Community health services

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This is the seventh 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, with its emphasis on primary and community care, offers great scope to community health services, for long the poor relation of the NHS, and particularly poorly resourced in London. The aim is to create services that break down the barriers between primary, secondary, and tertiary health care and concentrate on providing high quality care tailored to individual patients' needs. Thus a range of flexible options needs to be developed between acute hospital based care and the standard home care arrangements currently provided by district nurses. Examples include hospital at home schemes, nursing beds, and rehabilitation beds. Together community and primary care services need to consider weekend coverage, to conduct research, and to become a setting for education. The infrastructure for primary and community care must, however, be put in place before acute facilities are shut.

Community health services have for too long been the poor relation of the NHS, especially in London, where the emphasis has been on specialist acute services and hospital based teaching. The contribution which primary and community care can make to the well being of Londoners has gone largely unrecognised, so that the opportunities which the Tomlinson report presents should be broadly welcomed by those working in primary and community care as well as feared by those in the acute sector.¹ The very real difficulties in meeting the challenges set by Tomlinson are mitigated by a conviction that the welfare of those who live in London will be considerably improved if we succeed.

Principles

The principles underlying the King's Fund Commission's report, *London Health Care 2010*,² can ensure improvement so long as they become central to health care practice in London:

- London's health services must be planned and managed to serve the population rather than to perpetuate institutions
- Londoners should be much more actively involved in their own health and health care
- Health care in London must be led by primary health care
- Medical education and research should achieve international excellence.

Enacting these principles means a shift away from grand institutions towards general practitioner and community services, working in harmony in a way not usually seen in London or any other of our great cities.

The London context

Tomlinson himself asserts that inner London presents a "range of need unparalleled in the rest of England." Not only does it have exceptional population density, turnover, and high Jarman indices of social deprivation but there are also particular pockets where extreme unemployment or homelessness exists.

The current indices of deprivation fail to represent the level or distribution of need. For example, in inner London the overall standard mortality ratio is 125 as against the base of 100 for England as a whole. This is taken as a proxy for morbidity, but the London context, in which older and infirm people move elsewhere to die, dictates that inner London districts gain no benefit from the death statistic.

The proportion of the population receiving deprivation payments in inner London is 55.8% compared with 10.8% for all England. If we add to that some of the other special needs that exist in London the picture becomes bleaker. These include the needs of refugees, who flock to particular areas of London and who for a mixture of language and cultural reasons have needs for health and social services that are largely unmet.³ Likewise, the long term homeless, frequently undetected in the official statistics,⁴ use the accident and emergency departments of acute hospitals for their primary and community care. Homelessness in particular and social deprivation in general, along with unemployment, play a large part in the accumulation of long stay patients using mental health services.⁵ Lack of appropriate provision for people from ethnic minorities and lack of awareness of religious variations in modesty requirements have meant that some who need community and primary services have not had access to them while suffering discrimination from acute services.⁶

The review of capitation formulas proposed by Tomlinson, particularly the recognition of the inaccuracy of standard mortality ratios as an index of health need, the proposed inclusion of morbidity data, improved recognition of the needs of homeless people, and acknowledgment of the high costs in inner London offer an important mechanism for understanding and starting to achieve means of applying resources to communities based on need.

These are the real underlying problems with community health services. The King's Fund Commission also drew attention to the inequity in the provision of district nurses in different districts. Far fewer district nurses are employed per head of population in London as a whole, and non-London inner city deprived areas employ nearly 50% more district nurses. The deployment of health visitors shows the same pattern. If we add to this 3% less expenditure on family health services in London overall than in equivalent non-London districts and 4% less in inner deprived districts, the imbalance emerges clearly. The population's needs are not fully met by what is already provided, and inappropriate use of acute services continues.

The resources needed to provide services as close to people's homes as possible and minimise the need for admission to acute hospitals are considerable. Camden and Islington Community Health Services Trust, for example, employs over 2400 people based on over 100 sites, with an income of over £70m a year. In addition, the need to liaise with over 200 general practitioners, two local authorities, three community health councils, and about 800 voluntary organisations is no small task. Management of change is therefore a

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Home choice schemes may offer enhanced care for frail older people

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huge task in itself, while the need for additional resources to implement much of what is recommended in the Tomlinson report goes without saying.

Roles and relationships

A fundamental principle of a philosophy of care must be to make the needs of the user central to the service. This means looking at services for a particular group of patients as a whole, breaking down the artificial barriers between community, primary, and secondary care. From the user's point of view such labels are irrelevant: what is important is whether the services meet the individual's needs, fit together properly, and are provided to a high standard.

