When is a polyclinic not a polyclinic?

To appease concerns over the future of primary care, will we see polyclinics rebranded as health centres? **Rob Finch** investigates

Polyclinics will end traditional general practice in every area of the country, leading to factory-style care in supersized group practices, with no thought for continuity of patient care. That was the thinking that led GPs from Worcestershire to make a six hour round trip to 10 Downing Street to petition Gordon Brown against the policy last month.

Because of the frenetic preparations of many primary care trusts, doctors believe that, in the senior echelons of the NHS, word has gone out that every trust must have a polyclinic. Yet the Department of Health categorically denies a national policy of polyclinics. And even Lord Darzi himself told the House of Lords recently: "Those suggesting that I envisage the herding of GPs into polyclinics imposed from above have missed the whole tenor of my report, which is about ensuring that change is led from the bottom up by local clinicians."¹ His words were echoed by a departmental spokeswoman, who told the *BMJ*: "As Ara Darzi has said repeatedly since he started his review, it is for local people and clinicians, not the government, to decide what they want in their community as what works in one area might not be suitable for another."

Yet the Department of Health announced last October—not long after Lord Darzi's ideas were first aired—that it was ploughing £250 million into new health centres in every primary care trust, offering core GP services and possibly a range of other services such as dentistry and physiotherapy. There will be 152 new health centres and, for the areas with greatest needs, over 100 new GP practices, the department says.

Moreover, when tendering for these new

health centres, primary care trusts are likely to use the Alternative Provider Medical Services (APMS) contracting system, which has led to controversial corporate private sector provision of GP services.²

Consequently although the Department of Health claims that it is not imposing a polyclinic blueprint on every primary care trust, these trusts are forging ahead with their new "health centres," which some might say look remarkably like the polyclinics outlined by Lord Darzi in his plans for Lon-

don announced last summer.³ Some feel the term "polyclinic" might be quietly sidelined. David Stout, director of the NHS Employers' PCT Network, said: "I wouldn't be surprised if the polyclinic name is not used as it raises 'antibodies' in people," but he thinks that many of the ideas behind the concept will be adopted.

So what sparked the polyclinics idea? The model is common in Europe, Cuba, and the United States, but almost no comparable services currently exist in Britain, except a

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THE HOVE POLYCLINIC: “FLEXIBLE” BUT WHERE ARE THE GPs?

The Hove polyclinic was opened in 1998. The building is modern looking and flexible, and the doctors who use it say it can cope with change. The flexible layout was designed to help with referrals and communications between doctors and staff. The polyclinic was originally planned to replace an old general hospital, and it is now similar to an outpatient unit of a small hospital, sharing a site with a mental health unit and housing community care services. The building includes part of the medical school focusing on psychiatry. Access has been improved by diverting a local bus route through the site, and there is considerable parking.

Outpatient services, including medical and surgical outpatient clinics, physiotherapy, ultrasound, and x ray, previously provided at the old Hove General Hospital, are now provided from the Hove polyclinic. Its consultant led clinics are run by visiting consultants.

It was originally envisaged that GPs would also be located at the clinic, but in 1998 some local GPs had recently opened

new premises and were not prepared to move, for financial and strategic reasons. Plans are now under way to get GP led general medical services into the polyclinic, which would make it closer to the blueprint outlined by Lord Darzi in his Healthcare for London proposals.³

Terry Metcalf, who manages the polyclinic,

says: “Patients think it’s fabulous. There’s easy access—it’s not like a hospital building—it’s much more of a clinic building.”

Mr Metcalf feels that the initial transition was difficult for some consultants, as the environment was so different from the district general hospital ethos.

polyclinic in Sussex that dates from 1998 (see box). Healthcare for London, the body overseeing the consultation on Lord Darzi’s proposals for the capital, says that polyclinics will provide a “wider range of high-quality services, over extended hours, to the community—reducing the need for patients to visit hospitals.” It also sets out single site, networked, and in-hospital models for the locating of polyclinic services.

Consultation on the proposals has now finished, and although full results will not be available until June, Healthcare for London has let it be known that there has been “broad support” for the plans.

David Sissling, programme director for Healthcare for London, was tight-lipped on whether the London public had backed polyclinics—but the consultation does not ask what people think of the polyclinics idea, so it would be difficult to say. The consultation, in fact, only asks the public what services they would like to see in polyclinics and whether they should be networked or on one site.

Mr Sissling counters this, saying: “[Lord Darzi] spent a lot of time talking to clinicians in care delivery as well as people using the services—there was widespread engage-

ment and that informed his work. He set out an ambitious set of proposals that would improve health services across London and the health of people in London.

“Polyclinics were very much consistent with themes of improving health, wellbeing, and integrating services and improving access and localising services. The plan is to bring together a range of services in primary care settings including GP, outpatients, pharmacy, social care, diagnostics, long term conditions, and urgent care.”

