Applying community-oriented primary care methods in British general practice: a case study

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SUMMARY

Background: *The '75 and over' assessments built into the 1990 contract for general practice have failed to enthuse primary care teams or make a significant impact on the health of older people. Alternative methods for improving the health of older people living at home are being sought.*

Aim: *To test the feasibility of applying community-oriented primary care methodology to a relatively deprived sub-population of older people in a relatively deprived area.*

Design of study: *A combination of developmental and triangulation approaches to data analysis.*

Setting: *Four general practices in an inner London borough.*

Method: *A community-oriented primary care approach was used to initiate innovative care for older people, supported financially by the health authority and practically by primary care academics.*

Results: *All four practices identified problems needing attention in the older population, developed different projects focused on particular needs among older people, and tested them in practice. Patient and public involvement were central to the design and implementation processes in only one practice. Innovations were sustained in only one practice, but some were adopted by a primary care group and others extended to a wider group of practices by the health authority.*

Conclusion: *A modified community-oriented primary care approach can be used in British general practice, and changes can be promoted that are perceived as valuable by planning bodies. However, this methodology may have more impact at primary care trust level than at practice level.*

Keywords: *community oriented; older population; primary care; 75-years-and-over checks; health; needs assessment.*

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Introduction

CURRENT provision of health and social care for older people in Britain is undermined by structural and operational misalignment of primary health care teams, acute hospital and community trusts, and social services.[1] The forthcoming National Service Framework for Older People is intended to correct this situation. Since 1990, general practitioners (GPs) have been obliged by contract to offer annual assessments of health to their patients aged 75 years and over, using a number of broad headings to guide the assessment.[2] It was unclear what was intended when the contract for general practice was changed to include this obligation, but it was widely interpreted as a requirement to 'screen' the 75-years-and-over age group. While there has been extensive research into the possible benefits of regular screening of older populations, the introduction of the '75-years-and-over checks' provoked extensive debate because of the lack of conclusive evidence that routine screening was worthwhile.[3-5] There has been no consensus on the best methods for such screening, despite nearly 40 years of study, and subsequently no systematic approach to undertaking these assessments has developed, and they are widely ignored by GPs.[6]

In response, both to the low level of activity in primary care around health assessment for older people and to pressure from some GPs, Camden and Islington Health Authority initiated a project in 1996-1997 to develop innovative primary care for older people with the support of an academic department of primary care. This was designed using a community-oriented primary care approach to needs assessment with older people, utilising an extended primary care team with public health support and a range of methods for assessing needs and exploring potential service provision.[7] Community-oriented primary care methods were chosen because they offer the required systems approach,[8] recognise that change processes in complex organisations, such as general practices,[9] are cyclic and require a leadership that moderates and manages adaptation rather than attempting to control change,[10] and reflect action research approaches that promote primary care teamwork development.[11]

Community-oriented primary care

This model of innovation was derived from the King's Fund review of community-oriented primary care,[12] and takes the form of a cyclic process of design, development, and evaluation (Figure 1). This cycle allows a continuous process for developing primary care provision in a defined community on the basis of its assessed health needs through the

HOW THIS FITS IN

What do we know?

The most effective approaches to improving the health of older people in the community are still unclear, despite 40 years of research and development, and the introduction of the '75 and over' assessment programme in 1990. The National Service Framework for Older People identifies the broad themes that should shape service development, but does not offer developmental approaches suited to primary care. To promote health in older people innovative approaches are needed that respond to the complexities of health and illness in later life, and to current developments in general practice.

What does this paper add?

Community-oriented primary care methods offer a systematic approach to change that can enthuse professionals, engage patients, and produce innovative services tailored to suit local populations. This methodology can be implemented by practices or by primary care trusts.

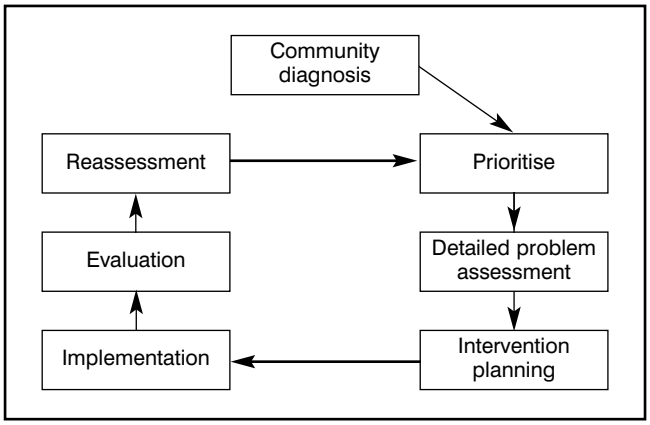

Figure 1. The community-oriented primary care cycle.

planned integration of public health and clinical practice.[13]

