8th Julian Tudor Hart Lecture 2014:

Include me out, exclude you in

INTRODUCTION

The first half of my title comes from Samuel Goldwyn, the Polish American film producer who sometimes struggled with the English language. The second part I added myself, for reasons which will become clear.

As a film producer Goldwyn was in the business of telling stories. My first story comes from *Fahrenheit 451*, the book by Ray Bradbury and film by François Truffaut, whose title records the temperature at which paper burns. In a totalitarian state where books were burned, each member of the resistance was tasked with remembering one book, to keep its story alive. As the future of primary care depends so much on health practitioners, and how they see their work, the Glyncorrwg story is one they need to know, not only how it started, but also how it may carry on.

So much of what Julian Tudor Hart pioneered at Glyncorrwg, a former mining village in South Wales, is orthodox now. He was the first doctor to measure the blood pressures of all his patients.[1] Famously, the last man to take part had the highest blood pressure of all, which remains an important teaching lesson. Julian and his wife Mary put their records into shape, converting from Lloyd George to A4, and then to computerised records, to establish the information system that allowed them to start by screening the records, not the patients; and to measure what they had not done (the 'measurement of omission'),[2] so they could describe, address, and reduce the 'rule of halves'.[3] Later, Julian could describe a cohort of patients with hypertension diagnosed at <40-years-of-age and followed up over 20 years;[4] be 'his own coroner', reviewing over 500 consecutive deaths in general practice;[5] and assess his impact on premature mortality after 25 years of practice.[6]

All this had impact, via research articles, opinion pieces, and books, but also by example. The 1991 *BMJ* paper is still the only paper in the literature which reports what a GP might achieve in a lifetime's practice.[6] Even with wide confidence limits, the observed 30% lower premature mortality was quite an effect, achieved not only via the delivery of evidence-based medicine (before statins) — as promulgated today by NICE and enshrined in the QOF — but also, importantly, and outside the QOF, via unconditional, personalised, continuity of care, provided for all patients, whatever problem or combination of problems they presented. Achieving this in one of the most deprived wards in West Glamorgan, demonstrated that the inverse care law is not a law of nature,[7] but a state of affairs that can be reversed.

In *A New Kind of Doctor*,[8] he looked back at the care of a man invalided out of the steel industry, with a list of problems we now call 'multimorbidity'.

Overall 'the story' is a success. For the staff at our health centre it was a steady unglamorous slog through a total of 310 consultations. For me it was about 41 hours of work with the patient, initially face to face, gradually shifting to side by side. Professionally, the most satisfying and exiting things have been the events which have not happened: no strokes, no coronary heart attacks, no complications of diabetes, no kidney failure with dialysis or transplant. This is the real stuff of primary medical care.

Julian was talking and writing about 'co-production', and the pace at which it could be achieved in a deprived community, 20 years before it became a policy catchword.[9]

Julian and Mary met as members of Archie Cochrane's team at the MRC Epidemiology Unit in South Wales which, in the 1950s galvanised whole communities for medical research, regularly achieving response rates of over 90%.[10] But Julian was frustrated by research rules, which meant that while he often observed gross pathology in participants, he could not intervene. So he left, to set up practice at Glyncorrwg, exchanging 'a life of facts for the facts of life', applying not only the epidemiological approach to clinical practice but also Cochrane's magic ingredient, the employment of local people who were streetwise and knew their communities well.

In a series of practice-based studies with very high response rates, Glyncorrwg became the pilot site for many of the early studies of the MRC general practice research framework, including a survey of urinary incontinence, collection of stool samples for a prospective study of faecal flora and bowel cancer, and community dietary salt restriction to intakes below 3 g per day.[11] The doctor went the extra mile in delivering health care; patients went the extra mile in taking part in research. While the Welsh coal industry went into decline, Julian was mining a hugely productive alternative energy source.

FUTURE CHALLENGES

Looking forward, as populations age and healthcare budgets tighten, the increasing challenge will be to enable patients to live well and long with long-term conditions.[12] In addition to knowing and coping with each condition, patients will have work to do in self-management, understanding and adhering to treatments, and accessing multiple points of service delivery. Too often, the NHS makes their task harder.[13]

The health service has a proliferation of specialist services, seeing themselves as separate hubs and specialising in what they do. With entry criteria, waiting lists, time-limited commitments to individual patients and discharge back to general practice when their task is done, such services are very different from the unconditional, inclusive, and continuous nature of general

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practice. That is not a criticism of the services themselves, but the cumulative effect is to make life difficult for many patients with multimorbidity.

General practice has many features which make it the natural hub around which local health systems should develop. No other part of the public service has the same levels of consistent contact, coverage, continuity, flexibility, long-term relationships, and trust. Patients are seldom excluded. Of course, hubs on their own are insufficient. They need to be connected via spokes, or links, to a wide range of other resources and services. The NHS needs wheelwrights to build such local systems.

KEY ELEMENTS OF INTEGRATED CARE

The health information systems we rely on today all had to be imagined, developed, tested, and refined before they could be used to audit and improve care. Two important new types of information are needed for integrated care.

First, primary care is a compendium of individual patient stories. Each is the product of serial encounters, involving all of the contacts a patient has with services. Whether the story has a good ending depends partly on professional expertise, but also on patient enablement and the extent to which patients and professionals are concentrating on the same goals. If the patient narrative is the unit of currency, is the currency weak or strong? Can we imagine ways of collecting and using such information?

Second, the social capital within a local health system is simply the sum of the relationships within it. Local health systems can be resource rich but people poor, or resource poor and people rich. What mechanisms do we have for assessing such social capital, to know whether the system is rich or poor, to support and reward the good, and to weed out the bad?

A Channel 4 TV programme asked why Britain's industrial revolution had centred so much in Lancashire, in North West England, before concluding that in that part of the country there was a critical mass of people who knew how to combine new knowledge, raw materials, and local people in productive local systems. The NHS needs similar leadership now, not for an industrial revolution producing goods for sale, but for a social revolution transforming health and social care. GPs can embrace or block this opportunity as they wish. Few other groups are so strategically placed.

In the Deep End project, involving the 100 most deprived general practices in Scotland, we have had some success in GP engagement, without which little else is possible.[14] We did this by listening to front-line GPs, capturing and giving voice to their views and experiences, recognising the essential, unconditional, inclusive, continuous nature of their work, co-designing new work, and trusting their judgement.

There is no blueprint for integrated care. Local health systems are so diverse in terms of history, geography, resources, personalities, culture, ethos, strengths, and weaknesses that there is no single formula for success. Each local system has to develop by trial and error, keeping what works and discarding what doesn't. Shared learning can accelerate the process. The best, indeed the only, people to do this are streetwise local teams who know their patients and communities well.

Julian Tudor Hart has often quoted Aneurin Bevan, who described the introduction of the NHS in 1948 as setting the nation 'on a new path entirely'.[15] Paths are made by walking. We need pioneers to make new paths for integrated care. Not all GPs see themselves as civic entrepreneurs, but those who do should be supported. They are needed to inspire the next generation. A GP in Wales did this before. Could Welsh GPs do it again?

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Provenance
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