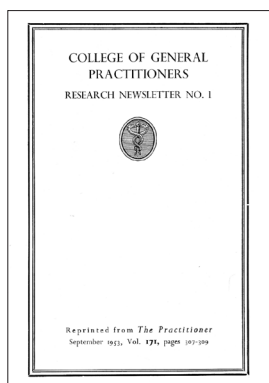


Editorials

The *BJGP* at 60

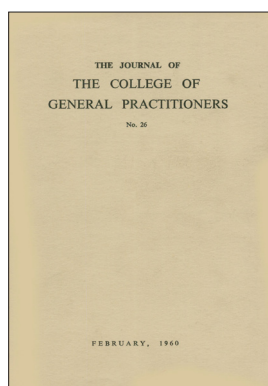
The *British Journal of General Practice* (*BJGP*) started life in 1953 as a cyclostyled newsletter called *Between Ourselves*, sent out by Dr Robin Pinsent, a Birmingham GP who was a founder member of College Council and the leader of the College's first Research Committee, to a small group of research enthusiasts. The first issue of the *Research Newsletter* was published in the same year, edited by Dr RMS (Mac) McConaghey, a GP from Dartmouth in Devon.



McConaghey's statement of the reasons for undertaking research in general practice in primary care, which forms part of his introduction to the *Newsletter*, can hardly be bettered:

*'There was a time in the history of medicine when all research was general-practitioner research, for there were none but general practitioners to undertake it. ... Jenner recognized the relationship between cowpox and smallpox, and Withering observed the diuretic effect of the foxglove leaf. Then came a change in the pattern of medical practice. Institutional care of serious illness and research in hospital developed on an increasing scale. The quest for more facts in the field of general practice slackened, and family doctors devoted their energies to relaying to patients the new knowledge that their hospital colleagues had gained. The flame of general-practitioner research burned low, to be fanned into occasional brilliance by such men as James Mackenzie and William Pickles. Now, once again it is being realized that opportunities to undertake research into conditions encountered in general practice are unique and wide, and that general practitioners have a duty to work on many problems which might otherwise not receive the attention they deserve.'*¹

These aspirations reflected the excitement of the early 1950s: the discovery by Francis Crick and James Watson of DNA and the ascent of Everest by Edmund Hillary and Tenzing Norgay. Ten years later, in 1963, the newsletter had grown into the *Journal of the College of General Practitioners*, and Mac was still at the helm. This was the year of the assassination of John F Kennedy, Bob Dylan's recording of *Blowin' in the Wind*, the Great Train Robbery, and Hitchcock's *The Birds*.



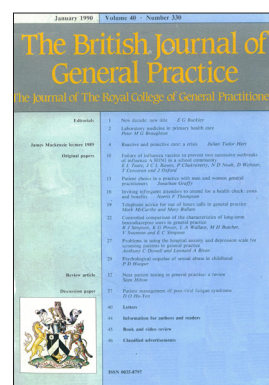
Two years earlier the National Library of Medicine in Washington, US, had independently included the Journal in *Index Medicus*, giving international recognition to the unique body of knowledge being collected through research in general practice. As Sir Denis Pereira Gray, editor of the Journal from 1972 to 1980, has pointed out:

*'This was the historic turning point. Two years before there was a general practice professor anywhere in the world, this small, nine-year-old, highly decentralised College of General Practitioners, with its scholarly editor in a remote provincial practice, established general practice as a new independent discipline, for the first time in the world.'*²

1973 will be remembered for Watergate, the end of US involvement in the Vietnam War, and the first transatlantic flight of Concorde. Value Added Tax was introduced at 10%, and a terylene College fellowship tie cost £1.77. Denis Pereira Gray's key contribution was to firmly establish the academic credentials of what was then the only peer-reviewed journal of general practice in the world. A rigorous peer review system and careful statistical assessment were key, while the

submission and publication of challenging and controversial editorial and discussion material was encouraged. The College nailed its colours to the mast by spending a substantial proportion of its budget (up to 20% at one point) on the Journal, and at the same time defending editorial freedom, which it has continued to do up to the present day. The Journal was subtitled the *British Journal of General Practice*, which became its formal name in 1990.

