Secondary care beyond Tomlinson: An opportunity to be seized or squandered?

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This is the third article in our series looking at the issues highlighted by the Tomlinson report into London's health care and medical research and education

The Tomlinson report's emphasis on primary care and its essentially quantitative analysis of hospital care in London leaves little space for a picture of how secondary care for Londoners should look. In this article Fiona Moss and Martin McNicol argue that most outpatient work does not need to be done in hospitals. With proper organisation and better premises a genuinely specialist consultative service can be provided in primary health care centres, with benefit to patients and communication between primary and secondary care doctors. Hospitals would then house those outpatient services that needed major investigative facilities and much reduced inpatient capacity. It may no longer be necessary for each acute unit to offer a full range of services. Such a pattern of secondary care will have implications for the organisation of accident and emergency services and for postgraduate training. Above all Moss and McNicol argue that Tomlinson's recommendations demand that general practitioners and specialists should re-examine the services hospitals provide and agree on the best settings for different sorts of health care and the most appropriate skills to provide it.

Central to Sir Bernard Tomlinson and his team's response to the task of considering "the provision of health care in inner London" and working out how to give Londoners better (and cheaper) health care is the need to concentrate delivery of care within a developed primary health care and community health service. The all important background is the pressing need to reduce the numbers of hospitals; increase efficiency; and reclaim some of the added and unaccountable 20% extra costs of health care in London.

This essentially quantitative approach gives little space to what this future improved health care for Londoners might look like. But within the report there are implicit consequences for the type of service provided by secondary care services as well as by primary care services. Understanding and visualising the qualitative aspects of health care are crucial for planning a service which is responsive to the needs of patients and not simply an exercise in rationalisation and cost cutting.

The role of district general hospitals

Traditional district general hospitals provide outpatient services for investigating and managing patients referred by general practitioners; a range of diagnostic services, most of which are available directly to general practitioners; inpatient services for managing acute emergencies and for elective procedures, most of which are surgical; and accident and emergency services. Despite the increasing trend to day case management, district general hospitals are dominated by inpatient bed provision. Outpatient and diagnostic services are seen as being secondary.

There have been changes within district hospitals, but most have been reactive and driven by the quantitative aspects of care—bed efficiency, waiting lists,

etc—and not factors such as appropriateness, effectiveness, or outcome. Little attention has been given to the type of secondary care needed by patients or their general practitioners and primary care teams.

The suggested shift towards increasing the proportion of care delivered in the community provides the opportunity to examine what hospitals provide, whether these are the best places to provide it, and what is meant by specialism and expertise. Failure to examine the qualitative aspects of secondary care and to engage both specialists and primary care practitioners in these discussions will not only be a missed chance but also result in a second rate secondary care service being shovelled into an ill prepared primary care system.

Outpatient care

Relatively little is known about the care provided in outpatient departments beyond waiting times for appointments and long waits within clinics. Trainees receive little or no training in outpatient practice, and in medical schools inpatient care dominates clinical teaching. Yet in England in 1990 over 37 million outpatient attendances were recorded in NHS out-

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patient clinics, of which over 8.5 million (23%) were new outpatient attendances. This compares with 7.5 million inpatient episodes, 1.3 million day cases, and 11.2 million new accident and emergency attendances.¹ Thus 65% of all hospital-patient contacts are for outpatient care. If reattendances at outpatient clinics are excluded new referrals to outpatients make up 30% of patient workload in secondary care. In acute specialties in 1990 in England there were 156.5 new outpatient attendances per 1000 population (1/6.4 people) and 481.5 reattendances (1/2.1 people).

