The government's opening bid is 8 am till 8 pm, seven days a week, but this is simply a non-starter because we don't have the capacity
Des Spence, p 39

Practice based multidisciplinary teams are crucial

General practice should be the hub of healthcare. **Richard Watton** asks why practice based teams are being dismantled

Practice based multidisciplinary primary healthcare teams are being dismantled and replaced with geographically based teams that do not contain general practitioners. Let our experience be a wake up call: there may be unintended consequences. Remember out of hours care? No one intended to make this worse, but a shambles was created simply by taking frontline responsibility from general practitioners.

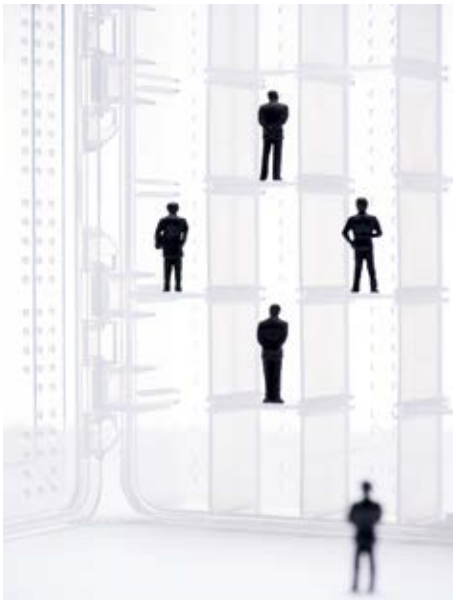
Thirty years ago we had a social worker, health visitor, physiotherapist, community psychiatric nurse, midwife, and a small team of district nurses all attached to the practice. We were a working team.[1 2] We discussed patients informally every day, and we met formally once a week.

We have lost these workers one by one. The social worker was removed when social workers ceased to be generic. She was replaced with a flow diagram showing us how effective the lines of communication would be between us and social services. That was the start of our interaction with social services becoming less frequent and often less helpful to us and them.

Then health visitors became geographically based to match their working boundaries with those used by social services. Now no health visitor attends our team meeting because their area of geographical responsibility relates to too many practices. Effective child care and child protection are now more difficult.

A physiotherapist used to see our patients in clinics at the surgery, visit our patients at home, and attend team meetings. Physiotherapy services were tendered out. The clinic based service went to one provider and the domiciliary service to another. Neither was funded to attend our meeting. The psychiatric nurse went to the community psychiatric team and they don't have sufficient staffing to attend our meeting. The midwife does her best to balance her commitments to our practice with her commitments to other practices and to the obstetric unit, but can rarely attend.

Now the district nurses are going, amalgamated with three other teams and based in a building separate from the general practices they are supposed to support. So far no other professional groups have been persuaded to join them. Even if they do create a working multiprofessional team rather than just housing other professions in the same building, this model would still be flawed because it would be a primary healthcare team with no general practitioners. To create a team without close working relationships between doctors, nurses, and other healthcare professionals shows a lack of understanding of the fundamentals of primary care teams.



The idea was that geographically based working would be better than practice based teams. It was a failure and was abandoned after a few years

To think that two separate teams sending delegates to each other's meetings and communicating by fax or telephone is an adequate substitute for effective teamworking is to misunderstand the principles of teamwork.

The changes have been planned by clever, well intentioned people from various backgrounds whose common feature seems to be little if any recent experience of frontline work as part of a primary healthcare team. For example, I wonder if effective care could be arranged for a patient who wanted to die at home when the doctors and district nurses are in separate teams; have not had the opportunity to discuss patient care or symptom control regularly; and fax is the method of communication recommended by their management.

I do not claim greater knowledge than the people involved in planning these changes, but my colleagues and I do claim far greater experience. Not only have we worked in an integrated team for 30 years, but also 12 years ago we lived through similar changes. All the non-medical professionals were moved from local practices to geographical bases. The idea was that geographically based working would be better than practice based teams. It was a failure and was abandoned after a few years.

The Royal College of General Practitioners recently restated that general practice should be the hub of healthcare.[3] Other resources can be regarded as spokes of the wheel. Experience shows that a practice based team approach is the best way to deliver care, particularly in deprived communities.

We need to provide more care in the community and reduce hospital admissions, but there is no evidence that geographically based primary healthcare teams that don't include general practitioners will do this. It is at best unproved and at face value nonsense.

Health and social care need to be integrated, but ways of doing this must be found that do not undermine established teams. Taking district nurses out of practice based teams does just that. This can only lead to worse continuity of patient care, lessening of the ability of the teams to cope with illness in the community, and an increase in admissions, not a decrease.[4 5]

Clinical commissioning groups must use their influence and power to ensure that when district nursing services are purchased in the future they are purchased in the form that will be most effective in delivering healthcare—that is, attached to practices always and practice based where possible. This is what most general practitioners want.

