AN OPTIMAL BALANCE?

Primary health care and acute hospital services in London

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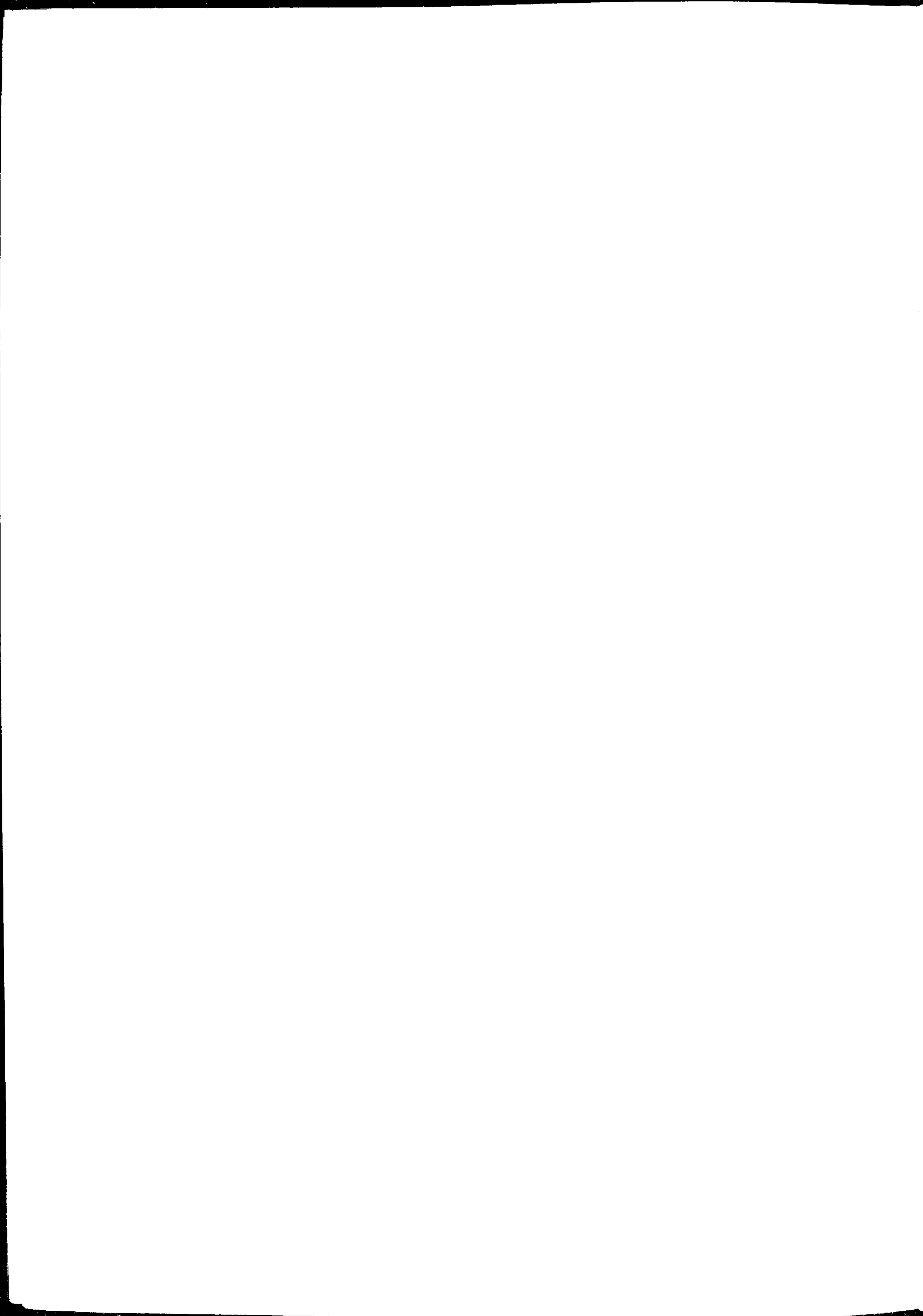

An Optimal Balance?

Primary health care and acute hospital services in London

Jane Hughes
Pat Gordon

King's Fund Centre

for the King's Fund Commission
on the Future of Acute Services in London

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EXECUTIVE SUMMARY

In the 1980s, after years of neglect, primary care became a major focus of government health policy. This was part of a worldwide trend which recognised primary care as the key to providing effective health services in the future. One consequence of this shift in policy is that it is no longer possible to discuss the future of any part of the NHS without considering the directions being taken by primary and community health services.

An Optimal Balance? explores the interface between acute hospitals and primary care. It describes developments which improve integration and shows how a shift towards primary care might be achieved. It goes on to examine the prospects for similar developments in London.

Chapter 2 describes the network of services which make up primary and community health services. As a whole they are much less visible and less well understood than hospital services but they are central to successfully meeting the government's aims for the NHS:

- earlier, safer discharge from hospital;
- more frail elderly people supported in their own homes;
- better co-ordinated, more flexible community care;
- more efficient and effective use of acute hospital services.

The interface between primary and secondary care

Chapter 3 explores the institutionalised separation of primary and secondary care in the NHS and the well-recognised problems this creates as patients move between hospital and community. It looks at the many different ways people have tried to improve communication about patients crossing the boundary between hospital and home. It also considers the reasons for inappropriate use of services, both in hospital and in the community.

Changing the balance between primary and secondary care

Chapter 4 describes alternatives to traditional ways of providing services in hospital beds, outpatient and accident and emergency departments. Four types of development are identified: putting primary care services into hospital buildings; moving out-patient clinics to general practice surgeries; providing care in people's own homes;

and establishing general practice beds in community hospitals. Case studies from Essex, Doncaster, Camberwell, Holland, Paddington, Lambeth and Peterborough are used as illustrations.

Could it happen in London?

Chapter 5 looks at the feasibility of introducing such developments in London on a scale sufficient to bring about a substantial shift from acute hospital care. Taking the 1981 Acheson Report as a benchmark, it discusses the infrastructure of primary care and highlights the changes that have taken place in the last ten years. It is optimistic about improvements but the most striking feature remains the variable quality and quantity of services in London. The image of a "rotten core" now seems too simplistic and it is recognised that different parts of London have very different constraints on developing better services.

The capacity to plan and manage primary and community health services has grown rapidly in the last decade. This chapter analyses the impact of this and other NHS reforms on London's primary care services.

An Optimal Balance? concludes that, while there is unlikely to be a "quick fix" to London's primary care problems, the current interest in relations between primary and secondary care opens up new possibilities for development. But without more resources and a more purposeful plan of development there is unlikely to be change on a scale large enough to support a substantial shift from acute hospital care. Five factors are listed which could accelerate change and encourage the spread of innovation:

- an investment programme for London's primary and community health services, which would not necessarily mean financing "more of the same";
- a London-wide strategy;
- regions becoming strategic development agencies for primary and community health services;
- growing alliances between general practitioners, as advocates for their patients, and health authorities as commissioners of services for their populations;
- combining the management of the family health services and community health services, to encourage high calibre managers and better integrated services.

Abbreviations

COPE	Community Orthopaedic Project in Essex
DHA	district health authority
FHSA	family health services authority
FPC	family practitioner committee
GP	general practitioner
LHPC	London Health Planning Consortium
NAO	National Audit Office
NHS	National Health Service

CHAPTER 1

Introduction

In the 1980s, after years of neglect, primary care became a major focus of government health policy. This was part of a worldwide trend which recognised primary care as the key to providing effective health services in the future (Ham *et al.*, 1990). An important consequence of this shift in policy is that it is no longer possible to discuss the future of any part of the NHS without considering the directions being taken by primary and community health services. Policy makers are now seeking better integration between primary and secondary care and want more care to be provided outside hospitals, by general practitioners (GPs) and associated community health services (NHS Management Executive, 1991).

This working paper for the King's Fund Commission on the Future of Acute Services in London is based on the assumption that change in this direction is desirable and inevitable. It explores the interface between acute hospitals and primary care, and describes developments that improve integration and show how a shift towards primary care might be achieved. It goes on to examine the prospects for similar developments being introduced on a wider scale in London.

Any review of primary care services must take as a benchmark the 1981 Acheson report, which was commissioned by the London Health Planning Consortium (LHPC) to define and suggest solutions to the problems of providing services in London (LHPC, 1981). It has not been superseded as the authoritative statement on primary care in London. We refer to it often, but we have not attempted to systematically update the detailed information it presented. Instead, our approach has been to highlight changes that have taken place since 1981 and, using practical examples, to illustrate what is happening at the "leading edge" of primary care nationally. As well as emphasising the possibilities for development, we have identified obstacles to change in London to give a realistic assessment of what progress might be made towards a more optimal balance between primary and secondary care in the foreseeable future.

