



‘Polyclinics: an integrating or disintegrating force?’

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The ‘NHS Next Stage Review’ being conducted by Lord Darzi has been billed as a ‘once in a generation’ opportunity to reinvigorate the health service.

Consonant with the review, Civitas is hosting a number of high-profile debates to explore the potential for consensus on some of the key themes. The aim is to bring together the grassroots of the medical profession, along with key stakeholders in the NHS, private sector and politics, in healthy, open and unassuming discussion, independent of government.

This is the third in the series, looking at the highly controversial issue of polyclinics. Engaging an audience of around one hundred interested delegates were **Professor Steve Field** (p.2), **Professor Steve Smith** (p.6), **Dr Oliver Bernath** (p.9) and **Professor Martin Roland** (p.13), with commentary by **Professor Sir Ian Kennedy** (p.15).

Comments (p.17) were also heard from: **Professor Nick Bosanquet**, **Dr Deborah Colvin**, **Dr Paul Conley**, **Dr Richard Taylor MP**, **Paul Robinson**, **Dr Francis Keaney**, **Andy Cowper**, **Dr Rodney Burnham**, **Professor David Haslam**, **Professor David Taylor**, **Dr Geraldine Strathdee** and **Nick Seddon**.

Introduction: Professor Aidan Halligan

There’s not been anything quite so controversial as polyclinics for quite some time; perhaps because we’re challenging tradition and custom in quite an open way and looking head-on at the power dynamic between primary care and secondary care.

Does it risk a case of ‘what the cat offered the canary’, with primary care swallowed up by secondary care and the possibility of increased disintegration? Are polyclinics the emperor’s clothes – it’s certainly a new, untried, model – or could they actually serve as a means to the integrated care we all so crave?

Professor Steve Field
Chairman, The Royal College of General Practitioners

Before I start, I should outline the role of the GP, not least because it gets played back to me by politicians in a very different way from what I understand it as and so leads to perverse policy implications.

Dr James Willis, who's one of our gurus in general practice, described it as this:

- Open-ended;
- Inclusive, rather than exclusive;
- Dealing in wholes, rather than parts;
- Personal and continuing. It means making patients feel you care about them and building respect, trust and personal integrity;
- Founded on science and evidence, but also involving the reconciliation of incompatibles, irrationalities and impossible expectations;
- Rejecting the inhuman, the formulaic; instead involving privileged access to people's deepest secrets, their bodies and their homes.

Professor David Haslam described the difference between generalists and specialists: GPs try to exclude the presence of serious disease while specialists aim to confirm the presence. GPs accept uncertainty, explore probabilities and marginalise danger, while specialists reduce uncertainty, explore possibility and marginalise error.

Primary care deals with most health problems for most people most of the time. Its priorities are to be accessible as health needs arise, to focus on individuals over the long-term, to offer comprehensive solutions to all common problems and to coordinate services from elsewhere when others are needed.

Crucially, we need to work with consultants and specialists closely. We need to work together – and that's one of the messages I want to put across. *I don't oppose polyclinics per se, just the way they are being introduced and perhaps some of the dogma behind it.*

George Monbiot in *The Guardian* wrote very recently: 'Labour's perverse polyclinic scheme is the next step in privatising the NHS', in which he lamented everything is getting bigger and further away. And that everything includes health care. Ara Darzi insists that polyclinics offer more choice and a one-stop-shop for health with access to a wide range of services, but at what cost to patients and the public?

The small business model of general practice was one of the founding bricks of the NHS 60 years ago; GPs were paid off by having us as independent contractors. Since then we've improved the quality of primary care, so that around the world the general practice is known as the jewel in the NHS crown.

As a College, we're therefore very concerned about the plans to introduce polyclinics across the whole of England. *It risks a 'Martini' style of health care: anytime, anywhere and any doctor.*

Newspaper headlines shout about problems of access and out-of-hours care, but even if polyclinics work for the young and upwardly mobile – like many advisors to government – they certainly won't suit the elderly, the vulnerable and those with long-term conditions.

General practice is geared towards all of us; it works because it looks after the patient as a whole for the continuum of their life. It is the workhorse of the NHS, with over 90 per cent of health care problems dealt with in primary care and over a million consultations every day.

It's also widely acknowledged as being the best in the world:

- In the Commonwealth Fund survey in 2006, we were highlighted as being the best of the six major countries that were investigated;
- A Healthcare Commission survey of general practice showed 75 per cent of people were completely satisfied that their main problem had been dealt with, with only 3 per cent unsatisfied;
- General practice is the most cost-effective part of the NHS, with GP consultations costing less than outpatient, A&E consultations or ambulance calls. In fact they're about the same as discussing your concerns with an anonymous nurse through NHS Direct.

So if it's so good, it begs the question why do politicians want to do things to it? And it's because the quality of care is not universal. We don't have GPs in some of our inner-city areas, or indeed our rural areas. The quality of care is patchy and needs to be improved.

To help our debate as a College, we convened a meeting of about 60 patients from London to look at the London Darzi proposals. The overwhelming majority were not sold on the idea of polyclinics and expressed reservations about the continuity of care and the doctor-patient relationship.

Anthony Halperin from the Patient's Association said 'what I believe patients want is to see their own GP, to have a regular relationship with their own GP and when they require further or more specialist care, to go to a hospital'. What the polyclinic risks doing now is interposing a third layer, the polyclinic, in the health system and I don't really see what the advantage is.

As well as threatening the continuity of care and the doctor-patient relationship, polyclinics would mean that patients need to travel further to access health care – a particular problem in the rural, as well as inner-city areas.