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FROM THE FRONTLINE **Des Spence**

General practice 8 till 8

Was Jeremy Hunt sincere in his support for the NHS and general practice at the Royal College of General Practitioners' conference earlier this month? Time will tell. But I did agree: primary care needs to be more accessible "out of hours"[1]—an idea as popular as spam fritters and mushy peas in general practice circles.

We already have out of hours services that provide cover. Why do we need more? Will more availability actually reduce pressure on emergency departments? And who will fund and provide increased capacity and access?

There is a need for more and better out of hours care. Currently, services are difficult to access and risk averse; often employ inexperienced doctors; and have limited access to patients' records. And many patients side step these services and go straight to accident and emergency.

Also, working people (our employers) are frustrated by our limited opening hours and having to wait weeks for routine appointments. The public considers us very well paid. But doctors are blind to these concerns because we are not NHS service users—we queue jump through our contacts. There is a strong public case for more access and weekend work. The government's opening bid is 8 am till 8 pm, seven days a week, but this is simply a non-starter because we don't have the capacity.

We could provide some evening surgeries during the week and morning surgeries at weekends

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So how can we improve the situation, most likely with no more money? Firstly, £1bn (€1.2bn; $1.6bn) a year is tied up in the quality and outcomes framework. Kill this half baked, overcomplicated, bureaucratic monster to free vast resources. Secondly, out of hours care is expensive: every telephone call costs at least £8,[2] and face to face consultations much more. Release some of these funds to local general practices. Thirdly, there are calls for more general practitioners.[3] This would be expensive and unnecessary. Most GPs work part time and indeed many today consider seven sessions a week "full time." If incentives can be given to encourage GPs to work two to four additional sessions a month this would hugely increase capacity.

So what is a practical response to the government if we reallocate current resources? Local practices could offer local telephone triage every day from 8 till 8. We could provide some evening surgeries during the week and morning surgeries at weekends. This would take the strain off emergency departments, improve the quality of care out of hours, and tackle the problem of access. This will require negotiation but it is feasible. The positive effect would be cooperative working between smaller practices and more mergers.

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DRUG TALES AND OTHER STORIES **Robin Ferner**

Raising more antibodies

Emil von Behring, who won the first Nobel prize for medicine, discovered antibodies against diphtheria toxin in 1890 and realised that the antibodies could neutralise the toxin.[1] Von Behring's work inspired Albert Calmette to raise antibodies to cobra venom in horses. Equine antivenin may stop you dying, but early reactions to it are common, and include rash, vomiting, abdominal pain, fevers and rigors, pruritus, dyspnoea, and hypotensive collapse.[5] More rarely it can provoke serum sickness.

A prescient *BMJ* editorialist wrote in 1981: "Monoclonal antibodies are expected to prove useful in three major aspects: the isolation and purification of rare antibodies and antigens, diagnosis, and treatment."[6] Engineered antibodies now furnish a host of selective MABs—monoclonal antibodies that hit the target, whether it is glycoprotein IIb/IIIa on platelets (abciximab), or the p40 protein subunit of the human cytokines IL-12 and IL-23 (ustekinumab), or somewhere in between. The names are potentially informative: -xi- means human-foreign hybrid, and -u- means pure human origin, while -ci- and -kin- refer respectively to cardiovascular and interleukin targets. Unless you work at Bletchley Park, though, it helps to have the codebook.[7]

Now rheumatology department specialist nurses infuse high cost, high efficacy antibodies into ambulant patients, who would in the past have been wheelchair bound. Monoclonals are increasingly important in fighting malignant disease, "naked" or attached to radioisotopes.[8]

Sadly, success is not guaranteed. Nebacumab (HA-1A, Centoxin), an IgM monoclonal antibody against the lipid A domain of endotoxin, should have been an effective treatment for endotoxic shock.[11] It didn't work.[12] Natalizumab, which reinforces the blood-brain barrier by targeting α4 integrins, increases the risk of a rapidly progressive multifocal leucoencephalopathy.[13] Now it seems that rituximab encourages reactivation of hepatitis B virus.[14]

Now specialist nurses infuse high cost, high efficacy antibodies into ambulant patients, who would in the past have been wheelchair bound

Infusion reactions are still a problem even with monoclonals, but things may improve. It seems that llamas and their camelid cousins make antibodies without light chains. These should be less immunogenic and easier to manipulate, so we are within spitting distance of better antibodies for treating human disease.[15]

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