Chapter 2 in this working paper gives a brief description of what is meant by primary care and provides a summary of recent policy developments which put primary care in context. The third chapter concentrates on the interface between primary and secondary care. It looks at how this interface might be managed more effectively, so that it does not become a barrier to care, and explores the issue of inappropriate use of services. Developments that span the traditional boundaries of primary care and hospital services are then described in Chapter 4, which give an indication of how relationships between

primary and secondary care may change in future. There are examples of GPs working in accident and emergency departments, services being relocated from hospital outpatient departments to GP surgeries, care being provided at home, and provision of GP beds in community hospitals.

Chapter 5 explores whether similar developments could happen on a wider scale in London. The shift away from hospitals and towards primary care is discussed in the context of London's unique social and demographic characteristics, its infrastructure of primary and community services, the capacity for managing and planning services, and the impact of the NHS reforms.

The final chapter pulls together some of the threads in the paper and identifies developments that could accelerate improvements in primary care and encourage a shift away from acute hospital services in London.

CHAPTER 2

Primary care

Primary care is a network of services that covers the whole spectrum of health and social care: prevention for the young and well, treatment of acute and chronic illness, rehabilitation, respite care, residential care, support at home for patients who are frail, elderly, disabled or acutely or chronically ill, and terminal care. Primary care is provided by general practitioners, health authority community health services, local authority social services, voluntary organisations, the private sector and unpaid carers who all play a part in that network.

Almost everyone in this country is registered with a general practitioner who is the doctor of first contact and the source of referral to other health professionals and agencies. GPs employ their own practice teams of receptionists, practice nurses and, increasingly, practice managers. Community nurses – district nurses, health visitors and school nurses – are the largest group of staff in health authority community units, which also include chiropodists, audiologists, clinical medical officers, physiotherapists, speech therapists and other specialists based in the community. Local authorities provide social services, home helps, residential care and day centres, as well as meals-on-wheels and loan schemes for equipment, aids and adaptations.

Services are delivered in a variety of locations – surgeries, health centres, residential care units, day centres and people's own homes – and as a whole are much less visible and less well understood than hospital services. Yet primary and community services play a vital role in the system of health care. These are the services that make it possible in this country to manage ninety per cent of care outside hospitals, to limit patients' length of stay in hospital and discharge them safely, and to maintain at home people who do not want to be institutionalised (Haggard, 1990).

The diversity of services and multiplicity of providers mean that collaboration is central to effective primary and community care. Services need to be planned and co-ordinated at a variety of levels to ensure reliable, integrated and appropriate care. This has to take place both "vertically" between primary and secondary care and "horizontally" between provider agencies in the community (Westland, 1990). Because three separate agencies – health authority, family health services authority (FHSA) and local authority – have responsibility for statutory services, planning is difficult but not impossible. Workers at street level who have patients and clients in common often collaborate more successfully than managers and planners in the various authorities.

In theory, one of the strengths of primary and community care is that it can respond quickly and easily to changed priorities, to newly

identified needs, or to local circumstances. It can be more flexible than services bound by the bricks and mortar of institutions. For example, in the last ten years there has been an increase in preventive work carried out in general practice. In London and other cities community health services have taken the lead in finding new ways of providing care to homeless families, ethnic minorities, housebound elderly people and other groups who find it difficult to use regular, mainstream provision. New and specialised services, such as stoma care and incontinence advice, have been established by community units. These developments have often been short term, under-resourced and poorly integrated with mainstream services, but they have been a source of ideas that have influenced the direction of services as a whole (Hughes, 1990a).

At its best, primary care in the NHS is known to be excellent, but it has also been shown to be fragmented, uneven, unaccountable and without adequate mechanisms "to ensure that all primary care reaches the level of the best" (Allsop, 1990). These problems have been most obvious in the inner cities. The 1981 Acheson report made a variety of recommendations to overcome the long-standing and severe difficulties of organising and delivering services in inner London and called for urgent action. These problems are discussed in more detail later in this working paper. General obstacles to improving standards in primary care have been lack of accountability of GPs, lack of investment, lack of power and managerial capacity in family practitioner committees (now FHSAs), and organisational discontinuities between district health authority services and general practice. In the last decade the government has introduced a number of measures designed to overcome these obstacles.

Government policy

From 1948 until the mid-1980s no fundamental changes were made to the organisation of primary and community health services. During the 1980s this altered dramatically and, for a variety of reasons, primary care became a focus for policy development (Allsop, 1990; Taylor, 1991). Here and abroad the rising costs of health care, demographic trends and changing patterns of illness led policy makers to place increased emphasis on prevention and to seek ways of providing care more economically outside hospitals.

In 1986 a green paper was published on improving primary care (Secretaries of State, 1986). A whole series of reports and enquiries followed and opened up debate on the future of primary and community care (Audit Commission, 1986; Secretaries of State, 1987; Marks, 1988; Griffiths, 1988). One result was a new GP contract which makes more explicit the services GPs are expected to provide in terms of hours of availability to patients, health checks and health promotion (DoH/WO, 1989). It encourages GPs to do more child health surveillance, care of patients with chronic conditions and minor surgery. For the first time GPs' pay has been linked to their performance in providing services to the whole practice population, rather than individual

patients. This is currently reflected in the target payments for childhood immunisations and cervical cytology. Practices must also submit annual reports to the FHSA. These changes and the introduction of computer technology to surgeries and FHSAs will allow GPs' activities to be more closely monitored and will eventually provide better information for service planning (Jenkins, 1990).

At the same time FHSAs, which hold the GP contracts, have been given increased responsibility, power and accountability. They are now responsible for providing services that meet the needs of their populations, actively managing resources rather than administering contracts, securing value for money, and ensuring quality of service. They are now accountable to regional health authorities for promoting better primary health care, and for the first time regions are responsible for integrating family practitioner services and hospital and community health services. According to Huntington (1990a) this "contains the potential for greater organisational integration and development of primary health care, which will be vital if we are to protect patient advocacy and the public health".

Community health services too have moved a long way in the 1980s following the introduction of general management and publication of the influential Cumberlege report (DHSS, 1986). Under the present wave of NHS reforms their future organisation is as yet unclear, but the scope for development is enormous as hospital stays shorten and home-based care expands (Beardshaw and Robinson, 1990).

Primary and community health services are now central to successfully meeting the government's aims for the NHS: earlier, safer discharge from hospital, more frail elderly people supported in their own homes, better co-ordinated, more flexible community care, and more efficient and effective use of acute hospital services (Haggard, 1990).

CHAPTER 3

The interface between primary and secondary care

In the NHS there is an institutionalised separation of primary and secondary care which creates well-recognised problems for integrating patient care between hospital and community. Exactly where the boundary between the two sectors is drawn is influenced by professional attitudes and practice, availability of equipment and resources, and public opinion. Well-established boundaries are valuable because they can help individual workers in complex organisations to gain a sense of identity and belonging. But boundaries can cause problems if they block communication, create confusion, delay treatment, cause patients to undergo unnecessary procedures, duplicate effort, increase costs, or reduce the likelihood of a positive outcome of care. Boundaries are inevitable; managing them so they do not become barriers is therefore central to achieving "seamless", high-quality services.

Communication

Patients move between primary and secondary care when they are referred by their GP to accident and emergency or outpatient departments, and when they are admitted to or discharged from hospital. Good communication is important to manage these transitions effectively but there is substantial evidence that communication often fails, with potentially adverse effects on the outcome of care for patients.

Both GPs and consultants feel that communication could be improved. Referral letters from GPs and consultants' replies are known to be an imperfect channel of communication (Wilkin and Dornan, 1990). GPs' letters are sometimes thought by consultants to contain insufficient clinical information and to lack a clear statement of the reason for the referral or the GP's expectations. GPs find some consultants' letters are too detailed, fail to answer the question asked and do not specify prescribing responsibilities. GPs and other primary care workers say they are often not notified quickly enough about hospital admission or discharge, and that they are not given sufficient information about the patient's treatment. A recent study in one inner-London practice found that staff had "incomplete and rather haphazard information about admissions and discharges" of elderly patients (Harding and Modell, 1989). Thus, even "a practice well-endowed with attached community staff and with close links to several nearby hospitals" could not respond reliably to give the support needed by patients and their carers.

People have tried many different ways of improving communi-

cation about patients crossing the boundary of primary and secondary care. Standard format letters have been suggested but not widely adopted (Wilkin and Dornan, 1990), and guidelines have been drawn up on the range of information to be included in referral letters (Marinker *et al.,* 1988). GPs and consultants feel there is scope for greater use of alternative channels of communication, particularly the telephone. Discussing patients can resolve problems quickly, and in some cases avoid attendance at an outpatient clinic (Hartog, 1988). Orthopaedic consultants in Doncaster have set aside a regular time when they are available for telephone consultation with GPs and this new service is being evaluated (Roland *et al.,* 1991).