The benefits of greater integration of primary and secondary health care have long been recognised, but the creation of a "care continuum" will greatly depend on health service managers and professionals working in partnership with the interests of the client at centre stage.

In particular, such developments will succeed only with the full engagement of general practitioners, who, in inner London, still have substandard surgeries and a dearth of proper health centres. Their goodwill and willingness to effect change will be crucial to transforming the community services.

Opportunities: what services could look like

With the break up of district services into separately managed units, some of which may be trusts, faster, better informed, and more imaginative decision making may produce tangible benefits for users of our services. Undoubtedly, some services traditionally set in hospitals can be provided more cheaply in the community. More important, however, is appropriateness and quality. We need to develop a greater range of options between high cost acute care at one extreme and the standard home care arrangements currently provided by district nurses.

For example, home choice schemes could offer an enhanced package of home care for frail older people who would otherwise require continuing care in hospital; the scheme could offer varying degrees of care, depending on the individual's needs. Secondly, intensive home nursing schemes can allow patients to be discharged earlier and cared for in a setting more conducive to recovery. These schemes provide intensive nursing at home in the early days after discharge, but they also allow for acute episodes to be treated at home and they provide emergency respite care. Hospital at home schemes are in their infancy in the United Kingdom but have considerable scope for

development, not for economic reasons—because they will not necessarily be cheaper—but because of the benefit they will provide to patients and their carers.⁷⁸ Thirdly, mental health services can include short term "rehabilitation/discharge facilities," which allow for better integration of and efficiency of use of acute psychiatric beds.

Opportunities abound for improving and developing primary care services in inner London.⁹ If that happens community services will flourish in tandem with them. But at the same time, there are major question marks over the lack of weekend provision of many services, as well as a perceptible need for day care and respite care of the West Lambeth "night hospital" variety. Meanwhile, mental health services are under increasing stress, with a 35% increase in statutory activity (under the Mental Health Act) between 1989-90 and 1991-2 in Camden and Islington alone. Now 43% of psychiatric patients are detained under the Mental Health Act, considerably higher than the national average, though not as high as the peaks of 80% in some districts mentioned in the Tomlinson report.

Post-Tomlinson community services will have to provide better and more flexible mental health services, weekend coverage in day centres, far more respite care, and schemes for supporting people at home who have hitherto been admitted.

We need new ideas to increase the repertoire of care available to our clients. We also need to research them properly, to be open to all manner of collaborative working with voluntary organisations (who often produce the germ of an idea in the first place), and to see the needs of carers as well as patients as central to our services. With appropriate funding, innovative schemes could be developed, expanded, and augmented. This will be especially necessary while the Community Care Act is implemented and evaluated.

Community hospitals

The report's enthusiasm for the concept of community hospitals is infectious. Sceptics have been muttering that all things go round in circles and here we are back at cottage hospitals again. Even if that were so, such models offer an excellent opportunity for providing local low intensity care with improved value for money. If acute hospitals become specialised centres for complex procedures with faster throughput then locally based "community inpatient facilities" will have to be developed. Excellent examples of what can be achieved are the Lambeth Community Care Hospital; London's hospices, with their inpatient, day care, and respite care facilities; and the service offered to elderly patients through the nursing beds at St Pancras Hospital.

Such ideas are being developed locally, and proposals already exist in many London districts for primary health care centres with community beds and general practitioners attached. These aim to provide low intensity care for patients under the supervision of general practitioners supported by multidisciplinary teams. They also present opportunities for consultants to teach medical students in a community setting, so enhancing the integration of primary and secondary care. The Tomlinson report's proposal for "primary care development zones," where services are developed and secured very quickly in accordance with local needs, fits in well with this objective, and good primary and community health services in London require this kind of rapid and imaginative development.

Teaching, research, and development

Research, of which there has historically been little in community health services, has a vital part to play in

ensuring that developments are considered objectively and the results disseminated as widely as possible. Comparatively little teaching has been done within community and primary health care services so far. The Flexnerian model of academic medical school teaching has meant that young medical students are given little teaching in communication skills, have little experience of community services, know little of medical sociology, and are protected from the realities of deprivation within the inner cities to an astonishingly large extent. The shift from acute to community health services should mean a shift in teaching patterns and a widening of students' experiences. This applies to other health care students as well, but is most worrying in medical training.

The Harvard Medical School's "new pathway" programme includes patient-student contact from day one and requires home visits in a health care system that is largely based in acute hospitals. It is therefore all the more surprising that such changes have been slow to take place in the United Kingdom. Action in the wake of the Tomlinson report should force the pace. That will have the dual effect of upgrading community services, hitherto thought of as unglamorous, and of integrating the acute and community sectors in providing academic and experiential teaching. Such a change is clearly in the interests of Londoners who use the community services, of those who work within them, and of the students themselves. Although change by education is relatively slow, the impetus to do it will be a powerful force in changing the weighting of power within medical schools.

