Primary care development zones

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

Most commentators on the Tomlinson report have agreed with its emphasis on improving primary and community care. The three elements of such a strategy are a remedial programme to bring primary care up to national standards, a programme to provide such services to people with non-standard needs such as mobile Londoners, ethnic minorities, and homeless people, and the development of an expanded model of primary care. No one model will be appropriate across all of London. The process should start with an audit of existing resources and services within each community, together with an analysis of needs. From this would develop a local programme with specific plans for investment in premises, staffing, training, and management. New contractual mechanisms may be needed to attract practitioners, improve their premises, secure out of hours services, and provide medical cover for community beds. There should also be incentives for closer working between primary and secondary services. No developments on the scale needed for London have been carried out in primary care within the lifetime of the NHS—but their success will be critical to the calibre of health services for Londoners into the next century.

The Tomlinson report's description of the inadequacy of primary and community health services in London commands widespread agreement.¹ On most measures of quality, primary care in the capital compares poorly with that in the rest of Britain. This comparison holds true even when inner London is compared with other English inner cities.²⁻⁴ Although providing good quality primary care is difficult in any urban area the depth of London's problems—and their persistence—do argue for special treatment.⁴ This will be needed even more urgently if the government accepts other Tomlinson recommendations and closes large numbers of acute beds over five to 10 years.

Could Tomlinson inspired "development zones" for primary care provide a fast track for improvement? How might they work? This paper outlines a strategic approach for developing primary and community health services in London. It sketches ways in which a development zone for primary care could be organised to improve services in the capital.

Any effective approach needs to build on the wealth of innovative pilot projects and experiments in primary and community health services.⁵ In the 12 years since the Acheson report much has been learnt about how to provide improved primary care in Britain's inner cities. However, this has often depended on individual special projects—and on the highly committed innovators who tend to run them.

If things are to change in London we will need to move from the piecemeal experimentation of the past decade to a sustained programme of development. This will require leadership and generous resourcing if it is to produce results.

Doing different things in a different way: a strategy for development

Any development programme for primary care must pursue three objectives simultaneously: to remedy

Developing primary and community care: a strategy

- Remedy existing deficits
- Provide non-standard services
- Expand the concept of primary care

deficits in the existing pattern of primary and community health services, to provide non-standard services for non-standard groups, and to expand the model of primary care.

A REMEDIAL PROGRAMME

The remedial programme should aim to make up the deficit in primary and community health services in the capital, to bring them into line with national standards. Investment in the 46% of general practitioners' premises which the Tomlinson report identified as substandard will be needed. So will improvements in the quality and quantity of conventional primary and community health services currently available to Londoners.

NON-STANDARD SERVICES

A service development programme is needed to provide non-standard services to groups for whom the traditional model of primary care, based on serving a family of fixed abode, is inappropriate. These groups of Londoners are very diverse. They consist of highly mobile young people and families, commuters, and tourists, as well as disadvantaged groups such as refugees. They also include some people from ethnic minorities, homeless and rootless people, homeless families, and substance misusers.

The small scale of primary and community health services give them the potential for meeting such diverse needs flexibly, in ways that institutions cannot. There are a wide variety of project based experiments to draw on when devising a pattern of services geared to the needs of marginalised groups: they include "sick bay" services for homeless and rootless people; services provided by salaried general practitioners or community nurses for families in bed and breakfast accommodation; interpretation and advocacy for people from ethnic minorities; and outreach teams for substance misusers and street and hostel dwellers with mental health problems.

The particular needs of London's mobile residents, commuters, and tourists have been less well explored, but possible areas of ways of meeting them include an expanded role for primary health care in accident and emergency departments and north American style "ambulatory care centres," where a range of walk in services, including specialist clinics and diagnostic facilities, are available.