Information technology will in time make transferring information between hospitals, general practices, community services and others quicker and easier (Pringle, 1990). The quality of information can be influenced by audit of referrals or discharges (Marinker *et al.,* 1988; Emmanuel and Walter, 1989). Standards for referral and discharge arrangements now being specified in the contracts between purchasers and providers of services will also help.

In general practice, protocols and guidelines for managing referral and investigation of patients are being developed. Shared care schemes, described in Chapter 4, can improve collaboration between hospital and community over the continuing care of certain groups of patients. The Department of Health is calling for hospitals to have written policies for discharging patients, so that the process is managed more efficiently and effectively (DoH, 1989). Unfortunately, the DoH guidance sees discharge planning as a medically-led activity. In reality, nurses, social workers and therapists play the central role. Up to now the emphasis has been on transmitting information from hospital to community services. As hospital stays shorten, it will be essential to establish two-way communication, to ensure that hospital staff have the information they need about a patient's circumstances early enough to prepare properly for discharge (Waters and Booth, 1991).

In London the difficulties of communication between primary and secondary care have been particularly severe. In 1981 the Acheson report noted that there had long been a "great divide ... between those working in the prestigious teaching hospitals and the GPs in the surrounding areas" (LHPC, 1981). Several years later, development projects in Tower Hamlets and Camberwell independently documented the practical problems this caused. Each side knew surprisingly little of the other (Allsop, 1990). GPs had no single source of information about the times of outpatient clinics, the services they provided and the names of consultants. Hospital staff had out-of-date lists of GPs and no details of the services offered by their practices. Even more importantly, managers did not give priority to fostering links between primary and secondary care. The projects themselves had to gather and disseminate much of the information necessary for making the connections that are essential to good patient care. These communication problems are by no means unique to London. A recent study of orthopaedic outpatient referrals in Doncaster revealed that some GPs seemed unaware that they could refer patients directly to hospital

services such as physiotherapy and the pain clinic (Roland *et al.,* 1991).

New channels of communication were opened in Camberwell: the project started a monthly information bulletin for GPs about district services and a series of "meet the department" meetings, at which consultants discussed with GPs the work of their department, the facilities it offered and clinical policies. These meetings were very popular with GPs, led to greater collaboration, and created opportunities for service developments which the project was able to support because of its base in the department of primary care at King's College Hospital Medical School (Morley *et al.*, 1991).

Other academic departments of public health and primary care have also taken a lead in supporting innovative practice and building better relationships between hospital consultants and local GPs. They have responded positively to Acheson's suggestion that they should accept some responsibility for fostering primary care in their localities (LHPC, 1981). They, in turn, have been strengthened by making links with younger GPs who have come into practice in the inner city in recent years. Some departments are now finding new roles as providers of independent medical advice to FHSAs – thus potentially extending their influence on primary care beyond the inner city. They are also at the forefront of fundamental changes in clinical medical education which, in the words of Professor Lesley Rees, dean of St Bartholomew's, "is moving from the hospital to the general practitioner's surgery" (Roberts, 1991). Teaching hospitals are finding it increasingly difficult to provide both suitable teachers and patients for their students. The case for basing more teaching in general practice was made persuasively in a recent *Lancet* editorial (Oswald, 1989), and this year, for the first time, students at King's College Hospital School of Medicine and Dentistry are being taught general medicine by GPs in their surgeries. So far, seven practices are involved at King's and the medical schools at University College and St Bartholomew's are said to be considering setting up similar schemes (Edwards, 1991).

This is just one illustration of how, by working together, GPs are beginning to establish closer links with the teaching hospitals. There are other examples of collective action by GPs, orchestrated by FHSAs, LMCs or GP forums, as well as academic departments, that aim to change relationships with hospital services and health authorities. Many are the direct result of the NHS reforms and the separation of purchasers and providers of services. GPs are beginning to recognise that presenting a "corporate view" of the shortcomings of local hospital services, as they experience them, could be a powerful force for change (Eve and Hodgkin, 1991). In Tower Hamlets, for example, the GP forum recognised the need for GPs to work together to influence purchasing arrangements and make an input into the contracting process. They commissioned the College of Health to collect information from local GPs about outpatient referrals and the quality of hospital services. The "ammunition" provided by this study has helped GPs to influence debates about what quality standards should be built into contracts for acute services (Hull *et al.,* 1991).

Purchasing authorities too are realising that GPs, with their first-

Box 3.1

INAPPROPRIATE HOSPITAL USE

Some reasons for inappropriate patterns of hospital use include:

- **less than optimal management of hospital resources (see, for example, Bosanquet and Fordham, 1987);**
- **insufficient support for acute services from other sectors, notably long-stay or geriatric beds, residential and community care, delaying patients' discharge once acute treatment is ended – the so-called "blocked bed" problem;**
- **a plentiful supply of hospital services causing low thresholds of referral, treatment and admission and enabling patients to remain in hospital for longer than average – the so-called "hungry hospital" syndrome, which is more apparent in some specialties than others (see, for example, Logan *et al.*, 1972; Roland and Morris, 1988);**
- **poorly-developed primary care services;**
- **professional attitudes and established clinical practices;**
- **public perceptions of the role, accessibility, acceptability and appropriateness of different forms of health care provision.**

hand knowledge of local services, can provide simple and direct assessments of the quality of hospital and community care. The results of a recent survey of GPs in Bristol led the purchasing health authority to change its priorities to reflect more closely the priorities of GPs. The authors suggest that forming close links with purchasing authorities may prove a more effective and efficient route for GPs to influence the provision of health care to their patients than fundholding (Hicks and Baker, 1991).

Inappropriate use of services

There are wide and unexplained variations in the rate of GP referrals to hospital services, use of outpatient services, the threshold for admission to hospital, waiting times for appointments and admissions, and patients' lengths of stay in hospital (see Box 3.1). Patterns of referral and hospital use tell us nothing in themselves about the efficiency or quality of care, but they have been the starting point for investigations into how appropriately services are being used. The focus has been on the misuse of expensive acute hospital services. It is generally agreed that a proportion of patients seen in accident and emergency and outpatient departments and using hospital beds could be more appropriately cared for elsewhere: in general practice, community clinics, other institutional provision, or by services delivered in their homes. Much less research attention has been given to inappropriate use of primary and community services, caused by long waiting times for outpatient appointments, delays in admission for acute care, or unplanned early discharge from hospital because of pressure on beds. In these circumstances, patients requiring acute levels of care are supported in the community by services that may not fully meet their needs. As the acute sector contracts, this may become an increasing problem if a planned expansion of supporting services in the community is not achieved simultaneously.

Hospital consultants are also concerned about the failure of GPs to refer patients who may need specialist care. Some say they are less worried by the few referrals they consider unnecessary, than by failure to refer or late referrals, which they perceive as more problematic and expensive (Wilkin and Dornan, 1990). However, this question has not been investigated thoroughly and there may be differences between hospitals and specialties in how referrals are viewed by consultants. In shortage specialities with long waiting times for outpatient appointments, such as orthopaedics and rheumatology, ways are being sought to manage more patients in primary care, reduce unnecessary referrals, and limit return visits to hospital (Helliwell and Wright, 1991; Roland *et al.*, 1991).

Attempts to resolve the problem of inappropriate use of acute hospital services involve examining the balance between acute hospital care, long-stay hospital provision, and primary and community care and finding ways of managing the boundaries more effectively. Some examples of recent developments that show the possibilities for change at the interface of primary and secondary care are discussed in the next chapter.

CHAPTER 4

Changing the balance between primary and secondary care

The leading proposals for transferring responsibilities from secondary to primary care were listed by Horder in 1985 as:

- more preventive work by GPs and primary care teams;
- more investigation in general practice, less in outpatients;
- fewer outpatient follow-up appointments;
- more minor surgery in general practice;
- more community hospitals;
- more "hospital at home" schemes.

These developments aim to get a better fit between patients' needs and the skills and resources available in different settings; to improve the effectiveness and efficiency of care; and in some cases to reduce its cost. However, Horder's (1985) observation that "All these proposals are contentious, if only because change is unwelcome" is just as valid today.

What alternatives are there to traditional ways of providing services in accident and emergency departments, outpatient clinics and hospital beds? Four categories of development can be identified: putting primary care into hospital accident and emergency departments, relocating services traditionally provided by outpatient clinics to GP surgeries, providing care at home, and establishing GP beds in community hospitals. These initiatives include rethinking existing roles and building new relationships in the delivery of services, creating entirely new roles for health workers, improving collaboration and communication, establishing new facilities, and developing innovative forms of care. They are described in more detail below. The examples used for illustration are mostly small-scale special projects, tested in one district and limited to a particular speciality or group of patients. Not all of them are in London. (In Chapter 5 we explore the prospects for similar developments spreading more widely in the capital.)