We should be clear that it isn't a quick fix for the NHS, for PCTs to herd GPs into big buildings. What we've got to do is build on the quality of care we've got from the smaller practices, so they work together in a federated way.

There are issues with single-handed GPs in some areas and the access to some care, but in other areas single-handed GPs provide fantastic care; what we would advocate is those single-handed GPs working together closely auditing their care and working with other GPs. By contrast, centralisation

into polyclinics could lead to fragmentation of care; it doesn't mean that if you have lots of doctors working together you can necessarily see the same doctor and follow on through that pathway.

It's interesting that the Russian system of polyclinics are being dismantled, yet now some of the people running them are saying hold on, let's not move to the UK model of general practice because they're now copying us. This is a real, real, problem.

What we want to do is move towards a new model of care, which might involve large practices, but also smaller practices: the federated model of general practice. We've done a paper on this – the roadmap – looking at how we could get small and large practices working together; how we could get better access to diagnostics; how we could build on the best of the best of general practice. We call it the federated model because by getting practices working together and working with a large centre – call them polyclinics if you will – but in a federated way.

Federations will allow GPs to provide local solutions to local problems; polyclinics or large impersonal Darzi centres being imposed in all PCTs in this country – particularly where high quality practices already exist – will not. They risk fragmenting care. It's remarkable we've got a system where lots of money is going into building infrastructure and new centres, and yet you've managed to alienate the professionals at the same time. It's complete nonsense.

Of course we support all of this investment – and support the move to commissioning and working as a primary health care teams – but think we should be working together much more closely. We're behind the introduction of finance, we're behind change in the NHS, but the professions need to be leading this: and this is the message we gave to Gordon Brown when we breakfasted with him last Friday.

David Cameron on the other side of the house said recently: 'where they [polyclinics] occur they should occur naturally as the voluntary combination of free agents, not as the latest structural reorganisation in the NHS'.

If large centres are going to come in and if you want to call them polyclinics – though we don't particularly like the name – then please do it with the support of the professionals and with proper consultation of the public and patients. The one per cent response rate to the survey in London is just not good enough.

Yes we do need to do something about improving performance, yes the college is ready to lead on that – we have a very good curriculum for training, continuing professional development and a pilot of provider accreditation – but please don't throw the baby out with the bath water.

In discussion:

Buildings are irrelevant; it's how the system works and how the professionals work together for the benefit of the patient, through clinical pathways and through general practice – the glue that holds everything else together.

The amount of time we've spent speaking about polyclinics with Ara Darzi in the primary care review panel is less than we have tonight; it really hasn't been on the agenda and is an unfortunate

consequence of an interim report published before we started talking. If we could put this to one side we could move on.

What we've been trying to push very hard is commissioning with specialist input and the importance of moving to an integrated care model. The vision that I have is to take the professionals with us and build shared autonomy until we have built an integrated model across the locality. A key part of this is a shift on the part of GPs from just looking at the patient in front of them to also looking at populations, as is a shift from splendid isolation to working as teams.

We've done some work with physicians and paediatricians here to look at how we can move things forward. We have increasing respect between primary and secondary care, but need to move this forward. The only thing I'd take odds with Steve [Smith] about is the description of outcomes based on needing to get the technology quickly as the be all and end all. In fact, most consultations in primary care are about the health of the individual. The amount of care in terms of those serious conditions is small in volume, but high in importance. We need highly trained, up-to-date GPs working seamlessly with specialists in a variety of models, with the patient at the centre of everything we do.

The paediatric issue is an intriguing one here. Children are part of a family who have social, emotional and schooling issues. There is a broad role for the generalist, but I've had a lot of meetings recently with paediatricians about how we could reach an integrated pathway for children, which would involve assessment centres, for example. Diabetes is another. The management of a stable diabetic is rules-based and best left to nurses who are better in this than we are. But most diabetics also have heart disease, renal disease and psychological and family problems, and the GP best placed in this case to manage co-morbidities and complex care. Conversely, we need help from specialists to provide more expert care in specific areas.

In my free time I help teach at one of the leadership colleges in Boston and the model we follow is that of disruptive innovation, which predicts that as you move towards a more rules-based system, you will move away from the specialists and towards the consumer/patient looking after themselves – as with diabetes. As technology improves, we will need to focus on self-care much more. This, and the importance of innovation and academia in primary care, must be a focus of the Darzi review.

As far as GPs themselves go, I do think it is unacceptable that single-handed GPs can work without sharing and auditing their practice with other GPs. PCTs haven't taken their responsibility of sorting out poor practice and performance and they need to. In some PCTs GP appraisal is not happening, in some there aren't any medical directors; how can you take forward basic safety issues without the leadership in these organisations?

The sooner we can sort out some of the perverse issues of the NHS, such as SHAs and how they manage their PCTs, the sooner we can move on. As soon as someone says something in Downing Street, it tends to provoke a knee-jerk reaction and an amplification and speeding up of change; at the moment there's a panic to get these Darzi-led centres in all of the PCTs, when really what we need is more time to consult with specialists, GPs and patients.

There is also an issue with the current structure in how we can work with patients, not just for targets. In breakfast last week, Gordon Brown said he'd heard this said a lot and wrote it down; whether this gets translated into action is another matter.

The Darzi review must also address the bizarre system of workforce planning we currently have, where we tend to create the same number/type of widgets, increasing or decreasing the silo – having more physios one year and less the next – whereas what we need to do is look at what health care will be like in the future and the staff we are likely to require. For example, the training of primary care nurses is terrible, because the outcomes and training just aren't there. They are training in hospitals, when they need to train in primary care and to facilitate self-care. We need to tear up the old rules on workforce planning and do something very, very different.

