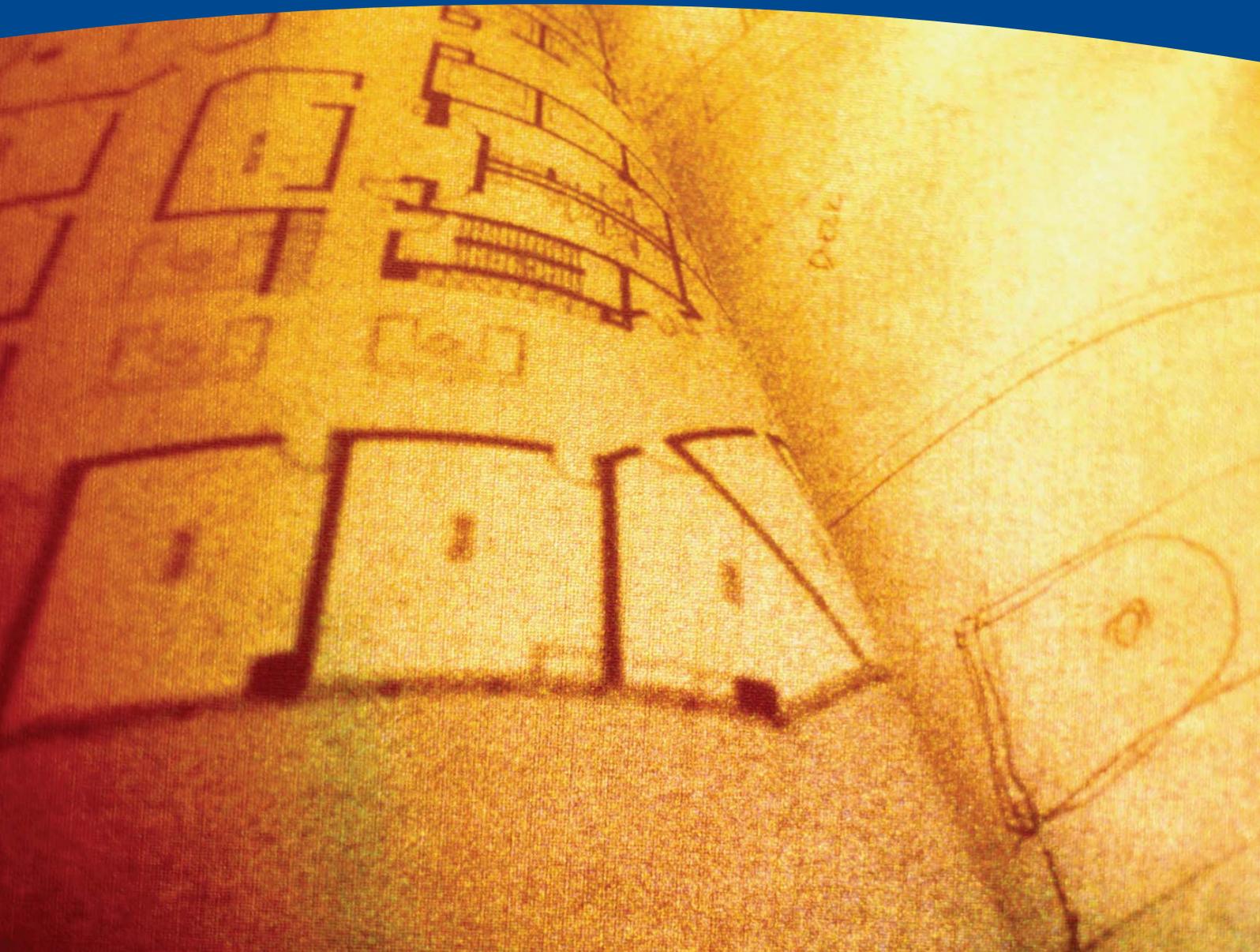




Ideas from Darzi: polyclinics



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Summary

In December 2006 NHS London asked Professor Lord Darzi to carry out a review of healthcare in London, resulting in his report *Healthcare for London: a framework for action*. He has stressed that the London review is not a template for local reform proposals. However, he is clear that polyclinics could help deal with three difficult issues common to many areas, namely:

- improving primary care
- better integration between primary and secondary care
- the future of relatively small district general hospitals and how they can play a wider role in working with primary care as part of the local health system.