By 1983, Graham Buckley had taken over from Simon Barley as the Journal editor and, like all editors had the challenging task of balancing the publication of original research, the dissemination of good clinical practice, and commentary on the interface between medicine and the socio-political context. The 1980s were times of great expansion of academic general practice, as the recognition of general practice surgeries as ideal undergraduate teaching environments dawned on the General Medical Council,³ and the universities began to look with more interest at community-based teaching. The early 1980s were also the time of Reagan's Star Wars initiative, the beginning of the Space Shuttle Program, and the arrival of cruise missiles at Greenham Common.



1993, and Alastair Wright is now in the editorial chair. The Maastricht Treaty has been signed and the Washington Peace Accords between the Palestine Liberation Organisation and Israel are on the table. These major international agreements were preceded by Sir Michael Peckham's review of research and development (R&D) in the NHS in 1991,⁴ and the influential Culyer report on R&D funding in 1994,⁵ which laid the foundations for a substantial and solid funding stream for primary care research for the next two decades. Wright, correctly,

focused on measuring and maintaining the impact of the journal. The bibliometrics showed that the *BJGP* was well ahead of other journals in the field, and could be judged objectively as 'probably the most read and influential journal of general practice in the world'.² As undergraduate teaching funding through the Service Increment for Teaching (SIFT, and its equivalent in the other countries of the UK) moved into the community, the departments of general practice and primary care in the medical schools enjoyed another period of expansion.



Research and development in primary care was further strengthened in 1997 by the important report on NHS Research and Development by Professor David Mant⁶ and the influential MRC Topic Review, led by Professor Nigel Stott.⁷ David Jewell became editor of the *BJGP* in 2000 and recognised the continuing tensions between maintaining the Journal as a service to the research community and as a publication of wider relevance and interest to a much larger College membership. There had been recent major disagreements between the owners and editors of both the *Journal of the American Medical Association* and the *New England Journal of Medicine*, and on one or two occasions, editorial independence at the *BJGP* also needed vigorous defence. By 2003 the human genome had been sequenced and the Iraq war had started. Three years later, with great farsightedness, Professor Sally Davies established the National Institute of Health Research and the National School of Primary Care Research, which, over the past 7 years, have added greatly to the opportunities for research and research careers in general practice and primary care.

So, 2013, 60 years on and where does this leave the *BJGP*? It remains the second most highly cited journal of primary care research in the world, although we are still waiting for the calculation of the 2012 Impact

Factor. Last year we recorded 1.2 million full-text downloads from the *BJGP* and PubMed Central sites, and 2.5 million page views across the two sites, with almost 1 million unique visitors: one-quarter from the US. We lead the field in our use of open peer review, our paper-short/web-long publishing strategy, our recently-introduced open access publishing arrangements and our support for reviewers. The *BJGP* archive is now digitised and fully searchable back to 1953. When we move to our new HighWire publishing platform next year, further significant improvements in presentation, appearance, accessibility, and functionality will emerge.

We now provide a superb service for our authors: the median time to an initial decision on an article submitted via our online manuscript handling system is 11 days. Following peer review and revision we give a final decision to 83% of our authors within 2 months of submission and to 93% within 3 months. Our ability to respond rapidly depends to a large extent on the diligence and quality of our peer reviewers — over 1000 of them — who we now try to support by providing detailed guidance on reviewing and additional material on critical appraisal and, in the near future, a systematic approach to feedback and comment on review quality. This is my opportunity to thank them all, and also to pay tribute to and thank most warmly the editorial team in the RCGP who make the Journal the excellent publication it is, and the members of our UK Editorial Board and the International Advisory Board for their friendship and advice.