Professor Steve Smith
Principal, Faculty of Medicine, Imperial College London and CEO of Imperial College Healthcare NHS Trust

Can I start by saying what I'm not going to do is get into the usual professional mudslinging between specialists and generalists, because I think there's a wide recognition that one of the most crucial issues facing health systems globally is the integration of health care.

I do however think it's extremely important, despite what Steve Field says, to recognise where our health system sits in the league tables of the world. Steve quoted the Commonwealth Fund and it's absolutely right, and rather surprising, that we are seen to have one of the best primary health care systems in the world.

But what they seem to have missed, however, is patient outcomes, where the UK is far and away from the best health care system. In fact, we have some of the worst outcomes for stroke, cancer and cardiovascular disease – which kill 75-80 per cent of us. This puts us down at the very bottom in terms of preventable deaths *before* the age of 75.

So before I start with my Royal College hat on, or professional specialist hat on or saying how wonderful GPs are, the first thing that professionals have to do in this country is ask – after 60 years of the health service – why we seem to be the leader in terms of social provision yet also produce some of the worst results in the developed world?

Personally, I don't give a damn what the system is, but what I do care about what is best for patients; and I don't just mean those people out there, I mean for me, for my family, for my friends. I think the chances of dying from breast disease in this country should be roughly the same as the chance of dying from breast disease in France, Germany, Holland or Japan. Unfortunately, it is far from the case.

So where do polyclinics fall into that system? Well, we could say that the poor patient outcomes are because our secondary care system is useless; it could be because we have very poorly trained surgeons; or that we don't have enough MRI machines or access to diagnostics; it could be that we have pretty ropey research and are not good at taking innovation forward; but I think it's probably unlikely. I think it's probably something to do with the system as a whole, with the system of primary care we have generated that is strongly disintegrated from the secondary care system and partially disaggregated from the tertiary care system.

Now, if the patients were compliant and did what the doctor said that might be fine, but fortunately one of the things we are dealing with is a completely different clientele who are not prepared to do what the doctor says; are not prepared to wait heaven periods of time. And judging from the stream of abuse that one of my more elderly patients was giving to one of my ambulance drivers this afternoon, this doesn't seem to be restricted to the younger generation.

The status quo as it stands simply isn't acceptable.

We are in a completely different environment and before we complacently think that the system we have had in the past is providing what patients want in terms of satisfaction and outcome, we need to look very hard at the opportunities.

Do polyclinics provide an answer; do they attempt to provide something that goes more towards an integrated system? To me, Steve Field's idea of a hub-and-spoke model seems a very attractive one, but what we have to recognise is that the old days of this Dr Finlay idea that you go to the doctor who listens to a careful history, puffs on the pipe and thinks about you and says 'that person's got throat cancer' are gone. That isn't how it works. Rather, someone has a symptom; some fancy test usually provides a diagnosis that usually costs quite a lot of money; and then you do a whole host of other costly things.

The nature of medicine has fundamentally changed. I know there's a whole host of general practice that has nothing to do with diagnostics, it's to do with those personal relationships – extremely important though they are – *but it could just be that the reason why we have such poor figures in cancer, stroke and cardiovascular disease is because the system we have got does not facilitate closeness between the fancy and less fancy medical care.*

It may just be that polyclinics might be able to bridge some of the gap; a mechanism for so-called integrated care. Though it is unclear what we mean by this. Does that mean that you go into one room, have a diagnostic done in the other, have an operation in the next and pop home for the evening? No. But integrated health care doesn't involve going to a single-handed practice in Ealing, then going to have an X-Ray, then going back home, then the next day going to have a blood test, then the blood test gets lost, then its repeated and it goes back to the GP, then you go to outpatients, have some more tests etc. I can't remember how many separate visits it takes to have your gall bladder removed! Patients just feel like shuttlecocks in this system; there is little or no integration of care.

If we continue to work in our silos, literally, then it is inevitable the patient loses out.

Whatever your view is on polyclinics, the bottom line that the status quo can continue just simply isn't good enough. You could argue in the past that there isn't enough money, doctors, MRI machines or resources, but we have had a very handsome increase in health expenditure in this country, and such arguments won't wash anymore.

A system delivered in 1948 is unlikely to be one that provides for the consumer needs of a society that has changed out of all recognition. At the very least polyclinics might have the opportunity to integrate more closely the care provided by specialists and generalists, for if you have diabetes, renal disease or mental illness for example, specialists have a lot to offer. When you have cancer, you don't want to talk to a generalist, you want to go to the person who knows absolutely the most about that disease. We have to find a way which equitably and financially brings those mechanisms together.

Interestingly, we at Imperial have a highly successful polyclinic, which integrates primary with specialist care, and uses the latest equipment. It's in Abu Dhabi. It's an extremely successful diabetic clinic; it runs with generalists, with diabetologists, with dieticians, cardiologists and renal medicine; they are all brought together for the patient, rather than the patient having to go off to see each independently. And it's not massively more expensive.

The system we have has not delivered for the British public; it has not delivered outcomes and levels of satisfaction which they would find acceptable. We need to look at new ways forward; I don't know if the introduction of this new system will be a great success, but we have to start changing the system in ways that seem rational and reasonable and not just talk about doing it.

If we are serious about integrated care, we do need to start creating new organisations and new structures, which can better meet the needs of patients. After all, the bottom line must be patient outcomes and patient satisfaction.

In discussion:

It is absolutely outrageous that organisations function just to look after themselves.