This report examines these issues. A separate report, *Ideas from Darzi: local hospitals*, will outline the history and current position of the model that has emerged at Central Middlesex Hospital and the lessons learned, illustrating that the development of polyclinics and hospitals are mutually dependent.

Polyclinics cannot be developed without the services around them. The development of a network of polyclinics without changes in the way that the hospital system works is likely to add significantly to costs and may have little impact on the outcomes of care. Equally, problems are likely if there are radical shifts in the way the hospital system operates without significant improvements in the capacity of primary and community services to provide specialist consultation, a very wide range of diagnostic services and other more specialist care.

Introduction

Professor Lord Darzi's announcement that he would like to see polyclinics adopted more widely has generated a surprising level of opposition, given that many of the principles behind the idea are in line with the way that healthcare is developing across the world. The design rules that underlie the idea of the polyclinic appear to be fairly uncontroversial.

- **Create larger groupings of primary care professionals** to create a critical mass that will allow an enhanced range of services to be provided and will be available for longer periods than has traditionally been possible.
- **Exploit economies of scale** to provide greatly extended diagnostic support with rapid access and turnaround and a range of other services that are difficult to offer in smaller practices. *Healthcare for London: a framework for action* also highlights improved telephone booking and reception services and better accessibility for groups of people, such as those with learning disabilities, the mentally ill, or those with language or cultural barriers.
- **Reduce the need for patients to travel to hospital** by relocating high volume work that does not require hospital infrastructure. One important finding from Bunny Hill Primary Care Centre in Sunderland is the extent to which many patients prefer a non-hospital setting, not just because of the convenience, but because of the associations that hospital has for them.
- **Integrate services** to break down the traditional barrier between primary and secondary care and to provide opportunities for specialists to work side by side with their colleagues in primary care. This is intended to improve access to specialist care and provide support to the development of more specialist skills in primary care. Creating greater integration between primary and

'The principles behind the idea of polyclinics are in line with the way that healthcare is developing across the world.'

secondary care also allows single clinical governance approaches to be developed for pathways that cross sectors. A good example is the way in which a shared approach across the health community in Sunderland has had a significant impact on reducing unnecessary dermatological surgery.

- **Create space for other services** including community health services and other related health, social care, leisure, housing and benefits services that patients, professionals and the community will value. This can improve convenience and create further economies of scale. Examples, from *Healthcare for London: a framework for action*, the Wellbeing and Treatment Arches Centre in Belfast and Sunderland are shown on page 4.

The patient's time has value

The NHS Confederation has been saying for some time that, if NHS services were designed as though the patient's time had some value, it is likely that the pattern of services currently provided would be very different. For example, if a GP practice does not provide phlebotomy the patient shoulders the cost of going to the hospital, parking and the time spent travelling and waiting. As a contributor to our recent *A clinical vision of a reformed NHS* report put it, many patients do not have much time to waste.

London – proposed services in a polyclinic

- general practice services
- most outpatient appointments (including antenatal and postnatal care)
- urgent care
- interactive health information services, including healthy living classes
- pharmacy
- community services
- minor procedures
- diagnostics – point-of-care pathology and radiology
- proactive management of long-term conditions
- other health professionals, for example, opticians or dentists.

Source: *Healthcare for London: a framework for action*.

Suggested additional services (from Belfast, Sunderland and elsewhere)

- citizens' advice, benefits, housing etc.
- dialysis
- chemotherapy
- teaching and training
- social care
- leisure and fitness services
- cognitive behaviour therapy (CBT) and other mental health services
- patient and social groups.

Questions of configuration

The London model

Healthcare for London: a framework for action proposes a system of polyclinics serving a population of 50,000 that encompasses a range of options, from a single centre – which may be free standing or part of a hospital campus – to a much more accessible federated or virtual model. See Figure 1 for different options for organisation.

