Care closer to home: past mistakes, future opportunities

Minoo Irani[1] Michael Dixon[2] John D Dean[3]

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INTRODUCTION

The Government White Paper on improving community health and care services (*Our Health, Our Care, Our Say*) proposes shifting care within particular specialties from hospital into community settings. The intention is to provide seamless care for patients when and where they want it, in more local and convenient settings. Professionals in primary and secondary care will need to respond by developing new ways of working to enable this policy to be effective. In this paper, we discuss the evidence of the effect of initiatives during previous health care reconfigurations to shift the balance of power from secondary to primary care. We also suggest a partnership model for primary and secondary care clinicians and discuss the potential advantages of working practices across the primary–secondary care divide.

Summary

- Shifting care within particular specialties into community settings is emphasized in the Government's recent White Paper;
- Two innovations in recent years involving the primary–secondary health care interface have been specialist outreach clinics and general practitioners (GPs) with specialist interests;
- Both models demonstrate increased levels of patient satisfaction, but may not be cost-effective;
- It is essential that mistakes of the past are not repeated, but opportunities for better integration of primary and secondary care are not missed.

THE CURRENT SITUATION

The Government White Paper on health care outside hospitals (*Our Health, Our Care, Our Say*) emphasizes a fundamental shift in focus that will provide integrated health and social care services in local communities and closer to people's homes;[1] however, the structure of health services in the UK remains fundamentally unchanged since the publication of the Dawson Report in 1920.[2] It consists of 'primary' health centres, 'secondary' hospitals and teaching hospitals. Traditionally, GPs have been 'generalists' and hospital based Consultants, 'specialists'. In recent years, boundaries have shifted and primary care is no longer synonymous with GPs and their teams, just as hospital based Consultants are not the only specialists in the health service. A sizeable number of Consultant level doctors are employed by Primary Care Trusts (PCTs) and work closely with primary care colleagues outside hospitals; conversely, a new breed of GPs with specialist interests has emerged.

PRIMARY–SECONDARY CARE DIVIDE

The interface between primary and secondary care has been the subject of interest and much debate in recent years.[3] In the UK National Health Service, there has been a sustained effort to shift boundaries and the balance of power from secondary to primary care. In the last five years, the emphasis of reform to break down traditional demarcations between different professional groups and organizations[4] did not achieve as much as expected; the vision of 'culture change' became confused with the more easily achievable 'structural change'. The result was that secondary care specialists remained firmly rooted within the acute hospital boundaries, primary care practices preferred to pursue and delivered upon various targets and PCTs were left to struggle with bearing the financial pressures resulting from weak commissioning models. There is a danger that practice based commissioning and payment by results could create greater division between primary and secondary care, unless a more inclusive vision of best care for all is embraced.

INNOVATIONS AT PRIMARY–SECONDARY CARE INTERFACE: SPECIALIST OUTREACH CLINICS AND GPS WITH SPECIAL INTEREST

Health care reforms and reorganizations have provided opportunities for innovation at the primary–secondary care interface in the past. The concept of specialist outreach clinics gained popularity during the introduction of general practice fund holding from April 1991.[5] The NHS Plan in 2000 was the trigger for enthusiastic uptake of the concept of GPs with specialist interests. We can certainly learn lessons from these two innovations. The messages from their evaluation could inform the current recommendation about moving patient care from hospitals into the community.

[1]Children's Services, Upton Hospital, Slough SL1 2BJ, UK
E-mail: m.irani@virgin.net

[2]College Surgery, Cullompton, Devon EX15 1TG, UK
E-mail: m.dixon@nhsalliance.org

[3]Bolton Primary Care Trust, Bolton, UK and Institute for Healthcare Improvement, Cambridge, Massachusetts, USA
E-mail: jdean@ihi.org

Two models of specialist outreach care have been described in literature:[6]

(1) Shifted outpatient model, where the specialist outreach clinic is much the same, apart from location, as a hospital clinic;
(2) Liaison-attachment model, where collaboration between Consultants and GPs aims to provide more effective joint care.