Putting primary care into hospitals

It has long been recognised that accident and emergency departments attract a proportion of people with non-urgent or minor conditions that could be dealt with in general practice. These patients are often described as "inappropriate attenders", despite studies showing that most have good reasons for deciding to go to hospital (Singh, 1988).

One-third to three-quarters of all attendances are deemed to fall into this category, according to the criteria used, and may be considered a burden by accident and emergency staff (Farmer and Chambers, 1982; Wong and Brazier, 1986; Cohen, 1987). Attempts to deter people from using accident and emergency departments for primary care have been largely unsuccessful: the "problem" seems to be remarkably widespread and persistent.

A study commissioned by the Acheson committee confirmed everyone's suspicion that inner-London accident and emergency departments are used as a source of primary care more frequently than departments in outlying hospitals (Farmer and Chambers, 1982). Part of the reason is the large number of commuters, visitors, tourists and temporary residents who are not registered with a local GP. However, the study also showed that the inner-London departments were more likely to investigate and admit patients, a finding that could not be explained by either the demographic characteristics of patients or the clinical severity of their complaints. The Acheson report (LHPC, 1981) recommended that inner-city accident and emergency departments face up squarely to their role as primary care providers – "it is inevitable that it will continue" – and equip themselves to fulfil it more effectively (LHPC, 1981). However, the majority have done little or nothing to change the way services are provided.

One exception is the accident and emergency department at King's College Hospital which has taken the approach suggested by Acheson and sees primary health care as a legitimate part of its work. 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 fewer referrals to other hospital services and more to GPs (Green *et al*., 1991). 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 (SELCA, 1991).

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. Once the results of the King's experiment are better known, similar schemes may be tried in other London hospitals. 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.

Box 4.1

SOME EXAMPLES OF SHARED CARE

- **In Doncaster support for primary epilepsy care is provided by a multidisciplinary team, including a consultant neurologist, GP clinical assistant, liaison nurse and social worker. Together with primary care teams they offer a comprehensive, community-based service to people with epilepsy (M. Taylor, 1989).**
- **At Whipps Cross Hospital in north-east London a rheumatology nurse practitioner post has been established to whom GPs can refer patients directly. The nurse also visits surgeries to discuss what the service can offer. The aim of the project is to modify GPs' referral patterns and reduce pressure on the specialist clinic (Wilkin and Dornan, 1990).**
- **In Camberwell, the Primary Care Development Project found a high level of interest in diabetic care among local GPs. The project set up a working group of four GPs and two consultants, who prepared a proposal for a shared care scheme. This was supported by local GPs who attended regular meetings for more than a year to do the groundwork for implementation, including designing shared care cards and establishing a diabetes register. Two nurse facilitators were recruited to visit practices and help the primary care teams organise systematic diabetic care. They work particularly with practice nurses. After three years the scheme is well established and meetings are held every two months for participating GPs and practice staff (Morley *et al.*, 1991).**

Moving from outpatient clinics to GP surgeries

A recent review of outpatient services by the National Audit Office (NAO) found large variations in waiting times for first outpatient appointments, in referral rates by GPs, and in policies on follow-up of patients, which raised questions about whether hospital resources were being used efficiently and effectively. Various suggestions were made to improve the planning, management and quality of services, including the need for consultants and GPs to review and clarify their respective responsibilities for care of patients with specific conditions. The NAO noted, however, that in most of the hospitals they visited this had not happened: "there were no clear standards and expectations for the referral of patients by general practitioners, or for the discharge of patients into the care of general practitioners" (NAO, 1991).

Although most outpatient services are still run along traditional and rigid lines, often to the dissatisfaction of patients and staff, alternatives are being developed to make services that were once provided only in a hospital clinic available in surgeries or health centres. One model is for hospital doctors to hold clinic sessions in GP premises. These initiatives tend to be idiosyncratic, isolated and involve only a few specialties, notably psychiatry, geriatrics and obstetrics. However, some fundholding practices have been quick to see that on-site outpatient clinics can both improve care and reduce costs (Benady and Barr, 1991). The aim is usually to increase attendance rates by making clinics more convenient for patients. Other purposes may be to improve communication with primary and community health staff, develop their skills and increase their experience of managing certain types of patients. Often, however, a traditional hospital outpatient service is simply relocated to a primary care setting, without otherwise altering the balance between primary and secondary care. In contrast, the shared care schemes which have more recently become popular have transferred responsibility for the care of some patients from hospital to primary care teams.

In shared care schemes GPs, practice teams and community health staff take on some or all of the routine management and monitoring of patients that has traditionally been done by hospital doctors in outpatient clinics. Usually a protocol is agreed which specifies who the patient sees when and where, and what examinations or tests should be carried out. Information may be exchanged through patient-held records or shared care cards. Perhaps the best known example is shared antenatal care, but growing numbers of GPs and consultants are sharing the management of patients with diabetes, asthma, hypertension and other chronic illnesses. Examples are given in Box 4.1. Some schemes have been initiated by enthusiastic consultants, others have started after pressure from a lobby of interested local GPs. Some health authorities and FHSAs have attempted to speed the process of developing shared care by employing liaison nurses or facilitators who help practices organise clinics and provide staff training (see, for example, MacKinnon *et al.*, 1989; Dant and Fraser, 1990).

The trend towards shared care has been fuelled by the increasing

employment of practice nurses, who play a central role in providing the primary care element of schemes for patients with chronic illness; growing numbers of vocationally-trained GPs who want to offer a comprehensive service and to keep up the skills and the special interests they developed during hospital training; the "computer revolution" in general practice which has greatly simplified identification and monitoring of patients with particular illnesses, and the new GP contract which offers a financial incentive in the form of fees for clinic sessions.

The development of effective shared care requires collaboration between GPs and consultants to agree a system and possibly to prepare protocols or clinical guidelines. This process may be important in itself for establishing personal contact, enhancing consultants' confidence in GPs' competence and increasing GPs' knowledge of hospital services and clinical policies. In some cases GPs have successfully negotiated direct access to additional diagnostic services to enable them to provide comprehensive care for their patients. For example, management of musculoskeletal disorders by GPs depends on open access to services such as radiology, physiotherapy and orthotics (Helliwell and Wright, 1991). Most shared care schemes maintain a clear separation between primary and secondary care, relocating work from one side of the boundary to the other. This is reflected in the way audit is built into shared care schemes: we know of no projects that attempt to assess the whole system of care; primary and secondary care are usually monitored independently, or the quality of primary care is monitored by the hospital department (Day *et al.,* 1987).

Where shared care works well, it can fundamentally change relationships between GPs and consultants and between doctors and nurses. It may also help to cement the bonds between team members working together to provide systematic care for a group of patients. GPs participating in shared antenatal care have also found a spin-off in terms of increasing their influence on local maternity care policies and the content of training provided by the hospital departments (Sloan, 1991). Consultants may even be prepared to relinquish care of low-risk pregnant women entirely to GPs and community midwives, such as in West Berkshire where half of all women now receive community obstetric care (Street *et al.,* 1991).

Shared care schemes are paving the way for GPs and primary care teams to form quite different relationships with consultants and hospital services in the future. There is potential for primary care teams to expand their roles in both diagnosis and treatment. In most areas GPs already have direct access to a range of hospital-based diagnostic services that they can use to help them decide whether referral to a specialist is necessary. Some consultants are keen to extend this idea and to enable GPs to do more diagnostic work and treatment themselves, but with much greater support from the hospital team than has been available in the past. Crucially, this involves replacing the current, inflexible system of formal, written referral of every patient who needs a specialist opinion with a much more informal, flexible system in which senior hospital doctors are readily available to GPs for consultation and advice. It may also involve introducing protocols for

Box 4.2

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 co-operation 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 (Pop and Winkens, 1989).

investigating particular conditions and GPs being trained to use more sophisticated or expensive diagnostic tests. One example of this way of working comes from the Netherlands (see Box 4.2).

In this country, open "colleague" relationships seem to be more common in the private sector, where consultants value and are prepared to invest time in building good relationships with GPs. There is already anecdotal evidence that the NHS reforms are stimulating consultants to take an unprecedented interest in their GP "clientele". Consultants with contracts to provide services to a district population will have an incentive to work more closely with local GPs – to get the kind of referrals they want and perhaps to negotiate changes in the balance of care away from hospital and towards the community. Some GPs may be prepared to extend the limits of shared care especially if they can claim clinic fees for this work. However, controls on clinics look set to tighten, with FHSAs narrowing their definitions of acceptable clinics rather than using these funds to develop innovative services (Jebb, 1990).

