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DOING DIFFERENT THINGS IN A DIFFERENT WAY: Possibilities for the post-Tomlinson primary and community health services development programme for London

Aim

To provide all Londoners with primary and community health services which both meet their needs for high quality health care and which - over time - can appropriately substitute for certain services currently provided in acute hospitals.

Strategic objectives

If Sir Bernard Tomlinson's recommendations are broadly followed, and primary and community health services are to improve at the same time as London's acute hospital beds are reduced, any development programme for primary care must pursue three strategic objectives simultaneously:

* **A remedial programme**

  This should aim to make up the acknowledged deficit in general practice and community nursing in London and bring these services in line with national standards.

  This will mean investment in the 46 percent of London GP premises which the Tomlinson report has identified as substandard. It will also involve improving the calibre of primary and community health services currently available to central London residents.

* **A service development programme to provide 'non standard' services to groups for whom the traditional family-of-fixed-abode model of primary care is inappropriate**

  Here the aim will be to devise a pattern of services geared to the needs of mobile and/or marginalised Londoners. These groups of Londoners are themselves very diverse. They include highly mobile young people and families, commuters and tourists, as well as disadvantaged groups such as refugees; some people from ethnic minorities; homeless and rootless people; homeless families and substance abusers.

  There are a rich mix of pilot and project-based experiments to draw on when attempting to make health services more accessible to marginalised groups. They include 'sick bay' services for homeless and rootless people; salaried GP or community nurse-based services for bed and breakfast families; interpretation and advocacy arrangements for people from ethnic minorities; and 'outreach' teams for substance abusers and street and hostel dwellers with mental health problems.

The particular needs of London's mobile residents, commuters and tourists have been less well explored, but possible areas of service development include an expanded role for primary health care in accident and emergency departments - as has been pioneered at King's College Hospital - and North American style 'ambulatory care centres', or continental polyclinics.

In the twelve years since the Acheson report documented the poor quality of primary and community health services in inner-London, much has been learned about how to provide a range of more accessible services in the inner city. The challenge will be to build on the wealth of this experience of innovation in a way that makes health services more accessible without creating a special 'ghetto' service for the inner city. This suggests that these services must be carefully integrated with mainstream health care provision.

* **A service development programme to provide an 'expanded model' for primary care**

The aim here would be to facilitate a shift of hospital based provision into high quality services based in the community. Here the challenge is not so much remedial as to move ahead of the rest of the country towards patterns of care that are likely to become much more common in the 21st century.

To achieve this, a diversity of developments will be needed, including shared care agreements and collaboration over protocols between GPs and consultants for the diagnosis and treatment of a substantial number of conditions; new roles and ways of working for community nurses, to encourage a wide range of specialist and generalist practice; 'hospital at home' and other high intensity home care schemes, including terminal care; developments in community-based specialist working such as paediatric home care and mental health and learning disabilities teams as well as the move of appropriate specialist referral clinics from hospital outpatients' departments into primary health care settings - if possible, with the active collaboration of general practitioners (GPs) and community nurses.

Once again, there is an opportunity to learn from the wealth of experimental and pilot models that have already been developed in London and elsewhere. To be successful, service development of this kind will need to inspire enthusiasm for change amongst London practitioners, and then build on their ideas and creativity in a positive way.

Appendix 1 gives examples of some 'expanded care' developments to illustrate ways in which primary care could extend its remit.

The scope of the development programme

To be effective in fulfilling its strategic objectives, the scale and scope of the development programme will need to go well beyond traditional methods of spreading good practice within the NHS. The programme should develop incentives for the provision of services tailored to the needs of practice populations, and to remove existing obstacles to high quality service provision.

Changes will need to be patient centred: investments must have demonstrable outcomes in terms of improved primary and community health services for Londoners. Thus, the programme must amount to much more than simple investments in bricks and mortar and go well beyond conventional methods of professional development for primary care practitioners. Crucially, they must be about service development.

To be successful in this, the programme should devise mechanisms for change which are not wholly dependent upon practitioners' preferences. At its best, primary care is both flexible and diverse: in London both these qualities will need to be channelled towards agreed programme objectives.

True partnerships between Family Health Services Authorities (FHSAs), Community Health Services (CHS) and Local Authorities (LAs) will also be needed, as well as the involvement of local people in service design and monitoring. London neighbourhoods are very different from one another. No one model of primary and community health services will be appropriate city-wide. If the changes are to command public understanding and support, Londoners must play an active part in shaping their local service mix to meet needs which they have helped identify. This is not just a matter of going through the motions of consultation. If communities have been actively involved in shaping new service patterns they are far more likely to defend them when they come under criticism.

