Ulster Medical Society

27 January 2011
Quality in General Practice—
Innovations in Training, Practice and Research
Professor Helen Lester
University of Manchester

Professor Cupples:

Good evening, everyone. You are all very welcome. I hope the voice travels okay; sometimes people think a microphone should be used but I think the room is small enough for people to wave if there is a gap in communication at any stage, please do.

This is a joint meeting of the Royal College of General Practitioners and the Ulster Medical Society. I'm delighted to see good representation for both societies here. We are also delighted to welcome Professor Helen Lester, who has come across the water today. She's a busy person, she is an actively practising general practitioner in Birmingham. She is Professor of General Practice and Primary Care in Manchester and she is the chair of the new Clinical Innovation and Research Centre in the Royal College of General Practitioners, so she has many strings to her bow. She is going to talk to us tonight about quality in practice.

Just before she does, I have a couple of announcements to make. One is, we will be delighted to see as many people as possible at the Ulster Medical Society dinner next Friday. John Craig is here tonight and you could avoid the cost of a postage stamp if you actually filled in a form and give it to him before you left.

We are also grateful to Tim Lowry and Kevin Lowry for sponsoring the meal for tonight, but that is the only way that [CFK?] have contributed to the meeting. So in case any of you do wish to know which I'm not sure you've actually taken onboard with you—if you could just take this back with you. At the end of the meeting there is a certificate of attendance for everyone who has taken part and John has those in his custody just at the moment, so they're not for distribution just yet. And lastly, just as Helen is starting to speak if I could ask if you wouldn't mind, please, just signing your name on the attendance register for this evening. We'd be very grateful. So, without further ado, could I say, "Welcome" to Helen and the stage is yours. Thank you very much indeed.

Professor Helen Lester:

Well, first of all, thank you very much for inviting me. Margaret invited me quite a few months ago and suggested that I should talk to this topic. It's one of those things that you say in the summer, yes, that will be lovely, and suddenly you realise it's Christmas and then you realise that January is around the corner. So this is a new talk with my new hat, if you like, as chair of SERC so I hope it goes alright. What I'm going to talk to you about over the next thirty, forty minutes is, I'm going to talk about some interesting innovations, or I think they're interesting innovations, and coming from the United Kingdom, because the one thing I think we're never short on, as medics, is good ideas. So when I looked on Google, ha—that well-known scholarly database, and put innovations in, I got back hundreds and hundreds of hits and I thought, this will be interesting. I wonder what other people think innovations means. And, of course, an innovation once you think about it, depends on who you are and where you practice and also, what time you practice. So, for example, the Royal Society of Medicine had an innovation summit last year, and they talked about things like tracheal transplants in children and artificial pancreases and I thought, this is all fascinating but I can hardly come along to Belfast and talk to you about tracheal transplantations, even though, academically, it is [interesting?].

Then the Harvard Business Review last year had a top ten list of innovations and that was things like robots in surgery and the Human Genome Project but there was some interesting things on there, as well, I think. Interesting for us, like the checklist project, which I am going to talk to you a little bit about, and evidence-based medicine and pay-for-performance. And I'm just bringing it a bit closer, I think, to us in primary care, at least, the Health Services Management Centre in Birmingham produced a report last year all about innovations in primary care, and that was about different ways of working. So that was about segmentation, defragmentation, about changing people's role and responsibilities so I'm going to talk a little bit about those sorts of things. And then what I want to do is bring them together, so you can see some of the commonalities behind these innovations. Try and bring it a bit more down to the sort of stuff that we do in everyday practice. Then I'm going to talk a little bit, because this is a joint meeting with the college, about some of the things that the college is doing, at the moment, that I hope you're going to be interested in, in terms of innovations. And finally, in an attempt to try and bring this all together I'm going to fly a kite with you all about the notion of scholarship in primary care. At this road, this is how my husband describes me, sometimes actually, and certainly the way I write and often the way I talk, which is, you know, you sort of know where she's going and wanders around a bit and you have to keep the faith it will get there in the end, and I hope it's reasonably attractive and interesting as we go. So that's a metaphor for the way I am, I'm afraid.

So, let's start with some of these Harvard Business Reviews innovation. Now, this is a WHO checklist. Now, there are two hundred and thirty million operations each year. That is one operation for every twenty-five human beings. I mean, a huge number of operations. Each year seven million people worldwide had some sort of surgical complication and one million people die as the result of a surgical complication. These are all figures from the WHO. Now, if you sort of took that from a public health perspective and you had something that had a morbidity rate or a morbidity of seven million, deaths of one million that's

actually—that's not quite as bad as TB and malaria but you're wandering along the road towards that end of the spectrum, anyway. So in 2004 the WHO thought, there has got to be better ways of thinking about how we look at morbidity and mortality in surgery. So they devised a nineteen item checklist, and it was piloted in eight hospitals around the world and you may have well see the results. These were rapidly published in The New England Journal of Medicine in 2009, and what they found is that the thirty-day inpatient mortality rate across these eight hospitals in different parts of the world dropped from 1.5 percent to 0.8 percent, which was statistically significant to a vast number of zeros. And as a result of that, this checklist is beginning rapidly filter through the hospital system. So, back in 2009, there were hundreds of hospitals using it, there are now thousands of hospitals using this across the world. So in terms of rapid dissemination this is really rapidly filtering through including my own local DGH. I've had patients reporting that they come back, and they've been asked questions time and time again and wanted to know "Why was I asked three times?" and I'd go, "Well, actually, this is actually good medicine. It's not bad medicine." Now, the thing I think is really interesting about this checklist is not that you ask is the site marked? and is the patient consented? and is there enough blood from blood bank? You know, it's all very important.