It is largely recognized that the specialist outreach clinics established in fund holding practices mainly resembled the shifted outpatient model. Early evaluation of benefits of this model was mainly limited to personal opinion. The most common benefit suggested was that specialist outreach clinics offered shortened waiting times for fundholders' patients.[7] Other benefits of this model were better communication and educational exchange between Consultants and GPs,[8] improved patient satisfaction, and greater efficiency resulting from a reduction in unnecessary follow-up attendances and lower non-attendance rates.[9] Roland and Shapiro use a systematic approach to bring together the work of most of the research teams who had been working on specialist outreach clinics during the early and mid-1990s.[10] The economic message was unclear, but it was concluded that there could be opportunities to improve services to patients by using outreach clinics, especially if specialist services were viewed as a whole rather than being established on an *ad hoc* and uncoordinated basis. The studies reported by Roland and Shapiro show the diverse ways in which specialists adapted their working patterns to accommodate outreach clinics—some of them replaced NHS clinics, some were carried out in addition and some were private arrangements between the Consultants and GPs.

A systematic review by the Cochrane Collaboration examined the benefits and costs of outreach in a range of specialities and in a variety of settings.[11] It concluded that simple 'shifted outpatient' styles of specialist outreach were shown to improve access, but there was no evidence of their impact on health outcomes. Outreach as part of more complex multifaceted interventions involving primary care collaborations, education and other services was associated with improved health outcomes, more efficient and guideline-consistent care, and less use of inpatient services.

The other major example of innovation at the primary–secondary health care interface involves the concept of GPs with specialist interests. Early evaluation consisted of observational studies.[12] A recent evaluation of such a service for dermatology[13] showed slightly greater patient satisfaction with their consultations and experience of shorter waiting times for their first appointment. Economic evaluation of the same service showed that costs incurred by the NHS for a GP with specialist interests service for non-urgent skin problems were about 75% higher than those for care provided in a hospital outpatient clinic.[14] While this single evaluation may not be generalized to all such specialist interests services provided by GPs, it certainly serves as a caution that this model may not be the most efficient way to increase specialist capacity. Further research into the cost effectiveness of GP with specialist interests services is required.

CARE CLOSER TO HOME: OPPORTUNITIES AND THREATS

The emphasis about providing specialist care more locally provides a unique set of opportunities for specialists and GPs. The shift towards taking a population perspective of specialist care and designing stepped care pathways for chronic illnesses can be realized if specialists work collaboratively with GPs.[15] Joint consultation models between specialists and GPs have been shown to reduce waiting lists for rheumatology in secondary care in a Dutch randomized trial.[16] Improved goodwill and communication between specialists and GPs is an added bonus. Most importantly, improved patient access to the specialist and convenience to the patient would be achieved.

However, simply relying upon local initiatives to develop 'shifted outpatient' models of specialist outreach clinics may not be the most cost-effective approach. Benefits of patient satisfaction and convenience could be offset by higher direct costs to the health economy from such an approach.[17]

Perceived threats by specialists of working in primary care could range from loss of Consultant 'status' to dilution of their skills by encouraging more services by GPs with specialist interests. However, it should be remembered that the initiative of GPs with specialist interests will have limitations with respect to the facilities for provision of the broad range of chronic disease care plus the time constraints. A North American study calculated that comprehensive high-quality management of ten common chronic diseases required more time than primary care physicians had available for all patient care.[18]

THE WAY FORWARD

In a recent paper, we have proposed establishing new models of provision led by primary and specialist care clinicians working together.[19] Similar approaches to integration have been advocated by others: Donaldson and Ruta[20] propose the concept of an integrated primary and secondary health and social care organization ('super-practice'). These superpractices would consist of primary care professionals with the appropriate skill mix and

ambulatory secondary care specialists, who could be employed, partners, or contracted in from hospitals. Lewis and Dixon, in their paper *The future of primary care*,[21] support multi-speciality groups or networks (including primary care physicians). In a joint statement, the Royal College of Physicians and the Royal College of General Practitioners have emphasized a commitment to joint working. They have suggested a 'balanced clinical partnership', in which primary and secondary care together develop and explore new ways of working and commissioning.[22]

Practice based commissioning provides a unique opportunity for groups of practices in primary care to assess the benefits of bringing specialist services closer to the patients' home. The success of this initiative would be significantly determined by the commitment of primary and secondary care professionals to provide 'The right service, at the right time, by the right people, in the right place.' This could be achieved by establishing partnerships which truly look beyond professional self-preservation or short term financial gains.

Partnership models of providing services have potential advantages for patients, specialists and GPs. Convenience of access, possibly less waiting times and improved continuity of care would contribute to improved patient satisfaction.