AN EXPANDED MODEL FOR PRIMARY CARE

The aim of a programme to expand primary care would be to provide in the community services currently provided in hospitals where this is appropriate and cost effective. To achieve this a very wide range of mechanisms will be needed. These include shared care agreements and collaboration over protocols

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between general practitioners and consultants for diagnosing and treating common conditions; new roles for community nurses, to encourage innovative forms of specialist and generalist practice; "hospital at home" and other high intensity home care schemes, including terminal care; developments in community based specialist working such as paediatric home care and mental health and learning disabilities teams; community hospitals and nursing beds; and the move of some specialist referral clinics from hospital outpatient departments into primary health care settings—if possible, with general practitioners and community nurses collaborating with their hospital based colleagues in patient management.⁶

Scope of the development programme

To be effective in fulfilling these strategic objectives investments must provide demonstrable improvements in primary and community health services for Londoners. To do this the scale and scope of the development programme will need to go well beyond traditional means of spreading good practice within the NHS. It must also amount to more than simple investments in bricks and mortar and extend beyond conventional methods of professional development for primary care practitioners.

In the development zone primary care arrangements cannot simply be left to the normal mechanism of allowing general practitioners to decide, within limits, what services they will provide. Authorities will need to analyse the services that need to be provided and ensure that they are in place. In doing this family health services authorities, community health services, and local authorities will have to achieve true partnerships as well as involving local people in service design and monitoring. London neighbourhoods are very different. No one model of primary and community health services will be appropriate across the whole city. If changes are to command public support, Londoners must play an active part in shaping their local service mix to meet needs which they have helped identify.

At the same time the managerial capacities of family health services authorities and community units—both trusts and those managed by their health authorities—will need to be strengthened. A common approach cannot be assumed: most district and regional managers have spent their careers in the acute sector, and have little understanding of the interlocking network of roles, relationships, and agencies that constitute primary care.

Primary care services for the homeless need to extend beyond special projects and become part of routine provision

Mechanisms

- Attract and retain good GPs
- Make early retirement easier
- Improve premises
- Strengthen links between primary and secondary services
- Train and develop staff
- Offer new organisational arrangements

A process for development

SERVICE AUDIT

Family health services authorities, district health authorities, community health services, and local authorities within the development zone should join forces with local providers to conduct an urgent analysis of existing services in their particular patch, their staffing, and the capital stock available for primary and community health services. This "mapping" exercise would aim to identify strengths and weaknesses in services and existing links between primary and secondary health care and between the NHS and local authority social services. It could pinpoint areas for improvement. Providers and service users should take part in these assessments.

A DEVELOPMENT PLAN

This analysis, together with information about the health status and needs of the population served, would form the basis of a local development plan—probably based on family health services authority areas.

Development plans would need to show that they can meet all three of the strategic objectives—for remedial action, non-standard care, and expanded care. They should also be able to show how each authority intends to cooperate with each other and with private and voluntary organisations to develop joint or complementary approaches to service delivery. To develop plans successfully agencies will need to work closely with local providers and community representatives. Stimulating their enthusiasm and creativity will be essential to the success of the programme.

Local plans will need to support their service development strategy with detailed plans for investments in premises; in staffing and training; in the organisational development of practices and community services ("teambuilding"); and in improved management.

Mechanisms for change

Various new mechanisms will be needed if "zoning" is to enable family health services authorities, district health authorities, community health services, and local authorities to make swift, concerted improvements in the primary care services available to Londoners (see box).

ATTRACTING AND RETAINING MORE HIGH QUALITY PRACTITIONERS

Existing contractual arrangements are inadequate as a means both of attracting sufficient high calibre practitioners to work in London and of rewarding them for providing an appropriate range of services. In fact the present system of capitation payments and deprivation allowances is an incentive for London general practitioners to maintain a large list and do relatively little with it. The fact that many do much more than this is no tribute to the perversities of the system.