The bit that I think is really, really interesting is these questions here—confirm all team members have introduced themselves by name and by role, and this, I think, where the message comes in for us in primary care. If you think about surgeons they perform in a theatre, you know, certainly when I was a surgical houseman and a SHO, it was about the surgeon as the prima donna in the middle of his operating theatre. Now, this is a long time ago and things have changed but they had not changed I think that much. So that I think the real innovation here is at the beginning of every operation the checklist says that you introduce yourself by your first name. So, I would say, "Hello, I'm Helen", not the surgeon but the equivalent would be—"Hello, I'm Helen Lester and I am a GP and my role today is…" and everybody in the theatre talks like that. So it really engenders a feeling of teamwork that apparently translates into better teamwork in practice, and I was thinking about that in the context of my own practice and thinking, well, actually, we think we have great teamwork but there are still some of my staff who call me Doctor Lester rather than Helen. It's not absolutely uniform. My patients at Christmas gave me presents, they didn't give the girls on the reception all presents. There were still things there even if you think you work in a completely flat structure you may not work in quite a flat structure as you initially think. I thought it was interesting to reflect on. So an innovation that you think is all about surgery but maybe has lessons for us in primary care, as well. One of the other things in the Harvard Business Review was evidence-based medicine. Now, I talked about things that rapidly disseminate like this surgical checklist. Well, you are all going to know—I'm sure you all know David Sackett, the BMJ editorial fifteen years ago—wonderful, concise description of what evidence-based medicine is.

But evidence-based medicine has been around for centuries. If you don't know the story it's worth knowing and if you do know it, it may be worth retelling. So, bear with me on this one. So James Lind was a naval surgeon on HMS Salisbury and although we'd known from [?] time that if you gave sailors lime juice, and that would prevent scurvy, it had never actually got implemented. So what he did, and I love this, he got twelve sailors who were all showing early signs of scurvy and he divided them up into pairs and he gave them cider; elixir of vitriol; seawater; a paste of garlic, mustard and horseradish; vinegar; or two oranges and a lemon. Now, he only had six days' worth, apparently, of the oranges and lemons. If you were in one of the other five little pairs you have fourteen days. This is a proper randomised trial back in 1747. It was a fourteen-day trial length. I think he split his [?] because he had two primary outcomes, he had gum disease and he also had skin conditions. But at the end of the fourteen days what he found was that nobody changed very much apart from the people on the cider who felt better, and those who had two oranges and a lemon had a dramatic recovery. However, it took seven years before James Lind was allowed, apparently, to talk about it because the admiralty didn't really like it. It didn't really fit with their prevailing notion of how you should prevent scurvy. It took fifty years before the admiralty actually introduced lemons as part of the rations of sailors. So, yeah, evidence-based medicine, there is no such thing as a new idea under the sun. It had been around for at least two hundred years before Sackett got terribly famous, telling us all how to do it.

Now, I should say some of the examples that I've chosen are things that I have been involved with in my academic life. That sounds like I'm being terribly arrogant, it's not meant to be. It just means I know where the bodies are buried, so I can talk about them if there are questions afterwards, if you like. So I have, for better or for worse an association with the quality and outcomes framework since 2005 where I was one of the academic advisors about it. So there was pay-for-performance, payment innovations was there and the Harvard Business Review of top ten innovations, and as we all know there are very many ways to pay doctors. None of them exactly right. QOF was introduced in 2004. Nobody ever worked out whether it was a quality improvement mechanism or whether or not it was a payment mechanism, nobody has still worked out what it is and that is part of the problem that we have now run into with QOF. But certainly in 2005 Porter Kelly who was medical director at RAND wrote an editorial in the BMJ where he said "This is an initiative to improve the quality of primary care but it is the oldest such proposal on this scale ever attempted in the world. With one mighty leap the NHS has vaulted over anything being attempted in the United States, the previous leader in quality improve-

ment initiative." So everybody thought it was a terribly good innovation. However, we have reached a point now where QOF is completely out of kilter with the rest of the world in terms of pay-for-performance. These are comparative stats from the States. In the States although pay-for-performance is very prevalent on average there are five performance measures in each of their little pay-for-performance systems. We have one hundred and thirty-four in ours. It's five to seven percent of physician pay in the States, it's twenty to twenty-five percent of ours. Now, there is a paper coming out in the BMJ tomorrow that I've had to write a college dispense of so, anyway, it's a paper about QOF and a group from Harvard and from Nottingham have had a look through using the [FIN?] database at the effect of QOF on hypertension measurement, hypertension control—

Professor David Hadden:

Sorry, as this is a joint meeting, I'm not sure about QOF …

Professor Helen Lester:

I am really sorry—Quality and Outcomes Frameworks and please do stop me if I say things that are bad like that, sorry. Pay-for-performance team in primary care. Yes, so this paper is coming out and what it is saying, and it's beautifully done. It's not a statistical error, it's beautifully done—it is that QOF has made no difference whatsoever to blood pressure measurements, blood pressure control, or longer-term cardiovascular outcomes, and they have data from 2004 onwards. This country has spent millions of pounds on QOF hypertension. It's spent billions altogether—QOF has cost a billion pounds a year. But it has spent millions of pounds on hypertension. So I'm going to tell you another story—I'm going to tell you a story of this ship, which is the Thomas W Lawson. Now, this ship was—you make ships, you build ships—this ship was built in 1902. This ship was built because people were worried that steamships were coming in and steamships were beginning to get all the work in terms of freight carriage quickly from the States over to Europe. So the people who made these sorts of sail ships thought, hmm bigger has got to be better. Rather than thinking, oh, steamships have come along. That is a completely new technology, I wonder if we should rethink the things that we are doing. So went, hang on a sec! If five masts is good seven masts must be absolutely fabulous. So they built this ship with seven masts in 1902 and this ship couldn't sit in most of the ports in Europe and this ship on about its fifth voyage from Philadelphia over to the United Kingdom sank to stop the Scilly Isles in 1907 because there was a really bad storm that the steamships were all fine in. But this ship had got so many sails that it went down, it went down with the loss of all bar two lives. And the moral for me is that QOF might have been a fantastic innovation in 2004 but what's now happened is that people think, "Oh, my goodness me! Other things are coming online, primary care is changing but we do have this thing called QOF—what we must do is we must add more to it. We just make it bigger"—but bigger is not necessarily better. So I suppose the moral is beware the innovation you wish for. So, I'm going to try and bring it a bit closer to home—those are the things that the Americans said—we're all fantastic innovationists.

I'm going to tell you a story about one of my patients, a little old lady who's 90. Very independent lady, never married, was a school teacher, much loved but is now 90 and is getting frailer, and looked after as well as she possibly can be by her neighbours. I had that sort of dreaded 28th December call over Christmas this year we were off—well, certainly in England, we were off for quite a lot of time. So it was really busy 27th, 28th and 29th were really bad days. Anyhow, I had a call and she had fallen the previous night. The paramedics had got called out and she had a broken leg. So her neighbours had got her upstairs—it looked like this, this is isn't her house for obvious reasons but when I was Googling the stairs I put in very steep stairs—ha, I love Google. This picture came up I thought, that will do. That's exactly what it felt like. I had these boots on and I was climbing up the stairs with hands on both sides thinking, I'm going to fall, I'm going to fall. So heaven knows how a 90 year old lady manages those stairs and the answer is she doesn't really very well. So her neighbours had got her into bed, a fiercely independent lady, actually fit as a fiddle in very many ways but now couldn't get downstairs, couldn't get herself out to the toilet, couldn't make herself a cup of tea. You're going to know this picture, you will all have had these sorts of pictures and I'm there and I walk through the door, and you know that thing where relatives take you into the other room before you're allowed to see the patient, and you think, this is going to be a long one. I'm in there and I'm sitting down with my bag and I'm thinking, I've got another five visits. Anyway, they were just explaining how difficult it was, they could no longer care for her. They were at the end of their tether and that they were not relatives, they were neighbours and I went upstairs and one of these neighbours said to me, "Well can't you admit her?" Last time she was like this doctors x, y, z admitted her, and I was thinking, I can't admit her. You know, there is actually nothing medically or surgically wrong with her. Anyway, a long preamble, what we now have, and I don't know if you have this in Belfast but we certainly have it in Birmingham, is a fantastic intermediate care service. So I was able to get back to the ranch, pick up the phone, speak to a real person and explain the situation and the social worker went out about two hours later. And respite care was found for her the following day but the neighbours knew that and they were quite happy to do another overnight shift, and she went into respite care for a couple of weeks, and during that time she began to think about whether she can stay by herself any longer and whether or not she needs to go into some form of residential care and she's gone back to her own house, actually, at the minute. But it's begun to make her think whether or not she should lose an element of her independence.

But what the intermediate care service has done is save an admission, kept her dignity, given her chance to think about what she wants to do. These are sorts of innovations in care that I think are really important, they make a huge difference to our patients' lives.