The process itself consists of defining and characterising the target community, identifying, listing and prioritising the problems most detrimental to the health of that community (and/or of most concern to the community itself), modifying the primary care service provision to that community in order to improve its health and, finally, establishing systematic monitoring, evaluation and reassessment of the effectiveness of the programme.[14] The community-oriented primary care orientation allows the selective application of risk factor identification and risk reduction techniques most appropriate to the risk factor patterns of the particular community, and this has been its main application in the United Kingdom.[15] However, the modest gains obtained by attempts to use community-oriented primary care methods in British general practice could be achieved by other means, and it is notable that British experience of community-oriented primary care methods (admittedly during a period of turbulence in general practice) did not make GPs enthusiastic about the approach, even when they could describe its benefits.[16]

This relative lack of success may be due to community-oriented primary care being a planned process applicable to rule-based organisations operating in a predictable and controlled environment, while general practice may need an emergent approach to change, in which managers foster a climate conducive to adaptation and experimentation in a dynamic and uncertain environment.[17] This paper describes a project that tested the feasibility of applying community-oriented primary care methodology, rather than a risk factor, to a relatively deprived sub-population of older people in a relatively deprived area (the London Borough of Camden).

Method

A mix of qualitative methodologies were adopted because of the advantages that these approaches offer in assessment of health technologies, particularly where the context in which the technology is applied may have an impact on the outcome.[18] A combined sampling approach was adopted for local general practices, allowing both theoretical sampling[19] (to test a hypothesis) and non-probabilistic sampling for generalisability.[20] The hypothesis tested was that practices with a track-record of innovation in any aspect of service delivery, which also expressed interest in the idea of developing services for older patients, would be able to introduce and sustain innovative forms of primary care for older people. To optimise generalisability, a sampling frame was used for practice recruitment, consisting of four exemplar general practices purposively recruited to represent different practice sizes and practice populations of differing levels of socioeconomic deprivation.

Intervention

The developmental approach used is described in detail elsewhere.[21] Two interacting developmental groups were established. These were:

1. a small academic support group assisting practices in understanding the community-oriented primary care process, providing research evidence, materials, and local agency networking as requested by the practices. This team also had the responsibility of assisting the practices in their evaluative process as well as evaluating the overall programme; and
2. a project steering group with representatives from the health authority, a specialist in old age psychiatry, academic GPs and academic nurses. This group had the remit to disburse up to £80 000 over two years to support new service proposals from the practices which were grounded in evidence and sustainable within existing practice resources after the end of the project.

Staggered recruitment of practices began in January 1997 and funding for the last practice ceased in October 1999. Practices were recruited to the project on the agreement that they would discuss their plans for service development with the academic support group and reach consensus about needs, plans, costs, and implementation before initiating new services. The practices were given the task of designing, implementing, evaluating, and sustaining new services for their older patients (Figure 1). The definition of the older

population and the method of beginning the diagnosis and prioritisation stage, were left to the practices to determine. The academic support staff encouraged frequent contact by telephone, letters, and face-to-face informal meetings, as well as formal group meetings. No formal instructions in community-oriented primary care methods were given to the practices, partly as a methodology but also to emphasise the emergent approach to development. The research group used the stages of the community-oriented primary care cycle to guide its own relationship with the practices.

Potential innovations were taken by the practices to a full steering committee meeting when they reached the stage where detailed costing was appropriate. Active support was offered at the implementation stage once the practice innovation had achieved ratification and an evaluation framework had been established, using elements common to all practices as well as methods appropriate to each innovation. The steering committee reviewed progress on a regular basis, discussing developments with practices and the research team. The research group produced a bulletin to inform the practices about the development of the project, convened meetings with the steering group and the practices, and communicated with practice staff at their request.

Evaluation

Evaluation was carried out using a triangulation approach, involving multiple sources of data, methods, and investigators from different disciplines.[22] The evaluation methods consisted of:

- participant observation of practice meetings where discussion of project development took place, with detailed note-taking of all contacts with practice members outside formal meetings to allow analysis of complex, evolving group processes.[23] Frequent contacts with the practices over a two-year period not only acted as support for the evolution of innovations, but also as a form of within-case sampling designed to optimise the content validity of the findings;[24]
- interviewing of purposively selected practice members of all disciplines, before and after the process, about problems of primary health care for older people and the impact of the community-oriented primary care model on their practice activity, using a semi-structured questionnaire to obtain contextualised insider perspectives;[25,26]
- analysis of documents produced by the practices describing their planned projects, methods of assessment, and practice level evaluation methods;[27] and
- feedback from steering group members following discussion with practitioners involved in the project.