At the same time, the managerial capacities of FHSAs and Community Units - both Trusts and Directly Managed Units (DMUs) - should be strengthened to permit them to meet the considerable challenges that they face as commissioners and providers of primary health care in London. Shared understandings about what constitutes good services will need to be developed between them, their local authority and private and voluntary sector partners, and district and regional health authorities. This cannot be assumed: most DHA and RHA managers have spent their careers in the acute sector, and have little understanding of the interlocking network of roles, relationships and agencies which make up primary and community health services.

LIZ: A primary health care development zone for London

A development zone for London's primary care - or "London Initiative Zone" (LIZ) as it is becoming known - could provide a focus for the concerted development of better services, and in the new premises, staffing and organisational arrangements needed deliver them. It should help provide the sustained support that health authorities are likely to need in order to maintain a focus on primary and community health services.

If investments are to be productive in terms of improved services for patients, however, the LIZ development programme must be carefully phased, and its new forms of service evaluated. The sections which follow suggest a possible form for this development programme, over a five year period.

A process for development

Service audit

FHSAs, DHAs, CHS, LAs within the zone should join forces with local providers to conduct an urgent analysis of existing services in their particular patches; their staffing; and the capital stock available for primary and community health services. This 'mapping' process would aim at an honest assessment of the strengths and weaknesses of existing services, and existing linkages between primary and secondary health care and between the NHS and local authority social services. It should pinpoint places where those linkages could usefully be improved. Local people or their representatives should be involved in these assessments.

A development plan

This analysis, together with information about the health status and needs of the population served, would form the basis of a local development plan - probably (although not necessarily) based upon FHSA areas. By plan we do not mean a fixed blueprint, nor volumes of paper, but a selective strategy to initiate and encourage change in a defined geographical area.

Plans would need to be agreed between FHSAs, DHAs, local authorities, and community representatives before LIZ funds were released. To develop them, the agencies would need to involve local providers and community representatives in detailed discussions about future service development.

Such plans should be able to demonstrate their capacity for evolving a new pattern of care that will meet all three of the strategic objectives for the LIZ programme listed above: remedial work; service development for groups disadvantaged by the traditional 'family of fixed abode' model of primary health care; and developments designed to shift appropriate services from acute into primary and community settings. They should also be able to demonstrate how the relevant authorities intend to cooperate with each other and with private and voluntary organisations to develop joint or

complementary approaches to service delivery.

Local plans will need to support their service development strategy with detailed plans for investments in premises; for staffing; for the organisational development of practices and community services ("teambuilding"); and for their improved management. In practice, such plans are only likely to succeed if they document changes to which providers themselves are already committed.

Mechanisms for change

A variety of mechanisms for change will be needed if the LIZ is to work effectively to enable FHSAs, DHAs, community health services and Local Authorities to make swift, concerted improvements in the primary care services available to Londoners:

1. Attracting and retaining high quality practitioners

Existing contractual arrangements are inadequate as a means both of attracting more high calibre practitioners to work in London and of rewarding them for providing an appropriate range of services. In fact, for GPs, the present system of capitation payments and deprivation allowances is, if anything, an incentive to maintaining a large list and doing relatively little with it. The fact that many do much more than this is a tribute to them as individuals, rather than a credit to the system as it stands.

Within the initiative zone, a range of new incentives need to be devised both to attract high calibre general practitioners and other primary health care workers to the inner city and to encourage them to to provide the right kind of services. In the case of general practitioners, it may be necessary for FHSAs within the zone to take on delegated authority from the Medical Practices Committee (MPC) for GP recruitment and for approved average list sizes. There is also a case for new forms of contracts, including salaried work for GPs, job sharing, part-time working, job rotations and time-limited, renewable commitments to a practice, as variations on traditional partnership arrangements.

Possibilities for a wider range of incentives linked to service development include:

* Remuneration packages with payments linked to the achievement of agreed service delivery targets for deprived or underserved populations (for example, services to bed-and-breakfast families; interpretation facilities for local ethnic minority languages, etc); for services which fulfill *Health of the Nation* and/or *Caring for People* objectives; and/or for 'shared care' and other arrangements which reduce dependence on hospital-based services.

* The introduction of innovative options for GP

out-of-hours coverage with appropriate remuneration attached.