This is going to be my last example before I move onto college stuff and I use this example because I've been quite involved with primary care mental health workers. Now, what I should have checked with Margaret and didn't—do you have primary care mental health workers in Belfast? Good, thank goodness for that! Phew. So mental health workers, they were announced in the NHS plan a long time ago now in 2000 and we were supposed to have a thousand of them by 2004—we didn't. But we were supposed to have a thousand of them and they were devised for a number of reasons. One of those is that thirty percent of our consultations in primary care had some sort of mental health element to it, and remember this is 2000 at the time it came out. Long before NICE guidance came out, long before we had notions for Steps care, long before improving access to psychological therapies came along. This is really when we did have ourselves, maybe a counsellor if you were really lucky, and probably an SSRI available to treat people with depression. I mean, there may have been some other things and I'm paraphrasing not terribly well here but there wasn't the range of workers that you can refer to back ten or eleven years ago. There was also a glut of psychology graduates—let's be really pragmatic here. There was a huge glut of psychology graduates and the government couldn't put them all through to clinical psychology courses, there just simply weren't the places. So one of the great wheezes that came out was lets have primary care graduate mental health workers. So, what happened was that there was a huge rush and it was done very well. Fantastic leadership here. There was a huge rush to get nineteen universities to provide the courses to train these graduate workers. There was lots of leadership at a local level to find the money to employ these graduates. My little team were given some money to do a trial and also to do some qualitative work to see about the value of primary care mental health workers and we found that they were the glue in the system—patients love them, describe them as the glue between primary care and sometimes secondary care. Or the glue between primary care and the voluntary sector. They had a great role in befriending, being with somebody—listening and being with is very important. Our trials found a significant increase in patient satisfaction with their care if they'd seen a primary care mental health worker. But in terms of implementation of innovations the things that we found were really, really difficult but interestingly around different cultures within the health service. Finding it difficult to accept a new worker so counsellors felt terribly threatened by these workers. Even though most of them were sort of 21-year-old lovely young women and they were largely women, actually, particularly the first cohort. So counsellors felt very threatened—CPNs felt terribly threatened by them—do they want my job? I had a terrible experience actually. I had to go and to talk to the annual meeting of British Counsellors down in London but I wasn't quite booed off the stage, but it was pretty close to it because I was extolling the virtues of graduate workers and they were all feeling terribly threatened by them. There was also a problem in practices; practices wanted to know—we had one practice manager who said, "Yes, but who pays for the photocopying?" And another one said, "Yes, but who pays for the paper?" So it wasn't getting the university courses right or the funding of them. It was the little bits about getting those cultural things right and once we clicked that the barriers to implementing this innovation were reassuring counsellors, reassuring CPNs, talking to the practice managers, talking to the PCs about the little things, and then these workers started to blow through the system and there are now about fifteen hundred primary care mental health workers. Not a lot but you know, they're there and I think they are part of the furniture now. So, what do you need to make an innovation stick? I think you need a clear vision of where you are going. I think the checklist—a really clear vision of what they wanted to do. You need effective leadership. A lot of the things I've talked about have had really effective leadership. You need really good teamwork. Staff need to understand their roles and responsibilities, they need to feel really supported in that. I was just saying with the primary care mental health workers—you've got to get it right culturally. It needs to make sense on the ground. It needs to make a difference to patients. I am now an absolute advocate for intermediate care in a way that I wasn't before that visit at the end of December. It needs to make things a little bit better.

So, I'm going to talk about the College and some of the College innovations. I'm not going to talk about the Centre of Commissioning because I realise there is no point—well, there probably would be a point if only to tell you how terrible it all is, at the moment. But I'm not going to talk about the Centre of Commissioning. I'm going to talk about some of the initiatives in training, some of the initiatives around clinical champions and a little bit about some of the initiatives and innovations around research that the College is currently involved with. So, let me tell you a little bit about education and training. As we all know three years training, at the moment, for the most complex, the most difficult job in the health service, there's three years training, which is just ridiculous. Medical Education England threw out the notion of five-year training about a year ago but Andrew Lansley has encouraged a new submission about five-year training, which I think is really very encouraging. And is particularly encouraging as to ensure that paediatrics and mental health training have a prominent part in any resubmissions about training and I think, actually, in terms of a great innovation for us, as a profession, I think if we could get five-year training it would make a huge difference on all sorts of different levels, including that status thing. I remember my first day at medical school at Cardiff in 1980 and I didn't

come from a medical family—I was the first person in my family to go to uni. I remember the surgeons standing in front of us and saying, "Half of you, I'm afraid, will end up as general practitioners" and I went, "Oh!" I've no idea why I thought that. I just went along with the herd—a terrible thing to be a general practitioner. I think five-year training will be a fantastic thing on all sorts of different levels for our patients, for the health service in terms of probably saving money in the longer term, as long as we remember to look ten years down the road and not two and a half years down the road. And good for us. Elearning for general practice if you've not discovered it, is well worth a look, it won a silver award at the eLearning Health Awards about three months ago and it covers the whole of the GP curriculum made for the GP registrars but frankly, I find it really useful. So it's great, if you've not seen it—there's Essential Knowledge update, which is made for us but actually do take a look at your eLearning for General Practice—I hope you will find it a really helpful way of thinking about your CPD needs. First Five is probably something that none of us had—I can't see anyone quite young enough to be part of First Five—I'm certainly far too old. First Five is an initiative in the College to take people from that moment when they qualify and that scary feeling—your first day in surgery. You know, you're the new GP. It's a bit like when you first passed your driving test, you know, that first time you're actually in the car all by yourself and that sense of fear that you didn't have when somebody else was by the side of you. That feeling again for new GPs, so there is a five year support group, basically. They've got a fantastic Facebook and they all use Twitter and all sorts of things that I don't really understand. But there is a great support network for GPs as they do as they go through their first five years and it's First Five that takes them up to their first revalidation. So, again, if you know anybody who is at that stage in their career it is well worth signposting them towards this feature innovations. And, finally, the College can be a bit GP centric but then it is the Royal College of General Practitioners, so I think we can be forgiven for that. But there is a General Practice Foundation now, it's been there for a couple of years. It's only got a couple of hundred people who have signed up, but it is very much made for practice managers, practice nurses and physicians assistants. So, again, if you are interested it's well worth again, looking on the college website because there was a group there, a newly forming group there to support practice managers and practice nurses.

