Expanding community-based health services

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ABSTRACT – The recently published White Paper on developing community-based health services contains proposals which will have a direct impact on a number of hospital specialties and on the provision of primary and preventive care in the community. Many of these developments are to be welcomed, but a clearer understanding is required of the most appropriate balance between hospital and community services in the future, of the educational implications of changing patterns of care in the NHS and of the resource implications of these reforms.

KEY WORDS: health policy, NHS, primary care, public health, secondary care

Introduction

In January 2006, the Government published a major White Paper, *Our health, our care, our say: a new direction for community services*,[1] following a public 'listening exercise' of unprecedented scale, which formed the basis for many of the proposals for the reform of health services. The White Paper set out to achieve four main goals:

- the provision of better preventive services, with early intervention
- more choice and a stronger voice for patients
- reduction of inequalities and improvement in access
- better support for people with long-term health needs.

The focus is firmly on raising the quality and quantity of healthcare delivered in the community. Key ingredients in achieving these aims include the establishment of practice-based commissioning in primary care, a shift of resources into prevention and from secondary to primary care and, crucially, more medical (and social) care being undertaken outside hospitals and in the home. In addition, of course, the White Paper is explicit about allowing different providers to compete for the provision of services, and contains the somewhat chilling phrase 'unleashing public sector entrepreneurship' in relation to the delivery of nursing, therapy and other services.

This White Paper appeared shortly after the publication of *Best research for best health*,[2] the NHS's new research and development strategy, which is itself likely to have significant effects on the organisation and the funding of clinical research and on the R&D income streams currently going into hospital trusts. The establishment of a small number of centres of academic excellence has the potential to create real winners and losers among the trusts. Both of these publications come slightly over a year after the introduction of a new contract for general practitioners in which, for the first time, highly specified targets, enshrined in the Quality and Outcomes Framework (QOF),[3] for the management of important conditions including diabetes, hypertension, stroke, asthma and severe mental illness, are related directly to practice income. Preliminary analyses indicate that the QOF may indeed be contributing to improving quality of care in general practice.

Much of this reform is, of course, predicated on the need to save money, to develop services which are more cost-effective, to increase 'productivity' and, at the same time, to respond to a range of pressures to improve the quality and responsiveness of health services, to increase access and to deal with a range of inequalities in service provision (Fig 1).

Background

The National Health Service Act of 1948 drove a wedge between primary care (general practice) and secondary care (hospital medicine), creating a bipartite health system which has survived, almost unscathed, until the present day. Key features of the NHS, some of them unique and some undoubtedly contributing to its well-recognised cost-effectiveness, include the outpatient referral system, personal registration of patients with individual general practitioners (with responsibility for assuring 24-hour medical cover) and an inevitable, sharp distinction between the hospital-based specialist role and community-based general medical care.

Over the years a number of initiatives and policy shifts have, to a relatively minor extent, blurred this sharply defined boundary. For many years a significant minority of general practitioners (GPs) have worked in hospital settings, as clinical assistants or hospital practitioners, often continuing to exercise clinical skills acquired during hospital training, such as endoscopy and minor surgery or expertise in specialty areas such as rheumatology and gynaecology. A recent survey of UK GPs found that, by extrapolation

from a sample of over 1,000 doctors, around 4,000 GPs are likely to be providing services outside their General Medical Services contracts (and frequently outside their premises).[4] The range of services provided is shown in Table 1. Community hospitals have had a chequered past, but in their heyday the GP surgeon, GP endoscopist and GP obstetricians were all familiar figures in 'cottage hospitals', generally situated in the affluent shires, and their re-emergency in the White Paper as important building blocks of enhanced community services is a welcome development.