Beyond numbers there is little information about outpatient care. Körner data on outpatient attendances do not yet include diagnostic information, and virtually nothing can be learnt about either the process or the outcome of outpatient care from routine data sets. Nevertheless, studies of patterns of referral from general practice have given some insight into the reasons for referral,^{2,3} and studies in Oxford have provided valuable information about the process and outcome of general practitioner referrals to hospital clinics for back pain and menstrual problems.^{6,7}

Such as it is the evidence suggests that the pattern of outpatient care undoubtedly needs to change. The changes to health care in London suggested by Tomlinson have major implications for the outpatient service. This part of hospital care is technically the

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most easily transferable into the primary care setting. Some of the work may be unnecessary and some of it may duplicate or be less useful than primary care provision. For many inpatient episodes there is an obvious need: a specialist with, for example, diagnostic expertise, decision making skills or technical competence; but the expertise of the outpatient specialist is less clear.

The specialist opinion

There are some circumstances where the role of the specialist is clear—for example, in diagnosis and management of unusual conditions, diagnosis of atypical presentations, and when technical competence is required. There are others where the role of specialism is less obvious—for example, in the routine follow up of patients with chronic conditions. Clearly the experience of seeing a large number of patients with a condition makes decision making quicker and easier. But at the same time it is not possible (or necessary), for example, for all patients with asthma to see a consultant in respiratory medicine. So some thought needs to be given to working out the added value of specialist attention and identifying those who will benefit most from it. If the changes to London's health service are to improve the health of Londoners then these questions need to be addressed by all concerned both in primary and in secondary care.

A specialist clinic service clearly should provide care that is appropriate and effective as well as accessible and timely. Such a service should give patients and their general practitioners the opportunity to discuss the choices of possible clinical interventions and be a source of other relevant information, including advances in treatment.

Moreover, the specialist opinion should not be seen as that given by a lone consultant. Specialism has developed within other health care professions as well; and the development of functioning teams within primary care is a model that could be adopted in secondary care. Referral to a specialist team or to a specialist other than a doctor should be part of the secondary care service.

Towards a truly consultative service

A deliberate move to transform the outpatient service into a truly consultative service would be one approach to resolving the mismatch between primary and secondary care. Such evidence as exists about the processes of outpatient work suggests that for most

consultations complex information is not required. As general practitioners generally have (or should have) ready access to diagnostic services, the information required for most of these consultations could be obtained before the consultation. Thus patients would expect and get a complete appraisal of their problem on one visit to the secondary care physician or surgeon. Time that would have been spent on further follow up appointments—currently estimated at 4.2 per new outpatient attendance¹—could be spent discussing the problem and the choices to be made.

Communication between primary and secondary care

The links between primary and secondary care are clearly central to developing a clinic service that is responsive to patients. These include direct personal association between health care personnel in both settings; the development of electronic linkage of information and records; and extended use of patient held records. Sound investment in modern communications technology is a prerequisite for any changes in the pattern of health care delivery. With good communication and easy dissemination of information “the secondary-primary care interface” now often experienced as a barrier should become less perceptible.

INFORMATION REQUIRED FOR CONSULTATION

Once communication is easy it should be possible to clarify both the information needed for a consultation and its purpose. Appropriate investigations would be organised at the time of referral and be available for the specialist consultation. One approach to bring this

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about would be to introduce protocols for investigation, agreed between primary care practitioners and specialists and developed to correspond to the five main categories of referral: for diagnosis or investigation; advice; treatment or management; a second opinion or reassurance; other.³

LOCATION: DECENTRALISED OUTPATIENT SERVICES?

Specialist consultations are mostly carried out in hospital clinics. But from the patients' perspective they would be better carried out locally in a primary care setting—unless there is a specific technical reason for them to be held elsewhere. The recommendations of the Tomlinson committee about funding and developing the fabric of general practice will allow family health services authorities and primary care teams to consider the need for adequate accommodation for additional consultative work.

Accurate estimation of the proportion of consultative work that could be undertaken in primary care is difficult, but information available about the nature of consultation suggests that the proportion is high provided that the organisational difficulties could be overcome. These are not insuperable; the difficulty is in disengaging from current service patterns and looking towards a modern patient centred approach to care.

The exact pattern of consultative services within the community will depend on the organisation of primary care. Providing a consultative service in single handed or small group practices presents greater problems

than in well organised health centres. If the service is aggregated within localities, as envisaged by Tomlinson, these will provide an ideal focus for decentralised specialist services. Numbers of patients attending such centres need to be enough to generate the work that will enable specialists to use their time efficiently.

