The tragedy is that poverty kills. Age at death is associated with postcode. Less money makes life harder and shorter in many ways: less education, poorer working conditions, more stress.1

Instead of taking money away, what happens if you give poor people money? Halfway through an eight year study of children’s mental illness, a casino opened in a Native American reservation in the United States. As a consequence, under the terms of the agreement, every Native American family received an income that rose annually. Before the casino opened, the researchers found that the poorer the family, the greater the risk of mental distress. After paying the families, however, the rate of mental distress among children who had once been poor was about the same as in children who had never been poor.2 By the time those children were 25, researchers still found persistent benefits in the group associated with the childhood cash injection.3

Tax credits mitigate in-work poverty. What about people who are homeless and out of work? A small project in London took 15 people who had been sleeping rough for four to 45 years.4 They were offered money—about £800 in the first year—and a personal coordinator, and they were asked what they needed. Thirteen accepted. People spent the money on small bills, food, or educational courses. Seven moved into accommodation, and, although questions undoubtedly remain about the long term usefulness and potential harms, this work carries a strong message about the power of cash in a system flexible enough to be kind.

For some time, cardiovascular risk calculators such as ASSIGN have promoted postcode as a risk factor, which has meant literally that we are treating poverty with statins. Medicine cannot compensate for poor political choices. Here’s a suggestion: why not treat health inequalities with the careful use of money?

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Agricultural policy, through its effect on price and availability of foods, is known to be an important determinant of health.12 14 15 The European common agricultural policy has historically protected the European sucrose (sugar beet) industry through interventions that have kept commodity prices high and prevented foreign imports. For the past decade, the EU has been phasing out these protections (“liberalisation”). This process will be nearly complete by 2017.

How the common agricultural policy has shaped diets
The common agriculture policy dates from 1962, when Europe was emerging from food shortages after the second world war. Its primary aims were to increase agricultural productivity, ensure a fair standard of living for farmers, stabilise markets, ensure availability of energy dense food supplies, and establish reasonable consumer prices. Its aims have not evolved as understanding of nutrition for health has improved and as new public health concerns have emerged, including obesity and diabetes. The policy has promoted overproduction of certain products, shaping European diets in ways that may have been detrimental for public health.15

Sucrose has been among the most protected European agricultural products. These protections have benefited sugar beet processors, who have in turn influenced sugar policies.20 The EU also maintained a production cap on high fructose corn syrup of about 5% of all sugar production, affording additional protections to the European sugar beet industry by preventing large scale replacement of sucrose with high fructose corn syrup.

Liberalising the sugar sector
Initial sugar reforms in 2006 reduced the minimum price guarantee and eliminated export subsidies. One study estimated that reducing the price guarantee could lead to a 7.5% increase in consumption of sugar sweetened drinks in France.22 Subsequent reforms, which started in 2013, go much further and will almost fully liberalise the sugar market in Europe, culminating with the elimination of production quotas and minimum price guarantees in 2017. When the reforms were introduced, the European Commission predicted that the commodity (or wholesale) price of sugar would drop substantially, production of high fructose corn syrup would treble, and production of sugars overall would increase by around 15% in the decade after quotas end.23 Early indications suggest these predictions are broadly accurate. The price of European sucrose has fallen about 40%, with analysts expecting an increase of around 20% in sugar production after 2017.24 25 The main players in the European sugar industry are growing larger and preparing to increase production to remain competitive. For example, in May 2015 Europe’s second largest sugar producer, Tereos, purchased the sugar distribution business of a UK based baked goods company. Tereos has also stated it will increase sugar production by 20% once quotas are abolished.24 Without price controls and quotas the only way for the European sugar industry to remain profitable is by increasing production.

Unintended effects on sugar consumption
Sugar supply and consumption in the UK has declined over the past 50 years (figure). The effect of the 2006 reforms on consumption is unclear, but the new set of sugar reforms go much further and may be more liable to increase sugar consumption through a variety of mechanisms. For example, lowering the cost of sugars to food processors will make it more economically viable to incorporate sugars into processed foods as an easy, inexpensive means of increasing palatability, potentially resulting in higher sugar content in foods that already contain sugars.