General practitioners and primary health care teams

Inner London has almost twice as many single-handed general practitioners as the whole of England and almost twice the number of general practitioners with over 2500 patients on their lists (see table). This has caused practical difficulties in developing primary health care teams. But the use of multidisciplinary neighbourhood nursing teams, organised on a locality basis and supporting several general practices, would improve the position of singlehanded general practitioners as well as providing a basis for multidisciplinary education and training.

In some parts of London 15% or more of the population are not registered with a general prac-

Some measures of the problems of health care in London

	England	Inner London
% Of resident population attracting deprivation payments	11	42
Standard mortality ratio for over 65s	100	125
% Of singlehanded GPs	11.6	22.2
% Of GPs with lists $\geq$ 2500	9.8	18.9

Data from Department of Health and Office of Population Censuses and Surveys.

itioner. The reasons may be several but include homelessness and cultural or language difficulties. Failure to reach these groups, however, means that authorities will not only be unable to meet their health needs but also be unable to meet the targets of the Patient's Charter and the *Health of the Nation*. Drop in centres would allow these people access to health care as the need arises and must be provided.

Challenges

Management information systems in the community are in their infancy but must be developed to allow better targeting of health care. Purchasers of health care will have to accept, however, that many community services do not lend themselves to being measured as easily as do many acute sector activities. Terminal care and rehabilitation services, for example, are not properly counted in terms of Körner statistics.

Some of what Tomlinson recommends can be done within existing resources by redeployment and innovative planning. Nevertheless, as he acknowledges in his report, real success in developing primary and community care will be achieved only through shifting resources—and only if sufficient transitional funding is found to ensure that service developments are put in place before the reductions in the acute sector.

Conclusion

The Tomlinson report represents a focus for thinking how best to provide health care for Londoners. It offers opportunities for making substantial progress over a short period and could provide just the catalyst we need to spark the chain reaction of change required by London health services. It does, however, have to be implemented as a package. Closing a few acute hospitals will not be enough: the primary and community care infrastructure has to be put into place, and resources have to be committed to make modern effective primary and community services for Londoners a reality.

- 1 Tomlinson B. *Report of the inquiry into London's health service, medical education and research*. London: HMSO, 1992. (Tomlinson report.)
- 2 King's Fund Commission on the Future of London's Acute Health Services. *London Health Care 2010*. London: King's Fund, 1992.
- 3 Karmi G. Refugee health. *BMJ* 1992;305:205-6.
- 4 Scheuer MA, Black M, Victor C, Benzeval M, Gill M, Judge K. *Homelessness and the utilisation of acute hospital services in London*. London: King's Fund Institute, 1991.
- 5 Thornicroft G, Margolius O, Jones D. The TAPS project. 6: New long-stay psychiatric patients and social deprivation. *Br J Psychiatry* 1992;161:621-5.
- 6 Martin P, Wiles R, Pratten B, Gorton S, Green J. *London's acute health services: a user perspective*. London: King's Fund London Acute Services Initiative, 1992.
- 7 Costain D, Warner M. *From hospital to homecare: the potential for acute service provision in the home*. London: Welsh Health Planning Forum, WHO, King's Fund Centre, 1992.
- 8 Marks L. *Home and hospital care: redrawing the boundaries*. London: King's Fund Institute, 1991.
- 9 Taylor D. *Developing primary care: opportunities for the 1990s*. London: King's Fund Institute, 1991.

ANY QUESTIONS

Is there a risk of upper respiratory tract infections being passed on when children share β_2 agonist inhalers?

I am not aware of any published work in relation to this question. Theoretically, however, it is possible that viral infections could be transmitted in this way under certain circumstances. Most viruses die as a result of exposure within a few hours, but it is likely that viable virus particles survive on the inhaler and may be transmitted in droplet form or as a contaminant on the hands or on the inhaler. Such transmission would be possible for the

common cold and for other respiratory viruses, such as rhinovirus or respiratory syncytial virus. If two people used the same inhaler within a relatively short time—even an hour or so—these infections could be transmitted. Transmission of bacterial infection is unlikely as a consequence of shared use, but there may be a theoretical possibility of transmitting tuberculosis. Under the circumstances it seems sensible to continue to enforce the recommendation that such inhalers should not be shared. —A RICHARD MAW, *consultant otolaryngologist, Bristol*