To give you a very simple example of the reverse, thinking of patients first. At Imperial we are in negotiations with the Department to allow general practice to run *completely* one of our very large A&E departments, lock, stock and barrel. Why? Because an experienced GP will more than likely make a better decision on whether extra, urgent, care is needed than a 28-year-old SHO. I didn't think GPs would be on for that, but believe me they are.

But what's the consequence? It means the trust will lose money, because I won't get income to pay for the consultant A&E specialist etc. But does that really matter? No, because I don't need to employ them. Financially the system is pretty neutral and will then enable us to focus on the 25 per cent of care that arises from emergency admissions.

There is also the issue of the GP going native, but what matters to me is not whether he has or not, but whether he gets the right diagnosis and treatment, not take risks with my life then that's better.

Furthermore if we genuinely put patient's interests first and give them choices, all the evidence actually points to the patient being a lot more conservative with resources than doctors and certainly the hospital doctor.

So again I would argue our system is not right; if the patient's interests are really at stake very different and surprising patterns of care would, I'm sure, emerge. Almost all of us agree something needs to be done around integration of care. How we get there and what it involves at the end, none of us actually knows, but we know it's the right way to be going.

To give an example: gynaecology. If you have something in the main that is 'gynae' you should go straight to a specialist. If you can construct services around all the things you need for women's health, right the way from the specialist to the specialist nurse to the generalist, you may start to get an integrated service. In one aspect of women's care we've been doing this for centuries: midwifery and obstetrics. As a specialist, the last thing you want to be doing is a normal delivery, because it's not your job, you don't need to be involved in it, and there are highly competent midwives who get ridiculously high levels of satisfaction. There is a pattern of integrated care.

Paediatrics is another area where a similar model of direct access to a multi-specialist team could work.

It would also make sense to introduce integrated clinics. Forty per cent of people seen by the medical profession already have a known diagnosis and do not need to be re-diagnosed; instead they need to understand the complications of their condition. Why should someone with established diabetes need to see a consultant, rather than a specialist nurse or dietician?

We need to break the system apart to produce integrated care and then work out financially how it's best to do that; my inclination is that we need competition between integrated health systems, not between primary and secondary care. I believe in competition, but it needs to be creative, not destructive; when it comes to hard outcomes we compete like hell against US outcomes and our colleagues.

Other systems of course do things a different way, but to take the example of France where there is greater consumer empowerment, there are a few things that clearly distinguish it from the UK system: one is you don't have to see a GP to see a specialist and the second is they have an institutionalised co-payment system.

Dr Oliver Bernath
CEO, Integrated Health Partners

For me, the polyclinic model has to be either:

- An operational model to deliver integrated care; or
- An infrastructure that's the answer to an operational need around integrated care.

I want to tell you a couple of patient stories that say a bit about where I'm coming from.

I'm a neurologist who's worked both in Kaiser Permanente and in the epilepsy centre of the University of California.

A typical patient I saw at the Univ. California medical centre – which, bear in mind, is one of the top ranking institutions for epilepsy care – would be a 40-50 year old who'd finally been referred to neurology, despite a long history of epilepsy, typically moderately controlled with two or three fits per year or perhaps just the one with good medication.

To the referring doctor this appeared quite satisfactory, but as a patient it's far from it. You don't have a driver's licence, you will have lost pretty much every job you've ever held and your professional life is in all likelihood on a downward slope.

This is tragic, particularly when you consider we could take this patient, do an aggressive test to see if it's an operative lesion and, if so, operate and discharge the patient hopefully seizure free. A wonderful outcome, but a terrible one if you think the whole thing should have happened thirty years ago.

Now, when I moved to Kaiser and became the Head of Department there, it was my job to ensure this *did* happen. But to my surprise at Kaiser I'd have my primary care colleagues ringing up and saying 'Oliver, I've got this 22 year old woman who seems to me to have temporal epilepsy, do you want to have a look at that a bit more intensively?'. I ask how many fits a year... 'ah, one', to which I first said 'I would thought that would be a satisfactory outcome', but he would say 'no, not at all, what is the long-term future of that?'

Unsurprisingly my rate of early assessment and operation was much better at Kaiser than the academic institution.

To move back to the UK. When I came back from the US, I was hired by St. George's Medical School in Kingston to set up an epilepsy centre. However, after a few months I made two observations: one, that there's no thought about funding anything; two, that in person I knew not a single one of my primary care colleagues. I even started going out to primary care practices and giving seminars to patient carers etc., where I thought I would meet the GPs, but I didn't.

This is just an inconceivable way of working. How am I supposed to identify early sufferers of epilepsy when from the GPs point of view he'd have to send a referral letter to see me – which at that time may take nine months – when a relatively simple question over the phone would have done the trick?

The disconnection between the specialist and primary care is the fundamental problem, which is what we must try to bridge in bringing about integrated care.

At Kaiser, we were all part of the same doctor's partnership (Kaiser has three companies: an insurer, a hospital operator and the doctor's partnership, which, incidentally is for-profit and hoovers up the surplus of the hospital operator every year). Therefore, all doctors, regardless of speciality, are part of the same partnership. It was of no benefit for me to say this is my primary care colleague's

problem, because it was our problem. We, as a financially thinking organisation, could only survive if we could avoid patient care complications that cost money; what is attractive is that this is a full alignment of patient interests with the financial interests of the organisation – a rarity in health care.

Now, I'm not saying we can transplant Kaiser to the UK and there's your answer, because Kaiser has a certain organisational structure, and one criticism is that it has never had rural reach, such as that provided in the UK by small GP practices, and this is the last thing we would want to disrupt.

