SOMERSET LMC

Newsletter

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A GENTLE REMINDER: PRIMARY CARE NETWORKS NEED ROBUST GENERAL PRACTICE

Inside this issue

A reliable source recommended the LMC executive to read an article written by Becky Malby in February (beckymalby.wordpress.com/2019/02/18/a-gentle-reminder-primary-care-networks-need-robust-general-practice/) and your editor could not improve upon the title. Dr Malby had been mulling over the late Julian Pratt's seminal "Practitioners & Practices" (1995) and worrying that the funding and policy focus on primary care networks (PCNs) could mean that, yet again, the developments needed in primary care are neglected. PCNs need a purpose: to be clear what work can only be done at PCN scale; work that cannot be delivered well at a local GP practice scale. In order to decide that participating practices will need to be clear about the work that is best done in general practice at its best. Otherwise the tendency will just be to shift burdens from general practice to the PCNs rather than to consider the work of PCNs as unique and different from the work of general practice. For PCNs to be effective and useful, general practice has to be the best it can be.

To this the LMC would add "Amen" and point out that, at least at first, PCNs are designed to shore up and help primary care to develop rather than to become the answer to the prayers of secondary, community or local authority care. Dr Malby makes the excellent point that when the NHS talks about the work of primary care the focus is on flow, on the right practitioner for the right work, on how to help people who struggle with life but compartmentalising people's lived experience only further fragments their care. She argues that this can lose the important "healing, caring and biographical" aspects of general practice which defines the craft of the GP. Just witnessing someone's illness can be rewarding for the patient. The editor remembers being astonished and feeling guilty on getting a thank you card from a patient with medically unexplained symptoms who had moved away: he thought he had failed to help for years.

PCNs will also be providing "personalised… multidimensional care to and with vulnerable people" but this working at scale will have to be defined by the complexity of what is needed. This cannot be about economies of scale: the rationalisation of resources to drive efficiency. Rather it is "organised general practice" "to support the maintenance of a certain technical expertise, to provide depth and quality to the collaborative network, to reflect the natural sizes of communities and to support team based approaches". A team based approach is not the same as skill mix which is generally a form of division of labour.

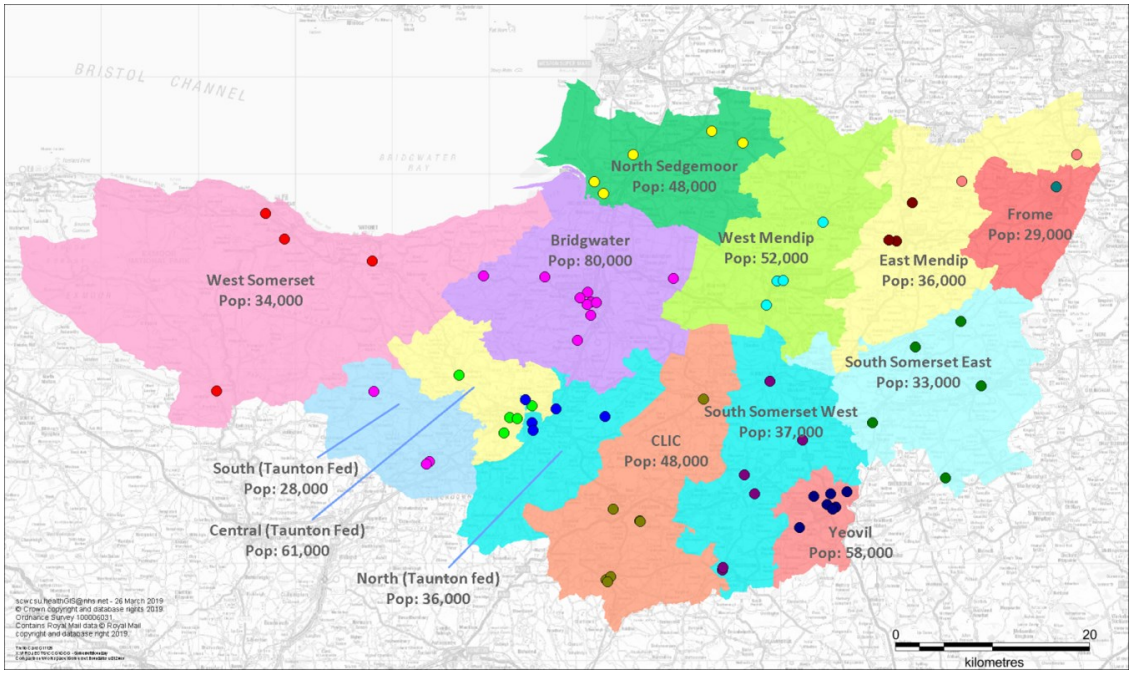
Consulting those "who are unwell or believe themselves to be unwell" is not the only work of general practice. Supporting the health needs of the practice population as a whole is a further dimension of general practice work. This often described in terms of how resources are allocated equitably but with traditional organisation of access the needs of the population are subverted by the needs of the individual – those that demand more get more of our time than those who might need it more, but don't ask. How often we recited "prevention is better than cure" but who can put it into action as we cope with the Monday morning firestorm of phone calls and "fighting fires" for the infrequent attender presenting in a crisis? To what extent, we might ask, has "traditional general practice" fed the cult of "doctor knows best" and so the very dependency we so often resent? "The work of general practice in working upstream of the presenting issues needs attention, if only to help manage the demand in later life, which means focusing on the health and wellbeing of the practice population alongside the individual." This raises questions addressed by the philosopher Jeremy Bentham or even by Mr Spock who

memorably said, “The needs of the many outweigh the needs of the few or the one.” The LMC welcomed the reversion of some public health matters to local government and PCNs will of course be dealing with local authorities in neighbourhoods.