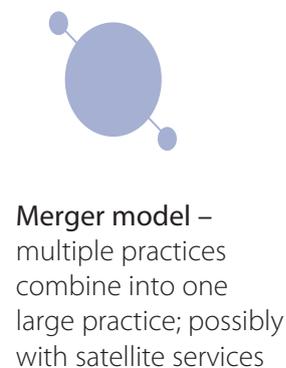
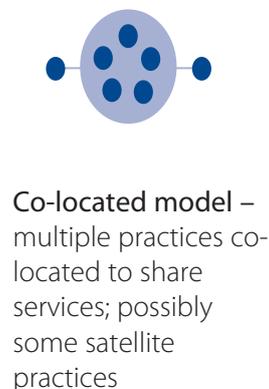
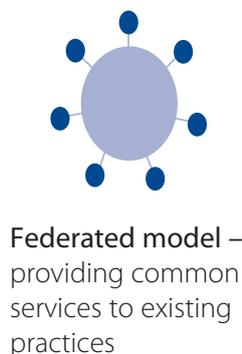
The following case studies outline how primary care trusts (PCTs) in Liverpool and Birmingham are making changes to meet local need.

The Liverpool approach

Liverpool PCT's ambitious plan for networks of primary care linking into neighbourhood health centres and NHS treatment centres, with a maximum of 15 minutes' walking time to GP services, takes a different approach to the size of the population served.

The Liverpool strategy aims to enable primary care and community services to achieve the highest possible quality of care in the primary and community setting, while allowing the appropriate movement of services currently provided in hospitals to settings closer to people's homes; and create opportunities to work with partners and stakeholders to ensure services are delivered in a joined-up way.

Figure 1. Polyclinics and GP services – three options for organisation



Source: *Healthcare for London: a framework for action*.

The evidence collected from stakeholder views, transport modelling and capacity planning indicated the following themes:

- the public are willing to consider the development of a new range of neighbourhood-based services, with extended opening times, as long as good accessibility is maintained to core primary care (continuity of care, medical advice and referral for specialist treatment)
- a large proportion of current community and primary care premises are not suitable for modern healthcare as described in the PCT's vision for primary care
- there is little capacity or flexibility in current premises to meet the shift of care from hospitals or to adapt to changing care pathways or healthcare technology.

Analysis suggested that:

- a population of about 20,000 to 25,000 makes sense for Level 1 facilities provided in neighbourhood health centres
- a larger population of around 100,000 to 150,000 is required for Level 2 facilities provided in NHS treatment centres
- good public transport access can be achieved with 20 to 25 centres
- the need to ensure that core primary care services are accessible within a 15-minute walk

'The Liverpool experience shows the importance of combining the involvement of local people and clinicians, with thorough and responsive analysis, to produce the best solution.'

indicates that there should be 50 to 65 access points around Liverpool.

Therefore, the key principles for the configuration of services based on the future shape of primary care in Liverpool will be:

- **Level 1 services** – neighbourhood health centres, offering the opportunity to enhance primary and community services (through more accessible opening hours and a greater range of primary and community services) will be planned and invested in on a population base of 20,000 to 25,000.
- **Level 2 services** – NHS treatment centres, offering the opportunity to shift services away from hospitals (through the provision of diagnostic, treatment and therapy facilities available for more accessible opening hours) will be planned and invested in, on a population basis of 100,000 to 150,000. See Figure 2 for a schematic map of Level 1 and Level 2 facilities.
- travelling times to the nearest primary and community service locations will be a fundamental factor in planning services:
 - patients' initial access to primary care via practice lists – the target will be to achieve initial access within a 15-minute walk for weekday hours
 - patients' access to full Level 1 services – the target will be to develop locations within a 15-minute public transport journey
 - patients' access to Level 2 services – the target will be to develop three locations within a 30-minute public transport journey.
- the need to achieve acceptable walking distances to initial primary care contact for advice and referral, leading to a 'hub and spoke' development of Level 1 services – this will mean the establishment of 20 to 25 Level 1 facilities (or 'hubs')

