ACUTE PERSPECTIVE

David Oliver: Should we shift more specialist doctors’ time into community care?

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Last month NHS England published Next Steps for Integrating Primary Care, also known as the Fuller stocktake report. It sets out ambitions for “streamlining access to care and advice” (including quicker same day access in primary care), “providing more proactive personalised care with support from a multidisciplinary team of professionals,” and “helping people stay well for longer.”

The report emphasises the importance of joined-up care systems, integration, and helping more patients access care in the community, but it brings no immediate prospect of tackling the growing crisis of workforce, morale, and workload in “core general practice.” One idea to emerge from commentary about the report—though not the report itself—is that somehow a cavalry of “medical consultants will be redeployed to save the GP system.” This is insulting to everyone in primary care, while even the notion of “hospital specialists” sets up false dichotomies.

GP armies “specialists” in primary care, just as secondary and tertiary care specialists are consultants in their disciplines. Those we routinely call “hospital doctors” are only traditionally employed by, or based in, hospitals. By their nature, some acute and interdisciplinary services and services can be provided only on a hospital site owing to economies of scale, facilities, equipment, rotas, and round-the-clock teams. But for others who work in ambulatory and outpatient care, community outreach, or collaboration, being based largely outside the hospital walls is more viable.

Many approaches already see consultants spending time in community and primary care, such as community geriatricians working with community multidisciplinary teams, community hospitals, or care homes. Palliative medicine is already strongly community based, as are mental health services. Community paediatrics is another long-established specialty.

More broadly, there’s a growing emphasis—now accelerated by the huge backlog in elective care due to covid—on redesigning the way we run outpatient care, not least for people with multiple conditions. There’s a move towards using specialist expertise in more innovative, less traditional ways, such as online advice and consulting or patient initiated follow-up. And we’ve seen changes to how secondary care specialists can ensure that they meet employers’ contractual obligations for ongoing follow-up, prescribing, referral, and investigations, in a way that doesn’t further overburden GPs.

So, what’s the issue with hospital doctors working more in the community? Well, secondary care specialties face a workforce crisis of their own. In a country that already has among the fewest doctors and nurses per 1000 people, only 52% of all advertised consultant physician posts were filled last year, with the highest vacancy rates in a decade, and hospital doctors, like GPs, are struggling with workload and rota gaps. They also often have to contribute substantially to acute and specialty on-call rotas on site, as well as hospital ward based medicine and procedure lists that can only happen on site, not to mention educational and management roles. Who would cover that work if hospital doctors were moved to community care? What would they stop doing to prioritise community roles?

Current access to training in primary and community care settings for higher specialty trainees is also very patchy. Different skills and mindsets from traditional, hospital based medicine may be required.

Finally, if we want to shift more specialty time into the community because it’s good for patient care and team working, fine. But we must heed the empirical and experiential evidence, repeatedly set out over the past two decades, that this won’t lead to big reductions in demand for acute care in a system with the fewest beds per 1000 in the developed world.23

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10 Richmond Group of Charities, Royal College of General Practitioners, Impact on Urban Health: Taskforce on Multiple Conditions. https://richmondgroupofcharities.org.uk/taskforce-multiple-conditions