Dr Malby concludes the greatest strength of general practice is how much we know about our populations, the power of the registered list. We now know that there is powerful evidence that continuity of care is good for individuals and for populations. “This care for and knowledge of place, has the mostly untapped potential of collaborating with the assets in communities to bring local people’s equal concern for their neighbours and friends into the work. This happens at the scale of meaningful communities, which are described by history, geography and identity which may or may not reside at PCN scale.” Some Somerset practices already do good work in their localities as do some groups of practices at a larger scale. The starting point is the identity of the community not the population size.

So developing PCNs will start with understanding the work of general practice and developing practices and teams to be the very best they can be with their local population. With that in mind it’s time to welcome and congratulate the new PCNs and their Clinical Directors who have been authorised by the CCG:

Bridgwater	Dr Catherine Lewis	**Central Mendip**	Dr Rob Weaver
Chard, Ilminster & Langport	Dr Christoph Kollmeier	**Frome**	Dr Rob Taylor
North Sedgemoor	Dr Joey McHugh	**South Somerset East - Rural Practice Network**	Dr Dan Edmonds/ Dr Steve Edgar (share)
South Somerset West (all SHS)	Dr Berge Balian	**Taunton Central**	Dr Stuart Baker
Taunton Deane West (Wiveliscombe/Wellington)	Dr Rachel Yates/ Dr Natalie Lister (share)	**Tone Valley**	Dr John Edwards
West Mendip	Dr Sam Rainsbury	**West Somerset**	Dr Kelsey Boddington
Yeovil	Kathryn Dalby-Welsh (Nurse, complex care lead)		



Some questions remain concerning the size and subdivisions of some of the PCNs and also the need for some cross border working to ensure some patients are not disadvantaged by geographical splits. We hope that the starting point of identity rather than size will be uppermost when considering the answers to those questions but the LMC agrees with the CCG that the CDs have a diversity of experience, skills and talents which together make a strong and impressive cohort. The LMC joins with the Somerset GP Board in promising to support these new Clinical Directors to make PCNs effective and useful and to make general practice the best it can be.

THE BEREAVEMENT JOURNEY
ALISON HICKS, COUNTY REGISTRAR

Bereavement is a sad fact of life and one that we all have to deal with, both on a personal level as well as a professional one.

I am aware that empathy for the recently bereaved is a shared concern across our varied fields of work. As such I ask for your assistance when considering the route that these families have to navigate in order to manage the complexities of the officialdom of death, our joint aim being to make the process as informative, clear and straightforward as possible, at all points along their journey.

With this in mind, we have improved the labelling of new MCCD envelopes distributed to surgeries, to show our Customer Service number for all bookings across the County, as well as our website, enabling relatives to book their appointment to register the death online.

We would appreciate it if the following information could be shared in cases where old stock is still being used up.

To book an appointment for deaths in Somerset please call 01823 282251 or
book online at:
www.somerset.gov.uk/contact-us/

Furthermore, the envelopes also remind doctors to complete their name and GMC number for identification purposes to avoid any delays when registering.

Finally, I would like to clarify the legal timeline for a registration of death (without referral to the Coroner), under the Births & Deaths Regulations Act 1953, which remains as **5 calendar days** rather than 5 working days as is generally believed.

Your consideration with these matters is much appreciated as always.

Alison Hicks
County Registrar

GP AT HAND EVALUATION PROVIDES CLEAR EVIDENCE BACKING BMA CONCERNS

Responding to the Independent evaluation report of Babylon GP at Hand by Ipsos Mori[1], Dr Richard Vautrey, BMA GP committee chair, said:

"This long overdue report reflects… many of the concerns we have been raising for some time about GP at Hand.

"GPs have been at the forefront of digital developments but these are always done with the benefits of all patients in mind, not just a select few. That is why we have consistently expressed genuine reservations about a system that has been rushed-out with little regard for how it impacts patients, practices and the wider healthcare landscape.

"As this report makes clear, this is a service used by predominantly young [56% were aged 25-34] healthy and affluent individuals,... looking for rapid answers to health questions... choosing convenience over longer-term quality and continuity of care. Indeed the rapidity with which large numbers of patients deregister [47% a month] and only to re-register with their previous practice provides evidence for this.

"All GPs are very concerned that, amid the ongoing workload pressures facing general practice following over a decade of underinvestment,...it is no surprise that certain groups are opting to register with a provider that appears to have significant additional resources to be able to offer 24-hour access.