Providing care at home

When discussing initiatives that offer alternatives to caring for patients in acute hospital beds a distinction needs to be made between those which aim to solve the problem of inappropriate use of acute inpatient services and those which aim to provide an intensive level of care, similar to that available in hospitals, for patients in their own homes. Both these purposes, however, may be served by some initiatives, for example the Peterborough Hospital at Home Scheme described in Box 4.5.

Studies have consistently found that some patients in acute hospital beds can be considered "misplaced" and could be more appropriately cared for elsewhere. The proportion said to be misplaced varies widely and different definitions are used. The term "blocked bed" has been coined to describe the problem of inability to discharge patients: often, but not exclusively, those who are elderly and chronically ill. Bed blocking is caused by lack of alternative, more appropriate facilities for care, or by inefficiency and delay in the process of referring and discharging patients (Ashley *et al.*, 1981). The results of a recent census in St Mary's and St Charles' hospitals in London illustrate some of the issues (Victor, 1989). Twelve per cent of acute beds were occupied by elderly patients whose discharge was thought by staff to be "delayed". Overall, the main reason for delay was that patients were said to need nursing care. In the medical and surgical wards they were waiting for geriatric care or assessment. In the opinion of medical and nursing staff eight per cent of acute beds were "blocked" by elderly patients, most of whom were thought to require some form of long-term institutional care.

"Bed blocking seems inevitable in wards that are attempting to cope with the steadily increasing proportion of elderly patients according to traditional models of care," concluded Coid and Crome (1986), who investigated the blocked bed problem in Bromley. They saw a

particular need for acute specialties and geriatric and psychogeriatric services to work together more effectively. Solutions to "misplacement" of patients in acute hospital beds are likely to require changes in many aspects of the way care is currently organised and delivered, including the management of admission, referral and discharge; relationships between medical specialties; collaboration between health professionals and with social services; provision of services in long-stay institutions, nursing homes and in the community; and how these relate to acute services. Most studies of blocked beds identify a lack of long-stay institutional care. However, the hospital staff who assess patients may neither fully appreciate nor consider the whole range of alternatives to acute, inpatient care. One is care in a low technology unit which provides nursing care and rehabilitation, for example GP beds in community hospitals, which are discussed below. Another is care at home, and we go on here to explore how home care services are developing.

"Hospital care at home" is the term used to describe schemes which bring into the home intensive levels of care associated with acute hospitals, supplying medical, nursing and rehabilitation services as well as social support and equipment (Marks, 1990). This may be an alternative to hospital admission or a means of reducing length of stay in hospital by providing continuing care after discharge. However, in her review of developments in home care, Marks (1990) emphasises that it is not simply an extension of the trend towards earlier discharge from hospital, a way of reducing demands on acute beds, or a short-term, cost-cutting exercise. "It is the deliberate and planned relocation of hospital-style services and equipment into a home setting." Some schemes provide extremely specialised high technology care. All hospital care at home programmes represent a new way of thinking about the balance between home and hospital care.

Broadly, there are two organisational models for hospital at home schemes. The most common is the creation of a specialised team, usually hospital-based, often linked to a surgical speciality, which may seek to involve generalist primary and community health staff. Examples are the Community Orthopaedic Project in Essex (COPE) (see Box 4.3), the Peterborough Hip Fracture Project, and the home support team for patients with HIV, based at St Mary's Hospital, London (see Box 4.4). The other model is a community-based, generic hospital at home service for a geographically-defined population which admits patients with all types of illnesses. The Peterborough Hospital at Home Scheme (see Box 4.5) is this country's most famous example, but there are similar, smaller-scale schemes elsewhere: in London, Lewisham and North Southwark Health Authority started one some years ago (Brown and Gordon, 1987). Some community-based schemes are more specialised: there are teams which nurse sick children at home, for example in Doncaster and Southampton (Atwell and Gow, 1985), and North Manchester has a stroke rehabilitation team (Brown and Gordon, 1987).

The need to reduce the cost of hospital services has made care at home more attractive, but cost effectiveness has been confirmed only

Box 4.3

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 carer with support from the COPE team. Research indicates that the scheme reduces stays in hospital by about fifty per cent (Gaze, 1989).

Box 4.4

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 (Smits *et al.*, 1990).

Box 4.5

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, but many of the patients would not necessarily have been admitted to acute hospitals (D. Taylor, 1989; Marks, 1990).

for some types of high technology home care. The evidence for early discharge programmes is more equivocal. One important source of confusion is that although home care may be intended as a substitute for acute hospital care, in practice it may also be used as a substitute for home or inpatient hospice care, nursing home placement, care in geriatric units or no care at all (Marks, 1990).

The schemes have important implications for professional practice and the organisation of services. Their success depends on the willingness of doctors to admit, refer or discharge patients to schemes. Relationships with mainstream primary and community health services, particularly district nursing services, may need to be renegotiated. Many schemes also require the creation of new, less-specialised posts such as patient aides and care assistants (Marks, 1990).

Providers in the acute sector may like the simplicity of extending their services beyond the hospital by creating specialist "outreach" teams with the aim of reducing patients' length of stay. Individual,

Box 4.6

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" (Victor, 1988). 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 (Victor, 1988).

"add-on" schemes can work well in the short term for certain groups of patients in a defined and manageable catchment area. It is unlikely, however, that they would be successful in freeing "blocked" beds, whose occupants are likely to need a variety of longer-term provision and help from a range of professionals and agencies. In London, with all the complexities of acute hospital services, a potentially much greater impact on the balance of care could be made by developing generic, community-based hospital at home schemes, geographically organised and taking referrals from multiple acute care providers. Purchasers of local services may find it more attractive and economical to build on the strengths of existing local community health and social services, and to use these to offer alternatives to acute and long-stay hospital care.

Providing care in community hospitals

Community hospitals are usually low technology units with GPs responsible for admitting and discharging patients. They form only a small part of hospital provision and are mainly in rural areas. Nationally, about 11,000 beds are under GP control, used by about twenty per cent of all GPs (Jones, 1986; Grant, 1989). However, a further substantial number of GPs work in GP wards in large hospitals and in obstetric units.

Some see GP beds as anachronistic: a remnant of an outmoded model of care incompatible with modern ideas about general practice. However, a recent editorial in the *Journal of the Royal College of General Practitioners* made a powerful case that GP beds enhance standards of GP care and should be a part of future health service provision. Grant (1989) argued that with acute hospital services under increasing pressure to use their high cost, high technology and specialised services to maximum efficiency, there is a greater need than ever to provide an intermediate level of care for patients who require good nursing care, paramedical services and general medical supervision but are unable to remain at home. Varying estimates have been made of the proportion of patients in acute hospitals who could be cared for in GP beds. Studies in Finland and Oxford have shown that provision of GP beds reduces the use of acute hospital beds (Jones and Tucker, 1988).

Community hospitals have never been a significant feature of London's services, although some outer-London districts maintain a small number of GP beds and two new "community hospitals" were established in the inner city during the 1980s. Paddington Community Hospital opened in 1982 and was closed in 1987 following a financial crisis in the district (North *et al.*, 1984; Victor, 1988) (see Box 4.6). Since opening in 1985, after a long period of local campaigning and planning, Lambeth Community Care Centre has developed a unique style of care and offers an inspiring, if isolated, example of innovation (Higgs, 1985; Winn and King, 1988) (see Box 4.7).

Many factors will influence whether GP or community nursing beds (see Box 4.8) play a part in the future pattern of services in London. One key issue is whether GPs are willing to extend their role to

inpatient care. Surveys consistently find that about half are interested in these developments (Jones, 1986). The two London experiments described in Boxes 4.6 and 4.7 show that GPs, particularly those in group practices, will use beds for intermediate care without being offered any financial incentive. In future, fundholding practices may have a greater incentive to ensure patients are appropriately placed – savings on inpatient care being used to fund other service developments – and may find having their own beds an attractive option. What is currently missing and urgently needed is information about the effectiveness and costs of care in GP units compared with other forms of institutional care or care at home.

Box 4.7

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 (Winn and King, 1987).

Box 4.8

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 (Brown and Gordon, 1987).

CHAPTER 5 Could it happen in London?

All the developments discussed in the previous chapter have been shown to work on a small scale or on an experimental basis. The feasibility of transferring more of the work traditionally done by London's acute hospitals to community and primary care depends on a variety of factors. The prospects for extending shared care schemes, introducing more home care, and expanding community hospital provision must be assessed in the light of the characteristics of London and its population, the infrastructure of primary and community services, the capacity for managing and planning these services and the changes being introduced as a result of the NHS reforms. Each of these factors is explored in turn, to raise questions about the future balance of services between secondary and primary care in London rather than to offer definitive answers.

London – a special case?