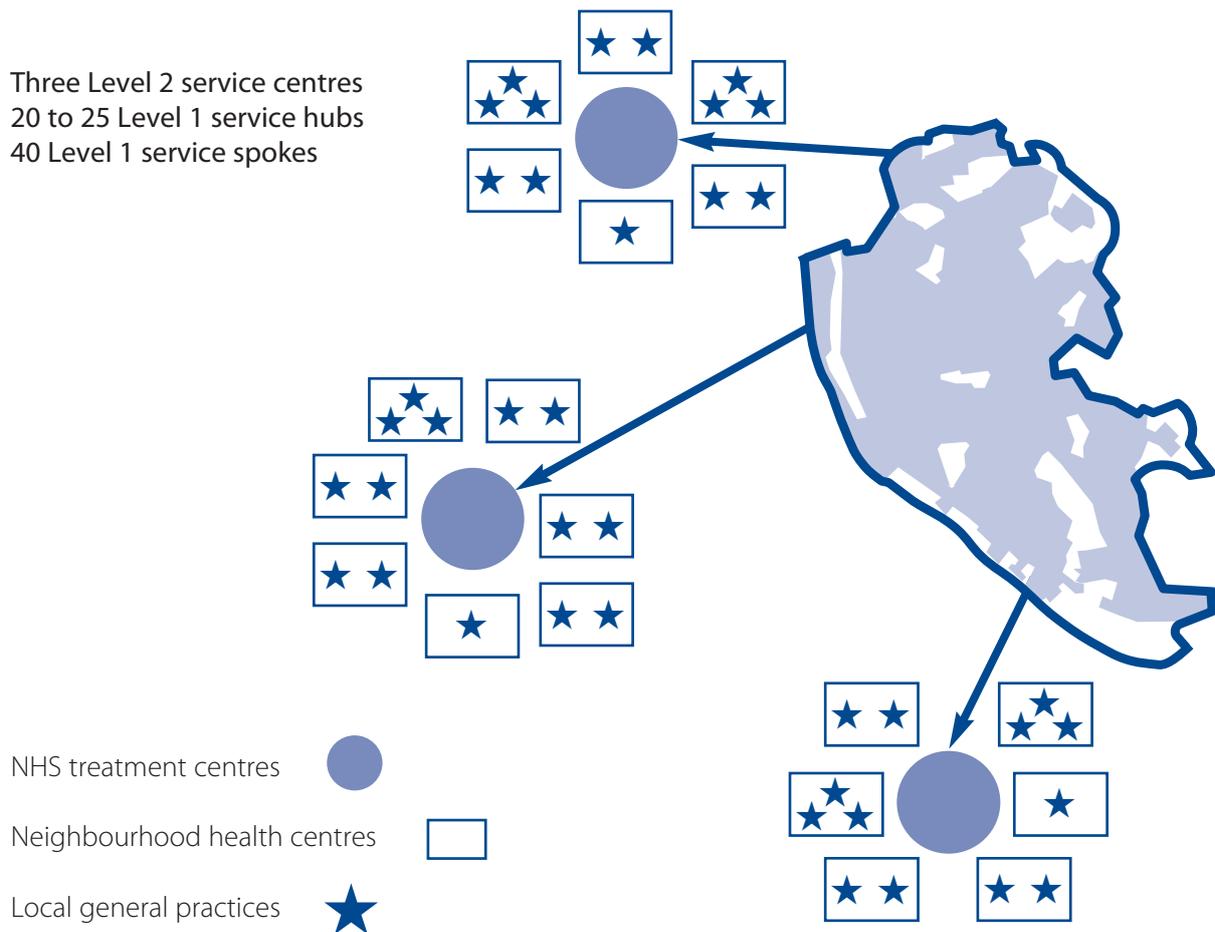
across Liverpool, supplemented by up to a further 40 locations ('spokes') for initial primary care contact for advice and referral.

- all GP practices will deliver services in line with the PCT's baseline specification for general practice.
- all healthcare facilities will be expected to meet required standards with regard to environment, health and safety, and functional suitability.
- all healthcare developments will explore co-locations and joining up of services with key

partners such as the city council, community and hospital providers.

The Liverpool experience shows the importance of combining the involvement of local people and clinicians, with thorough and responsive analysis, to produce the best solution. The ongoing process of engagement and willingness to take into account stakeholder views and to adapt to emerging evidence, means that the plans have been met with overwhelming public, political and professional support.

Figure 2. Schematic map of Level 1 and Level 2 facilities in Liverpool



Source: Liverpool PCT.