The main challenge for the future is one that all my predecessors have shared: how do we ensure that the Journal continues to flourish as a world-recognised publisher of top-quality primary care research, backed up by intelligent and influential debate and opinion, supplemented by interesting, entertaining and provoking non-research material, all in a single publication? You

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can't please all the people all of the time, as Abraham Lincoln discovered, and it may be that over the next few years, with changes in the paper and digital publishing environment, these functions will become separated. Whatever changes take place, the editor and the College remain committed to the continued publication of high quality peer-reviewed research.

Roger Jones,

BJGP Editor, London.

Provenance

Freely submitted; not externally peer reviewed.

DOI: 10.3399/bjgp13X671470

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What sustainability means for primary care:

primary care leads to better overall resource use and higher quality outcomes

EFFECT OF THE ECOSYSTEM ON HEALTH

The concept of sustainability in its broadest context is an easy one. It is about using resources wisely in a way that not only protects the environment in which we live here and now, but also takes account of the needs of our planet's inhabitants in the future. I choose my words carefully; as humans we are only one species in this ecosystem and our future wellbeing is inextricably linked with the rest of the biosphere. Climate change presents a major threat to the biosphere and there is overwhelming evidence that the activities of mankind are contributing to this phenomenon. The stress that the wider ecosystem is being put under is likely to impact on health in many ways and as GPs, health is our core business. Margaret Chan, the Director General of the World Health Organization, described climate change as the biggest threat to health in the 21st century. In part she is right but the implications for health will run far longer than this century alone.

Since the Industrial Revolution the ever-growing world population has been consuming planetary resources at an ever-increasing pace. This is true of many types of resource, however burning the locked stores of hydrocarbon in the form of coal, gas, and oil has led to a rise in CO₂ levels in the atmosphere, resulting in climate change. If we continue as we are then climate modelling predicts a 2–5 °C increase in ambient temperature by 2050; the projected impact of the higher range is devastating. The report of the UCL/Lancet commission on climate change and health¹ gives an authoritative account of the likely health impacts of global warming. Our healthy existence is made possible by a self-regulating environment staying within quite narrow habitable confines, much like the homeostatic processes that keep us functioning as human beings. Our biosphere is showing signs of great stress, with species extinctions at a rate not seen in millions of years. We rely on the biosphere in ways we understand and in ways that we don't. *Sustainable Healthcare*² has recently been published and I thoroughly recommend it for its easy reading and accessible style. Excessive consumption is also directly affecting health and wellbeing with rising levels of obesity and the consequent rise in associated long-term conditions.

"The delivery of health services in the western world is in itself part of the problem."

The delivery of health services in the western world is in itself part of the problem. The carbon footprint of the NHS is estimated to be 21 million tonnes of CO₂, 25% of the total public sector in England.³ We are developing an understanding that delivering health care the way we have done comes at a price. Antibiotic overuse has led to the development of super-resistant organisms and we understand the clear and direct effect that this has on health. The contribution to our overall greenhouse gas emissions and other pollutants attributable to the health sector also has direct effects on the health of our population. The causation and exacerbation of respiratory conditions especially in urban areas being just one example. The Climate Change Act 2008 has set enormous legally binding challenges for carbon reduction and the healthcare sector is not immune from these. It seems clear that to continue with a 'business as usual' attitude in the face of these challenges is not an option. We are seeing the resource pressure already starting to bite with the first manifestations being the financial squeeze combined with a shift in demography and patterns of illness. I suspect that this is a landscape that is here to stay.

WHAT DOES THIS MEAN FOR PRIMARY CARE?

What does all of this mean for the healthcare system and in particular for GPs and primary care? General practice and primary care are important elements of the solution and need to be seen and valued as such. The evidence is clear that high quality primary care leads to decreased overall costs and better health outcomes. The penny dropped with me at

the RCGP Annual Conference in Harrogate last year, that the best way of future proofing the healthcare system in the UK is to invest in the education and skills of GPs and their teams, in short, helping them to deliver high quality generalist personalised care. At the heart of this is the skill to deliver bespoke patient care and manage risk without resorting to over-medicalisation and consequent high resource use. The old maxim that prevention is better than cure resonates well with the sustainability agenda but employing GPs to tackle issues like obesity uses expensive skills to close a door once the horse has bolted. There is of course an important role for high quality general practice to manage the problems associated with long-term conditions in order to decrease high resource emergency admissions to hospital.