However, what we must try to offer – and what we try to offer at IHP – is help for local GP practices to consolidate in a way that enables them to integrate care and be the motor behind the health care community. We, as an organisation, would enable GP colleagues stay in independent practices, but help when it comes to management infrastructure, data crunching etc., and operating capital risk and clinical services where the practice is too small. This may be through chronic disease management programmes or diagnostic facilities, for example.

The secret source is finance, the budget. Practice-based commissioning (PbC) budgets have a little spark of the idea in it by saying there's one budget-holder, the GP, who is accountable for where this money gets spent, but it's not really delivering that.

A more advanced option, call it PbC Plus, could do this. If a GP practice could take on a hard budget and if they're actually responsible and autonomous enough to use it effectively, then we could lose the balloon-squeezing and redistributing of problems elsewhere. We would have one balloon; and enable the GP to work with their epilepsy specialists and ask, as a team, how do we look after the patient?

How do polyclinics fit in? Babcock & Brown, our investors, are absolutely right in realising that you need an operational idea before just putting infrastructure on the ground. Too many LIFT schemes have seen services relocated into new buildings with higher costs and yet the services are just the same as before. Too many of these new health centres are just facilities management centres; they make sure the light bulbs are on, but in terms of how the services actually work together and provide better patient care, that's nobody's responsibility. Yet this is exactly what needs to be delivered.

The polyclinic should be the operational delivery of an integrated care model, with or without a building around it. The question has to be what organisational delivery do we want to change and, following on from this, what buildings do we or don't we need?

In discussion:

With regard to commissioning, I have high hopes for the paper on commissioning by Mark Britnell and David Colin-Thome in June/July, which will, I understand, push integration strongly within a new primary and social care strategy and enable GPs to really influence what happens in terms of PbC.

The glue that holds Kaiser together is not having the financial envelope open, but the financial binding into one budget. What is important is aligning financial incentives and monies coming out of a unified budget. And patients have choice – they don't have to go into Kaiser.

From a structural point of view, what is missing is a natural counterpart on the provider side to that on the commissioning side. In Germany for example, I wouldn't be sending my invoice to the regional commissioning organisation (i.e. PCT), but to the doctor's association who would then negotiate with the PCT.

Commissioning as it's set up in England is trying to do too much; the commissioner should determine what they want to buy and at what price *but not* get into the business of trying to tell the provider how to do their job; you need someone on the provider side to do that. Otherwise, the buyer and the seller end up being managed by the same organisation, which makes no sense.

It should be up to the providers to display *value*, in order to see where the waste and value lies. For example, a patient waiting eight weeks for an MRI scan is eight weeks of waste, but there's no price tag put against this wait in terms of value to the patient. If there was, and if the utilisation rate of an MRI scanner fell from 120% to 80% yet there was no wait, in pure cost terms this would be less profitable, but in value terms it may well be more.

When I first talk to my GP colleagues I typically ask them how much they spend on an asthma patient per year and they don't know. Then I ask them how do you compare to your peers and who gets the better outcomes? Again, nobody knows. Yet in any other industry providers certainly would do. It's just inconceivable that a provider knows so little about the product that they deliver. Providers should be able to tell PCTs that they've spent x amount on a 23 year old who has asthma and diabetes *with said outcome*.

PCTs will then have the opportunity to shift business to you if your colleague gets a worse outcome for a higher rate. If the focus was on mapping out value, not cost, I'm sure we'd be working very differently. The power of a protectionist trust would be dramatically reduced and the pressure would be on to work for the patient.

Much has been said about the importance of (and current lack of) communication in the NHS, for example. It was exactly part of the system at Kaiser that I had a roaming phone where generalists and specialists could contact me all of the time to ask questions; transferred to Kingston in the UK and it didn't take long for the Chief Executive to say if you're spending half your day answering the phone with generalists' questions, we're not getting any income.

On top of this we also need to think about communication with the patient. Integrated care is about integration between primary and secondary care, but also guided self-care of patients. 99.99 per cent of the time the diabetic patient looks after themselves. In epilepsy it's largely the same.

In Kaiser, my mobile phone was not only available for GPs to ring in, but also for patients. As an epilepsy doctor, patients had my email address and phone number to ring at any time if there were any side-effects from medical changes. When I introduced this, my colleagues thought I was mad, but patients are extremely sensitive to not wasting a doctor's time, as they are with the use of other health care resources. I had very few phone calls and most of them I wished they had called me the day before.

To make guided self-care work we have to ensure the patient is capable of looking after themselves, but also that they are comfortable that they can do it. This comfort will only come out of the

assurance that the patient can reach somebody quickly if something goes wrong and if you can monitor those that are at risk. We mustn't forget the patient in any discussion of integration.

Professor Martin Roland
Director, National Primary Care Research and Development Centre,
University of Manchester

There's a danger of agreement here! Oliver wisely avoided the word polyclinic, because he was talking about function rather than structure. I am going to use the word, but I want to dissect the current debate in terms of what goes on in them. There are three things being talked about:

- Merging, or putting, GP practices into things called polyclinics;
- Putting community-based services into polyclinics (basically new buildings);
- Moving specialist care out into the community.

The most contentious issue is the first. There are good and bad things about this. On the positive side if you move small practices into larger ones they can share facilities and it offers the opportunity to upgrade the estate, which is seriously deficient in some areas.

So why would we say no? Because if you move disparate small practices into central locations then patients may have to travel more and if practices merge then patients lose choice. Patients also like small practices and on average – surprisingly to some – they do better in quality terms than larger practices. The reason for that is because quality of care in small practices is bi-modal. Small practices include doctors who are so good that they won't work with anybody else and so bad that no-one else will work with them!