"Others, such as older patients with more complex conditions, and those without access to smartphones, are unsurprisingly not using the service, and [so] rapid expansion within the NHS [c]ould create a two-tier health system.

"Continuity of care lies at the centre of traditional general practice, with local surgeries...[at] the heart of communities. We are glad that the report has noted the risk that GP at Hand poses to this, while highlighting the frustration experienced by patients when they wish to see a doctor face-to-face or they require more long-term care...

"This is therefore not primarily about the technology but a pattern of healthcare delivery with a focus on relatively affluent and healthier people having access to a service with a higher GP-to-patient ratio, which ultimately widens health inequalities for everyone else. Whilst we'd all like a GP on hand every hour of the day, the wider system cannot deliver that without a massive increase in funding and workforce expansion.

"That GP at Hand's patients are using the practice far more than the average patient would visit their own practice begs the question of whether a wider rollout, in an already overstretched NHS, would be able to cope with additional demand...

"Ultimately, the NHS must decide what it wants to prioritise, quick access or continuity and quality of care, because one is likely to come at the price of the other."

[1] www.hammersmithfulhamccg.nhs.uk/media/156123/Evaluation-of-Babylon-GP-at-Hand-Final-Report.pdf

The Queen Elizabeth Hospital

Rules for in-patients

(For the information and guidance of Patients and their Relatives)

[Some extracts of a leaflet from the mid 1940s found by the Chairman of LMC in his box of House Job memories. Capital letters are as written. The Special List is clearly the origin of the famous "danger list." When reflecting on the draconian visiting hours one may choose to reflect that hospital acquired infections, like DVTs and pressure sores, were virtually unknown in those unenlightened times.]

You must bring your identity card, national health insurance record card and ration book but do not bring rationed food.

CHARGES: The hospital exists to help people who cannot afford to pay for their own treatment elsewhere. Patients who belong to the Birmingham Hospitals Contributory Association…will, subject to presenting a satisfactory Voucher, or Certificate, be exempt from Maintenance charges. Patients who do not belong…are required to pay the Maintenance cost or as much as possible towards it. Patients will not be asked to pay more than they can afford. The Hospital will continue to treat freely those whose financial circumstances are such that they are unable to pay the charge or to join a Contributory scheme. All patients must be prepared to give the Hospital Authorities such information as to their circumstances where any doubt exists as to the suitability of their admission.

AMBULANCE SERVICE

Admission to Hospital. Patients requiring an ambulance to bring them to the Hospital should make the necessary arrangements through their own Medical Practitioner…Patients will be required to pay for the use of the ambulance according to the distance and the basic charge within Birmingham Area is 12/6 per journey. Outside the City boundary the charge will be at 1/- per mile… Contributors to the Association will be conveyed FREE OF CHARGE…when a Contributor produces a Voucher to the Association.

Discharge from Hospital. Only in the case of patients who, in the opinion of the Hospital Authorities are unfit to travel by ordinary methods of transport, can an ambulance be obtained when the patient leaves the Hospital. In such cases the Ward Sister will order the ambulance. The charges will be the same as above.

In-patients are not allowed beer, wine or spirits, unless such have been prescribed by an Honorary Medical or Surgical Officer: and no liquors, fruit, or provisions of any kind shall be brought into the hospital by patients or their friends without permission from the Ward Sister.

SMOKING. Ward Sisters may permit patients to smoke at recognised hours on the Balconies and in the Day Rooms only, subject to the consent of the responsible Medical Officer.

It is the rule and practice of the Hospital, in the interest of the public, to make POST-MORTEM examinations in every case of death, unless a formal objection be made…within 12 hours of the death of the patient.

Any patient refusing to comply with the Rules of the Hospital will be liable to be discharged. Any patient so discharged will not again be received into the Hospital without an order by the House Committee.

Telephone enquiries as to the condition of ordinary patients can be answered only

BETWEEN 9.30 and 10.30 a.m.

And 3.0 and 4.0 p.m.

Enquiries for patients on the **SPECIAL LIST** will be answered at any time. Patients on the **SPECIAL LIST** are those who are dangerously ill and operation cases immediately prior to and following their operations.

VISITING. Visiting days are Sundays and Wednesdays from 2 p.m. to 3.30 p.m. Patients are allowed two visitors only at the bedside at one time, and these must leave the Ward and hand over their visiting card before any other visitors can proceed to the Ward. No patient is allowed more than four visitors during any one visiting period. Children under 12 years of age cannot be admitted as visitors. With the exception of patients on the Special List, visiting cannot be allowed in the **Children's Wards**.

Relatives and friends are advised to include the **CHRISTIAN** Name(s) and **Ward** on all correspondence (especially Telegrams) addressed to patients at the Hospital.

DONATIONS. Any patient who wishes to make a donation to the Hospital as a mark of appreciation for the services which the hospital has given, can do so by the sending it to the House Governor's Office. Such donations will be gratefully acknowledged and be applied to the treatment of others who cannot afford to make provisions for their own treatment.

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