Specialists would function as commissioners and providers of their service; moving out of the traditional hospital environment would make them sensitive to the wider health needs of the local population. In an era dominated by patient choice, specialists would be able to engage in these discussions where they predominantly take place—in primary care. In parallel to this, GPs would have a greater say in how specialist services are provided for their patients. They would also be less exposed to the dangers of competition for primary care provision from private providers. Once primary care collaborations have specialists on board, they will be a strong force for quality health care delivery in a competitive market.

CONCLUSION

Professional and practice boundaries between primary and secondary health services will need to be revisited following publication of the white paper on health care outside hospitals. Specialist outreach clinics and GPs with specialist interests have made a small contribution towards shifting these boundaries in recent years. If the optimal balance between patient satisfaction and cost of the service is to be achieved, innovative models of service delivery are required.

The emphasis upon providing health care closer to the patients' home provides opportunities for primary and secondary care clinicians to establish meaningful partnerships which could further improve working practices across traditional professional boundaries.

Competing interests None declared.

REFERENCES

1 Our Health, Our Care, Our Say: a new direction for community services. London: DoH, 2006

2 Lord Dawson of Penn. *Interim Report on the Future Provisions of Medical and Allied Services*. United Kingdom Ministry of Health Consultative Council on Medical Allied Services. London, HMSO, 1920

3 Carey T, Garrett J, Jackman A, *et al*. The outcomes and costs of care for acute low back pain among patients seen by primary care practitioners, chiropractors, and orthopedic surgeons. *NEJM* 1995;**333**:913–7

4 Department of Health. *Shifting the Balance of Power within the NHS: Securing Delivery*. London: DoH, 2001: 5

5 Bailey JJ, Black ME, Wilkin D. Specialist outreach clinics in general practice. *BMJ* 1994;**308**:1083–6

6 Creed R, Marks B. Liaison psychiatry in general practice: a comparison of the liaison- attachment and shifted outpatient clinic models. *J Roy Coll Gen Pract* 1989;**39**:514–7

7 Tod ED. Should Consultants do sessions in GP fundholders' practices? A GP's view. *Br J Hosp Med* 1993;**50**:636–7

8 Dunbar J, Vincent DS, Meikle JN, Dunbar AP, Jones PA. Outreach clinics in general practice. *BMJ* 1994;**308**:1714

9 Bailey JJ, Black ME, Wilkin D. Specialist outreach clinics in general practice. Centre for Primary Care Research Report 1994. Manchester: Department of General Practice, University of Manchester, 1994

10 Roland M, Shapiro J. Specialist outreach clinics in general practice. Abingdon: Radcliffe Medical Press, 1998: 69–82

11 Gruen RL, Weeramanthri TS, Knight SE, Bailie RS. Specialist outreach clinics in primary care and rural hospital settings. *Cochrane Database Systematic Reviews* 2005;**4**

12 Nocon A, Leese B. The role of UK general practitioners with special clinical interests: implications for policy and service delivery. *Br J Gen Pract* 2004;**54**:50–6

13 Salisbury C, Noble A, Horrocks S, *et al*. Evaluation of a general practitioner with special interest service for dermatology: randomised controlled trial. *BMJ* 2005;**331**:1441–4

14 Coast J, Noble S, Noble A, *et al*. Economic evaluation of a general practitioner with special interests led dermatology service in primary care. *BMJ* 2005;**331**:1444–8

15 Gask L. Role of specialists in common chronic diseases. *BMJ* 2005;**330**:651–3

16 Schulpen G, Vierhout W, Heijde van der D, Landewe R, Winkens R, Linden van der S. Joint consultation of general practitioner and rheumatologist: does it matter? *Ann Rheum Dis* 2003;**62**:159–61

17 Powell J. Systematic review of outreach clinics in primary care in the UK. *J Health Serv Res Policy* 2002;**6**:177-83

18 Ostbye T, Yarnall K, Krause K, Pollak I, Gradison M, Michener JL. Is there time for management of patients with chronic diseases in primary care? *Ann Fam Med* 2005;**3**:209–13

19 Dean J, Dixon M, Irani M. Breaking down the walls: the future of specialist services in non-hospital settings. *Br J Healthcare Man* 2006;**12**:182–4

20 Donaldson C, Ruta D. The NHS revolution: health care in the market place. Should the NHS follow the American way? *BMJ* 2005;**331**:1328–30

21 Lewis R, Dixon J. *The Future of Primary Care: Meeting the Challenges of the New NHS Market*. London: King's Fund, 2005

22 Royal College of Physicians of London. *Making the Best Use of Doctors' Skills—a Balanced Partnership*. Joint Statement April 2006. London: RCP, 2006