The Heart of Birmingham approach

The Heart of Birmingham Teaching PCT has taken a radical approach to improving quality through the development of an out of hospital care modernisation strategy. The strategy sets out how the teaching primary care trust (tPCT) will deliver its share of the Towards 2010 programme – an ambitious programme of health and social care redesign across the local health economy (a population of approximately 600,000) – as well as developing the capacity and capability of existing primary and community care services.

The model of care described within the 2010 model is that of delivering care as close to the patient's home as possible, supported by access to the nearest acute hospital when needed. In practice, this approach would involve a major expansion of community services with a substantial increase in the number of community staff. It would also include an accompanying enhancement of the facilities from which services are delivered and a much closer integration of services between the NHS, social care and the voluntary sector.

The model set out in the tPCT's strategy can be described in the following way:

- **Level 0** – health prevention and wellbeing; services developed in conjunction with every other level of care.
- **Level 1** – primary care; 24 centres for general practice and an increased range of primary and community support services. Some outpatient type appointments will take place in these centres. They would serve a population of between 10,000 and 15,000 with extended hours and weekend openings.

The tPCT is working with clinicians to produce a tiered service specification for the 24 primary care centres – a development of its previously published corporate franchise strategy. Some of the inherent systems will be tested with practices from April. This test period will allow time to review and refine the specification and to progress work on issues such as the financial framework and contractual arrangements.

- **Level 2** – outpatients and diagnostics; three centres where the majority of outpatient appointments will take place, together with the facilities to carry out tests and have x-rays and scans. These centres would serve a population of approximately 100,000.
- **Level 3a** – intermediate care; three/four centres providing a combined total of 75 community beds for patients who do not need the specialist input of an acute hospital but who still require some clinical intervention or supervision. One of these centres will encompass a dedicated stroke rehabilitation unit, while others will be developed in partnership with the local authority.
- **Level 3b** – urgent care; a number of centres providing treatment for minor injuries like cuts and sprains and other urgent health problems that prevent a patient from waiting for a normal GP appointment.
- **Level 4** – acute care; this significant shift of work will allow the acute trust to develop a viable business case for redevelopment and site centralisation in a new smaller acute hospital.

'The tPCT's strategy sets out how it will deliver its share of the Towards 2010 programme.'

Key lessons so far

Engagement not consultation

Liverpool PCT has dedicated very significant resources to talking to the public, local government and other stakeholders about the principles they should be using for planning, long before any discussions of the actual model. Its experience, alongside the difficult reception that proposals for polyclinics have received, demonstrates the importance of what the chief executive of Liverpool PCT calls 'industrial scale public involvement'.

Standards and systems

There is strong evidence that better-organised healthcare produces better outcomes and experiences for patients and is less stressful for staff.¹ Both international experience and the logic of the models discussed above strongly suggest that systems of care have to be purposively designed and supported by pathways and clinical governance. If primary, secondary and social care professionals are to work together effectively, then common approaches are going to be required, so that patients can be safely handed over and all professionals understand the role and capabilities of the others.

Information systems

The requirement for common systems and approaches implies that there should be one patient record and shared information systems. Unfortunately, NHS Connecting for Health was

conceived in quite a different way and information sharing across the whole system – to include social care and independent providers – is a significant challenge.

Incentives and payment systems

Any approach that seeks to reduce the use of hospitals or outpatients creates a strong financial disincentive for hospitals to collaborate. The money a hospital saves when an outpatient attendance or diagnostic procedure is moved to primary care is low, meaning that income falls much faster than cost. There are solutions, but the tendency to treat the tariff as though it is written in stone is a problem here. Any developments in this area are by definition going to be out of line with the tariff which, at best, reflects the average cost of practice two years ago. It is important to identify the right thing to do clinically and to make funding flows support this. Gainsharing, transitional relief (subject to the constraints of the competition code) and a variety of other mechanisms are available to deal with this, but it requires high-quality and mature relationships.

Impact on other parts of the system

Integrated polyclinics with their own in-house pharmacy are seen as a potential threat to independent pharmacists and there may be similar threats to other contractors and PCT provider services. However, there are ways of rectifying this, for example, by using e-prescribing so that the local pharmacists can provide services to patients.

