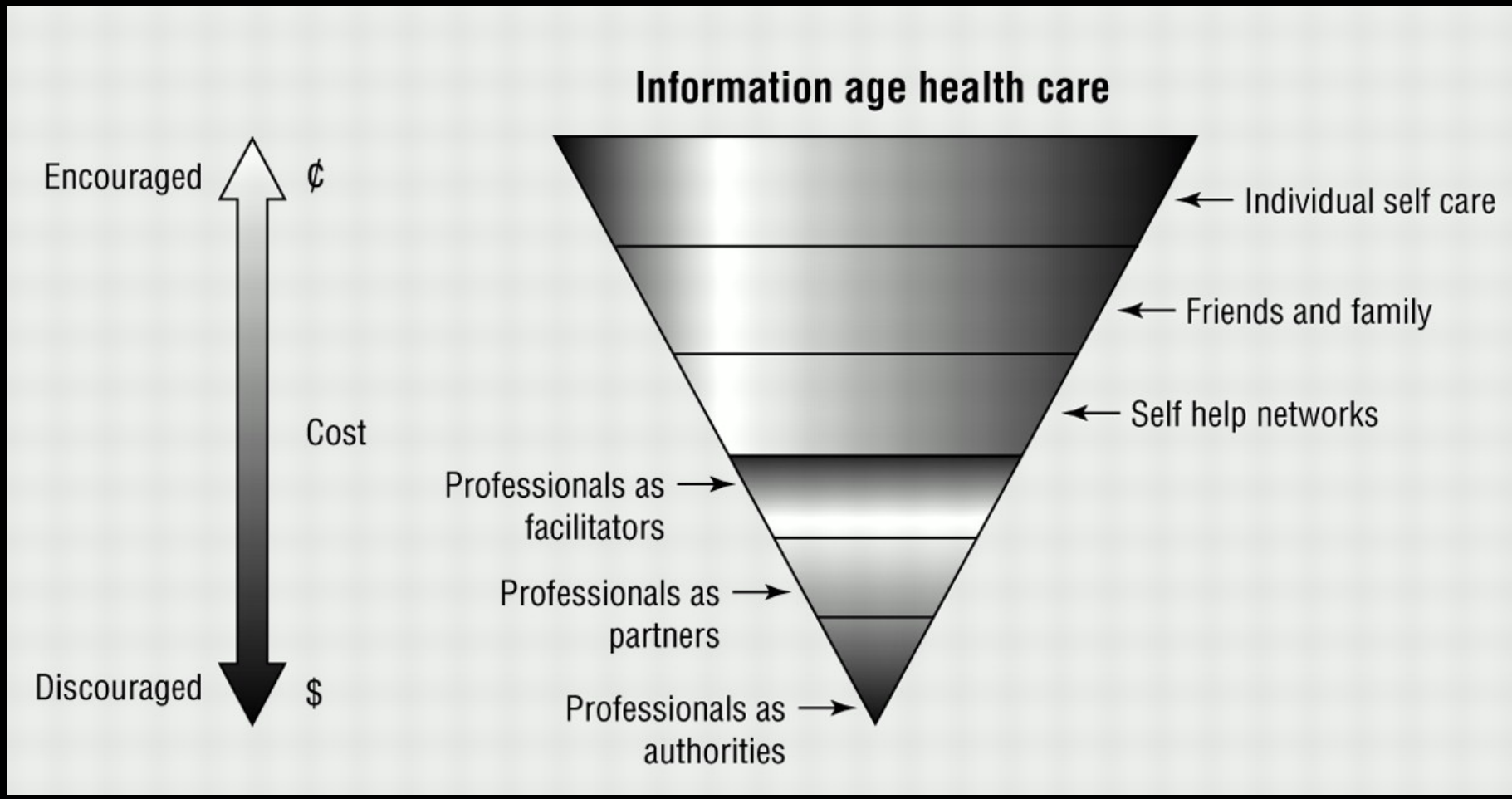
- Overworked, underpaid (what's new?)
- Declining status (could be a good thing)
- Trained for one thing, doing another
- Having to change fast from one world to another (who isn't?)
- Declining control over their own destiny (but still more than most of their patients)

Why are GPs so fed up?