The concept of a 'primary care-led NHS' became fashionable when health service planners realised that countries with strong primary care services seem to spend a smaller proportion of gross domestic product on health, although the experiment of primary care trusts (PCTs) taking a leading role in commissioning hospital as well as community services was less than a resounding success. More recently the programme to develop general practitioners with special interests (GPwSIs) and practitioners with special interests (PwSIs) has been developed jointly between the Department of Health (DH), the Royal Colleges and specialist societies, but evidence of the clinical advantages and cost-benefits of the scheme is, to say the least, thin. A recent well designed randomised trial and accompanying cost-effectiveness analysis of dermatological services provided by GPwSIs showed that clinical outcomes were comparable to specialist services, that patient satisfaction ratings were high and waiting times shorter but that consultations with the GPwSIs cost almost twice as much as they did in hospital outpatients.[5-7] Alternative portals of access to the health service have been developed, including walk-in clinics in the community (now recognised as being very expensive) and diagnostic and treatment centres. Specialist outreach clinics enjoyed a vogue, and although they were undoubtedly useful in particular geographical circumstances, such as in community hospitals remote from district hospitals, their clinical (and intended educational) value was limited, and the opportunity costs (missed opportunities to undertake clinical care and other duties) of taking specialists away from their base hospital were found to be high.[8]

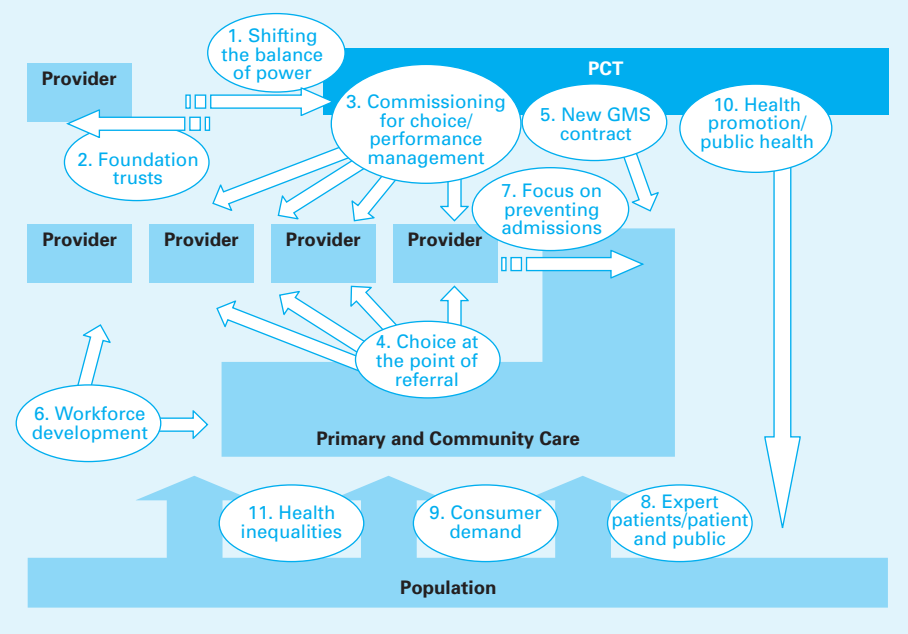


Fig 1. Drivers for change in the NHS. GMS = General Medical Services; PCT = Primary Care Trust. Adapted with permission from a presentation by T Mahmud.

What are the problems?

If the White Paper is the answer, what is the question? Following the Government's pledge to match Organisation for Economic Co-operation and Development healthcare spending norms, and in the wake of the Wanless report's[9,10] predicting the necessary costs of an effective health service, it has become apparent that pouring more money into the current NHS has not dealt with some of the long-term difficulties of the service. These include, among others, wide variations in clinical quality, unacceptably long waiting times for specialist opinion and hospital inpatient treatments in many specialties, uneven access and quality in primary care, poor support for people with long-term conditions, lack of joined-up information systems and care pathways, and a continuing emphasis on a sickness service rather than a health service. The GPwSI scheme, for example, was intended to reduce waiting times in high-demand specialties such as ENT, ophthalmology and orthopaedics by delivering over a million consultations 'in the community' by 2006. It

Table 1. Top 10 clinical interests and clinical sessions of respondents (n=390).[4] © *British Journal of General Practice.*

Clinical interests (n=282)			Clinical sessions (n=152)		
	n	%		n	%
Diabetes	57	20	Diabetes	26	17
Dermatology	41	15	Dermatology	16	11
Family planning	34	12	Minor surgery	13	9
Paediatrics	25	9	Family planning	12	8
Gynaecology	25	9	Occupational health	11	7
Minor surgery	23	8	Gynaecology	8	5
Cardiology	20	7	Cardiology	7	5
Psychiatry	18	6	Endoscopy	6	4
Acupuncture	18	6	Acupuncture	6	4
Drug addiction	17	6	Geriatrics, orthopaedics, paediatrics, palliative care, sports medicine	5	3

appears from preliminary evaluations that the GPwSI programme is unlikely, except in some very particular circumstances, to represent more than a drop in the ocean, and it may well turn out that the extra resources would be better spent by improving staffing levels in hospitals, not to mention real concerns about changing the fundamental nature of the generalist role of primary care physicians.