Change before moving

An important lesson is that ways of working should be changed before moving to a new building, where practical.

Design

It is important to have a well-designed building that makes extensive use of natural light, shared common areas and reception space, and a flexible design that allows multiple uses with a few rooms dedicated to special purposes. The ability to extend and to dock mobile imaging or other services is also an advantage. Professional interaction is one of the key benefits of the polyclinic model, so including space that allows different professionals to meet and work together is very important and should not be regarded as a luxury.

Good access to public transport and the availability of car parking for patients and staff is an issue. Some of the patients at the Berlin polyclinic, Polikum, were prepared to move doctors rather than follow them to a new site with limited car parking.

Misconceptions and concerns

The polyclinic model is not a panacea. It represents the culmination of a number of long-term trends in healthcare delivery. If done well, it will build on the best of primary care. This section examines misconceptions and concerns, some of which will prove to be valid if the model is not carefully implemented.

Making savings

The Patients' Association was reported in the press as saying that the model is all about saving money.² However, it is missing the point to say that the main reason for pursuing the polyclinic model is to generate savings. The polyclinic model is designed to improve the quality and effectiveness of services for patients and the efficiency of providing services for organisations and their staff. These benefits may not always involve cost savings. Department of Health (DH) and Treasury documents seem to suggest that out-of-hospital care is cheaper. However, there is sparse evidence to indicate that savings are made by moving care from one location to another. Primary care buildings tend to be cheaper than hospitals but little money can be saved unless the hospital is actually closed, which is unlikely. There will be examples, such as the Heart of Birmingham case, where the new model allows a hospital to consolidate and make net savings. However, in many cases dispensing with a workhouse and replacing it with a 21st-century building will mean that any savings made are required to meet the costs of new capital. There is stronger evidence that well-organised and integrated systems improve cost-effectiveness, reduce follow-up appointments, reduce duplicated tests and improve the quality of care. These may produce savings, some of which may be 'cashable'.

Increased cost

In direct opposition to the Patients' Association, the British Medical Association (BMA) suggests that the model may increase costs by creating too much capacity.³ While too little capacity is inflationary there is also a danger here. Increasing capacity, particularly in areas such as minor injuries or walk-in centres, can lead to increases in activity that produce very little benefit or simply replicate services that have already been paid for in primary care or hospital services. The illusion that savings are being made is created because the average cost of these treatments falls. However, the total cost to the whole system may be rising, particularly as the fixed costs of acute providers are very high. The only way of dealing with a loss of income in the short term is often to look for income from other sources. The problem of supply-induced demand is a particular hazard here – increasing the availability of services produces demand, the threshold for treatment falls, but little health gain is produced. This means that additional services need to be thought about very carefully to ensure that, if they are providing a substitute for existing services, the existing services reduce their capacity correspondingly or shift to other types of activity, providing this is affordable and actually required.

Rural areas

The BMA is concerned that the polyclinic model is inappropriate for rural areas and that introducing it would waste money. They are almost certainly correct, although elements of the virtual model could be adapted to market towns in rural areas and different solutions could be developed based around community hospitals.

The end of general practice and threats to continuity

The Royal College of GPs (RCGP) is quite clear about where it stands:

“Unfortunately, the polyclinic or super surgery idea as it stands plays down the importance of general practice in favour of ‘Martini’ healthcare, which is fine for people who only need to see a doctor occasionally and are otherwise healthy and able-bodied, but will be a very different story for more vulnerable patients who need their GP.”⁴

However, the case studies presented above and international experience suggest that there is no need for the key elements of general practice to be undermined. The Berlin polyclinic, Polikum, uses a web-based scheduling system to ensure that patients who want to see their own primary care doctor can do so. The other models presented above also respect the importance of the patient-doctor relationship and so can maintain continuity for those who need and want it.

While the NHS Confederation has been critical of the way that recent policy has ignored the importance of continuity, it is possible to overstate the case. Evidence compiled for the Service Delivery and Organisation (SDO) programme showed that face-to-face continuity is important for patients who are heavy users of primary care and have multi-morbidity, but that continuity of information is probably more important. The results of conjoint analysis research in Liverpool and empirical data from elsewhere suggest that a significant number of patients will trade accessibility for continuity of relationship with a named GP. It may be that continuity is more important for doctors than it is for some of their

patients. Ensuring appropriate continuity and choice so that it can be maintained for those patients for whom it matters will be important in any new model.