The price drop in sugar and increased availability of high fructose corn syrup may also result in sugars being added to a broader range of foods. Apart from sweetness, high fructose corn syrup has benefits for flavour, stability, freshness, texture, pourability, and consistency, and it can be used in both sweet foods and some savoury foods.
Use of high fructose corn syrup in Europe is relatively low at present but the removal of the production cap in 2017 will make it feasible to produce and use. The United States shows the potential effect of this change. The US government declared high fructose corn syrup to be “generally recognized as safe” in 1983, removing any restraint on its use. Following this, sugary drink manufacturers replaced sucrose with cheaper high fructose corn syrup. In the 30 years since, there has been a long-term decline in the price of carbonated soft drinks relative to food (fig 2, see thebmj.com). By contrast in the UK, where sucrose remained the predominant sweetener, the price of soft drinks relative to food has risen. Moreover, in the US sugar consumption increased by 20% over the 15 years after the introduction of high fructose corn syrup, even though sucrose consumption declined. Other differences between the US and Europe make it difficult to predict whether Europe would see a similar size effect.

Substantially cheaper sucrose and high fructose corn syrup may also lead to greater marketing of foods high in sugars because these foods will remain profitable—and potentially more profitable than in the past. This may encourage industry to resist regulations designed to reduce the use of sugars.

The EU Trade Commission and the UK Department for Environment, Food and Rural Affairs (Defra) have supported these reforms because of the opportunities they bring for the European and UK processed food industry. Defra has stated that “the boom in global demand for western-style foods is creating huge opportunities for growth in [the sucrose and food manufacturing] sector which [the UK] should not hold back.”

Good health needs good agriculture policy

European agricultural policy, and particularly sugar liberalisation, has largely not considered health. Although some weak public health objectives have been incorporated recently, health is not listed as one of the policy’s five main objectives. The structuring and sequencing of the reforms in 2006 and 2013 indicates that they were designed to benefit industry, not public health.

The timing of the sugar reform is particularly unfortunate, creating a tension between agricultural policy and health policy and generating mixed signals for the food industry. There is a risk that ongoing and proposed measures designed to reduce sugar consumption (such as reformulation to remove sugar, taxes on sugar sweetened drinks, and marketing restrictions) could be undermined by larger trends in price and production of sugars in Europe.

Possible effects on health inequalities

There is already a socioeconomic gradient in sugar consumption among adults and a similar gradient in consumption of sugar sweetened drinks, which are a major source of added sugars (fig 3, see thebmj.com). Foods containing high levels of sugar are among the cheapest foods. Any reformulation to increase sugars in processed foods is unlikely to happen equally across all product lines. Cheaper processed food items, marketed on price rather than quality, may be most liable to reformulation to incorporate more sugars. These cheaper foods are purchased and consumed more often by people in lower socioeconomic groups, who are more price sensitive consumers. Consequently, this reform may disproportionately increase sugar consumption among lower socioeconomic groups, contributing to widening health inequalities.

Messages for policy makers

Since agriculture policies can shape food consumption and nutrition, they should explicitly integrate health. We should aspire to agricultural policies that promote a healthier diet, which can also deliver improvements in sustainability. Agricultural policies should be subject to full and meaningful health impact assessments to estimate the scale of potential population health effects and help identify solutions to mitigate health harms. There was no such assessment of the sugar reforms. Although challenging, the relative success of health impact assessments in transport and integrating health into transport decision making suggests it is achievable.

Given financial pressures on industry to reformulate foods to incorporate more sugar (or at least maintain existing formulation), it may be necessary for governments to mandate targets for reducing sugar contents of processed foods and implement robust systems for monitoring compliance. It will also be important to monitor food prices, diet, and health to determine the effects the reforms have on the cost and availability of foods, sugars in the food supply, and diets, including patterning of consumption among socioeconomic groups.
Regulation of CPD won’t improve patient outcomes

An individual approach is more likely to increase safety

A recently updated European Union directive attempts to control continuing professional development (CPD) by collecting credits but may have the perverse consequence of decreased relevant learning and a negligible effect on quality. When CPD is informed by political imperative rather than professional practice we risk the focus moving to compliance with regulations and away from locally driven, professionally effective processes of deciding where and how clinicians or teams should develop their own practice to serve patients better.