Londoners have traditionally relied heavily on hospital services – because they were readily accessible and primary care was poorly developed – and this is a trend that has been difficult to reverse. One argument is that the special social, economic and environmental circumstances in the capital mean that a higher level of hospital-based services will continue to be required. Particular challenges to health service providers in London are the mobility of the population, people living in poverty, growing numbers of elderly people and their lack of family support, the ethnic diversity of the population, and those who are inadequately housed or homeless. The problems are not likely to lessen. Government policies have increased unemployment, deepened the poverty of those in the lowest-income groups, and caused a national housing crisis with dramatic effects in the capital.

High population mobility has important consequences for any preventive or continuing care programme based on general practice lists. Some practices report that forty per cent of their list changes each year and the rate may increase now that patients are able to change their GP more easily (Roberts, 1991). For GPs participating in shared care schemes this means extra work and increased costs compared to practices whose patients stay with them from the cradle to the grave. Housing conditions certainly place a limit on how many people could benefit from hospital at home schemes (D. Taylor, 1989). Poverty and the availability of carers also need to be taken into account, since care at home inevitably places extra demands on patients, their families and friends. While many people especially value the personal care and

continuity provided by GPs, a shift towards more GP-based services in London may further disadvantage the small but significant group of people who are not registered with a GP and who rely on direct access to services in hospitals, hostels, clinics and elsewhere (Victor *et al.*, 1989).

To move care out of hospitals and to successfully meet the needs of disadvantaged groups in London's population, schemes that have been developed elsewhere must be adapted to suit the London context. A single blueprint for services would be inappropriate however because London's neighbourhoods are so diverse (Powell, 1990). The ideas underpinning existing schemes could be taken as a starting point for developing initiatives compatible with needs in a particular locality. For example, Lambeth Community Care Centre was based on the community hospital concept. This was transformed by the planning team, in discussion with local people and practitioners, and the result was a unique facility right for those who use it and work in it (Higgs, 1985).

The infrastructure of primary and community care

The most striking feature of primary and community services in London is the variable quantity and quality of provision. At best their distribution seems unrelated to the population's needs; at worst, those with the greatest needs seem to be receiving the poorest care. However, the image promoted by the Acheson report (LHPC, 1981) of services in the capital having a "rotten core" may now be too simplistic. The report painted an unremittingly bleak picture of stagnant, unco-ordinated primary care services struggling – and

Box 5.1

THE ACHESON REPORT

In 1980, the London Health Planning Consortium appointed a study group, chaired by Professor Donald Acheson, to "define the problems of organising and delivering primary health care in inner London ... [and] to identify the measures required to overcome these problems". The study group's report, published in 1981, identified as the main difficulty slow development of general practitioner services in the capital. Compared with elsewhere in the country, inner London had few group practices, much higher proportions of single-handed and elderly practitioners, and few primary health care teams. Many doctors were practising from inadequate premises and were isolated from GP colleagues and other services in the community. In addition, health authorities had difficulty recruiting and retaining sufficient health visitors and district nurses. The implication was that standards of primary care in inner London were below those found elsewhere. The study group made 115 recommendations designed mainly to stimulate the development of general practice in London, by:

- **creating more attractive opportunities for GPs to enter practice, for example through retirement for elderly GPs and amalgamation of single-handed vacancies;**
- **improving practice premises;**
- **encouraging the formation of group practice;**
- **establishing well-resourced academic departments of general practice which would raise local standards of practice by providing continuing education to GPs and practice staff.**

Other measures aimed to:

- **increase staffing levels and improve working conditions for community nurses;**
- **improve the accessibility of primary care services to the public, especially disadvantaged groups;**
- **reduce the barriers, improve communication and integrate planning between GPs, health authority and local authority services.**

sometimes failing – to keep pace with the demands placed upon them (see Box 5.1). A legacy of the report's emphasis on the difficulty of improving services and its complex prescription for change has been persistent pessimism about the future of primary care in the city centre. However, in the last decade much has happened to make the future look more promising. In particular, the measures that have been introduced to increase managerial control over primary care services have created new possibilities for implementing change successfully in the inner city.

General practice

The infrastructure of general practice in London – the number of practices, size of partnerships, the extent of practice teams and the quality of premises – was one of the main concerns of the Acheson report. It showed that although most of inner London was "overdoctored" according to the criteria laid down by the Medical Practices Committee, general practice in the capital had not developed in the same way as elsewhere and did not offer the same opportunities for providing up-to-date, high-quality primary care. In 1979, single-handed practices were in the majority, a relatively high proportion of GPs continued working after the age of sixty-five, and many surgery premises were substandard. Few practice staff were employed and professional isolation was all too common. Inner London's declining population meant that there were few opportunities for younger, vocationally-trained GPs, with aspirations to provide a different style of primary care, to enter practice and change this pattern. Outer London was assumed to have similar, but less severe, problems.

Ten years later there has been sufficient change to show that the cycle can be broken in inner London, but that it has by no means caught up yet with the rest of the country. What seems to have happened is that a nucleus of dedicated and energetic younger GPs has worked against the odds to establish modern, adequately-resourced group practices in parts of the inner city. Their achievements have not been easily won (Siddy, 1986). Developing a run-down, inner-city practice can take five to ten years of hard work and substantial financial and emotional investment. This is often enough in itself to deter some doctors from starting.

Practices have found help from a variety of sources: entrepreneurial FHSA managers encouraging the formation of group practices and use of the cost rent scheme to improve premises, new monies for capital investment in some areas, facilitators and special development projects set up after the Acheson report, and employment of a wider range of practice staff. Many have received professional support from departments of primary care. However, not all GPs who want to improve standards have found the practical support, resources and encouragement that they need to carry their plans through (Dennis and Malin, 1988).

Diversity is still the strongest characteristic of London general practice: the best and the worst co-exist only streets apart. Doctors practising 1950s medicine, with rudimentary facilities and a "queue

outside the sickshop" before every surgery, can be found minutes away from groups which aspire to the "new, new general practice", are supported by extensive primary health care teams, modern equipment and computers, and give priority to prevention and anticipatory care (Livingstone and Widgery, 1990). It no longer makes sense to think in terms of a dichotomy between inner and outer city: "not all inner-city areas suffer from high need and poor general practice, while not all outer-city areas have low need and good general practice" (Powell, 1990). Researchers in other conurbations, for example Manchester, report similar findings (Wood, 1983a; 1983b). The quality and problems of general practice need to be assessed on a much smaller scale than they have been in the past.

Work by Bosanquet and Leese (1988) has shown that the area in which a practice is located influences its development strategy – that is, whether services are provided in innovative or traditional ways. Innovative practices are more common in rural and affluent suburban areas. They have more partners with a younger average age, are more likely to be computerised, and are more costly to run but likely to have higher incomes. Urban areas have more traditional practices with "low incomes and few practice resources" which "face great disincentives to investment" (Leese and Bosanquet, 1989). They found that even the innovative practices in urban areas were less able to take advantage of financial incentives and had a smaller margin available for developing their services. The authors therefore suggest that it is now more important to identify "areas of developmental difficulty" and to target these, rather than inner-city areas, for help to improve services. Others have warned that current policies will increase the polarisation between large well-run practices and small poor practices. "The former will have incentives to increase their staff and patients while the latter may struggle with diminished resources and increased commitments" (Allsop, 1990).

Different parts of London have different constraints on primary care service development, but premises remain the single most important obstacle to change in many districts. The reasons are complex: few suitable buildings may be available, costs of development are high, and GPs may be unwilling to make the necessary investment. However the current system of improving premises is viewed, it is an "inefficient way of achieving an appropriate stock of primary health care buildings for the 1990s and beyond" (Morley *et al.,* 1988). Poor premises limit the possibilities for developing services: for example, London practices employ about forty per cent fewer practice nurses and ancillary staff than the national average (Benzeval *et al.,* 1991).

Some areas of central London still have substantial numbers of elderly GPs and single-handed practices, but when vacancies arise there is usually no difficulty finding enthusiastic, vocationally-trained recruits. The picture is very different, however, in some multiply-deprived parts of outer London, such as Barking, which British-trained GPs find unattractive. Here recruitment is almost exclusively from overseas-trained doctors, who may have turned to general practice after finding their progress in hospital medicine blocked (Winkler,

1990). There is evidence that these practices have low incomes and are less innovative than practices established by British-trained GPs in more affluent areas (Bosanquet and Leese, 1988).

Community health services

Community health services in London are also uneven in quantity and quality. The Acheson and Harding reports first drew attention to the different levels of community nursing provision and the varying mixes of staff working in primary care (LHPC, 1981; Standing Medical Advisory Committee, 1981). In the late seventies and early eighties some districts, especially in central London, had serious difficulty recruiting and retaining enough trained and experienced staff to maintain basic levels of health visiting and district nursing services. Few primary care teams based on general practice had been developed and, where they had, there was evidence of a "Matthew effect"* exacerbating differences between well-endowed practices and others without teams (Joseph, 1989). Managers seem to have found this effect particularly difficult to counter in their resource allocation policies, and it has serious and long-standing consequences for inequalities in service provision.