There is still, it seems, an acceptance that a continuous, comprehensive and coordinating role for general practitioners remains an essential component of cost-effective healthcare. General practitioners, whilst readily embracing the clinical and financial opportunities offered by the QOF and the new contract, have gradually withdrawn from providing the kind of 24-hour service that was commonplace 20 years ago, so that home visiting, night cover and even Saturday morning surgeries are less and less frequently provided by individual GPs or their practices, with cooperatives and deputising services of various kinds, supported by NHS Direct, taking the majority of out-of-hours calls. Notwithstanding the financial commitments, including further increasing the proportion of total NHS spend in primary care, it is interesting that the White Paper envisages that many of the problems faced by the NHS, which have their roots in hospital care, will find their solution in the community. The focus on the six specialties in which care will be shifted significantly into the community, as discussed below, is one example of this; it might well be that re-engineering and re-conceptualising some hospital services would have similar or greater potential benefits. It is not difficult to detect a hint of the naïve thinking of 1948, that providing care free at the point of need might, in the end, begin to reduce healthcare costs.

The White Paper: solutions?

There are some very welcome new developments. The news that a colorectal cancer screening programme will begin this year is long overdue; the commitment to provide better access to non-drug therapies for mental health is another welcome innovation; the development of the community pharmacist role is also to be welcomed and the commitments to improve community health services for young people, including an emphasis on sexual health, and for those with mental health problems, as well as an aim to put more resources into end-of-life care are all excellent. Self-monitoring of chronic diseases, such as anticoagulant control, and better access to sexual health facilities are also excellent additions.

The provision of 'care closer to home' is of particular relevance to specialist medicine, although it is not yet clear whether the polyclinic model in central Europe or the Kaiser Permanente model in the USA are directly transferable to the UK. The much-trumpeted features of Kaiser may derive, in part at least, from the choice of populations for which the Health Maintenance Organisation programmes were set up. There are still about 40 million uninsured Americans. Over the next 12 months, however, the DH is committed to working with ENT, trauma and orthopaedics, dermatology, urology, gynaecology and general surgery to 'define appropriate models of care that

Box 1. Providing dermatology, ENT and general surgery outside the hospital.[1]

Specialty	Model of care
Dermatology	• Wherever possible, patients with long-term skin conditions such as psoriasis and eczema should be managed by appropriately trained specialists in convenient community settings and should be able to re-access specialist services as and when needed. • Many specialist dermatology units already provide up to 30 per cent of their services in community settings, usually in well-equipped community hospitals. This type of service should be encouraged wherever possible. • PwSIs and specialist dermatology nurses can have an important role in providing care close to home for patients with skin disease. Health communities should develop these services where they are not already in place.
ENT	• Where appropriate, otitis externa and rhinitis are suitable for GP/PwSI management in the community. • The use of multi-disciplinary teams, including scientists, should be increased both within and outside the hospital setting. • There is the potential for appropriate day-case surgery to be performed in community hospitals where patient volumes justify recurrent and capital costs.
General surgery	• Where appropriate, specialised clinics should be established in the community, for example rectal bleeding clincs. • PwSI-led services, such as varicose vein and inguinal hernia clinics, are suitable for local, out-of-hospital settings (dependent on local need). • The more efficient use of current operating facilities and intermediate-care step-down facilities can improve quality outcomes and improve patient satisfaction.

ENT = ear, nose and throat; GP/PwSI = general practitioners/practitioners with special interests.

can be used nationwide' to provide support for practices and PCTs in commissioning services in these specialties. The proposed models of care for each of these are shown in Boxes 1–3. Dermatology, already a favourite target for GPwSIs, is seen as a particularly appropriate clinical area for community-based care, but the examples for ENT and general surgery seem merely to be the tip of a very large iceberg. It is not entirely clear how the care pathways and models of care for orthopaedics, urology and gynaecology are likely to have a major impact on hospital workload, waiting times and the improvement of clinical outcomes. It will be very interesting to see how successfully these controversial plans can be taken forward in the attempt to shift care in the ways outlined in the White Paper.

