Quality after QOF

With Prof Stewart Mercer

Key points and issues raised:

- **Clusters**
  - GP lead has 1/2day per month funded and cluster lead has 1/2 day per week funded

- **Integrated joint boards** (IJBs)
  - One per HSCP (6 for GGC)
  - In Glasgow there are 3 divisions of the HSCP (NE, NW and south) each has a clinical director (e.g. NE is Paul Ryan)
  - Who is involved? Secondary care? Each HSCP has a number of representatives from social and health then non-voting members from 3rd sector. They are usually people in managerial roles rather than workers within each sector so they take advice from the relevant subcommittees when matters arise – in our case they would be the GP subcommittee, LMC (the Area Subcommittee also involves optometrists, dentists, pharmacist.). That is a simplified version as it's quite complicated, Jim said there are no GPs on the IJB but that's not unexpected as though they make the decisions these are based on recommendation of the subcommittees. There is a representative from secondary care (again not a consultant).
  - What have they been doing? Are there reports available? They are in charge of the pot of money for primary health and social care. The IJBs have been formed for under a year but there are reports on Glasgow city's page.
  - How does this relate to/ impact on the new GP contract? The HSCP don't control the SAF nor are they involved in the new contract discussions.
  - It is variable for each board as to whether or not a GP is included
    - ?implications for primary care if not involved in policy/decision making – danger of GPs becoming isolated from the "bigger picture" of the health and social care partnership if they are concentrating on the clusters
  - There is a list analyst (statistician) on each HSCP, but not clear what their role will be.

- **CARE Plus**
    - Discussed this primary care complex intervention involving extra time for extended consultations, training and support for practitioners and patients (e.g. in mindfulness and behavioural activation)
    - https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-016-0634-2
    - Importantly, the intervention was found to be cost-effective at <£13,000 per QALY

- "Behavioural activation"
    - Psychology theory used to encourage behaviour change by breaking down into very small steps where the first step is very easy, and subsequent positive behaviour is 'activated' after small steps are taken.

- **Social prescribing**

    - Link worker project
        - Therapeutic and Linking role
        - No exclusions, open-ended
        - Full report will be published in March 2017, but Scottish Government have already made manifesto commitment to 250 Links Workers (40 new links workers expected in 2017)
        - Will be good to have both "hard" (e.g. antidepressant prescribing, A&E attendances, frequency/duration of consultations) and "soft" (e.g. patient satisfaction) results
    - Movement from era 2 to era 3 care where there is less regulation and more collaboration – see Don Berwick's writing, e.g. http://jamanetwork.com/journals/jama/fullarticle/2499845
    - ALISS.org

- Practice safety climate questionnaire
    - Would it be a useful tool before/at the start of the pioneer scheme and after?
    - Is there a tool already in place to measure GP stress?

The influence of Julian Tudor Hart

With Prof Graham Watt CBE

Key points

- An overview of Julian Tudor Hart's work – watched video
- JTH born in 1927, so aged 21 at birth of NHS in 1948
- Glyncorrwg was the first health centre in Wales in 1962
- Health care as the last 'gift economy'
- Emphasis on addressing patients' needs and on using them as allies (huge resource)
- Educating patients over serial encounters – takes time
- JTH's anticipatory care was about addressing other problems at the end of a consultation – now mainstream (e.g. QOF)
- Incredible story of Charlie Dixon – the last man in the village to have his blood pressure checked by JTH (his diastolic BP was 170!)
- JTH recognised the importance of publication in order to be seen/taken seriously

Critique of medical education

- Undergraduate training has not changed in 30 years!
- http://www.sciencedirect.com/science/article/pii/S0140673673910490
    1. Training – not long/tailored enough
    2. Nature of people who apply to medicine - often not attracted to GP as it is not "acute"
    3. Massive skew in undergraduate teaching towards medicine and surgery, against GP

JTH's 5 lasting contributions to primary care:

1. Measurement of Omission (see paper in Resources)
2. Mining resources of human energy (local knowledge/buy-in)
3. Applying epidemiology to clinical care
    - High coverage rates
    - Anticipatory care
    - Rule of halves
4. GP as the custodian of public health of a defined population
5. Clinical and economic consequences of patients as producers (see 'A New Kind of Doctor')