Privatisation and reduced quality

There is concern that opening up contracts to the private sector will have an adverse impact on quality and that there is not a level playing field between the private sector and incumbent GPs. However, this seems to ignore the fact that GP practices are independent for-profit contractors already. The key is to ensure that the contract is properly set and monitored; attention needs to be focused on this and PCTs will need strong contractual levers and increased capacity.

A model in which polyclinics are staffed only by sessional doctors would not be acceptable for patients who feel that continuity is important. Nor will it be appropriate if providing high-quality, pathway-based care built on strong clinical governance is the priority.

Inequalities in access

The arguments here appear to be based on a presumption that polyclinics will be single buildings rather than the more sophisticated systems of care that are actually being proposed. The name ‘polyclinic’ is clearly a liability in this respect. However, as noted above, there is some centralisation and aggregation implied in some of these models. The question has to be, to what extent is the compromise in terms of travel times offset by improvements in quality, reduced travel to hospitals and convenient appointment times? The most needy patients should receive the highest quality primary care.

Conclusion

The NHS Confederation has long believed that the only way improvements in health services can be driven forward is if patients' views are heard and acted upon. Patients and members of the public should be encouraged to take a substantial role in shaping their local healthcare system and be kept informed of progress and any decisions that affect them.

Involving local people in polyclinic development is particularly important, especially against the backdrop of public concern and criticism. As shown in the Liverpool case study, Liverpool PCT's development of services combined the involvement of local people and clinicians with thorough analysis to produce the best solution, leading to plans being met with overwhelming support.

Discussions with a mix of managers and clinicians at an NHS Confederation event earlier this year showed general optimism about the potential for the polyclinic type of care. There was also a strong view that the polyclinic model need not, if carefully executed, disrupt the elements of general practice valued by patients.

The model is based on a number of common design principles and there are several ways to turn these into service models, depending on the local context – for example, looking at what is already available and what patients and the public prefer in terms of access and the quality of other services.

Some element of standardisation, or at least the use of pathway approaches, makes the design and operation of more integrated systems easier to achieve. This is also important for developing shared clinical governance that will be a key part of any model that brings GPs and specialists together for managing patients with complex long-term conditions.

Both payment and commissioning systems need to start by asking what the right thing is clinically and what will most benefit the local population. As the tariff will always lag behind leading edge practice, local flexibility and innovative solutions will be needed to manage transition and share the gains between hospitals and primary care to produce more cost-effective care.

Workforce and systems redesign will be an important part of creating a successful polyclinic model. A polyclinic with multiple receptions, separate records and different systems would mean that many of the advantages that could be available would be lost. Where possible, details should be worked through and implemented before a move to new buildings.

Better information and research on the cost-effectiveness of the models is required. A key learning point is that it cannot automatically be assumed that the polyclinic model is cheaper. It may be higher quality, it could well be more cost-effective and it could reduce the use of hospitals significantly, but whether these savings can be turned into cash that can be redeployed is doubtful. There is a tendency for capacity freed up by moving activity to a polyclinic to be filled with additional work. This adds to costs and if there is a drop in the treatment threshold this activity may not be cost-effective. Making the most of the expertise in the hospital and avoiding this risk means that significant changes to the hospital will be required, alongside a redesign of elements of primary care.

For further information on the issues covered in this report, contact Nigel Edwards at nigel.edwards@nhsconfed.org

Further information

Healthcare for London: a framework for action.

www.healthcareforlondon.nhs.uk

Our NHS, our future: NHS next stage review – interim report.

www.dh.gov.uk (Gateway ref 8857)

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Ideas from Darzi: polyclinics

Professor Lord Darzi has been commissioned to carry out a review of the NHS in England. This report examines polyclinics, a high-profile feature of his vision. It outlines the key design rules underlying the idea of polyclinics and

examines three possible models for polyclinics. It then addresses key lessons learned so far from these approaches and misconceptions and concerns arising in reaction to the polyclinic model.

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