Data obtained from these methods were reviewed by the research team and discussed with the steering group, to identify themes relevant to the evaluation. Three approaches for evaluation of this data were used: descriptive, grounded theory, and testing against an existing framework. The description allows conceptualisation of data and relation of concepts to permit a theoretical rendition of reality.[28] A grounded theory approach allows themes and categories to emerge through iterative analysis of large quantities of data, so that new theoretical analyses can develop.[28] Testing against an existing framework allows comparison with international experience of community-oriented primary care methods. This triple approach was used because of the limited application of community-oriented primary care methods in British conditions. Our objectives were :

1. to obtain a description of structural developments in each practice in terms of the definitions of older people and of the community that were adopted, the innovations that were planned, their implementation, their evaluation at practice level, and their sustainability, including uptake by other practices and agencies;
2. to produce an analysis of the processes followed by the practices, in terms of themes that emerged during the evaluation, from observation and steering group discussion; and
3. to utilise a four-level model of evidence and data utilisation in diagnosis and prioritisation, implementation and evaluation, derived from experience of community-oriented primary care initiatives in the USA.[29] This is reported elsewhere;[21] the results described here refer to the first two objectives.

Results

The structure of innovations

The characteristics of the practices and the changes introduced by them are shown in Table 1. The detailed outcomes for each practice are reported elsewhere.[30-32] The extent to which the process of change became embedded in practice activity varied, and no efforts to innovate were successful. Not all developmental cycles were completed. One exemplar practice was able to develop a complex assessment and management package, but was not able to evaluate it. Sustainability was a problem for all practices. The end of fundholding prevented one practice from continuing its new service, and none of the other practices have additional resources from their primary care groups to pursue their initiatives. However, elements from the innovations developed by the exemplar practices were incorporated into a wider health authority programme of service development for the older population, aimed at 40 practices in the locality, and by two primary care groups.[33]

The processes of innovation

The following themes emerged as being important in the development process, during the study period:

1. the apparent underlying model of health used by the practice;
2. the approach to equity;
3. the range of assessment methods deployed;
4. the roles of different practice members in diagnosis, prioritisation, design and implementation;
5. patient or public involvement at any stage;
6. 'connectedness' to other agencies arising from the project; and
7. the role of the research group.

Table 1. The structure of innovation in participant practices.

Practice	Diagnosis and prioritisation	Design and implementation	Resources used	Evaluation methods	Change sustained?
Practice 1 with six whole time equivalent (WTE) GPs, not fundholding	At-risk groups recognisable within population	1. Targeted assessment of the housebound, patients with polypharmacy, and nursing home residents aged 75 years and over 2. Exercise classes for patients aged 75 years and over 3. Case management of complex cases identified in 1 above, with consultant geriatrician	1. Half-time practice nurse (new post) 2. Sessional exercise therapist, once weekly (new post) 3. Consultant session (already funded), one per month	Data collection on uptake of assessments, findings from assessments, processes of management and outcomes for patients intended but not completed	Exercise classes continue, funded by the practice, but also extra funding available for exercise promotion across the health authority. Practice nurse moved to research post
Practice 2 with one WTE GP, not fundholding	Public perspectives are important to service delivery and planning	1. Trial of needs assessment tool that uses informant history, patient perspective and professional judgement, for patients aged 75 years and over 2. Focus groups of selected patients aged between 65 and 70 years to discuss health needs and service requirements for an ageing population	1. Photocopying costs for questionnaires 2. Costs of literature search Research staff time for three focus groups of one hour each	1. Comparison of problems identified with each assessment approach 2. Themes arising from focus groups	1. New assessment tool not adopted because there is no advantage over existing approach
Practice 3 with three WTE GPs, fundholding	Patient care fragmented, older people living alone assumed to be in greater need	One-stop shop for medical, nursing, chiropody, physiotherapy and benefits advice, for those aged 75 years and over not living alone	Sessional costs of physiotherapist and chiropodist, every fortnight, plus computer decision support programme for benefits advice	Uptake of services, before/after measures of quality of life, patient satisfaction	Intention to extend service halted by end of fundholding arrangements
Practice 4 with seven WTE GPs, not fundholding	Low incomes of significant group of older people a threat to health	Benefits and resources outreach for patients aged 80 years and over	Benefits advisor, four sessions per week	Documentation of uptake, benefits obtained and other services provided	Extended to PCG level in two areas

Table 2. The processes of change.

	Practice 1	Practice 2	Practice 3	Practice 4
Concept of health used in the project	Absence of illness, therefore focusing on disease and disability	Health as wellbeing, therefore focusing on autonomy and patient perspectives	Health needs maintaining, producing a servicing model of care	Socio-economic circumstances shape health
Perception of equity	All new services were targeted at groups perceived to have high levels of tractable need	Older population seen as under-served	Older people living with others seen as under-served compared with those living alone	Socio-economic inequity a premise of the innovation
Roles of different practice staff in diagnosis, prioritisation and design	GPs and manager led on diagnosis and prioritisation, nurses led on design	GP and nurse collaboration	GP led at all three stages	GP led at all three stages

Table 2 continued on next page

Table 2. The processes of change (continued).