Mandatory or voluntary CPD?

Political interventions seem to assume that doctors do not take responsibility for keeping abreast of emerging knowledge in their disciplines. Why else would we require a directive demanding proof of CPD?

But no robust evidence shows that mandatory CPD throughout Europe will ensure a minimum standard of knowledge. But CPD cannot replace inadequate training systems, facilities, funding, and staffing levels.

The UK national medical revalidation programme incorporates discussion of CPD. The General Medical Council has decided not to regulate CPD activity directly, although professional bodies set requirements for their members. Other countries, including the Netherlands, have systems based on the collection of credit points. But no evidence shows that healthcare has better outcomes in countries with mandatory systems.

Thinking the unthinkable about the NHS

Some may use the NHS funding crisis to bring in policies previously off limits.

Talk of financial crisis in the NHS is almost as old as the service itself. And in the 30 years I have been involved in health policy I have seen crises come and go. But the current pressures facing the NHS look to be on a different scale.

The chancellor of the exchequer’s spending review on 25 November will have huge consequences for all public services. The fact that the government has ringfenced funding for the NHS and promised it an additional £8bn might suggest that the health service has less to worry about than other departments.

But there are worrying signs ahead.

Getting a commitment to additional funds was a coup for NHS England’s chief executive, Simon Stevens. But this amount was premised on the NHS making a substantial improvement in efficiency and in controlling demand—equivalent to at least £22bn of additional work for the same money.

Restraining pay rises to 1% accounts for up to £5bn of the £22bn. But staff shortages in the NHS and wage inflation elsewhere will make this difficult.

Managing demand, illness prevention, and moving care into other settings through new models of care and so on are expected to contribute a further £5bn or so. The evidence to support success in these areas is mixed.

Potentially serious delay

The remainder comes from raiding central budgets and some stringent efficiency improvements by providers. But history is not encouraging when it comes to getting the NHS to be a smarter purchaser or to reduce clinical variation or adopt best practice. NHS England’s expectation was that the extra £8bn would be “frontloaded” to compensate for this and the lead time required to implement new care models. But because the Treasury saw this being funded from economic growth and savings elsewhere there is some concern that it would prefer the additional money to be delivered later in the spending review period. Such a delay would be potentially serious.

Even with large scale efficiency improvements and a funding increase, in 2020 the NHS will be spending roughly the same per person in real terms, after adjustment for changes in the age and size of the population. This leaves little headroom for the improvements that NHS England would like to see in care of people with learning disabilities, mental healthcare, and primary care. And this does not
**What of informal learning?**

The requirement to collect credits for identifiable educational events assumes that learning for CPD must be a formal event, although it has been questioned whether such events change physicians’ behaviour and outcomes. Regulations that focus on formal provision of CPD may miss much of the personal education that doctors undertake.

We are aware of more than 40 professionally valuable ways of learning, many of which are unlikely to be the focus of mandatory CPD associated with collecting points at courses and conferences. These ways may be the most important because they are more likely to be based on a doctor’s own practice and preferred approach to learning, helping to bring learning back to practice.

We favour the Academy of Medical Royal Colleges’ definition of CPD: “A continuing process, outside formal undergraduate and postgraduate training, that allows individual doctors to maintain and improve standards of medical practice through the development of knowledge, skills, attitudes and behaviour.”

A CPD process that involves individually identified learning needs and wishes, individual learning plans that respond to those needs and to individual preferences, and plans for bringing that learning back to the team and the practice is shown to reflect effective professional ways of improving healthcare.

Unitary, mandatory political regulation of CPD may contribute to a negative trend, reducing or restricting the freedom of professional action with no guaranteed effect on patient care and safety. We recommend freedom for each country to choose its own way.

CPD is an important tool, but patient safety is more directly related to how care is organised and whether resources are sufficient. CPD systems must be integrated with practice—not conceptualised as a separate set of events.

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Thomas Zilling is vice president, European Association of Senior Hospital Physicians, Brussels

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**ACUTE PERSPECTIVE**

David Oliver

**Is the NHS at war?**

What else could explain such repeated economy with the truth from health ministers and the Department of Health’s own “war information ministry” (or press office) when discussing NHS funding, efficiencies, and services?