* Incentive payments for providing medical cover to local community care centres or nursing bed units.
* the use of health promotion funds to encourage opportunistic health promotion activities according to agreed criteria; the development of 'at risk' registers; and an information base for practice list needs assessment.

2. 'Exit' arrangements

It may be useful for FHSAs within the zone to take on responsibility for arranging early retirement packages, where these can be demonstrated to be in the interests of the service.

3. Premises improvement

Problems with the quantity and quality of primary health care staffing in London are partly a reflection of the capital's long standing problem with primary health care premises. A combination of high site values, unpleasant locations and planning problems have meant that large, management oriented practices are a rarity in the capital. In practice, it can be extremely difficult to locate a large enough site which is accessible to the practice population, to obtain planning permission, and then to finance a suitable building. But without a suitable building, practices can neither employ their own staff nor encourage CHS attachments. The cost-rent schemes which have worked well in other parts of the country have largely failed in London. New mechanisms - and new monies - are needed. These might include:

* additional London weighting for cost-rent schemes;
* FHSA part-ownership schemes;
* the separation of premises ownership from GP pension arrangements.
* work with the London Boroughs within the zone on expediting planning procedures for primary health care premises.
* the development of expertise in the design of primary health care premises.

4. Relationships between primary and secondary services

The gap between primary and secondary health care has tended to be greater in London than elsewhere. In any development plan, ways of encouraging collaboration between primary health care practitioners - both doctors and nurses - and their hospital-based colleagues need to be actively pursued. Possible means of doing this might include:

* Incentives for improved collaboration between specialist teams and practice teams in the management of patients with long-term conditions, to agreed standards and criteria.

* Incentives for the relocation of appropriate specialty referral clinics in primary health care premises. This should be done in a way that will permit collaborative working between general practitioners and other members of the primary health care team and their consultant colleagues. Simply relocating traditional hospital outpatients' clinics in health centres will be insufficient.

At the moment London's hospital doctors are dismayed by past retrenchement and the prospects of further cuts. It is imperative to encourage them to come forward with innovative ideas for more effective and efficient ways of linking primary and secondary care.

5. Training and staff development

Delivering improved primary care to Londoners will depend both on new resources and on the individual capabilities of primary health care practitioners from a range of disciplines *and* on their ability to work together. Ways of building these skills and capabilities in ways which relate to the health needs of particular practice populations could include:

* Support for post-graduate and further education being linked to personal development plans for individual practitioners and members of the team. Where appropriate, these could reflect local service development priorities.

* Management development, 'teambuilding' and organisational development plans could be worked up by practices in the light of local service priorities, and approved and funded by FHSAs.

However, a great deal of thought will should take place in the training and staff development sphere, especially as the development of the 'expanded' model of primary care begins to call for new roles and different ways of working from service providers. This will be true both for general practitioner training and for community nurses.

6. **New management arrangements for primary health care providers**

Many smaller and single-handed practices in London provide good quality and highly valued care. However, because of their size, many of these will find it difficult to provide a wider range of services. 'Consortia' arrangements and other ways of linking such practices with each other, with the CHS and local authority social services and/or with larger practices or secondary care providers will need to be developed.

7. **Management development for FHSAs, DHAs and community units**

If the key agencies responsible for managing the capital's primary health care provision are to be effective at implementing a development programme of this scale and magnitude, it will be important to invest in and develop their own management capabilities.

Who belongs in the LIZ?

Any system of 'zoning' which gives special status and extra funds to one set of authorities and not to others is bound to create winners and losers - and frustrations for those outside the magic line. In London, this issue will need to be handled sensitively if it is not to exacerbate the already perceptible disadvantage experienced in certain parts of deprived outer London. In many instances, what goes on inside the LIZ will be just as relevant outside it (and vice versa). People must not be made to feel that their problems and their efforts are of no interest simply because they are on the wrong side of an arbitrary divide.

Conclusion

A concerted development programme for London's primary and community health services is badly needed, but developing and implementing it will be a mammoth job. Nothing on a similar scale has been attempted within primary care over the lifetime of the National Health Service. However, its success will be critical to the calibre of the health services available to Londoners in the next century.

As such, it should be treated as a major programme of investment in the infrastructure of the capital, and appropriately resourced with both money, and the equally important human currency of ideas, creativity and enthusiasm. The programme will have succeeded if - in fifteen years time - primary health care in the capital has lost its status as the perennial national laggard; the quality of the services it offers matches or exceeds those enjoyed in the rest of England; and London has become a place where aspiring primary health care practitioners in all disciplines aim to work.