On a parochial level there are simple things that we can do within our practices and primary healthcare teams, including prudent energy and water use, use of consumables of all types, and recycling when we can. One-stop services lead to faster care and decision making, increased patient satisfaction, and fewer patient journeys.⁴ There is clear evidence that better continuity of care leads to fewer hospital admissions. Ipsos MORI consistently rank GPs as the most trusted professionals in the UK and we must not underestimate the influence that we have; demonstrating engagement with the sustainability agenda in our surgeries is not likely to go unnoticed.

CCGs AND THE FUTURE

The advent of clinical commissioning groups and the influence that they will have on the provision of services is potentially

"Ipsos MORI consistently rank GPs as the most trusted professionals in the UK and we must not underestimate the influence that we have ..."

the biggest game in town. Integrating care around the needs of patients, and in doing this working with small groups of trusted providers of care rather than duplicating services and operating with multiple companies, is likely to improve patient care and minimise the total resource cost. Historically, commissioning has been about securing volumes of activity aimed at providing a population with its wants and needs, often by professionals working in ways and places that have changed little for decades. This has led to the structure of care being delivered in much the same way as it was at the inception of the NHS in 1948 with a persistent primary and secondary care divide. There is an urgent need for clinical commissioners to think holistically about the care pathways that they develop. If they and hospital trusts were responsible for the overall societal costs of care provision then service delivery would look very different indeed.

In the face of the evidence that primary care leads to better overall resource use and higher quality outcomes, the recent Nuffield Health Report⁵ showed that in 2011–2012 spending on hospital care grew by 1.2% compared with a 1.2% reduction in spending on GP services. In England the spending on primary care services was £400 million lower in 2011–2012 than it was in 2009–2010. At its most basic, for general practice itself to be sustainable it needs to continue to be an attractive career choice for the next generation of medical students and doctors in training. There is evidence that the working pattern in general practice runs the risk of becoming unbearable over the next 3–5 years.⁶ The RCGP needs to work collaboratively with the Academy of Medical Royal Colleges and the BMA to call on the NHS England and the equivalent bodies in the devolved countries to improve the share of general practice funding from within the NHS funding allocation. A small redistribution in favour of primary care would bring with it the potential to decrease the overall environmental footprint of the NHS.

Finally, perhaps the time has come for a

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radical review of what we want our NHS to be and do. Maybe only a Royal Commission on the future of the NHS would help us with this.

Tim Ballard,

RCGP Sustainability Lead and incoming Vice Chair of RCGP Council, UK.

Provenance

Commissioned; not externally peer reviewed.

DOI: 10.3399/bjgp13X671489

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Is 'practice size' the key to quality of care?

Let us look for better clues than size

THE ENIGMA OF PRACTICE SIZE

Imagine key stakeholders in primary care — managers, politicians, policy advisors, and patients — have gathered to draft an ideal primary care structure. Some argue for large group practices, others say smaller practices are better, others that team work or salary payment is the key. Is there evidence that would help them? Moreover, is there an optimum sized general practice in terms of delivering safe, quality care that is also highly rated by patients? Or is general practice, by its very nature, best served by practices of different sizes and contexts?

The review in this Journal on 'whether practice size matters for the quality of care in primary care' does not resolve these questions.¹ Many researchers have tried to find a relevant relationship between attributes of quality and practice size and it is interesting and sobering to see what is left after sifting the evidence. It isn't a great deal. Defining the optimal size of a practice is a complex decision.