Models of care

Different models of decentralised specialist care are likely to emerge for different groups of patients. Patients with some relatively common chronic conditions such as asthma, diabetes, and rheumatoid arthritis are often looked after effectively in primary care without specialist intervention. Indications for specialist care should reflect a need to ensure the optimum outcome for patients or to help address the uncertainties of either practitioner or patient. These needs will differ between conditions and between patients. For a diabetic patient care may include regular specialist funduscopy, whereas for patients with rheumatoid arthritis specialist care may be directed at those with active disease or whose drug treatment needs monitoring.

Diabetes centres—Diabetes centres offer a useful example of a change from old style clinic practice into a service which can provide more comprehensive clinical and educational care.⁸ The central role of patients in their own care is emphasised by the information provided by the British Diabetic Association about what patients should expect from clinic visits. The importance of incorporating measurement of the outcome of care into the organisation of diabetes centres has been recognised.⁸ Outcome and related process measures may be clearer in diabetes than in other conditions, but any change in the pattern of service must be accompanied by measurement of outcome.

Cancer is another condition where care is properly dispersed through primary, secondary, and tertiary parts of the service and where coordination is necessary to provide patients with seamless and responsive care. For many patients with lung cancer and other malignancies receiving palliation, care is already based in the community and provided by primary care practitioners, often in conjunction with symptom control teams and other specialists in palliative care. But coordination with secondary hospital care can be patchy, and failures of communication and education have been highlighted by consumer surveys.⁹ These are important issues, particularly as patients with cancer may need quick access to specialist opinion and treatment.

... the need for the outpatient specialist is less clear

Clinical practice in secondary care will probably become further specialised, and Marshall Marinker's suggestion that the primary care physician will be the only true generalist is soon likely to be true. The role of the secondary care physician will increasingly be in diagnosis. By relocating a specialist consultative service to primary care the links between specialists and those undertaking continuing care in the community will be greatly improved—and probably provide more effective health care than the present fragmented service.

Effective follow up for chronic problems would be provided in this primary setting and management, undertaken principally by primary care health professionals, as already seen in hypertension and diabetes.

The residual outpatient practice of the district general hospital carried out on site would consist of those aspects of secondary care which need specialised technical activity or expensive equipment—for example, major invasive investigative procedures such as gastrointestinal endoscopy, bronchoscopy, or cystoscopy and specialised imaging, such as contrast radiography or computed tomography or magnetic resonance imaging. But crucial to even these aspects of care will be links with primary care.

Inpatient care

The Audit Commission's stand is for daycare, and day case activity has doubled in the past 10 years.¹ Given the rapid pace of technological change, particularly the development of minimally invasive surgery, current estimates of the potential for day case surgery are likely to be underestimates. If the properly supported and developed primary care facilities envisaged by Tomlinson are provided then much surgical work could be undertaken on a day care basis with subsequent limited need for support provided in the community. Hospital surgical practice would then be left with three main areas of work: assessment and management of emergency surgical conditions; technical surgery; and highly intensive care after major surgery.

The surgical service would also incorporate specialist assessment, mostly in the community setting, of the need for and appropriateness of elective intervention for surgical conditions. Surgeons also need to collaborate with primary care teams to provide seamless care after surgery. With improved facilities some minor operations could be carried out in primary care centres. Specialist surgeons would carry out some of these and also provide training.

Similar patterns of work can be envisaged for other specialist groups, with variations in emphasis depending on the specialty. For example, technical procedures make up a very small part of a physician's work load.

"Hospital at home" schemes¹⁰⁻¹² have improved the quality of care for the continuing care for many patients,¹³ and expansion of these schemes will both allow more day care treatment and otherwise reduce the need for inpatient care. Major reductions in the hospital bed numbers could be achieved, probably as high as 50%.

Accident and emergency services

The use of the accident and emergency services by people in inner London in place of primary care was noted by the Tomlinson inquiry along with the projects looking at the effect of deploying general practitioners in accident and emergency departments to address these problems. Accident and emergency departments have unique links with their communities and with primary care, which need to be developed con-

structively in the context of the likely changes in primary care.