NHS England, for example, has proposed £22bn (€31bn; $34bn) of “efficiencies”—but economists, policy experts, and NHS leaders in their droves say that these cannot be delivered. The government’s “up to £8bn extra investment by the end of this parliament,” the most NHS England dared ask for, won’t sustain even current service levels.

Nine in 10 hospitals forecast deficits, and clinical commissioning groups face serious hardship.

Patrick Carter’s review identified only £5bn of savings at best, and most recent savings have come from pay freezes, not from new ways of working. Everyone—including the ministers and communications teams who repeat the mantras—knows that there’s a crisis and that the solutions proposed are inadequate.

Consider the huge cuts to social care. The health secretary, Jeremy Hunt, ignored them in his “25 year vision” for the NHS, as well as the £22bn savings and the cost of reorganisation since the Health and Social Care Act. The Department of Health, while pushing...

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include funding for new hepatitis C drugs, other new treatments, the cancer strategy (£400m), seven day services (possibly over £1bn), and several other items on the shopping lists of ministers, pressure groups, and professionals.

We have already seen the government begin to take the line that some of these items are included in the funding they have promised. This is, at the very least, open to debate.

The big question in the long term is how realistic the assumptions about efficiency improvements are and whether the NHS has the wherewithal to deliver them. The assumptions have been developed from the top down—but how they translate into local action is not clear. Success is going to be determined by the effectiveness of local implementation, and clinicians will be vitally important here.

In the immediate future the provider side of the NHS is in deep trouble financially and performance is slipping. There does not seem to be a clear plan for how to deal with this. Predicting financial crises in the NHS is a risky business. But the situation is worrying. It should not be assumed that the government will bail out the NHS. Some people in positions of influence might find that a crisis provides opportunities to develop various policies that had previously been off limits politically, ranging from charges, service restrictions, and much more wide scale use of the private sector. Thinking the unthinkable may become an attractive option for policy makers who believe that all other avenues have been exhausted.

When 25 November comes around one thing will be clear: the NHS is not immune from the effects of continuing austerity.

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Everyone—including the ministers and communications teams who repeat the mantras—knows that there’s a crisis and that the solutions proposed are inadequate for a “seven day NHS,” has glossed over the problems surrounding recruitment in primary care and some hospital specialties.

Examples of non-evidenced magical thinking are legion. Take the projections for a 3.6% reduction in urgent activity in clinical commissioning groups, while emergency department attendance is spiralling. Or the push for telecare to “transform” three million lives, leading to the end of care homes. Or the Better Care Fund, with its big, undeliverable promises, leading to the end of care homes.

If the tanks really were rolling in, I’d hope that those in Whitehall might let us know; but we’re not at war. So, how about some straight talking about funding and performance pressures? The public and the staff can take the truth—and they need to hear it.

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Kenneth Sunderland Holt
Pioneer in developmental paediatrics

Kenneth Sunderland Holt was at the vanguard of what would come to be known as developmental paediatrics. His early conviction that children's neurological conditions should be seen as developmental disorders and treated holistically, as part of family-centred care, is now standard practice. But it wasn't in the 1960s, when he introduced this approach.

“This was a time when children who were then described as ‘handicapped,’ were not considered educable and generally managed in care homes,” recalls Alison Salt, an expert in paediatric neurodisability, in a memorial tribute. “In this era he was indeed a pioneer.”

Like many pioneers, Holt trod a lonely professional path at times and had to convert others to his way of thinking. This might have been hard for someone who was naturally “unassuming, softly spoken, and not pushy,” had it not been for his “quiet authority and steely determination,” suggests his eldest daughter, Caroline Gillies, who followed her father into medicine.

A period of postgraduate training with the first professor of child health, Ronald Illingworth, at the Children's Hospital, Sheffield, and a research fellowship in 1958 at the Medical School and Children’s Centre in Iowa—then one of the leading US centres in childhood disability—inspired Holt to set up the Ryegate Centre in Sheffield, for children with cerebral palsy. It was here that he introduced multidisciplinary assessment and interprofessional training, neither of which had been done before in any clinical arena, let alone child disability.