There is conflicting evidence on the ability of small practices to deliver high-quality care and the views of physicians, patients, and health service managers can be at variance.²⁻⁵

Moreover, while bigger (and increasing) practice teams are the norm in some countries, such as the UK, smaller practices and indeed single-handed practitioners are prevalent throughout much of continental Europe with comparable or better⁶ systems health outcomes. The review in this Journal¹ suggests that when patients are asked, smaller practices have an advantage; whereas when chronic care and preventive services are the outcome, larger practices can do better. The review therefore condenses the evidence and our primary care planners would have some information for making choices for their desired primary care structure. Yet, we may have to conclude that to look for 'evidence that group practices or larger practices are providing better care' is, perhaps needlessly, looking for the Holy Grail.

VARIATION IN CARE

There is considerable variation between practices in quality of care and it can hardly be explained by size. There are perhaps more relevant structural aspects of the

"There are perhaps more relevant structural aspects of the practice organisation associated with better quality of care than practice size."

practice organisation associated with better quality of care. For example, there is evidence that in the UK longer booking intervals, good teamwork, and support for preventive care all show a correlation with better quality of care.⁵

In the Netherlands a strong, nearly linear, relation was found, for example, between the 'overall time the GP spends on the patient' (including secondary activities, continuing medical education, and being on call) and quality of care.⁷ With each extra patient over 2000 patients per GP however, quality of care declined. There was no such relation with quality of care and the 'number of consultations per patient' or the 'time the GP spent in the practice'. Other structural keys for better quality of care are 'listed/registered patients' and 'continuity of care'.⁸

MORE PROMISING CLUES

So what do we have to tell our team of primary care planners? Well, based on the actual evidence, very little. We have little information on how much leadership, autonomy and peer pressure we would want GPs and staff in practices to receive in order to foster better quality of care. Should we support practices to offer a broader scope of therapeutic and diagnostic services in primary care? Is an egalitarian team structure better than having some hierarchy? What degree of part time job/presence is required? Is it good to focus on the variation between GPs and invest in the process of analysing the variation with peers or with the team? Which other professionals (pharmacist, social worker, physiotherapist, and so on) should be

integrated in the practice to provide better quality of care? Should all GPs or staff be paid a salary or be private care providers? Decisions on these matters are based on conventional wisdom. Research in this field is often inconclusive; yet important for the future design of our premises, teams, and services.

A FUTURE STUDY DESIGN

A possible study design would require the collaboration of thousands of health centres and practices. If these centres could be tempted to collect data (for example, as part of a practice visit scheme) on all relevant structural, process, and outcome data available using the same format, it could shed light on a lot of these research questions. Most practices already collect such data but not in a coordinated way and not using comparable indicators; especially across geographical and country borders. The review shows that analysis of variation in quality of care in a multivariate analysis against organisational aspects is feasible. The EPA-project was such a study, using a collaboration of nine European countries that agreed on a common set of indicators for structure and process.⁹ Although the project got The European Health Award for its benefit to population health, funding stopped.¹⁰

A few other studies have shown the potential of analysing such a database. For example, training practices are associated consistently with a broader scope of services, better patient scores, and less workload and job stress for the GPs.¹¹ We also found that while larger practices do not deliver better chronic care, the workload of

"With each extra patient over 2000 patients per GP however, quality of care declined."

"If thousands of centres could be tempted to collect data (for example, as part of a practice visit scheme) on all relevant structural, process, and outcome data available using the same format, it could shed light on a lot of research questions relevant for policy decisions. This can be done."

GPs in larger practices is less with more tasks delegated to practice nurses.¹² Such a database could help address some of the answers raised above.

Most quality assessment/improvement is focused on population-level measures and this helps to provide safe quality care and should apply to all practices, but must not be at the expense of the precedence of the relationship between individual patients and health practitioners.¹³ The same applies in seeking to identify the optimum practice size. Any search for an ideal practice size must not be at the expense of the focus on the individual patient or practitioner.

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Provenance

Commissioned; not externally peer reviewed.

DOI: 10.3399/bjgp13X671498

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