



Primary Care is more than Health

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Visionaries are not always popular. They challenge the status quo. Lord Darzi's clear vision is that primary care is more than health care. To somebody from a social care background that is music to the ears. Too often primary care has been seen as the exclusive prerogative of health. Indeed the Editor in Chief, theme editors, associate editors and Editorial Board members of this new journal are eloquent testimony to the medicalisation of primary care.

The mish mash of life problems which come to the GPs surgery - to adopt the Editor's phrase- may be housing related, may need social care services, or self-help groups to support the individuals.

Sometimes of course they need medical help but they also need a system which is also able to address these other problems without an endless trail of referral letters to other agencies.

The vision set out by Lord Darzi is appealing but how can it best be realised? The traditional response of politicians has been to seek structural solutions. The NHS has suffered at the hands of successive reorganisations which create discontinuity in the personal relationships which are essential for the delivery of partnership working. The chaotic introduction of PCTs means that only now 6 years on are they in a position to meet some of the wildly ambitious expectations set for them.

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Achieving those expectations means that patient experience has to be given a higher weighting than it has had hitherto despite countless ministerial speeches asserting Patients First.

The saga of mixed sex accommodation is salutary. What Ministers and hospital managers construe as single sex accommodation is not what patients mean.

Until adjustments are made to management thinking this issue will continue to rank high on the list of patient grievances, rendered more acute because of the much trumpeted commitment to eliminate mixed wards.

User experience needs to dictate the future pattern of primary care provision.

And what users want is ease of access and seamless services. In a highly mobile society like London with new arrivals from around the globe the traditional model of general practice has to be adjusted. What works in Bromley may not be right for Inner London so it has to be a locally tailored approach.

The pressure on A and E from those who could be dealt with in GP surgeries will not be dealt with by triage schemes or placing GPs in A and E. Patients come to hospitals because they are seen to offer greater security, 24 hour access and sometimes because their own background and culture has no equivalent of the GP.

Darzi makes it clear that polyclinics are a way of thinking rather than a sparkling set of new buildings and calls for experimentation with different models. Those models have to include social care provision. Having launched the current debate about the future of social care Minister seem to have ruled out as too expensive the Scottish system of free personal care.

If that is the case **we need urgently to find ways of addressing the tension between those services which are free at the point of access and those which are to be part funded by service users.** This tension is played out in the issue of personalisation (surely one of the ugliest buzzwords in current usage).

Those with long-term care needs including older people are being encouraged to manage their own individual budgets thus giving much wider choice and cutting out the bureaucratic infrastructure. Yet this group who most need integrated health and social care struggle to understand what they are entitled to free of charge and what they have to pay for- sometimes it is the accident of who they saw first which dictates the basis of services. That is neither rational nor equitable. The Department of Health is reported to be considering a pilot of individual budgets which would include both health and social care. Mental health where both elements are essential to the well being of patients could be fertile territory for such a pilot.

In thinking about integrated health and social care it is refreshing that Lord Darzi is not fixated about structures. We have had a surfeit of suggestions from the Northern Ireland model through to local authority commissioning health care instead of PCTs given their statutory responsibility for community well being. It is however **people who make structures work, not the other round.** And there is no substitute for the face to face communication within a multi disciplinary team to think through the best way to create services which

are centred on the patient. The phrase multi disciplinary team suggests a plethora of professionals.

A genuinely patient centred approach would have the patient and family carers as part of the team together with voluntary sector groups and self help groups.

So a few modest suggestions;

1. A pilot of individual budgets covering both health and social care in mental health
2. Experiment with different models of polyclinics
3. Recognise that local solutions to local needs means a postcode lottery in that Hackney and Harrow may want different models
4. **Seize the retirement of many single handed GPs in the next few years as an opportunity to reshape primary health care**

And perhaps Mr Editor make certain the journal is about primary care in its widest sense and reflects the contribution of other agencies to good quality services to people in need !