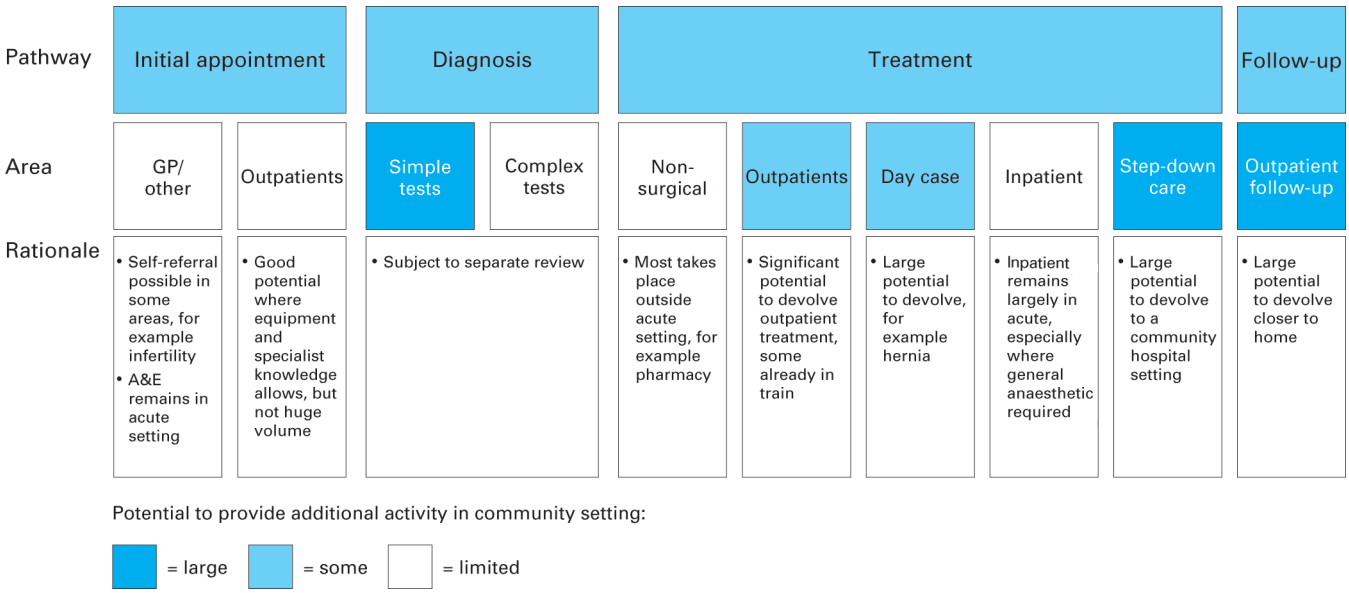
The renaissance promised for community hospitals also requires close scrutiny. Although in certain geographical circumstances the enhancement of intermediate care, providing just the kind of services that the old cottage hospitals provided, but going beyond respite and terminal care to embrace acute admissions and procedures and intermediate-level interventions, is likely to be of value, although not a nationwide panacea. PCTs, however, are now charged with consulting locally and considering new care options in relation to their existing community hospitals, and there is discussion in the White Paper of significant capital investment to support this scheme. Interestingly, the Local Improvement Finance Trusts programme, responsible for public/private partnership development of primary care premises, which offers significant opportunities to improve premises and services, particularly in urban environments, receives little attention. Super-surgeries run by 'entrepreneurial GPs' do get a brief mention, although how these are likely to be funded and how the old primary care estate can be transformed into new builds is not discussed at all.