- Increasing accountability (can't be avoided)
- Front line workers in the last "socialist" institution
- Left picking up the pieces in a world that's abandoned the poor and lost ways of coping with pain, sickness, and death
- Nemesis (promised too much)

Possibilities for the future


Industrial age medicine
Encouraged
$
Cost
Discouraged
¢
Professional care
Tertiary
Secondary
Primary


Information age health care
Encouraged
¢
Cost
Discouraged
$
Individual self care
Friends and family
Self help networks
Professionals as facilitators
Professionals as partners
Professionals as authorities

Simple steps for a 21st century health care system: Institute of Medicine

Current Approach

- Care is based primarily on visits
- Professional autonomy drives variation in care
- Professionally controlled care
- Information is a record
- Decision making is based on training and experience
- Do no harm is an individual responsibility
- Secrecy is essential
- System reacts to need
- Cost reduction is sought
- Preference is given to professional roles not system

New Approach

- Care is based continuous healing relationships
- Care is customized determined by the patients values and needs
- The patient is the source of control
- Information is shared and flows freely
- Decision making is evidence based
- Safety is a system property
- Transparency is necessary
- Needs are anticipated
- Waste is continually reduced
- Cooperation between health and social work professionals is a priority

Institute of Medicine report: six challenges for health care organisations

1. Design seamless, coordinated care
2. Make effective use of IT, including automating patient records
3. Manage knowledge so that it is delivered into patient care
4. Coordinate care across patient conditions, services, and settings over time
5. Advance the effectiveness of teams
6. Incorporate measurement of care processes and outcomes into daily practice

Renegotiate the contract between doctors and patients:

- "All doctors are problem doctors"
- Why don't doctors act on poorly performing colleagues?
- Like any tribe doctors will stick together
- "There but for the grace of God go I."

Renegotiate the contract between doctors and patients:

- **Patient's view**
  - Modern medicine can do remarkable things
  - You, the doctor, can see inside me and know what's wrong
  - You know everything it's necessary to know
  - You can solve my problems
  - Come to think of it, you can solve all our social problems

Renegotiate the contract between doctors and patients:

- **The doctor's view**
  - Modern medicine has limited powers
  - Worse, medicine is dangerous
  - We can't begin to solve all social problems
  - I don't know everything
  - The balance between doing good and harm is very fine
  - I better keep quiet otherwise I might lose my status and my biggish salary

