

Say no to 'Martini' health care

Many column inches and much air time has been devoted to Lord Darzi's review of the NHS (www.ournhs.nhs.uk/), with 'polyclinics' or 'supersurgeries' dominating the discussion.

Although the media has suggested turf warfare between expert generalists and specialists it is important that we look behind the headlines and think carefully about the proposals in the review and how they will affect our patients.

The Royal College of General Practitioners (RCGP) has consulted widely with its membership on both the London and the England reviews and is concerned that the plans to introduce polyclinics across the whole of England could lead to a 'Martini' style of health care – any time, anywhere, any doctor.

As the proposals in the review are advanced, these concerns urgently need to be addressed.

Polyclinics are not the answer

The RCGP does not deny that improvements are needed in the NHS – it's a sad fact there are some patients who are not getting the services or the standard of service they deserve – but would argue that 'one size fits all' polyclinics are not the answer.

Polyclinics, as they currently stand, focus purely on diseases and technical care and don't take into account the values and strengths of general practice and, crucially, the needs of patients.

When you consider that there are about 250 million consultations between patients and GPs in the UK every year and that 15% of the entire population sees a GP in a 2-week period (Pereira Gray, 2002) making sure that we get primary care services right is of paramount importance for specialists as well as GPs and patients.

Continuity of care

A key point which appears to be overlooked in the polyclinic proposal is that GP surgeries provide more than just clinical care. As family doctors, GPs are there throughout a patient's life, providing personalized and lifelong care. Personalized care has been recognized as a core charac-

teristic of the GP's role for many years. It was first described in the influential definition of a GP's job in 1969 (Royal College of General Practitioners, 1969) and reinforced by the Department of Health (1996) and most recently by the RCGP (2007a) in its new curriculum for GP training.

A study in the *British Journal of General Practice* (Baker et al, 2007) found that interpersonal continuity was important to between 63 and 75% of patients, particularly those with poor health consulting with routine problems. The majority also wanted to consult someone who would take time to listen and who was familiar with their clinical history.

The issue of the importance of continuity of care was also highlighted in a 2005 CFEP report *What do patients think of their health professionals and their practices* (Greco and Jenner, 2005), which showed that patients seeing their usual clinician rated communication skills higher than patients seeing someone else.

In addition, there is first-hand evidence that polyclinics are not what most patients want. To help the RCGP to respond to Darzi's London NHS report *A case for change* a public meeting was organized at the RCGP to discuss with patients their experiences of primary health care, and what they wanted to see happen in the future.

The consensus was that if general practice is going to change, it must change for the better. The overwhelming majority were not sold on the idea of polyclinics and expressed reservations about the effect on continuity of care and the doctor-patient relationship.

Patients are worried, and rightly so, that their care is becoming increasingly fragmented. One of the reasons for a general dissatisfaction with services in the NHS might be that insufficient attention is paid to values like continuity of care. Yes, change is needed, but not at the expense of personalized care.

Restricting patient choice

The RCGP is also concerned that polyclinics will be set up in, and run by, exist-

ing hospitals and used as another means of generating income for the hospital trust. This would be bad news for patients, who may need to travel further to access care, and who may also feel anxious about going into hospital – they need to know that they will be referred to hospital only when absolutely necessary. Internal referral between the floors of a large acute foundation trust's building would also restrict patients' choice, which we all know is one of the government's key priorities.

Despite these reservations about polyclinics, it is important to say that the RCGP is not opposed to the concept per se. In fact, in some areas of the country, for example cities with large, mobile populations, or areas with insufficient health-care provision, they may work well.

The fact remains that although seeking direct access to health care as and when needed may be an attractive option for people who enjoy good health and rarely have to consult their GP, those who rely on their local practice, such as the elderly and patients who suffer from co-morbidity, do not want to see a different person for every appointment or keep having to repeat their medical history and circumstances every time they see a different health professional.

So how can we provide more integrated care while maintaining the personal care so valued by patients and practitioners alike?

Federations: the way forward?

Before Lord Darzi's review was announced the RCGP published on its own blueprint for the future of general practice.

The Future Direction of General Practice – a Roadmap (Royal College of General Practitioners, 2007b) has the backing of the UK's major primary care organizations and advocates GP practices working together in 'federations' to deliver a wide range of services such as X-rays, scans, mental health services and even minor surgery in a community setting, meaning that patients would be referred to hospital only when absolutely necessary and that GPs and specialists would work more closely to deliver seamless care and aftercare.