So to just say that we don't like this model of small practices is too crude a way of looking at it; we should say yes to moving practices into polyclinics where the estate is poor and where the quality of care in those practices will be improved, but the blanket notion that everyone needs a polyclinic that GPs should move into is too simplistic.

Secondly, the issue of community-based facilities: district nurses, physios and investigative facilities including MRI and PET scanners, for example. In a sense this is easier. You don't want these people scattered all over the place and to put them all in one situation – including social services – seems to make sense.

But is it cost effective to do so? I'm surprised – or maybe I'm not – that there's been little analysis of the cost of it all. The Darzi review makes it sound as though we can have everything we've ever wanted, but actually we can't. Frankly I shouldn't have an MRI scanner in my polyclinic if it's only going to operate at 40 per cent of capacity and the local hospital with a more up-to-date scanner is trying to work out whether it can see patients up to 10pm to make the most cost-effective use of it.

Yes, let's have kit in the community, but not if it's going to make more expensive use of NHS resources.

Third, the idea of moving specialist care out in the community, closer to home. We carried out an evaluation of NHS pilot sites on closer-to-home and, to start with, an awful lot of them were actually not closer to people's homes! That aside, there are two elements to this idea; one is getting consultants out of their nasty hospitals and putting them in the community and the second is inventing new types of specialists in the community, i.e. GPs with a special interest (GPSIs).

Moving consultants out is inefficient if all they do is the same thing they did in the hospital. We've tried this before; it was called fundholding and they were called specialist outreach clinics. In this scheme, specialists saw less patients, they didn't bring the junior staff out with them and they didn't actually talk to the GPs either. If specialists are going to come out then they have got to come out in new models of working like Steve and Oliver have described; without this the situation will only improve in rural areas if we're starting to value the patient's travel time significantly.

To the new type of specialist: the GPSI. These are a really good idea and patients certainly like them. There's only a few caveats. Firstly, early work showed GPSIs may be more expensive than specialists working in hospital settings, because their salaries tend to be higher. But this has changed with PbR, where GPSIs can bid to provide specialist care in the community that the hospital doctors can't compete with because they can only bid at tariff. The artificially distorted market works in favour of GPSIs at the moment, but when that gets sorted out, we may find again GPSIs are more expensive.

However, if what we're trying to do is increase specialist capacity then we might put up with this, so long as their quality is good, which it probably is. The evidence from the fundholding era, particularly in relation to minor surgery, was that if there was inadequate support, there could be serious or significant problems of quality when you moved care that was given to specialists to generalists. There are also parts of the country where GPSIs are at war with their local consultants, which is unacceptable and probably gives unsafe and dangerous care.

But otherwise, indications are good. Government guidelines last year on how GPSIs should be trained are also welcome in this respect, though sadly they made it advisory rather than mandatory and required that GPs should have support from consultants, but not from *local* consultants.

One thing we should recognise with GPSIs however that we are likely to get supplier-induced demand. If I have a patient in my surgery with a bit of a rash that I don't really know what it is but it doesn't look too serious, I probably wouldn't trouble a dermatologist with it. However if I have a GPSI colleague who knows a lot about skin, I may well send him there – though there probably is a benefit to the patient.

So what can we conclude from this? At a time when the government is in trouble for wasting large amounts of money on the NHS and spending too much on doctors' salaries in particular, what's missing is sufficient discussion about how we can provide care more effectively, and more cost-effectively.

We risk an expensive excursion into building new buildings without adequate consideration as to what they're to do. Instead, we need to think very carefully about what the function of things that

go on in the buildings are and the impact on the system as a whole. We must, must, start looking at the system as a whole. The polyclinic model taken alone has the potential to fragment if the driver for Chief Execs is that if you don't stick one of these things up you'll lose your job – which is the sort of decision-making that goes on in some parts of the NHS.

If so, then we definitely won't get the potential we could do out of any new developments.

In discussion:

If I could change one thing in the next few months – not that there's a chance of this happening – it would be the payment system. Payment-by-results is payment by activity and a very good system when what you want is more activity, but for so many other things it really is a perverse way of doing things. The purchaser-provider split between primary and secondary care is so antithetic to integration.

And if we are talking about integrated care, we also need to think about how we keep care out of the hands of specialists, because they do very expensive things. Though we do need good communication with them!

Isn't it crazy that we cannot communicate by phone or email? In 1986 I set up a scheme in Doncaster called Boneline, which was a rota of orthopaedic consultants, who sat by the phone for half an hour each day for GPs to call in with questions about orthopaedic patients. It would be better to have this all the time.

**Commentary: Professor Sir Ian Kennedy
Chairman, Healthcare Commission**

Everybody thinks that peace has broken out in this room, but there's a large undercurrent of references to Stasi, the Soviet Union and governmental interference. Bear in mind this isn't a politics-free zone.

A lot of sub-themes have also emerged: that the NHS is still largely an information-free zone; of communication, competition and choice. Looking at GPs, for example, there's lots of claims about them doing this and that, but I haven't seen the evidence about GPs and the quality of care except through the Quality and Outcomes Framework (QOF), which may or may not measure much about the information of quality of care. Not least it doesn't measure misdiagnosis or non-diagnosis, because this doesn't appear in the figures.

There is also the extreme danger of talking about these developments in isolation. Polyclinics are one initiative of many. Sometimes the DH and others bring together a paper describing system reform of some such, when what it actually describes is about eight different initiatives re-

engineered as a coherent policy, when it's not. Polyclinics should be seen as interacting with many other things.

Where we have general agreement is that it should always be about outcomes for patients; that's what's driving us.