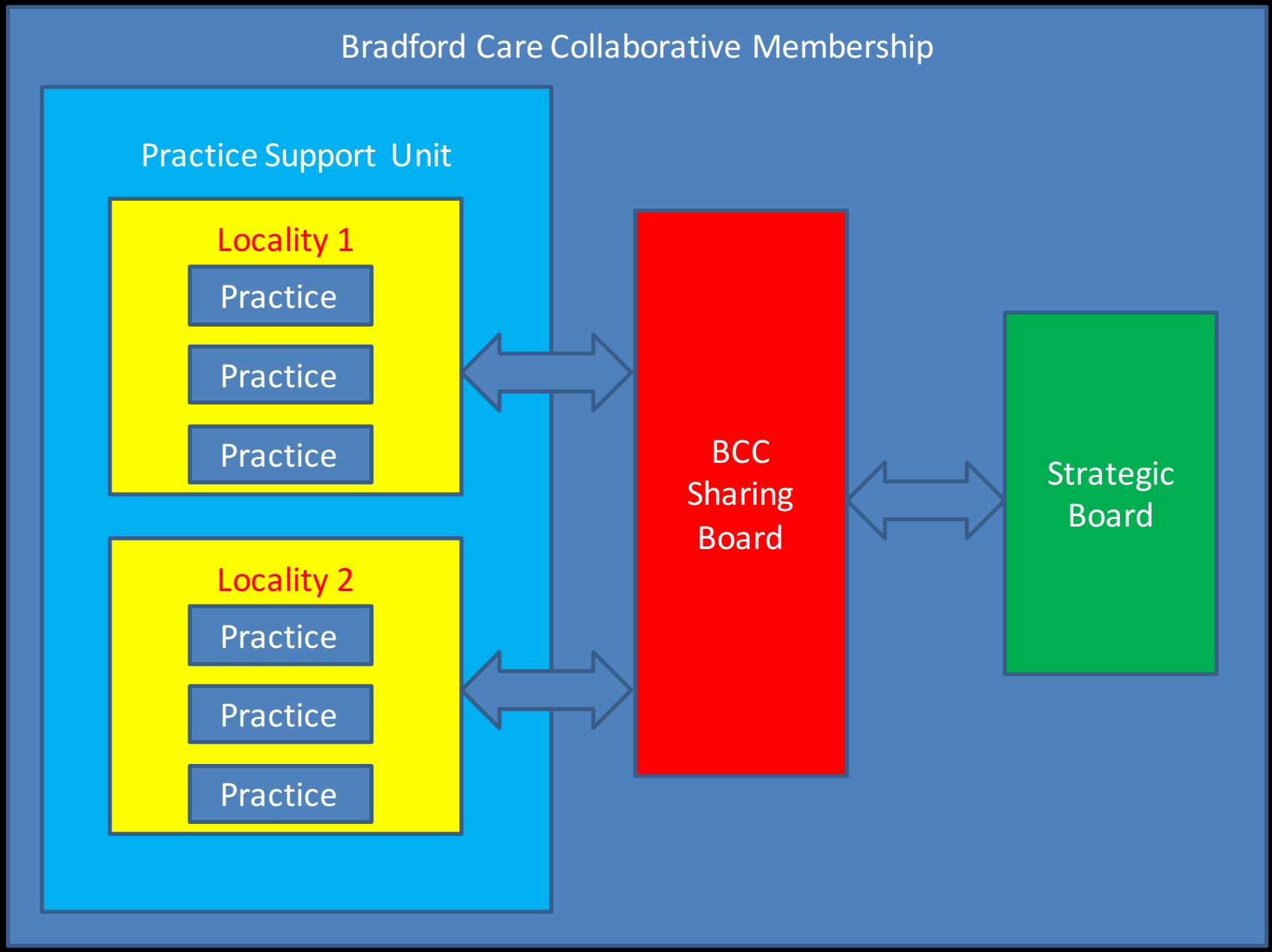
Renegotiate the contract between doctors and patients:

- **Both patients and doctors need to know**
  - Death, sickness, and pain (mental if not physical) are part of life
  - Medicine has limited powers and is risky; errors happen
  - Doctors don't know everything: they need decision-making and psychological support
  - Some patients know more than doctors
  - We're in this together
  - Patients can't leave it all to the doctor
  - Doctors need to be honest to patients about our deficiencies

What is Westcliffe doing?

Moving to the Bradford Care Collaborative

1. Take all work in the practice to the PMS contract
2. Allow groups of partners to continue their 'private' work as individual partnerships
3. Form a clinical governance board
4. Form a strategic management board
5. Ensure clinicians do what they are trained for
6. Ensure administration has functions many practice (economies of scale)
7. Share clinical expertise across the group
8. A single partnership ensures resource can flow across the structure
9. Localities of practices work to maintain a list based system


Bradford Care Collaborative Membership
Practice Support Unit
Locality 1
Practice
Practice
Practice
Locality 2
Practice
Practice
Practice
BCC Sharing Board
Strategic Board