Holt’s innovative approach prompted an invitation from London’s Great Ormond Street Hospital to set up the first national postgraduate centre for the multidisciplinary assessment of complex childhood disability in 1965. And in an era of well demarcated medical hierarchies “he not only saw the potential of having clinicians from other disciplines working in the specialty, but he also genuinely respected their expertise,” notes Tricia Sonksen, who worked with Holt at the Wolfson Centre.

Holt designed the building that housed the Wolfson, and he fought hard to include a residential unit so that multiply or severely disabled children

John Rodney Ellis Dathan
Consultant renal physician (b 1940; q London Hospital 1964; MD, FRCP), died from cancer of the pancreas on 20 July 2015.
John Rodney Ellis Dathan (“Rod”) took up a full time post in Southampton and south west Hampshire and took over clinical responsibility for the tiny Lymington New Forest Hospital. Over the following 25 years he transformed it from a slow stream convalescent unit and cottage hospital into a vibrant medical unit. Predeceased by his daughter, Rod leaves his wife, Helen; two sons; and seven grandchildren.

Alan Gooding
Former general practitioner Hollytree Surgery, Farnham, Surrey (b 1933; q Guy’s Hospital 1958; DRCOG), died from myocardial infarction on 31 July 2015.
Alan Gooding was evacuated during the second world war to relatives in Pembrokeshire, where his love of rural community life began. For 36 years he was a general practitioner and also served the community in the Order of St John Ambulance. He leaves Jeanne, his wife of 55 years; four sons; and six grandchildren.

Peter F Knight
Senior consultant anaesthetist St Mary’s Hospital, London (b 1931; q 1954; DA Eng, FFA RCS), died from progressive supranuclear palsy on 25 March 2015.
By the time Peter F Knight qualified from medical school, he had already assisted with some 400 procedures requiring anaesthesia. His career at St Mary’s Hospital started in 1963. In his retirement, Peter developed Pick’s disease, which eventually deprived him of speech. He leaves his wife, Jo, and three children from his first marriage.

Michael Espir
Former consultant neurologist and principal medical officer with the Civil Service Medical Advisory Service (b 1926; q Cambridge 1950; FRCP, MFOM RCP), died from a stroke on 1 July 2015.
Michael Espir developed polio in 1947, which left him with mild permanent leg weakness. In 1979 he was appointed to the Civil Service Medical Advisory Service, as honorary consultant neurologist at Charing Cross and Northwick Park hospitals, and as honorary lecturer at Queen Square. He leaves his wife, Valerie; four children; and numerous grandchildren and great grandchildren.
Terence Reginald Mitchell

Former consultant haematologist (b 1941; q Charing Cross Hospital, London, 1965; MA, MD, FRC Path), died from pleural mesothelioma on 3 July 2015.

In 1981 Terence Reginald Mitchell moved to establish a new department at the James Paget Hospital, covering Great Yarmouth and Waveney. He developed laboratory and clinical services and took forward plans for one of the first day centres treating haematology and oncology patients. He set up services in East Anglia and continued to work in this area after retiring from haematology. He leaves his wife, Anne; two daughters; and a grandson.

Anne Mitchell

Cite this as: BMJ 2015;351:h4786

Raymond Leslie Parsons

Former consultant geriatrician Loddon Trust (b 1939; q Westminster Hospital, London, 1964), died from cardiac failure after severe influenza on 2 April 2015.

Raymond Leslie Parsons (“Ray”) worked in clinical pharmacology before specialising in geriatric medicine. In his mid-70s, he studied for a masters degree in medical law, planning to use these skills to offer effective help to doctors in need. Outside medicine he spent time with his family, supporting and encouraging his children and grandchildren.

Pam Harper

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Richard Lehman on prescribing spironolactone

How do you share decisions with patients in practice? It is far more complex than just using evidence synthesis and decision aids, says Richard Lehman, who uses the example of prescribing spironolactone as add-on treatment for heart failure as a case study to highlight the difficulties and key issues.

http://bmj.co/spironolactone

The straw men of integrative health and alternative medicine

Timothy Caulfield is frustrated by the arguments used by supporters of complementary and alternative medicine (CAM) to fight back against sceptics such as himself. In an effort to put an end to this practice, he debunks the four most annoying CAM straw man arguments.

http://bmj.co/strawmen_alternativemed

Do I need to be more mindful?