But then I heard that the NHS has not got a great deal to be proud of after 60 years in terms of the performance it's delivered by way of outcomes for them, which should persuade us of the need for change. It was put 'the status quo cannot and must not survive'. That of course does not mean we go down one particular route, but that the status quo is not delivering.

Yet then I heard, in my opinion, a good deal of romantic rhetoric about the glories of the existing system. To a degree I thought this to be out of touch. The 1948 legacy in terms of the division between primary and secondary care was probably the worst decision ever to inflict on any health care system. And that legacy may still be ruling us to this day.

Still, in that 'something must be done' there was a lot of agreement. 'Hub and spoke', integrated care, a federated model were all mentioned; all more or less aimed at bringing things together.

But the danger of that is that I've been in meetings for 40 years or so where we've always agreed that integrated care is a great idea, but everyone leaves the room with a different impression of what it means.

From this discussion we can, however, say that we're not talking about buildings; we may be talking about some kind of structures, but we are talking more about breaking the 'system' apart a bit and putting it back together in a different and more integrated manner.

If we do so, as Steve Field said, we should proceed slowly and plan a little more thoughtfully. And if we all agree that there is some 'hub and spoke' model of integrated care, it should be an operational model to deliver better care. In essence this is a way of doing things not an end in itself; a different way of working; a different pattern or model. Only if you can deliver what you are after should you pursue it.

And if it is going to be a different model, it must be managed to a large extent by professionals *in concert with patients*.

What concerns me though is that I did, nonetheless, hear echoes of tribal warfare and barriers. If you are claiming to have different ways of working, then you must put those tribal barriers behind.

Steve Smith talked wonderfully in terms of maternity care, but as someone who has done some investigations in this area, there are tribal battles between nurses, midwives and doctors, neither of whom presume to talk or listen to the other. We must confront this.

As regards the realisation of these needs, a few things are vital. The idea of financial incentives and whether it can be done outside the 'Kaiser model' needs to be taken forward; as does the idea of financial disincentives – the local acute trust not reforming for fear of losing income; as does the production of 'value'. Though value, in my opinion, is a term that has got hijacked by economists,

because what is really value is *what patients find valuable*. That may not relate wholly to money, rather what they feel they need against a legitimate discussion of what is possible and affordable.

To Mr Brown we can say there are three things we really care about: localism, commissioning and value for money. You can do it all by organising care locally, listening to what people value in their community, commissioning that and having the good sense to foster the work between professional and patient: that will produce integrated care.

Whether that is in a polyclinic is not as important as what is the ultimate goal.

Comments and Questions:

Professor Nick Bosanquet, Imperial College: How can we really get integration moving in the next few months? My nominations would be to:

- Completely scrap the idea that it's about buildings – let's start describing the services that we want first then go for the buildings;
- Focus on IT and communication to build on what GPs have achieved already;
- Focus on integration and the sharing of information in diagnostics, in order to give GPs more shared potential in early detection and the use of diagnostics;
- Start thinking of GPs as people who can really contribute to local investment and services.

Dr Deborah Colvin, The Lawson Practice, Hackney / Polyclinic Project Board, Healthcare for London: The most important thing is thinking about outcomes and how we make people better, yet there is still this divide between primary and secondary care which is to do with professional gravitas and money.

While that's still there I can't see us progressing; if the polyclinic can do that and get us working together and properly embrace practice-based commissioning with a real budget to bring the most amount of care to the most amount of people, then it's worth trying.

Dr Paul Conley, GP in Hampshire / Circle: At Circle we've found great enthusiasm on the part of consultants and GPs for collaborative working, but the barrier as far as the consultants go has been the policy of some of the acute trusts who've forbade their consultants from entering into discussions with any other provider organisations.

On the professional front, however, we find that GPs and consultants are more than happy to work together. Here, buildings aren't that important, rather the aligning of incentives and re-engineering pathways to get rid of a lot of the unnecessary steps that we've talked about.

Dr Richard Taylor, MP: I think we have a huge opportunity here and welcome all the talk of integration and the purchaser-provider split, which has been an absolute disaster. The source of the opportunity is that Gordon Brown is on his knees and he's got to have some policies that appeal to the ordinary person. We all want integration. We don't want to be told we've got to have a

polyclinic; we want the GPs and the patients to decide exactly what is needed in a particular area for integration. We need an NHS that listens to doctors, to patients and is what people want.

Paul Robinson, CHKS: What do we mean by integration and for things to be different for patients? Most the doctors I know are happy to talk to another if they can get them on the end of the phone....but can they?

Two examples from urgent care: someone turns up at their GP and the GP would like someone else's opinion on their condition. But he can't get hold of anyone within 14 days and they're then forced to admit the patient. I used to work in Cornwall – not a lot of neighbours – but on a regional basis I often thought why not have a consultant rota or telephone clinic? Then the GP could avoid sending the patient x number of miles, when they could have worked on a quick bit of advice there and then.

The one statistic that staggers me the most is that 26% of patients are turned around on the same day now after an emergency admission. We're clearly not getting good communication and it's not just going to be solved by buildings. Polyclinics are a distraction; putting people in the same place doesn't make a difference.

Dr Francis Keaney, South London & Maudsley NHS Foundation Trust: What do you suggest in terms of getting rid of the current models of commissioning or having new models of commissioning or none? It seems to me that that this is the standing most in the way of integration.

Andy Cowper, healthpolicyinsight.com: It's an interesting draft that we now think buildings might be the enemy. I've been to a lot of conferences recently on urgent and out-of-hours care and one of the dangers that's often been highlighted about putting GP-front-ends on A&E is that they go native and prescribe more tests and drugs!