Institute of Medicine report:-Objectives Westcliffe

1. **Design seamless, coordinated care**
   - A large group of clinicians with varied skills support a wide population of over 50K. This allows a more varied work force
2. **Make effective use of IT, including automating patient records**
   - Use of Smart phone technology for palpitation
   - Use of smart phone technology for blood pressure management
   - Use of web portal for management of dyspepsia
   - Use of booths for case finding of dysrhythmia and hypertension
3. **Manage knowledge so that it is delivered into patient care**
   - Use of VCS (directly commissioned) to support social prescribing and the PPGs
4. **Coordinate care across patient conditions, services, and settings over time**
   - This remains a challenge
5. **Advance the effectiveness of teams**
   - Use of specialist nurse teams in anticoagulation/cardiovascular disease/respiratory disease/complex elderly care.
   - Directly employing pharmacists to do face to face review
6. **Incorporate measurement of care processes and outcomes into daily practice**
   - All practices receive the dashboard report at the clinical governance board

However…

However…

This endeavors to preserve list based general practice….

…as this is our current contractual model

However…

PULSE
At the heart of general practice since 1960

OPINION
General practice is burning, but I refuse to lose all hope - Dr Des Spence

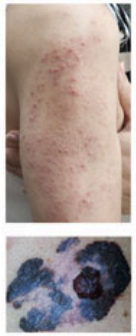
Stevens: We must consider alternatives to list-based general practice

8 July 2015 | By Caroline Price

The practice-list based model of general practice could be replaced in future under plans for reorganising primary care, the head of the NHS in England has told a conference of academic GPs.

NHS England chief Simon Stevens said there were benefits of having care planned around defined patient lists, but added the changing needs of the population meant 'other ways of interacting with primary care' were essential.

Although Mr Stevens did not explain what other models could be used, he said a move away from practice lists was 'happening', and asked whether we should 'close our mind' to such changes.



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3 NHS to spend £15m on training 1,000 GP physician associates by 2020

Are there benefits?

- Urgent care
  - In the current model are patient ”choosing” the ED department as ‘non list based urgent care’

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GUIDELINES

Are there benefits?