A little bit about clinical champions—Matt Halton is our clinical champion for learning disabilities—we have twelve clinical champions at the moment covering a disparate range of subjects. We are just about to interview for four more in social exclusion, nutrition for health, which is just another word of saying obesity, domestic violence and chronic pain. So we are soon going to have sixteen clinical champions. But I just want to tell you a little bit about the work that Matt Halton has done. He has produced some fantastic guidance around caring for people with learning disabilities. People with learning disabilities are fifty-three times more likely to die before they should with the general population. They have the same consultation rates as people without a learning disability so it's not the physical facts that they have a problem with but it's the fact that we have ten minutes and it can be very difficult to communicate with people with a learning disability and we're not very good at it, frankly. Physical health promotion, health education, illnesses that can be picked up early, people with learning disability have much higher morbidity and much higher mortality rates than the general population but there is also very good evidence that if you look you find and if you find you can make things better and what matters now is producing some fantastic guidance based on the Cardiff Health Check that takes you through as a practice how to give a really good annual learning disability check from sign language and cards that you can use. From copies of letters that you can send out that make sense to somebody whose IQ is perhaps seventy. The reason I know that this innovation is going to be implemented is that my wonderful, wonderful husband came home about two months ago and he plonked this thing down on the kitchen table and he said, "This is the sort of thing that you should be involved with in the college." And I went, "[?] GP, thank you very much." You know, ordinary cold-faced proper doctors, like my other half, have picked it up and thought, this is really going to help me in practice and that is going to change little by little the care that our really needy group receives.

Research Ready—now, I'm going to talk a little bit about research because it's sort of my background. At the moment there is only four hundred and fifty practices who have taken part in Research Ready but hurrah, at last with Margaret's help it is now available right across the United Kingdom. So, you can, if you want to, go online and you can go through these five core modules online and at the end of it you will be ready to do some research in terms of understanding good clinical practice, understanding the latest guidance on trial management, on ethics, on research governance. It takes about half a day, to be honest. Most practices ask their practice manager, or if they had a senior practice nurse who is very involved in research, to do it. We have evidence from the four hundred and fifty practices who've already been involved in Research Ready that it really does increase their confidence in terms of taking part in research. So seventy-two percent of them said that they were involved in research before they did Research Ready and ninety-two percent after this little bit of training are getting involved in research. And, actually, while I'm banging the drum about research something like three thousand nine hundred practices across the United Kingdom are now involved in some sort of research, which actually was quite a surprising number to me when I finally got it out of the primary care research network, and something like thirty percent of all patients who have been recruited in the research network are recruited from primary care.

Trouble is I'm slightly worried that primary care has been handmaiden here. That we are the sort of site that sucks up patients into other people's trials. I think it is incredibly important that schemes like Research Ready and other schemes empower front-line general practitioners to take their really good ideas and turn them into research projects. I'm going to give you just a few examples of where people have done that with academic support but nevertheless, have been able to do that. These are the GP research papers of the year for the last five years. So—we've got Willy Hamilton in Bristol, who produced a lovely paper on the BMJ last year that shows ovarian cancer is not the silent killer, that women do present, often months before the diagnosis is made, with abdominal distension, with urinary frequency, and with abdominal pain. This is a cohort study and it's probably associative rather than causal because of the methodology but certainly, pretty good evidence that actually if a woman under 50 comes in with those symptoms that there's a one in forty chance that she's going to have ovarian cancer. Well worth thinking about an ultrasound scan. We know from Frank Sullivan's fantastic trial—Frank Sullivan is a GP in Dundee, that actually you treat Bell's palsy with prednisolone. In fact, it has no place in the treatment of Bell's palsy. Now, what an important question, you know. The Oxford [?], came from the Department of Primary Care in Oxford, again involved front-line general practitioners—if a school-age kid comes in and has been coughing for two weeks even if they've been immunised, think hooping cough, was the bottom line of that study. Really important, really clinically interesting questions. This study by Antony [Harndon?], front-line GP in Oxford, basically said, there is no point in giving little ones with acute conjunctivitis chloramphenicol—it makes no difference whatsoever to the outcomes. It's a waste of time. Chris Greenhouse, lovely study looking at lung age. If you tell patients what their lung age is they're statistically significantly more likely to give up smoking, I put these up because I think they are fantastic examples of front-line driven questions, nothing to do with pharma—some of them were trials. Really important questions. I have rather cheekily put that one on because that's my paper back in 2005 and I've put it on because I did it on a song. Cost me five thousand pounds that study. We ran eighteen focus groups with people with serious mental illness and general practitioners and we got them talking to each other face to face about what their care could be like and what we heard at the end of it was people with schizophrenia telling us that primary care is the cornerstone of our care. Even though, traditionally general practitioners have said, "Nothing to do with me, mate." People with the illness said, "Oh, yes, it is."