Mindfulness is all the rage at the moment in both the counsellor’s room and the mass media. general practitioner Samir Dawlatly observes that being mindful, or being focused on the present, is the challenge that faces all doctors dealing with patients, and wonders if he could benefit from this current trend of therapy—if only for his patients’ sake.

http://bmj.co/mindfulness

Women in surgery

The obstacles and sexism that women face in medicine, particularly surgery, have been the subject of much recent debate. In a cheering and inspirational blog, Amy Godden says that gender inequality in the operating theatre has been the least of her hurdles. She talks about her experience and says that progress has been made for women in surgery.

http://bmj.co/women_in_surgery
LETTERS

Selected from rapid responses on thebmj.com. See www.bmj.com/rapid-responses

PLACE OF DEATH

Keep death out of hospital

One of Pollock’s key messages (Analysis, 10 October) is that “hospitals will remain the place where most people die,” but why? We need to demedicalise death, recognise its inevitability and normality. For 99% of human existence dying has had little or nothing to do with doctors. Doctors have a role, but if deaths continue to occur in hospital then death will remain medicalised.

The whole trend in healthcare is to move it to the community. Doctors who spend their life in hospitals forget what dangerous, horrible, frightening, uncomfortable places they are. Along with prisons, they are “total institutions,” where wanting to stay up late listening to Pink Floyd is seen as rebellion.

Richard Smith

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ALCOHOL AND PREGNANCY

Don’t blame pregnant women for drinking

O’Brien rejects bullying intelligent people just because they are pregnant (Head to head debate, 10 October). He recognises medical professionals’ duty to respect patients’ rights but misses the alcohol industry’s tactics to confuse people.

Alcohol consumption during pregnancy is the main cause of preventable mental impairment in the West. It is a high risk behaviour that no guidelines recommend. The American College of Cardiology states: “complete abstinence is easier than perfect moderation.” The only people who seem to expect moderate alcohol use are those who support the failed responsibility deal.

Good advice should be non-stigmatising. It is unreasonable to ask pregnant women to be superhuman when we are all drinking more. A kind society might see us all cut our drinking to help avoid fetal alcohol syndrome: one that offered effective interventions, rather than pointing the finger of blame. Instead of demonising women who can’t stop drinking, the government should step up to the public health challenge.

Alain Braillon (braillon.alain@gmail.com), Susan Bewley

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SMOKING CESSATION

Facilitating smoking cessation in mental illness

The prevalence of smoking in the general population continues to fall, but not for people with severe mental illness. Standard NHS smoking cessation services may be less accessible to those with mental illness (Clinical review, 10 October), and few studies have examined the challenge of translating efficacy into effectiveness in this group.

Embedding smoking cessation interventions into routine primary and secondary mental healthcare might help. The SCIMITAR trial piloted a drug based smoking cessation intervention plus a behavioural support programme designed for people with severe mental illness, delivered by mental health practitioners. Participants randomised to the intervention engaged well, whereas none of those randomised to usual treatment went on to use routine NHS smoking cessation services. The National Institute for Health Research Health Technology Assessment Programme is now supporting the large scale SCIMITAR PLUS trial, which will fully assess the clinical and cost effectiveness of this bespoke smoking cessation programme.

Suzy Ker (s.ken@nhs.net), Joe Reilly

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PAYING GPs FOR SERVICE

Scotland’s projected changes to general practice

Scotland is moving away from the tick box world described by McCartney (Views and reviews, 10 October). We are negotiating a contract to replace the Quality and Outcomes Framework with new proposals that incorporate the Royal College of General Practitioners’ (RCGP) vision of a “peer-led, values driven” model of quality, leadership, and governance. GP “clusters” will be responsible for local quality planning, be given resources to undertake quality improvement, and will demonstrate the quality assurance needed in a modern health and social care system.

We do not underestimate the difficulty in delivering the changes needed, especially when general practice is being resourced at record low levels and workload and workforce are ever increasing challenges. Putting patients and locality at the centre and rebuilding professionalism will be key to reversing negative views about general practice. This approach will also enable the delivery of integrated and community delivered care, as described in the Scottish Government “2020 Vision.”

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