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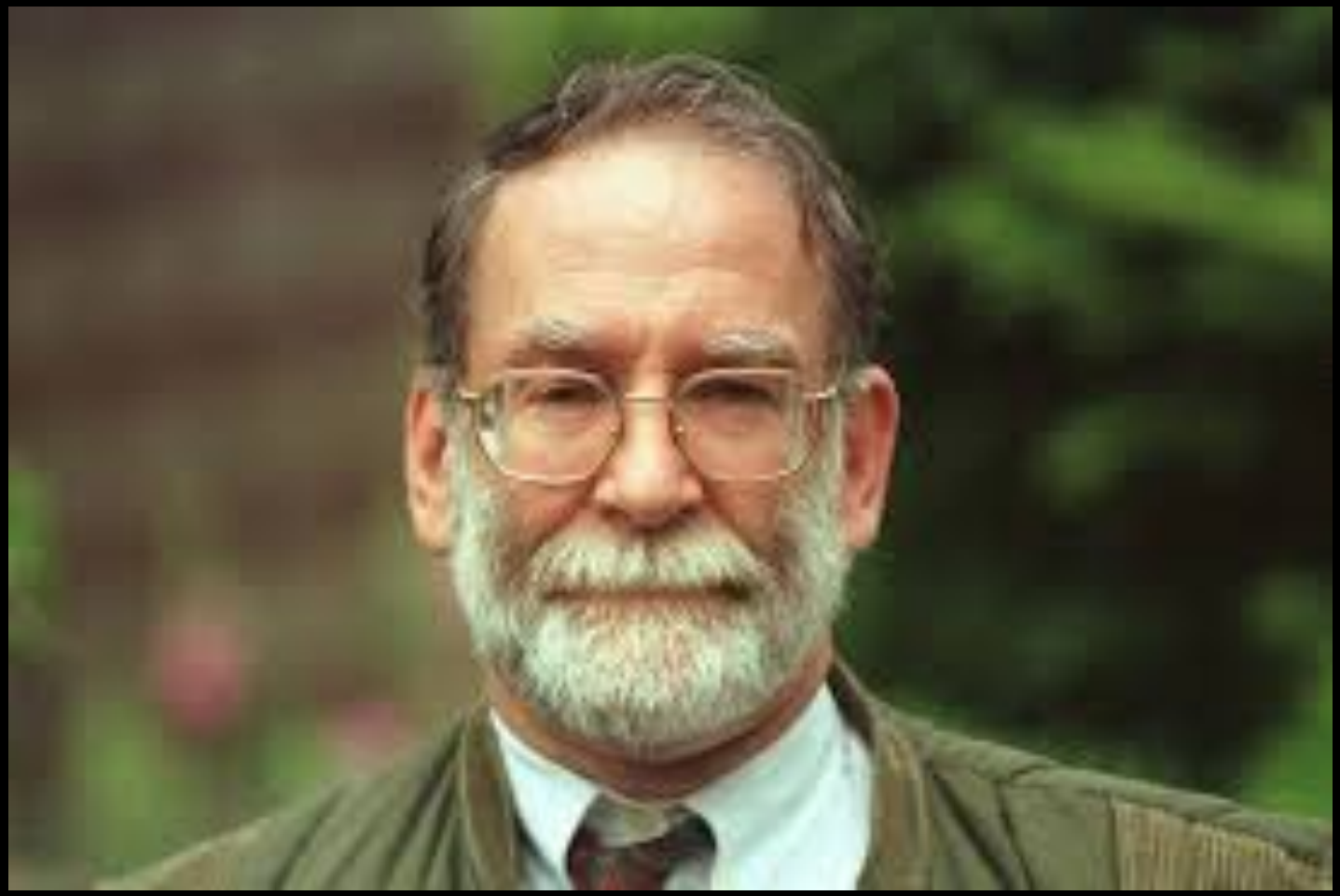
- Access where and when in need
  - Attend any GP anywhere for care
- The market drives the system
  - If the GP has poor access, attitude etc. then the “customer” will go else where…



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History of Scottish Medicine to 1860
John D. Comrie (1927)