With regard to commissioning, the ideas underpinning it in terms of use of data and thinking about outcomes aren't going away whether purchaser-provider orientated or otherwise. But how would we make integration pay under the current system?

Dr Rodney Burnham, Registrar, The Royal College of Physicians: The central thing that's come out tonight is the importance of communication. When I became a consultant in 1981 I knew all my GP colleagues, we worked closely together and had meetings in the academic centre every Monday, they got to know me, they would phone me and we would talk. That was integrated care. Obviously things weren't as good as they could have been, but this has to be the way forward.

We must improve the degree of communication. If you work together with your primary care colleagues together with patient representatives, you can devise pathways of care and encourage better commissioning based on collaboration rather than competition – what Chris Ham calls 'internalising commissioning'. The only way world class commissioning will work is if it commissions world class services and the only way to do this is to have the generalists and the specialists working together with patients to devise these services.

The only competition that is valuable is on outcomes. I want my results to be better than him down the road and doctors by nature are competitive; they want to be better in terms of what they do, but competition between organisations is useless and a waste of time, causing cost shifting and all

the other things Porter & Teisberg have identified. If you're a Chief Exec who's under pressure to deliver the financial bottom-line then it's very difficult to introduce change if your organisation is going to be defunct and you're going to be out of a job. Government has made a big mess of top-down imposition.

The importance of good communication applies to the DH too. Polyclinics may or may not be a way to improve communication across the system, but they must not be imposed on people. Lord Darzi did a roadshow in Cambridge and doctors there said to him 'we don't want a polyclinic', to which he said 'well, you don't have to have one'. They then wheeled up the Chief Executive of the PCT who'd been told by the apparatchiks in the DH 'thou shalt have a polyclinic'. It was more like Stasi than Darzi.

This brings me onto the other important thing, which is leadership and innovation. In our survey [with the RCGP] of fellows and members of both colleges, responses revealed over 300 examples of working together in an integrated way, despite all the perverse incentives and problems with PbR (which is so difficult, because information that comes back from trusts on costs is wildly inaccurate). If we can get to a situation where doctors are in a position to lead, not where all negotiations are held between managers, we could get towards integrated care.

Polyclinics are only a good idea if they improve the system – 'teams without walls' is what is important: independent of organisation, of location and structure. What we want is people working together – collaborating, not competing.

Professor David Haslam, President, The Royal College of General Practitioners: Integration is the key here. For most of my working lifetime I had very good relationships with local consultants and I knew who they were. Then the choice agenda arrived and all my choices got washed away because I was forced to refer to units rather than individuals, as this was the way that the trusts could equalise waiting times. If you had someone good, unsurprisingly they had a longer waiting list, but this was unacceptable. Ever since choice came in, patients have only had real choice in the private sector.

Polyclinics are a complete irrelevance. The bullying in pushing out the process into the system is desperately unnecessary and should be reversed.

Professor David Taylor, School of Pharmacy: We have the example of France which historically has had a lot of choice for consumers, but a payment system that doesn't really encourage integration. Yet somehow – and perhaps it's something to do with consumer choice – it seems to work better.

So I'm not sure about this driver of integration thing. And this 'consensus' against competition worries me slightly. Sure, if you have imbalanced competition this needs effective regulation to sort it out, but as a consumer do I may quite like choice between one GP or another which is genuinely different; and do I want to be able to go to a pharmacist and get different services? Probably.

It seems to me that the NHS is a deeply anti-competitive organisation and doctors to a large degree are responsible for being complicit with managers in ensuring that. When we talk about integration and polyclinics and so forth, many seem to delight in thinking we can eliminate local competition. This deeply disempowers consumers.

In certain circumstances aggregations of polyclinics might make sense – particularly if you wanted to close down a district general hospital – but in many areas they are an irrelevance. However I think the agenda is different; it's people who have managed large organisations getting confused about a market.

Dr Geraldine Strathdee, Oxleas NHS Foundation Trust: A reflection on communication. Back in 1984 we did a study of the extent to which psychiatrists in this country were out doing clinics in primary care and were amazed to find 20 per cent worked there. The question is did those outreach clinics work? And the answer was yes if the model was one of consultation, communication, teaching, training and mutual learning; but no if the psychiatrist took on the hospital clinics in just the same way as they would do in a hospital clinic. The major advantage of having mental health more closely aligned with primary care is the reduction of stigma and stress for patients.

In order to do something different, the function has to be fundamentally reviewed. If you have a well-managed system that is extremely clear about its functions and is using the best evidence-based evidence to create this, you can make anything work.

In this new review and way forward, is it possible to consider that we really need to adopt a more causal evaluation of the reasons why patients seek health care in the first place? In mental health we have enormous numbers of people signed off on incapacity and invalidity benefit; and if this lasts more than 6 months they are statistically more likely to die than ever work again! My plea is: can we move away from just looking at symptoms to look more fundamentally at the societal causes of illness? We spend a huge amount of resources in our health system paying people to remain ill and paying people to be chronic attendees of physical health clinics, which is wholly unnecessary.

Nick Seddon: We've heard quite a lot about how the NHS spends a lot of money, yet no-one knows how it's spent nor understands how value actually comes out of the system. We've also heard about the value of integration and moving towards what might be termed the Kaiser model.

But is it possible to achieve what Kaiser does in terms of efficiency savings and cost-effectiveness without that being a financially closed system, i.e. without there being financial institutional integration? Is it possible to have a loosely federated integration without the financial incentive and still achieve the same kind of outcomes?

With thanks to Mr Bernard Ribeiro and The Royal College of Surgeons of England for hosting this debate.

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