The White Paper does provide firm and persuasive direction

Box 2. Providing orthopaedics, urology and gynaecology outside the hospital.[1]

Specialty	Model of care
Orthopaedics	• With suitable diagnostics, there is potential to shift up to 40 per cent of outpatient consultations to the out-of-hospital setting. This shift could take place through both the transfer of care to non-specialist healthcare professionals working in collaboration with the orthopaedic consultant, and through orthopaedic surgeons providing care in the out-of-hospital setting. • The use of intermediate, setting step-down care can free up hospital beds, thus improving surgical efficiency.
Urology	• There is a large potential for new pathways, and to involve suitably trained non-specialists in the management and treatment of certain conditions. • Where appropriate, and with suitable diagnostic support, male and female bladder dysfunction, stones and andrology can be locally managed in the community.
Gynaecology	• Where appropriate, non-specialist healthcare professionals can perform out-of-hospital management, investigations and treatment for certain conditions, such as infertility, menorrhagia and menstrual problems. • Self-referral to specialist infertility clinics, as evidence suggests that 90 per cent of presentations to primary care are referred on to specialists.

Box 3. Shifting care from hospital to community: the potential for change.[1]



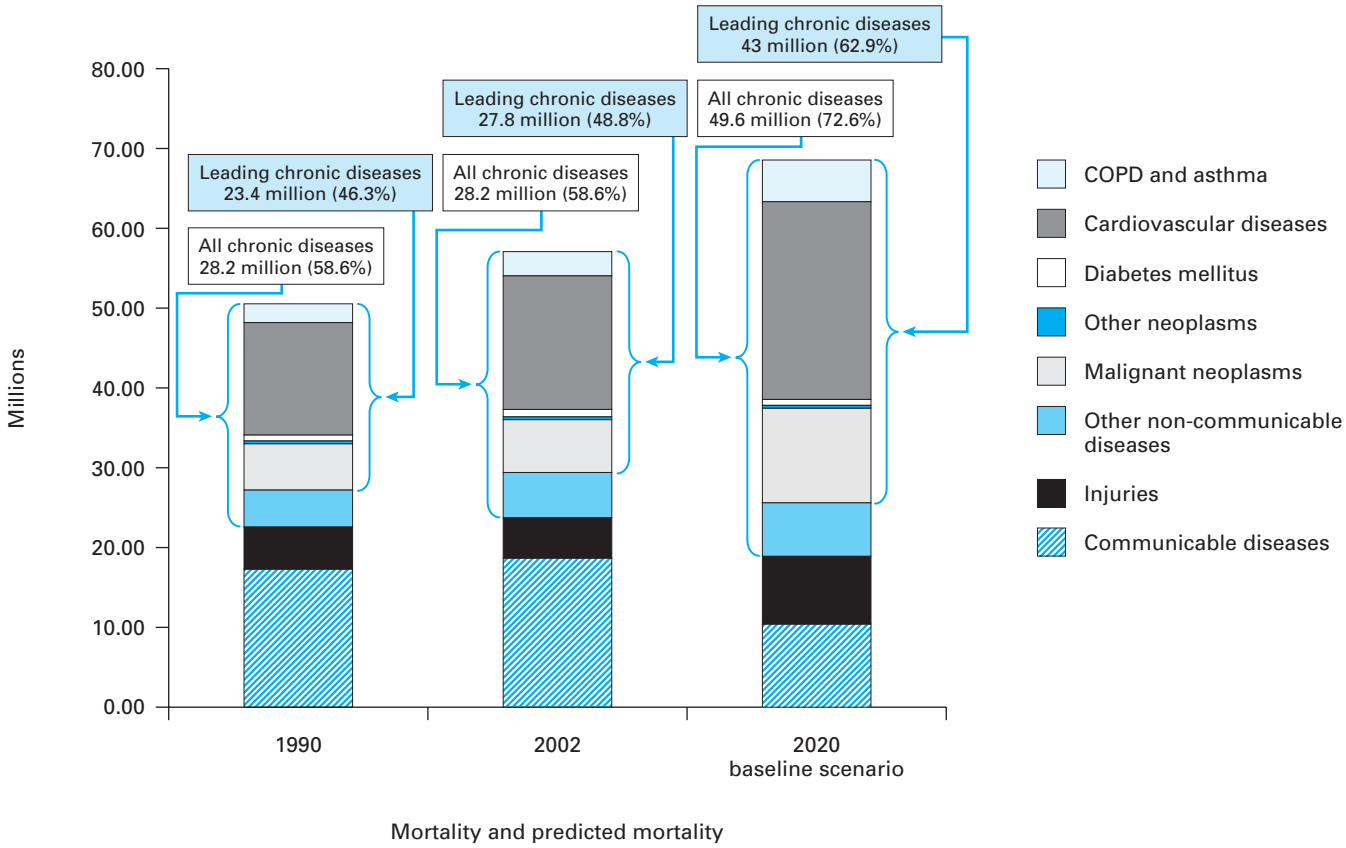


Fig 2. Mortality and predicted mortality from leading chronic diseases. COPD = chronic obstructive pulmonary disease. Adapted with permission from a presentation by T Mahmud.