NICE National Institute for Health and Care Excellence

NICE guideline

Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use

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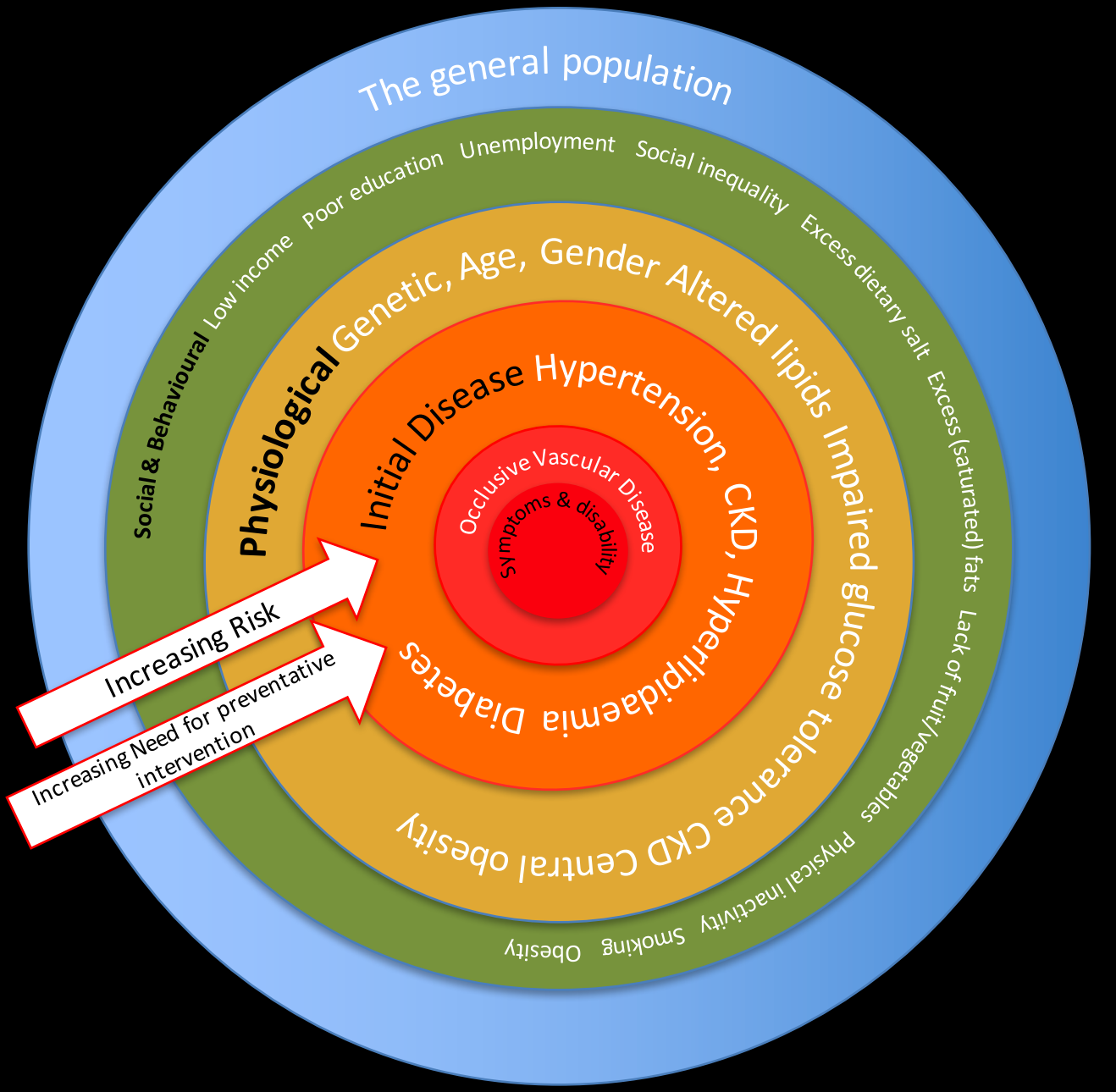
ACUTE CARE

Are there concerns?

All are at risk from Cardiovascular disease



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CONTUNITY OF CARE

Are there concerns?

VULNERABLE PATIENTS

Are there concerns?

DOMICILLARY CARE

Are there concerns?

MENTAL HEALTH

Why bother with the future?

The point is not to predict the future but to prepare for it and to shape it

Fay's Thoughts…

- The list will survive in some form
- "Super-practice" will come (50-100k)
- "Super-practice" allows specialist clinical teams
- "Super-practice" allows smart management
- Technology will allow patients to be managed away from the practice building
- "Super-practice" will have to work with PH
- Domiciliary care needs serious consideration
- Acute care and Continuing care do not have the same solution

Why bother with the future?

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Change the whole model

- **Now: doctors are natural scientists who apply their knowledge to solve patients' problems**
- **Future: doctor are change managers who help patients overcome or adapt to illness, come to terms with death, or change the lifestyles to stay healthy**

Christian Koeck: Professor of Healthcare Policy and Healthcare Management at the University of Witten/ Herdecke

What will survive as the world changes completely:

1. Clear ethical values
2. Being clear about our mission (what we are trying to do)
3. Putting patients first
4. Constantly trying to improve
5. Keep listening
6. Remain therapeutic when others would become persecutory
7. Accept limitations
8. Basing what we do on evidence
9. Leadership and teamwork
10. Learning and more learning

Thank you for your attention

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