Heather O’Meara, chief executive of Redbridge Primary Care Trust and member of the London commissioning group with responsibility for the London polyclinic pilot project, says that the development of the plans is still embryonic. “It is a learning process. It doesn’t pre-empt the outcome of the consultation process. We are exploring the type of services you would expect to see in a polyclinic. The majority of PCTs have expressed an interest in being part of this first phase, but that doesn’t mean they will all end up building polyclinics. PCTs have said that Darzi’s plan was very similar to plans they had. In Redbridge we had consulted on what we were calling ‘primary care resource

centres’ and we were already down the line in our discussions with GPs.”

But David Stout gives a somewhat different slant. Although he says that the idea of polyclinics has officially been discussed only in London, he admits to “a degree of compulsion” on the issue.

He also admitted that a focus on buildings and the mental twinning of the polyclinic and the health centre policy had made people feel “uncomfortable.” While the use of the name polyclinic might be dropped, the idea of integrated care will be used,” he told the *BMJ*.

Integrated care is certainly supported by the royal colleges. In a document to be published soon, the Royal College of Physicians, the Royal College of General Practitioners, and the Royal College of Paediatrics and Child Health support the idea of “teams without walls” not shackled by traditional political boundaries of primary and secondary care or physical boundaries of buildings.

Martin Roland, professor of general practice at the University of Manchester, also supports integrated care, though he thinks the best way to improve integration might be to involve hospital specialists in joint

commissioning with GPs rather than by pursuing a policy that focuses exclusively on commissioning led by primary care.⁴ He says one of the chief driving forces behind the idea of polyclinics is the perceived need to merge small practices in highly deprived areas where the quality of services is low. "Providing good premises and facilities for such practices could make a big difference to care," he says. But he points out that surveys show that patients of small practices rate their practices more highly than patients of larger ones, both in terms of access and continuity; the need is for more high quality practices, not necessarily bigger ones.

Another driving force behind polyclinics is the idea that these centres would provide facilities for specialists to see patients in the community. But, Professor Roland says, moving consultants into the community could be more expensive, because it would mean the loss of the economies that exist in hospitals. It could also cause problems if community bases were not suitable or approved for training junior hospital staff. Although some specialist services in the community could be run by GPs with Special Interests (GPSIs),

there was a risk that by undercutting the payment by results tariff for relatively simple cases, GPs could destabilise secondary care trusts, which are required to bid at the Payment by Results tariff for this work. "The last thing we need is a system that sets GPs up against consultants," he said.

In a few places, however, clinicians are beginning to work together and to take the lead in implementing the polyclinic model. In Whitstable, Kent, for example, GP John Ribchester and his colleagues have struck a deal with an independent sector provider, Circle, to create a multimillion pound polyclinic. It will house a pharmacy, a minor injuries unit, and six GPs on a new site as a branch of the existing practice, which covers a booming population. Due to open in December, it will also play host to consultant services commissioned by the NHS, including elective surgery in a laminar-flow theatre, and even visits from mobile MRI scanners.

Dr Ribchester says that the plans started with the practice getting to grips with the "spirit" of the 2006 primary care white paper and being commissioned by the local

commissioning consortium to run services including echocardiography, sigmoidoscopy, and hearing tests. The polyclinic is based on the principles of integrated care pathways, he says, and it aims to reduce the to-ing and fro-ing that patients might get from a typical GP referral through to final treatment. In some cases, for example that of a torn knee cartilage, the polyclinic might enable a patient to go from diagnosis through to a finished operation and home in a single day. The idea could work just as well with no permanent on-site GPs, or even as a project shared between a federation of practices. But he is well aware of the heated medico-political rhetoric around GPs being lumped together in polyclinics and has sympathy for colleagues concerned by reports of polyclinics being rolled out in every PCT regardless of need.

"With polyclinics it is how you do it. If it's foisted on you it's going to feel bloody awful and threatening," says Dr Ribchester, adding that the clinician led venture with Circle (which is itself almost half owned by NHS staff) allows a great deal of self determination on both sides. "I think this is something that Lord Darzi ought to look at. If you impose things on GPs they will not be happy bunnies."

In principle, the Whitstable polyclinic plans may sound like a GP surgery bolted on to an independent sector treatment centre. But Massoud Fouladi, medical director of Circle, insists the scheme is not such a centre. Instead, he says, it represents a UK variation on the Kaiser Permanente model of care in the United States. The development stems from its integrated pathways and from being a system that is owned and run by the doctors and other staff who work for it.

"Clinical leadership is a key part of it in a meaningful way—not as an advisory board but actually running the business," Dr Fouladi says.

Rob Finch is a freelance journalist, London
roberto_finchley@hotmail.com

See **NEWS** pp 907, 911

- 1 *Lords Hansard* 10 Oct 2007, column 301. www.publications.parliament.uk/pa/ld200607/ldhansrd/text/71010-0010.htm#07101045000075
- 2 Mayor S. GPs challenge London PCTs as practice contracts go to private companies. *BMJ* 2008;336:412-3.
- 3 Day M. Polyclinics open till 10 pm proposed for London. *BMJ* 2007;335:61.
- 4 Roland M. Assessing the options available to Lord Darzi. *BMJ* 2008;336:625-6.

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