SFB [Scientific Foundation Board of the RCGP]—we have funded one hundred and forty projects since 1995: Tom Fahey in Dublin, Chris Butler in Wales, [Kamish?] in Leicester, Robert Gadsby in Warwick, Paul Little in Southampton, Carl Hannagan in Oxford. These people when they were really junior, when they were really starting out back in the mid-1990s, they applied for little tiny grants of ten thousand pounds from the SFB and on the whole their first or their second paper were something very small, very pragmatic funded by the SFB. So if you're looking for seed-corn funding for ideas that you just want to test out, think about the SFB. So, time is running on and I've told you lots, I hope, about innovations. But this is the bit where I want to fly a kite with you about scholarship. So I've talked about every day innovations and I was thinking, how do we get every day innovations into practice? What would that actually mean if I'm trying to teach medical students or I'm talking to associates in training or First Five and I thought, well, maybe it's about having a scholarly attitude to everything we do. Maybe it's about being scholarly when we're in front of our patients, when we are talking to our staff, when we're doing our audits, when we are training the medical students. Then I thought, let's find a decent definition of scholarship then, and this is Ernest Boyer's definition of scholarship, and this boy was a US commission of education back in the 70s and 80s and he worked at Harvard for a while and he came up with this sort of four segmented definition of scholarship, which I think really rings true. It's about the scholarship of discovery of original research, it's about the scholarship of integration which is translational research, really, sort of stuff that we do at research papers of the year. The scholarship of application, so what we do in practice and then, finally, it's about the scholarship of teaching. So, that's about communicating effectively with your partners but also with your medical students and with your trainees. I thought, yeah, that is actually something that has an intrinsic sense to it. So I'm going to finish with yet another story—as a true story. You know New Year's Day and you think, I must clean something? So I thought, I'll clean out the garage. I got boxes and box files everywhere and I got bored of cleaning, so I thought I'd open up my box files and see what was in them. This is a true story and I opened up this one box file and it had 1984 written on the side of it and I used to learn by tearing articles out of journals, not from the library, but tearing articles out of journals and felt-tipping them and I wondered what was important in 1984. They're all yellowy and smelt very musty. I found this article—I was a final year med student in '84 and, I keep mentioning my husband, we had just started going out and that made me feel very old. I found this and I'd highlighted it when I was a final year and I decided I did want to be a general practitioner by the final year but I'd highlighted this from John Horder, John Horder is the past president of the college and that's his painting and apparently you can buy it and it helps the college new building fund. But anyway, John Horder is a beautiful painter as well as a fantastic general practitioner and ex-president. So John Horder wrote, and I'm going to read it out because I think this is beautiful. "So, for me, there is no dividing line between academic and ordinary general practitioners. Indeed, the idea that any doctor

could be nearly a practical worker responding to patients demand according to set habits of mind acquired along since seems ridiculous. None of us can survive without some sort of updating the challenges of what we thought before and forces us to question it and to decide which is right." But some do it more often and more deeply than others but he is saying that we can all be scholarly. That we can all be part of everyday innovations and I would suggest if we can that can only be good for our patients. So I will leave you with that thought. Thank you very much for coming and for listening.

Professor Margaret Cupples:

Thank you very much, Helen. I'm looking towards Professor Scott Brown who is the chair of the Royal College. He is going to lead from here.

Professor Scott Brown:

Thank you very much Margaret. I've been extremely impressed with the surgical safety checklist so that I have to tell you that I am Scott and I am here to fend off the wall of questions, which are going to come immediately rolling towards Helen Lester. Helen, thank you very much for a wonderfully stimulating fifty minutes. I had a look at my watch as I used to do frequently when I was a student in this building, and I have to say the first time that I looked at my watch was almost at the end of your presentation so that's a fairly useful barometer and how interested we all were. Open to the floor I'm sure many of you have questions. Not least perhaps some of our secondary care colleagues to have some of the abbreviations explained.

Professor Helen Lester:

Oh, yes, I am sorry about that.

Audience member:

Thanks for a great talk, Helen. I was interested in much of your talk but particularly near the beginning was your remarks about hypertension and the Quality of Outcomes Framework and your assertion that could not demonstrate any improvement in outcomes on the basis of QOF, and I must say my early impressions of QOF, once you got used to it I had convinced myself that, certainly in diabetes, QOF concentrated the mind quite nicely and quite useful on actually very important outcomes measures and very important interventions and I had convinced myself that in fact I was controlling my patients, or my patients' care was much improved. So following through to QOF the comment about how QOF is developed and problems we now face with QOF but I'd be interested in your comments on—is that right across the board, do you think, that Quality Outcomes Framework is not making any difference to the quality of care we are giving our patients, and it's purely a payment system?

Professor Helen Lester:

I don't think it's across the board, actually, I don't. I think the problem with the hypertension—I know the problem with the hypertension because we've got data on this at work, is that the achievement rates were very high pre-QOF so, if ninety percent of the general practitioners are already measuring blood pressure and getting blood pressure below 150/90, which is not that hard to do on the whole, then there's nowhere to go. I think on the more challenging indicators, and in diabetes there are some more challenging indicators, I think if anybody did look at that they would find some changes but I think some of QOF is just too simple and we were doing it very well to begin with. And so, I'm not remotely surprised. When the BMJ sent me the paper and said, "You're going to get asked some questions. Do you want to have a quick look?" I read it and thought, "Yeah, I'm just not surprised" but the message is you've got to start with things that we're not doing very well and incentivise that. Not keep on adding more and more and more to it. I think you strip it right out, to be honest. I think you take half of it out, you half its size and then what you put in are things where we know we aren't doing very well, where a ten percent increase will have real meaning for many patients. That's what I think.

Audience member:

The other implication of QOF is that it would cause a very substantial change in the philosophy of general practice because there are now more and more primary care asthmatic specialists, diabetic specialists etc, etc. Usually with a given practice you find that one doctor takes a particular area and the longer it goes on the more expert he or she becomes, the more deskilled the other partners become unless there is a real attempt to continue educating these in practice and very often there is not the time for that, and you try suggesting in a partners' meeting that doctors move around and somebody now does epilepsy and somebody does this, and produce a lot of blanching.