APPENDIX 1
AN 'EXPANDED MODEL' FOR PRIMARY CARE

The following case study examples are intended to provide concrete examples of the ways in which primary health care could extend its scope to cover certain aspects of the diagnosis, treatment, surveillance and care of patients that currently take place largely in acute care hospitals. These examples are not, of course, exhaustive - they are intended to be illustrative only.

Home support and hospital-at-home schemes

HOME SUPPORT FOR HIV/AIDS

The St Mary's home support team was set up to complement the role of primary care teams working with patients with HIV disease and AIDS in greater London and to ease the load on special hospital services. It comprises six specialist nurses, a GP-trained medical officer and a receptionist. The team provides practical nursing care, emotional support for carers and patients, and advice and guidance to primary care teams. It is hospital-based and the hospital is the main source of referral. However, an important part of the team's work is to liaise with the patient's GP and district nurses and to help mobilise community services. Its policy is to encourage patients to use the services of the primary care team and it has been successful in seventy-nine per cent of cases. "Inevitably, though reluctantly, the home support team occasionally assumed total care of a patient in the community." It sees educating primary care staff members about HIV and changing their attitudes as an important part of its role.

ORTHOPAEDIC HOME CARE

Specialist orthopaedic home care teams aim to return patients to their homes much sooner than usual after surgery. The Community Orthopaedic Project in Essex (COPE) is staffed by a community nurse, physiotherapist, social worker, occupational therapist and carpenter, who makes any necessary home adaptations. The scheme is not restricted to "young elderly" people, those with ideal home circumstances or those with otherwise good health. Sixty per cent of people using the scheme live alone, but most have some family member or friend who agrees to act as a carer with support from the COPE team. Research indicates that the scheme reduces stays in hospital by about fifty per cent.

THE PETERBOROUGH HOSPITAL AT HOME SCHEME

The Peterborough Hospital at Home Scheme was set up over ten years ago to treat at home patients who would otherwise occupy hospital beds. Twenty-four-hour nursing cover is available from the community nursing service with help from a bank of nurses and patients' aides. Medical responsibility rests with the GP. The majority of patients are elderly,

suffering from strokes and cancer, and many are terminally ill. Because it is a community-based scheme, links with GPs are better than with hospital consultants, and it has been more successful in preventing admission than in facilitating early discharge. Evaluation showed that the scheme was often cheaper than acute hospital care. However, many of the patients would not necessarily have been admitted to acute hospitals.

Better linkages between primary and secondary care

EXAMPLES OF SHARED CARE SCHEMES

* At the Whittington Hospital in North London, 65 per cent of local GP practices are now involved in a scheme which encourages them to provide systematic monitoring of their patients with diabetes. With GPs' help, consultants at the Whittington have constructed a computerised register of people with diabetes, and this is used to generate six-monthly 'prompt' letters to patients to make an appointment with their local practice for a thorough check up. These letters are signed by Whittington consultants. Monitoring is done by a variety of primary health care practitioners: in some practices it will be GPs; in others, practice nurses.

  Patients hold their own records, and evaluations have shown the 'prompt' system to have a 90 per cent success rate in terms of stimulating patients to seek monitoring from primary health care teams. Outcome evaluations have shown this method of diabetic monitoring to be as effective as hospital-based approaches, and more effective than leaving practices to fend for themselves. Patient and practitioner satisfaction with it is considerably higher than for traditional methods.

  Development of the diabetic register has gone hand-in-hand with a major educational effort on diabetic management for local GPs, which involved both the Department of Medicine at the Whittington and the Department of General Practice at the University College and Middlesex School of Medicine. Management protocols have been developed collaboratively, and primary health care practitioners now have much improved access to hospital resources, including speedy referral to specialists for at-risk cases and easy access to a dietician.

* In Doncaster, a multidisciplinary team consisting of a consultant neurologist, GP clinical assistant, liaison nurse and social worker supports people with epilepsy living in the community. Together with primary health care teams, they offer a comprehensive service based in the community.

* In Camberwell, the Primary Care Development Project established a working group of four GPs and two consultants who prepared a shared care scheme for the management of people with diabetes. Local GPs supported this activity and attended regular meetings for over a year to prepare the way for implementation of the scheme. They designed shared care cards and established a diabetes register. Two nurse facilitators were recruited to visit practices and help the primary health care teams organise systematic diabetic care. Their work centres on practice nurses.