Accident and emergency units also need to consider their relationships not only with primary care but also with their specialist colleagues. There is a case for acute admission wards; for emergency admissions to be looked after by the relevant specialist team; and for assessment to be done by trained staff and not as part of a haphazard and undersupervised training process.

Rehabilitation

The need for rehabilitation is increasing, particularly among elderly patients who need help to cope with the consequences of cerebrovascular disease. Much of this care is undertaken in hospitals under the direction of physicians with or without skills in the care of the elderly, neurology, or rehabilitation.

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The problems of rehabilitation and how best to assess its effectiveness have yet to be fully worked out.¹⁴ But there is some evidence to suggest that home physiotherapy may be more effective than day hospital attendance in patients with stroke who have left hospital.¹⁵ How much rehabilitation needs to be in hospital or under the direction of medical staff is unclear.

The emphasis on providing care in the community requires us to make a deliberate attempt to alter the current conventional medical approach to rehabilitation; to look at alternative patterns of care; and to look at different, and probably more appropriate, ways of assessing outcome with a move away from the "medical/therapy model."¹⁵ As community based care develops the resources of the acute hospital will be required less for rehabilitation.

The future of secondary care

There is relatively little qualitative information about routine practice in secondary care. The "new start" offered by the reforms and now in London by Tomlinson should prompt doctors to explore the benefits of specialisation not just in terms of numbers but also in terms of improved outcomes. This will mean ensuring that relevant information which can be used to evaluate routine practice in all parts of the health service and across the primary and secondary care interface, is collected methodically and routinely.

It may no longer be necessary for each acute unit to offer a full range of services. A deliberate approach to increasing the number of patients treated with a given condition by one team is likely to lead to an improvement in outcome. The evidence suggests that the benefits obtained are enough to justify a change in the traditional pattern of offering a full range of services in each local hospital. But we need to watch for points where the trade offs between one aspect of quality and another begin to change.

The move towards hospitals becoming highly specialised areas of technical expertise is likely without the recommendations of Sir Bernard and his team. The push towards quantitative achievement (greater efficiency and turnover at the expense of regard for patient satisfaction) is inexorable within a poorly funded service. But if this highly technical service can be developed with strong links to a strengthened and vibrant community and primary service with

appropriate and equitably distributed resources then patients are likely to gain. Without such links we are likely to witness the disintegration of the NHS within London.

New district general hospitals will have much of their specialist staff applied outside their walls. There will be much smaller residual outpatient facilities for patients who need high intensity investigation or intervention. The inpatient facility will be much more acute. The pattern of staffing may change, perhaps with the emergence of acute care specialists. The hospital will be smaller and it may even no longer be a general hospital, but it will be a much more appropriate organisation to serve the needs of its community.

Training in hospital medicine—The changes suggested will have profound effects on both the jobs of trainee doctors and their training. Improved bed efficiency with more patients admitted into fewer beds has already increased the daily workload of trainees and made some aspects of training about inpatient care difficult. Training in outpatient care has never been high on anyone's agenda.

The development of a new style secondary care in London should include a complete reappraisal of the role of trainees and their training. New models of working need to be developed. For example modules of training could be devoted entirely to clinic care with separate modules for inpatient care and learning techniques and others spent in general practice. There is the opportunity to create genuine training posts which do not expect trainees to work beyond their competence but allow them to develop their skills.

Conclusions

Londoners are facing the loss of some of their cathedrals of care which have looked after many generations of the capital's population. The reasons for this are cogent. The service is crumbling financially and the fabric will soon follow. The loss needs to be replaced with a service responsive to the needs of Londoners. Adequately resourced and designed with patients and their needs as the focus, a new pattern of care in which primary and secondary care develop as a true partnership could emerge. To do this specialist and primary care practitioners will have to think beyond old entrenched approaches to practice. Health care in the capital could become a source of pride for Londoners and a model for care for others.

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