Professor Scott Brown

Any other questions?

Professor Gary McVeigh:

Could I challenge you on your last point about hypertension? I don't feel that hypertension is particularly well treated or controlled in the United Kingdom. I think that statistics would show, I can't remember exactly but ten percent in the UK were actually controlled and the vast majority were not controlled adequately at a level of 140/90 and the Americans used to say that the British didn't control the hypertension at all. I just wonder what your…

Professor Helen Lester:

I think that perfect measure of physically putting the cuff around—we do have very good evidence and it's way over ninety percent pre QOF—the audit targets actually most GPs were hitting for hypertension. But the proper guideline targets is quite right—we weren't doing anywhere near as well. I think about

seventy percent, which means there were thirty percent of people that were not having their blood pressure adequately controlled so I'm arguing more about the process and intermediate outcome measure but you see, and again, this isn't about QOF—what I think we should do with it is what the VA did in the States—the Veterans Association did in the States—where they had tightly linked measures where what they would do is they would say, if someone's blood pressure isn't well controlled you then put in a measure that says that something was done in response to that poorly controlled blood pressure. So maybe medication was increased or, you know, more lifestyle advice but you have to do something in response to too high a blood pressure and as you pay for the actions of improvement. So I think there is so many ways that I can think imaginatively about this not just keep throwing money at it.

Professor Gary McVeigh:

I agree with the therapeutic inertia and you definitely see it in secondary care, you see it especially with the juniors and the hypertension diabetes clinics that I work in that, you know, you will find that blood pressure is not even adequately checked because you tend to see the terminal digit bias of 140/90, 150/90, the chance of that is one in sixteen, so you just know that the blood pressure hasn't been checked correctly to start with, and that you will find that quite often just below the threshold when you come along and check it, it's nowhere near that threshold. There's a therapeutic inertia, that they don't want to increase [treatment?].

Professor Helen Lester

Agree.

Professor Philip Reilly:

Could I whine a little more?—because some years back, albeit [?], well a little, I'm sorry but it's an interesting innovation over the last several years—these several years ago you were—when you weren't, I'm sure, told to produce an editorial, were involved in an editorial, around hypertension, which I will leave because…

Professor Helen Lester

[That's Mark's work?] … that has an equality in the BMJ

Professor Philip Reilly:

Exactly, that's where I would like to take it a little bit further because it's more than just diseases, doctors—GPs and other doctors too, may I say—are interested in the whole person and that other paper, which you would know better than me, I'm sure, was able to demonstrate that in part, at least , we were able to do things that probably people thought was impossible. Now, that to me is a real effort because in a sense hypertension, we have problems with hypertension, I mean, Professor Rothwell in several sessions in the Lancet this last year begins to make us really challenge looking at hypertension. Let's looks at the socio-economic issues that—would you like to care to comment on those?

Professor Helen Lester:

I have to say part of the reason why I got involved with QOF in 2005 is that I've always worked—I am going to answer the question you raised—I have always worked in very deprived parts of Birmingham in the inner-city and I have observed poor care, that makes me sound like I'm a paragon of virtue, but I observed really poor care, and I always thought QOF, I always hoped QOF would actually bring the tail of the comet up and that's why I got involved. I know people say to me, "Oh, Helen, the trouble is those marvellous, marvellous people and we're being stymied in our wonderful holistic care", and I'm saying, "Look, you know, you are clever enough to do both. Really, frankly, you're telling me that you can't tick a box and look at a patient?" I was having none of that. It's about the tail of the comet that you move on and I do generally believe that QOF has done that and it's not just I believe. There is Mark Ashworth's lovely paper at the BMJ about hypertension. There is Tim Doran's paper in The Lancet in 2008, where he looked at the effects of QOF on pretty much every practice—he divided every practice in the land into deprivation quintiles and he showed that over a three year period the gap between the least deprived and the most deprived narrowed from 4.4 to 0.8 percent and that made QOF technically an equitable intervention, which is really rare. So I do think QOF has done some good or I wouldn't still be involved with it. I think it has moved the tails of comet on. But I think we're now at the Thomas Lawton stage, you know, you don't keep bunging masts up.

Professor David Hadden:

I'm going to call you Dr Lester because I don't know you. When I know you well I shall call you Helen [laughter]. My question really is I'm a little concerned about your hope that there will be a five-year training for general practice. When we qualified in the old, bad old, days we were told that the aim of the medical school in Belfast was to create a safe doctor and we had five, indeed we had six, years in my time, and we thought we were pretty well trained at that stage, and many of us were happy and went out into family practice. But of course, there is great need for further expertise in this so, I'm just concerned if the message goes out that if you want to be practice general practice, primary care, in the future that you've got to do five years in the medical school and then another five years. I don't think that's what you're saying, you're saying that there should be five years as a trainee, if you like but that's not really the same as saying that you're not doing general practice that you can't do it until you've done five years extra—or what are you saying?

Professor Helen Lester:

What I'm saying is that actually you've got your

F1 and your F2s and then, at the moment, you going to have three years where some of that will be spent in primary care as a trainee and then obviously two years will be spent in hospital, still. What the college is saying, and I agree with this, I'm not trying to—I absolutely agree with this—is that that three years should be five years of which a lot of that, maybe four years of it, would be doing hospital-based specialities.