* At Whipps Cross Hospital in north-east London a rheumatology nurse practitioner post has been established to whom GPs can refer patients directly in order to reduce pressure on the specialist clinic. She also makes visits to local surgeries.

A DIAGNOSTIC CENTRE IN THE NETHERLANDS

Since 1979, local GPs have been able to use a "diagnostic centre" in the university hospital in Maastricht. Its aims are to improve the service provided in primary health care and enhance cooperation between GPs and specialists. It offers consultation by telephone, devises protocols for diagnostic procedures, and audits GPs' diagnostic work-ups. To prepare for telephone consultation - which takes place at a mutually convenient time - the specialist uses detailed information about the patient provided by the GP. GPs using the centre are given feedback about their requests for diagnostic tests. This has resulted in more rational and efficient use of tests and an overall decrease in requests.

'Intermediate' or community care centres

PADDINGTON COMMUNITY HOSPITAL

The Paddington hospital had twenty-four beds staffed by nurses and auxiliaries. A physiotherapist, occupational therapist and social worker were based on the premises; a speech therapist, dietitian, and dentist visited when necessary. GPs admitted patients and provided twenty-four-hour medical cover. Despite predictions to the contrary, local GPs were keen to use the hospital and sixty-five doctors in twenty-five practices had admission rights. The hospital was exceptional in trying to involve such a large number of general practitioners. However, it was actively used by a minority of GPs, mainly those in group practice.

In its final year the hospital was used by five main categories of patient: rehabilitation (27%), carer relief (20%), convalescence (14%), acute medical (14%), and observation (12%). However, there were important changes in this pattern between 1982 and 1986, notably increases in the proportion of patients admitted from acute hospitals and in those admitted for carer relief, rehabilitation or convalescence, and a decrease in patients who were acutely

ill. Turnover of nursing staff created problems and some GPs said the time needed to care for patients in hospital was a drawback. Although the work of the hospital was closely monitored, it was impossible to evaluate its effectiveness or to make useful comparisons with other forms of care.

LAMBETH COMMUNITY CARE CENTRE

Lambeth Community Care Centre offers assessment, continuing care and rehabilitation to patients of thirty-eight GPs from ten local practices who have contracts to work at the centre. It has twenty beds, a day unit for thirty-five to fifty people and, in addition to nursing care, provides physiotherapy, chiropody, speech therapy, dentistry, social work and welfare rights assistance. Clinical responsibility for patients remains with the GP, who arranges twenty-four-hour medical cover, but care is planned and carried out by a multidisciplinary team. The centre has an explicit, patient-centred philosophy of care, which gives high priority to encouraging patients' autonomy. Community health staff and social work teams are encouraged to continue seeing patients while they are at the centre. Strong ties have been developed between the centre and the local community.

COMMUNITY NURSING BEDS

A different type of intermediate care is provided in Doncaster by a unit with ten beds to which community nurses can admit patients to give carers short-term respite. The unit was opened in 1980 and has strict admission criteria: patients should be elderly people receiving care at home from community nurses whose carers need relief on a planned basis to alleviate stress or because of a temporary crisis. The maximum length of stay is two weeks. Many patients require high dependency care. Medical cover is provided by the patient's own GP, but admissions and discharges are made by community nurses.

Primary care in an hospital accident and emergency department

GENERAL PRACTITIONERS IN A AND E

King's College Hospital sees primary health care as a legitimate part of the work of its accident and emergency (A and E) department. An experimental primary care service was set up in the department and has been evaluated over the last two years. Local GPs employed on a sessional basis see patients who are determined by the triage process to have problems of a primary care type. Forty per cent of attenders come into this category. Analysis of the results has shown that GPs managed the consultations equally effectively but very differently from accident and emergency medical staff, using fewer X-rays and tests, prescribing less frequently, and making fewper referrals to other hospital services and more to GPs. Levels of user satisfaction were high but primary care attendance rates did not increase during the

course of the study. There are plans to continue and extend this work, and it is already influencing the thinking of the local purchasing authority.

These results suggest that involving GPs in accident and emergency departments may have many benefits, including more appropriate care for patients, increasing the effectiveness and efficiency of accident and emergency services, savings in the use of hospital resources, improving the morale and job satisfaction of staff, and breaking down the professional barriers that exist between accident and emergency departments and local GPs. This is, however, just one way of managing the interface between accident and emergency and primary care. There may be others, including "walk-in" clinics associated with general practice that have been suggested as appropriate for some groups of people and some parts of central London.