	Practice 1	Practice 2	Practice 3	Practice 4
Range of assessment methods deployed	Standard instruments for assessment of activities of daily life (ADL), depression and cognitive impairment, plus consultant clinical assessment or exercise therapist assessment in selected individuals	Needs assessment tool capturing patient, carer, and professional views, plus focus groups	Sequential assessments by different professionals, with GPs synthesising information	Structured interview about benefits, unstructured interview about other resource problems
Who implemented the innovation?	Nurse recruited for the project	Practice nurse	GP, practice nurse, and other professions allied to medicine	Citizens Advice Bureau (CAB) adviser
At what stage were patients or the wider older population involved?	As recipients of services	At needs assessment, and through focus groups	As recipients of services	As recipients of services, and through a postal satisfaction questionnaire
Links to other agencies	To transport, social services, and leisure facilities	None	To physiotherapy and dieticians	To CAB
Research group role	Fortnightly supervision for nurse	Literature review, needs assessment tool, focus groups, data analysis	Evaluation methods	Initial negotiations only

Table 2 shows how the cycle of development proceeded in each practice. The concepts of health underlying the diagnoses made and priorities decided were varied, but all contained an explicit (if different) understanding of inequity in later life. The role of different practice staff in the early stages of the cycle varied, but no practice appeared to engage clerical and administrative workers, and in only one practice was a doctor fully involved in the implementation of an innovative service. Public and patient involvement was as service recipients in all but one practice where an effort was made to involve 'younger older' people in priority setting,[32] and there was variation in the range of other agencies contacted as a consequence of the project.

Discussion

To establish a community-oriented primary care approach, a practice must first have a defined population, a means of involving the community in raising its own health status, access to necessary clinical and epidemiological skills, and commitment to increasing the accessibility of practice services to the community.[34] Community-oriented primary care therefore appears to be an attractive model for promoting change in British general practice, which, with its registered populations, widespread computerisation, well-developed academic networks, and relatively easy access to public health expertise, would appear to be in a good position to implement this approach to innovation. The explicit potential for public involvement in the community-oriented primary care method also helps it to fit in with the current policy climate in Britain, in which public participation is a priority issue for primary care groups.

This project shows that selected general practices can develop and implement innovative, locally appropriate primary care services for older people, using limited short-term funding, if supported in a non-directive way by an academic department familiar with the nature and problems of general practice, and steered by a multi-professional management group including public health professionals from the health authority. This support entails sourcing knowledge, training in evaluation skills, provision of assessment tools, networking, and problem solving. The approach taken differs from the earlier experiments undertaken by the King's Fund in that there was no formal training for the practices in community-oriented primary care methods, but their scope for innovation was greater. Concerns that minority groups in the population will be neglected if unskilled primary care teams undertake public health functions[35] do not appear to be substantiated in the exemplar practices, which have not only focused on the needs of older people, but on particularly disadvantaged groups within this population — those with chronic diseases, those less supported by services, those with unmet needs, and those with low incomes and limited resources. Practices were not free to innovate for any population group, of course, since their target group was identified for them, and they had to satisfy the steering group that their proposed innovation did meet a real need; we do not know what priorities might have arisen if a free choice of target group had been given. However, the very limited public involvement in the processes of diagnosis, prioritisation and design in the exemplar practices is disappointing.

The main barriers to achieving and sustaining change arise through lack of time, unanticipated problems, ineffective co-ordination, competing demands and crises, insufficient skills and inadequate training.[36] All of these may have played a role in the uneven development of innovation in the four practices, particularly given the decision not to train practices in community-oriented primary care methods and the non-prescriptive approach taken by the support group. A study of only four practices is insufficient to shape policy, for factors promoting or inhibiting development may vary considerably from practice to practice. Observational studies are difficult to evaluate because of the subjective biases inherent in qualitative research methods. Despite the complexity of the evaluation methodology, the exact contribution of different elements of the programme to the outcome is not always clear; this is predictable, according to dynamic models of service development, where case studies of change necessarily contain degrees of uncertainty but are still usable as guides to action.[37]

However, both primary care groups and the health authorities have decided to resource components of the innovations developed by the practices, which to some extent validates the developmental process and its evaluation. Previous efforts to promote primary care for older people, through the '75 and over' checks introduced in 1990, have not been successful at making a model of development that combines practitioner creativity with external support attractive. This community-oriented primary care approach may be a useful mechanism for primary care trusts seeking a way to test out new, locally applicable solutions to wider, centrally determined plans, such as the National Service Framework for Older People, before attempts are made at widespread implementation.

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