about the need to improve the care of long-term conditions outside hospital. The impact that the non-communicable diseases currently have, and will have in the years ahead, on the health of nations is depicted in Fig 2; stroke, coronary heart disease and diabetes will continue to exact a huge toll in the civilised world, particularly in the context of the current obesity epidemic. The emphasis for care in the future is on a combination of patient-centred self-care and more effective and better-organised preventive care in general practice, supported by a range of non-clinical professionals, critically including community pharmacists. The DH's vision of the way in which individuals can be empowered and enabled to take control of their chronic conditions is indicated in Fig 3 where the majority of people with long-term conditions undertake most monitoring and treatment decisions themselves. Ingredients in this ambitious programme include trebling the investment in the expert patient programme, continuing to embed highly specified criteria for care of chronic conditions in general practitioners' QOF and contract, and providing information and information systems to support patients. The use of advanced technology is spelt out in some detail, including ideas for self monitoring of blood pressure, heart rate and blood glucose, domiciliary-generated spirometric and cardiac readings, in-home touch-screen and video links for patients to self-monitor and to feed information to health professionals, and even bed sensors and other assistive technology to monitor movement and sleep patterns in elderly patients with chronic disabling problems. Unfortunately the White Paper is somewhat short on the full analysis, because the critical linkages between these expanded community-based services and hospital-specialist services need to be spelt out and agreed, and this detail is at present missing from the document. Although undoubtedly beyond the scope of the White Paper, many of these 'holistic' approaches to care, and

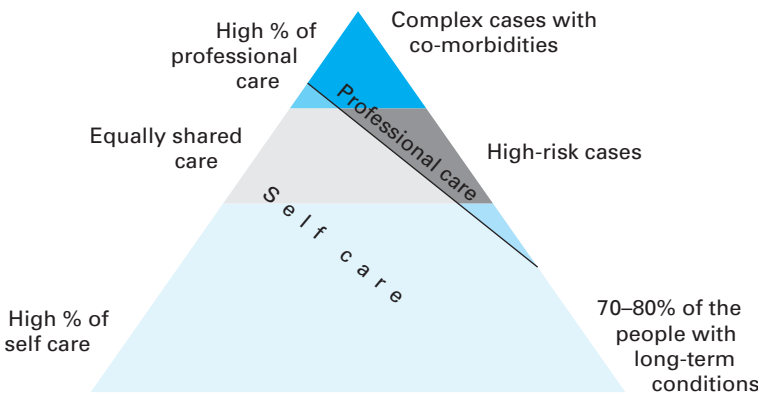


Fig 3. The place of self care in chronic disease management.

the increasing profile being given to prevention and health promotion, have major implications for medical education, requiring little short of a paradigm shift in the way that medical students are prepared for professional practice.

Unanswered questions

Despite a number of welcome concrete proposals and financial commitments, it is difficult to escape the conclusion that some of the fundamental questions about the structure and function of the NHS have not been addressed, and that a more comprehensive analysis, including consideration of the critical role of the provision of specialist services in hospitals, has not been undertaken. Whilst there is strong evidence to support the continued benign gatekeeper role of the generalist physician, and the retention of many of the core values of traditional general practice, the tribalism that inevitably accompanies the current structures continues to pose problems. Education and training are scarcely mentioned in the White Paper yet the way in which we train our doctors for the future lies at the heart of the future of our health service. The current reorganisation of PCTs and strategic health authorities surely offers opportunities to rethink ways of establishing structures for joint planning and a united primary–secondary care solution to these problems but there is little in the new proposals to encourage mutually respectful new thinking about the shape of a health service fit for purpose in the 21st century.

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