Under the federated system, generalists and specialists would work together more closely to ensure that hospitals were reserved for acute illness, specialized investigations and major surgery. This blurring of the boundaries between primary and secondary care means that both clinicians and resources can be used wisely, saving time and money.

A fact not quoted often enough is that general practice already represents superb value for money. In fact, it is the most cost-effective part of the NHS – GP consultations cost less than outpatient consultations, accident and emergency consultations, and ambulance calls and GP care for a whole year costs, including bank holidays, less than a single day's hospital admission (Pereira Gray, 2002).

Polyclinics certainly aren't a cheaper option – they will be costly to run. If they won't save money and won't necessarily improve patient care, why impose them on GPs when, by and large, the care they provide is effective and valued by the majority of patients?

Learning lessons from ISTCs

The RCGP is concerned that polyclinics will be forced on local health communities in a style reminiscent of the Department of Health's last 'great idea', independent sector treatment centres (ISTCs). We are con-

vinced that pump priming the establishment of polyclinics in order to bring in provision of GP services by large multinational companies in areas of the country where there is no need is a waste of NHS resources and could lead to a destabilization of high quality practices in their vicinity.

Lessons must be learnt from the imposition of ISTCs. A recent article in the *British Medical Journal* (Pollock and Godden, 2008) argued that no good evidence is available to support the ISTCs programme, which saw some private centres being imposed on local primary care trusts, with little or no consultation with NHS staff or community representatives, and sometimes despite strong opposition (House of Commons Health Committee, 2006). If polyclinics are to be introduced there should be a strong evidence base, collaboration with stakeholders and crucially, they should be based in areas of need.

Family doctors all around the country are working to meet the changing needs of patients by offering a wider range of services, working in partnership with their local health authority and the voluntary sector, and commissioning the services that are needed by their specific patient populations. This initiative and dynamism is what we want to see rolled out nationwide, and what the RCGP as a College is committed to working towards.

KEY POINTS

- Polyclinics could lead to 'Martini' health care – any time, anywhere, any doctor.
- Patients value continuity of care and the doctor–patient relationship.
- The Royal College of General Practitioners recommends a federated system with GPs and specialists working more closely to deliver seamless care and aftercare.
- Lessons must be learnt from the imposition of independent sector treatment centres.
- To improve patient care we must build on the strengths of general practice.

Conclusions

If we are to move forward and genuinely improve patient care in the UK we must have recognition that general practice is not a stumbling block to an improved, thriving NHS. Rather, by valuing it and building upon its strengths, it could be the solution to this very problem. **BJHM**

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- Baker R, Windridge K, Bankart J (2007) Interpersonal Continuity of Care: a cross-sectional survey of primary care patients' preferences and their experiences. *Br J Gen Pract* **57**(537): 283–9
- Greco M, Jenner D (2005) *What do patients think of their health professionals and their practices?* CFEF UK, Exeter
- House of Commons Health Committee (2006) *Independent sector treatment centres*. Fourth report of session 2005–6. vol 1, 2006. The Stationery Office, London (www.publications.parliament.uk/pa/cm200506/cmselect/cmhealth/934/934i.pdf accessed 29 February 2008)
- Pereira Gray D (2002) *A Dozen Facts about General Practice/Primary Care*. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4127488.pdf accessed 29 February 2008
- Pollock AM, Godden S (2008) Independent sector treatment centres: evidence so far. *BMJ* **336**: 421–4
- Royal College of General Practitioners (1969) The educational needs of the future general practitioner. *J R Coll Gen Pract* **18**: 358–60
- Royal College of General Practitioners (2007a) *Training Curriculum for General Practice*. Royal College of General Practitioners, London (www.rcgp-curriculum.org.uk accessed 29 February 2008)
- Royal College of General Practitioners (2007b) *The Future Direction of General Practice: a Roadmap*. Royal College of General Practitioners, London (www.rcgp.org.uk/pdf/Roadmap_embargoed%2011am%2013%20Sept.pdf accessed 29 February 2008)
- Secretary of State for Health (1996) *Choice and Opportunity. Primary Care: the future*. DoH, London