Much has changed in community services in the last decade. In some districts they benefitted enormously from the introduction of general management, the stimulus of the Cumberlege report, and the decentralisation of management to localities. In the mid-eighties, despite many community units having to take their share of spending cuts, morale was high and staff felt they had found new purpose and direction. The pace of change was unprecedented, many developments taking place under the banner of assessing service quality and improving standards of care. Community nurses in particular have been keen to re-examine traditional methods and experiment with new forms of service delivery (Hughes, 1990b).

The rapid growth in the numbers of primary care facilitators and practice nurses in recent years has been welcomed by some as an increase in resources in the community (Robinson, 1990). However, a closer examination of these developments is required. From where have so many staff been recruited so quickly? Some managers suspect there has been "poaching" from the limited pool of trained and experienced community nurses, and they fear it will be increasingly difficult to replenish, especially in London where staffing problems are said to be getting worse again. In July 1991 the journal *Health Visitor* reported that thirty per cent of health visitor posts in Tower Hamlets were unfilled – a vacancy rate "of crisis proportions". What exactly are practice nurses doing? There is little reliable information, but it seems their major contribution is in the field of screening, health promotion and management of a few chronic illnesses. One thing is clear: they are not duplicating the district nurse's work of providing nursing care at home for elderly, disabled or acutely ill people, or the health visitor's role in child development surveillance.

Another cause for concern is the current rapid turnover in community health services management which has left some London

* "Unto every one that hath shall be given, and he shall have abundance; but from him that hath not shall be taken away even that which he hath."
St Matthew xxiv, 40.

districts without enough senior managers to maintain a high profile for community services in the health authority. Vacancies may be increasingly difficult to fill as a result of the NHS reforms and the new opportunities opening up in FHSAs. This depletion of management at such a crucial time in the development of provider units could clearly jeopardise the future of community health services in London.

The search for better co-ordination

An important thrust of developments in primary and community care in the last decade has been the search for better ways of co-ordinating services provided by different agencies and practitioners. The general practice-based primary health care team, neighbourhood nursing teams, patch working, locality management and case management have all been heralded as solutions to the problems caused by organisational and professional boundaries, the ideal being to provide "seamless" care for the client, with no fragmentation, duplication or gaps in services. Each method has its advocates, its strengths and weaknesses, and all have been tried in London. However, the particular method adopted may be less important than managers giving priority to integrating services and ensuring this aim is pursued actively from policy level to the point of delivery of services to individuals.

Drawing GPs into the process of developing comprehensive and co-ordinated primary and community services is a particular challenge. Various methods have been tried. In Newcastle, a "joint statement of intent" has been drawn up by the local medical committee and community health services management. It makes explicit that the primary health care team is the focus of providing care and gives a basis for negotiation about the development of services for which GPs and community health services are jointly responsible, such as child health surveillance, family planning, health promotion and immunisation (Brown and van Zwanenberg, 1989). In Coventry, a proposal has been put forward for "neighbourhood directorates" which provide a means for GPs to participate in the management of services (Taylor *et al.*, 1989).

In the development of community care, the important role GPs play as gatekeepers to other services is increasingly being recognised. For elderly and disabled people, and especially for some ethnic minority groups, GPs are the main point of contact with community care services (Cameron *et al.*, 1989). Current government policy is to "recognise and build upon the major role that GPs now play as providers of community care" (DoH, 1990a). However, little thought seems to have been given to the resources and support that GPs and community health staff may need to make a full and effective contribution to community care.

The infrastructure of primary and community services in London appears stronger in some respects than it was ten years ago. Many examples of innovation and change on a small, local scale can be found. These developments have tended to involve group practices, take place where community health services have been well managed and adequately resourced (or additional resources for development have

been made available), and require good collaboration between different service providers. Thus, to support a substantial shift away from acute hospital care the essential changes are:

- to accelerate the movement to group practices. Well-managed groups with practice teams allow GPs to organise their time efficiently, pursue their special interests and extend the range of services they offer to patients. It has been suggested that providing primary health care facilities, such as health centres, may be a more effective means of achieving this in the inner city than offering financial incentives (Smith and Barr, 1988);
- to maintain the integrity of community health services, and preserve a workforce large enough "to offer care seven days a week, with support systems such as communications, home loans and dressings, co-ordinated to a common pattern so that other organisations know what can be provided when they plan for care" (Haggard, 1990). Services need to be well organised and managed if they are to respond to changing needs, including more generic and specialised home care;
- to better co-ordinate the whole spectrum of primary and community care.

The challenge, then, to those responsible for managing and planning primary and community services is to establish an infrastructure of services that could support managed change on a much broader front than the largely unplanned "creeping development" of the 1980s.

From creeping development to managed change in the 1990s?

The Acheson report criticised the lack of co-ordination across primary and community services and between primary care and hospital services (LHPC, 1981). Planning was largely absent at all levels: from policy making at authority level to day-to-day co-operation between practitioners working in the same neighbourhood. One of the report's main concerns was to emphasise that family practitioner committees (FPCs) should take the lead in relation to improving practice premises and filling practice vacancies. These are decisions that can have a longlasting influence on patterns of general practice.

Since 1985 FHSAs have gradually accrued powers to help them manage and plan services more effectively, but they have varied in the speed and enthusiasm with which they have embraced their new role. The "new contract" for GPs, introduced in April 1990, has particularly extended FHSAs' powers to monitor the services provided by GPs. The contract has not been welcomed by the majority of GPs, who argue that it is increasing their workload with few obvious benefits for patients, and bringing few financial advantages, particularly for practices in urban areas (Chisholm, 1990; Morrell, 1991). Attitudes towards change have hardened. The new contract may succeed in getting GPs to do more screening, health promotion and some shared care, but there is little in it to encourage them to reclaim work from hospitals. Fees have been

introduced for minor surgery, but evidence is emerging that although more GPs are claiming minor surgery fees, the work they are doing will not significantly decrease demands on hospital services. Most claims are for injections and truly minor operations, such as cryotherapy to warts (Pulse, 1991). Even if GPs feel confident to carry out more complicated procedures, the current fee may not be a sufficient incentive.

However, the new contract has introduced the principle of relating payment for services to coverage of the practice population. This is a very different basis for remunerating GPs than item-of-service payments. Its simplest and most obvious application is in preventive services but it could be extended to other areas of treatment, opening up new possibilities for planning services on a population basis. In contrast, the deprived-area supplement to the basic practice allowance, based on Jarman index measures, is seen by some managers as a retrograde step, since it does not link remuneration with service quantity or quality.

Many London FHSAs have an opportunity to make a real impact on the pattern of services now that the new regulation requiring GPs to retire at seventy has come into force. How the FHSA deals with "succession planning" in areas with a high proportion of elderly, single-handed practitioners, such as Kensington, Chelsea and Westminster, "will do more to determine the future structure of general practice than changes made by practices themselves" (Bosanquet, 1987).

This may be the "window" that some inner-city FHSAs have been waiting for, but questions continue to be raised about FHSAs' abilities to manage change. Do they have a sufficiently clear vision of what services should look like in ten or twenty years' time and the management capacity to successfully move reality closer to the ideal? There are currently few signs that FHSAs, district health authorities and local authorities are urgently hammering out plans and strategies for primary and community services in the 21st century. Naturally, each has more pressing business. But it is now that FHSAs must make decisions about practice development that may determine the pattern of general practice for the next twenty or thirty years. Which practices should get resources for developing premises, employing more staff and extending services? Which will offer the "best return" on these investments? This, as Huntington (1990b) has pointed out, is a "considerable dilemma" for urban FHSAs which are responsible for practices of extremely variable standard.

Community health services, too, urgently need a clear vision of the future. There is still intense speculation about how they will eventually fit into the reformed NHS and various models have been described for managing community health units as a whole and for community nursing services (Constantinides and Gordon, 1990; DoH, 1990b). In future there could be many different ways of providing these services, and new possibilities for developments at the interface with hospital services. The danger, of course, is that such "constructive anarchy" will generate developments as uneven and unco-ordinated as in the past and on a scale too small to support a substantial shift away

from hospital-based care. Many people believe that unifying the management of primary and community health services under a single authority is the only way to attract high-calibre managers, guarantee provision of a broad range of well-integrated, high-quality and accessible services, enable more flexible and innovative use of resources, and ensure a solid foundation for a planned, large-scale transition to primary care.