Professor David Hadden:

Surely that's an impossibility. You cannot do all the specialities for a long enough time because the time you've done six speciality one will have changed, and its guidelines will be totally different. So you have to live with it as it develops surely.

Professor Helen Lester:

I get that point but I remember arguing with my fellow SHOs that we should be [moved?] every three months in our SHO jobs because I remember that tremendous feeling in the first six weeks that you're learning curve was vertical and it was fantastic and all this new information and new things and new knowledge and new technical things that you were taught, and I used to think after three months I'd probably sussed it, I was very arrogant but I was young. But there was this—and I do think that having that exposure to more secondary care so that you get obs. and gynae. and paeds. and cas. and mental health and more general medicine, you know, care of the elderly. I think to have that ability to suck all that information in at a young age and then to take that into primary care and then, of course, to keep updated because you're right we're out of date so quickly. I do think that that's a good thing. I feel bad arguing but I do, if you like, take it as a personal opinion. I feel that more that we can equip the younger graduates with extra knowledge, I'm hopeful, and extra skills, I'm hopeful that they will be better general practitioners.

Professor Scott Brown:

We're going to keep it in the right wing—Colin?

Dr Colin Mathews:

What Professor Hadden said was—following on from that—if they were going to move to five years, and take his point, it would be very difficult to have people in hospital for that length of time and one of the things that I'm noticing now in people coming out are that the younger doctors doing lots of training in hospital but they don't get enough general practice training to deal with the none disease that they see in general practice and they become frustrated in the job because they've got so, if you like, high powered in their training they're coming out wanting to see disease and they're not comfortable in seeing none disease.

So if there is going to be five years training it has to be paediatrics in general practice not serious paediatrics as in hospital. It has to be diabetes in general practice, not what Professor Hadden did in the Royal…

Professor Helen Lester:

I'm with you one hundred percent and that's another story. When I did my GP training I hadn't done any mental health training, at all but I'd done my year as a trainee and I knew that I needed to go and do some psychiatry before I would allow myself to apply for a partnership. Do you know there is this callowness where you don't care when you're young. I went to see the professor of psychiatry in Cardiff, he was a high-flying geneticist, and I said, "I need to do some mental health training but I don't need to work with you. I don't want to go to a geriatric ward either, I need to go and work in a"—I don't think they had NHTs in those days—"I want to go and work in the community, I want to work with the CPNs, I want to know about the sort of people I would referred in that I shouldn't refer in. I want to learn what I should do in primary care" and actually I think mainly because he was scared of me he let me do that. So I had a year in the community and made up jobs for me that allowed me to go and do exactly what you're saying, which is to have relevant training of primary care so I think that's the trick; we can't just have paediatrics doing six months because that's going to get us nowhere. So I absolutely agree with you and that needs to be written in.

Audience member:

I hope psychiatry realise you are demonstrating wonderful insights.

Professor Scott Brown:

Any other questions? Gentleman here you had your hand up.

Audience member:

I was just going to say that I qualified as a GP two years ago. I have to say if it was five years training from the F2 I wouldn't have applied. I think that twelve years as being locked into a system where you have relatively little freedom to shape it yourself is a lot.

Professor Helen Lester:

What would you have done?

Audience member:

What I'm enjoying doing as much as possible is going back into hospital at times. I do a little bit of locum work and emergency and medicine. I wish that there was more in other specialities and I could usefully spend a month here and a month there. That would be—I'd really enjoy that because having now done some general practice I kind of know what I want to learn. Whereas, when you're running through before you've done your practice you don't know what is going to be useful. But I don't see much opportunity now.

Professor Helen Lester:

I think that is a really good point and I think it's also about the timing of when you do your general

practice at the beginning—I didn't realise until I had finished all of my supposed training that I had a huge hole in what I needed to know and had to go and find out myself. But I think what you're saying is absolutely right, if you have some kind of job at the beginning you can know what you need to know but I'm going to differ over five years and there we go.

Professor Scott Brown:

Very interesting. Any other questions?

Professor Philip Reilly:

Just by way of a comment, there is very little under the sun that changes in some ways. One of the phrases that colleagues and me—and I am extremely old now in these terms—was 'coming up for air'. That's what people, when we started in our first cohort of people actually having training for general practice but most people thought we were out of our tree but amongst us was the phrase 'coming up for air' and when I think of what you've said today you 'come up for air' at various points and that's when you need to be ready and you need to have enough whit to realise to utilise that appropriately. I know it's quite a challenge but it's actually very important.

Professor Scott Brown:

Time for one more?

Audience member:

Just another comment, three years ago our practice manager took all her secretaries of the practice into her room and said, "Hands up who wants to be a phlebotomist." I thought this was a little bit of lateral thinking because she had heard from the nurses they were overworked and had too many bloods to take especially at half past eight in the morning for fasting sugars and lipids and so on. So I thought that was a little bit of lateral thinking and innovation.

Professor Helen Lester:

Absolutely, everyday innovations. I agree.

Audience member:

And I was surprised two hands went up.

Professor Scott Brown:

Thank you very much. We've heard a little bit tonight about evidence-based medicine and right from Sackett onwards and I suppose if we're going to test the theory tonight we might want to look at Ernest Boyer's definition of scholarship—I noted down discovery, integration, application and teaching and I think Helen tonight you've been a wonderful example of that. So I offer you the evidence and I'm sure along with me you're going to want to once again thank Professor Helen Lester for a very thoughtful presentation.