Within the development zone new incentives need to be devised both to attract high calibre general practitioners and other primary health care workers to the inner city and to encourage them to provide the right kind of services. In the case of general practitioners it may be necessary for family health services authorities to take on delegated authority from the Medical Practices Committee for recruiting general practitioners and approving average list sizes. There is also a case for new forms of contracts and variations on traditional partnership arrangements, including salaried posts, job sharing, part time working, job rotations, and time limited, renewable commitments to a practice.

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

- Remuneration packages with payments linked to the achievement of agreed service delivery targets for deprived or underserved populations; for services which fulfil the objectives of *The Health of the Nation* or *Caring for People*; or for "shared care" and other arrangements which reduce dependence on hospital services
- Innovative options for out of hours coverage with appropriate payments
- Incentive payments for providing medical cover to local community care centres or nursing bed units
- The use of health promotion funds to encourage opportunistic health promotion activities according to agreed criteria; the setting up of "at risk" registers; and the establishment of an information base for practice list needs assessment.

EXIT ARRANGEMENTS

It may be useful for family health services authorities within the zone to take on responsibility for arranging early retirement packages, where these could be shown to be in the interests of the service.

IMPROVING PREMISES

Cost rent schemes which have worked well in other parts of the country have largely failed in London. New mechanisms are needed—along with new money. These might include:

- Additional London weighting for cost rent schemes
- FHSA part ownership schemes
- The separation of ownership of premises from general practitioner pension arrangements
- Work with the London boroughs on expediting planning procedures for primary health care premises
- A centre of expertise in the design of primary health care premises.

RELATIONSHIPS BETWEEN PRIMARY AND SECONDARY SERVICES

The gulf between primary and secondary health care is greater in London than elsewhere. In any development plan ways of encouraging collaboration between primary health care practitioners—both doctors and nurses—and their hospital based colleagues should be actively pursued. Possible means of doing this might include:

- Incentives for hospital and practice teams who

collaborate to manage patients with long term conditions to agreed standards and criteria

- Incentives for siting specialty referral clinics in primary health care premises. This should be done in a way that will encourage primary care practitioners and their hospital based colleagues to collaborate on patient management.

TRAINING AND STAFF DEVELOPMENT

Delivering improved primary care to Londoners will depend on the skills of primary health care practitioners from a range of disciplines and on their ability to work together. Ensuring that these capacities relate to the health needs of particular practice populations could involve:

- Support for postgraduate and further education being linked to personal development plans for individual practitioners and other staff which reflect local service development priorities
- Management development, team building, and organisational development plans could be developed by practices in the light of local service priorities, and approved and funded by the family health services authorities.

NEW ORGANISATIONAL ARRANGEMENTS

Many smaller and singlehanded practices in London provide good quality and highly valued care. They will, however, find it difficult to provide a wider range of services. Consortium arrangements and other ways of linking such practices with each other, with community health services, with social services, and with larger practices with an extended range of facilities will need to be developed.

Conclusion

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

As such, it should be treated as an investment in the infrastructure of the capital and appropriately resourced with both money and the equally important human currency of ideas, creativity, and enthusiasm. The programme will have succeeded if, in 15 years' time, primary health care in the capital has lost its status as the national laggard; the quality of the services it offers matches or exceeds that enjoyed in the rest of England; and London has become a place where aspiring primary health care practitioners in all disciplines aim to work.

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- 2 Boyle S, Smaje C. *Primary health services in London: an analysis*. London: King's Fund Institute (in press).
- 3 Jarman B, Bosanquet N. Primary health care in London: changes since the Acheson report. *BMJ* 1992;305:1130-6.
- 4 Metcalfe D. Care in the Capital: What needs to be done. *BMJ* 1992;305:1141-4.
- 5 Hughes J, Gordon P. *An optimal balance: primary health care and acute hospital services in London*. London: King's Fund, 1992.
- 6 Moss F, McNicol M. Secondary care beyond Tomlinson: an opportunity to be seized or squandered? *BMJ* 1992;305:1211-4.