Others are looking to regional health authorities for a policy lead now that they are financially and managerially responsible for both districts and FHSAs. Regions' past remoteness from local services and apparent lack of interest in primary care means that there is much ground to be made up if they are to overcome the separatist traditions of FHSAs and districts and influence future developments. This is already beginning to happen. South East Thames region's acute services strategy, for example, explicitly recognises the significance of primary care to the future of the acute sector (SETRHA Acute Services Strategy Group, 1991).

If a region's strategy includes a move away from hospital-based care it will need to answer questions about the scale of change and investment needed to support such a shift and how it is to be implemented. In future, regions are likely to exert most influence on the pattern of care by shaping purchasers' priorities to ensure that resources are available for primary care developments. Their success will depend on purchasers being able to establish their "sovereignty" in the market. There are doubts about whether this will happen in London, where individual purchasing authorities will be relatively weak in relation to the large and prestigious acute hospitals, which may succeed in dominating the contracting process. An explicit, coherent, London-wide strategy for a shift towards primary care, jointly agreed and actively pursued by all four regions could add weight to purchasers' demands. Unfortunately there are few precedents for regions collaborating effectively on plans for services in London (King's Fund College, 1987). Even responding to the homelessness crisis in London, which all acknowledge requires cross-boundary working, was not easy for the four Thames regions. An outside catalyst, in the form of the King's Fund, was needed to stimulate setting up a steering group and appointing a team of workers.

The introduction of GP fundholding, with GPs acting as purchasers of some secondary care, is another development that offers a promise of changing patterns of hospital use. Its potential is being tested, initially in self-selected practices, mostly outside London and other large cities. Relatively few GPs in London have shown an interest: of the seventy-two "first wave" fundholders in the four Thames regions, only eight practices are in inner London. Fundholding practices are unlikely to emerge as a force for major change in the capital. More promising are the alliances beginning to form between groups of non-fundholding practices and purchasers. Working closely with purchasers may turn out to be the most effective way for GPs in London to influence the quality of services their patients receive.

CHAPTER 6 Conclusion

In this paper we have focused directly on the interface between primary care and acute hospital services, highlighting both general issues and those more specific to London. We have discussed how the division of labour and relationships between the two sectors might change in the future. The examples show that it is possible to reduce unnecessary demands on acute hospital services and to use the skills and resources in primary care more fully and effectively. They also offer new ways of managing the boundary, so that communication is improved and patients' transitions are as smooth and uncomplicated as possible.

We have raised questions about whether a shift away from acute hospital services towards primary care could happen in London. There is no doubt that it is happening elsewhere in the country, albeit unevenly. Although we are optimistic about the improvements that have been made in London's primary care in the last ten years, doubts still remain about its overall capacity to support any large-scale change without additional resources and more rapid and purposeful development of services than currently looks likely to occur. For years London's primary and community services have had to absorb the effects of reductions in acute hospital provision, and we are concerned that this may have exacerbated the geographical and social inequalities in care that have been so apparent in the past.

All the progressive schemes that we describe depend either on GPs with adequately staffed and resourced practice teams, or on community health services with enhanced levels of staffing and training, or on both working together. Because London and its services are so diverse and good data is difficult to come by, we have not attempted to assess the scale of changes in staffing, management, organisation and delivery of services that would be necessary for primary care to take on more of the work traditionally done by acute hospitals. What we can say with confidence is that for the majority of GPs, practice teams, community nursing teams and paramedical services these conditions are the exception rather than the norm. This is not an argument for completely redesigning London's primary health care system. We believe that NHS primary care with its emphasis on personal responsibility for individual patients, continuity of care and multidisciplinary teamworking is right for London. It is a model which has not been surpassed in any other health care system. But it needs to be extended and adapted and to become more flexible, in order to provide a good service to all the different groups of people who make up the population of the capital.

It is clear from the slow pace of change since the Acheson report that there is not likely to be a "quick fix" to London's primary care problems. However, the NHS reforms have stimulated a new wave of interest in relations between primary and secondary care and opened up new possibilities for development. A more solid foundation on which to build new forms of care could be emerging now that some districts and FHSAs are grappling with needs-based planning of comprehensive primary care services for defined populations. In the final chapter of this working paper we identify some of the developments that could accelerate improvements and encourage the spread of innovation.

Resources for primary care

It is impossible to escape the conclusion that greater investment in London's primary care and community health services is urgently needed to achieve a more even standard of care throughout the capital. However, an investment programme does not necessarily mean financing "more of the same". The present rules and regulations surrounding primary care finance often seem to hinder rather than help the setting up of flexible services to meet London's special needs. This must be reviewed, along with the potential for pooling development resources across FHSA and district health authority (DHA) budgets. The NHS Management Executive has identified this as a task for regions which are now responsible for both FHSA and DHA finance. Capital investment for primary care is also something they will want to review. Inadequate practice premises, for example, have long been identified as a major obstacle to progress in many parts of London. They isolate practitioners from their colleagues and limit the scope of practice-based services. But improvements have been slow. The initiative lies largely with individual practices and is influenced by the inclination and personal circumstances of each doctor, as well as the potential for site development. The cost rent scheme is the main method of providing and developing premises. Through it, the NHS acquires financial responsibility for a mixed bag of primary care buildings which may or may not provide value for money or scope for changing patterns of service.

A London-wide view

Each of the Thames regions is going to have to shift resources towards primary care to achieve the kind of changes we describe in this working paper. Each will be tackling similar problems to which there is likely to be a limited range of solutions. The argument for joining forces to develop a coherent, London-wide strategy is compelling.

The regional role

Regional health authorities are being asked to play a crucial strategic role in developing primary care services now they are managerially and

financially responsible for both FHSAs and DHAs. They also have "the opportunity to influence the deployment of resources across primary and secondary care and to ensure the most effective balance of care is secured at local level" (NHS Management Executive, 1991). One approach is for regions to give an explicit policy lead on primary care and follow it through the regional review process, offering financial incentives for managers who achieve their objectives for shifting services from secondary to primary care. Another is to act as a development agency for purchasing authorities, helping them to spot and disseminate good practice and to develop quality standards for primary care services.

Pulling the purchasing lever

Purchasing authorities are already forming ideas about how the balance between primary and secondary care should alter and how the contracting process might be used as a lever for change. Alliances are growing between GPs, as advocates for their patients, and health authorities as purchasers of services. Fundholding practices are currently taking the lead in negotiating new deals with hospitals but it may be the strength of alliances between GPs and purchasers which ultimately changes patterns of hospital use on a larger scale.

Changing traditional ways of working will also depend on continued efforts to improve communication and relationships between doctors and nurses working in primary health care and those in hospitals. Initiatives that promote dialogue between GPs and consultants, enable transfer of skills, foster joint approaches to managing and auditing patient care all have a role to play in overcoming entrenched attitudes and improving the effectiveness and efficiency of services. In the longer term, one of the most potent forces for change may be general practice-based teaching in undergraduate medical education (Towle, 1991).

Strengthening management

Primary care and community health services will need to attract high-calibre managers to enable them to meet their new responsibilities for care of patients outside hospitals. Community services and FHSAs are still "poor relations" compared with acute hospitals because they offer managers jobs with control over smaller budgets, responsibility for fewer and lower-status staff, lower salaries and generally less prestige. This must change if management is to be strengthened. The NHS Management Executive (1991) has suggested that joint appointments could help integration as well as making best use of scarce manpower. However, many people believe that combining management of community health services and family health services is the only way to create jobs that will attract top managers.

Management restructuring is clearly not enough in itself to accelerate improvements in primary care. But it can be a catalyst for change as long as managers are committed to an outcome which

develops primary care as the "principal focus of responsibility for health, with secondary care as an essential subordinate resource available to help meet this responsibility" (Foster, 1991).

For primary and community health services to become the principal focus of the NHS there needs to be a profound shift in attitudes and resources. What we are talking about is standing the NHS on its head after forty-three years of domination by the acute hospitals. Local initiatives of the sort we describe hold the promise of finally tipping the balance in favour of primary care but concerted action is needed to strengthen and extend them, and turn the brave words of politicians and policy makers into reality.

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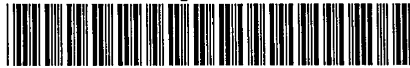
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An Optimal Balance? Primary health care and acute hospital services in London was prepared to inform the work of the King's Fund Commission on the Future of Acute Services in London. It is being published in advance of the Commission's strategy for London in order to inform debate about the future of health care in the capital. This paper should not, however, be interpreted as in any way anticipating the recommendations of the Commission's final report.

The King's Fund Commission on the Future of London's Acute Health Services' terms of reference require it to "develop a broad vision of the pattern of acute services that would make sense for London in the coming decade and the early years of the next century". With this in mind, the Fund's London Acute Services Initiative has undertaken a wide-ranging programme of research and information gathering on the Commission's behalf, of which this working paper represents one part.

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