PROGRESS IN THE MOVEMENT OF ACUTE SERVICES FROM HOSPITAL TO PRIMARY AND COMMUNITY CARE

Christine Farrell
Caroline Glucklich

January 1994

INTRODUCTION

During the past two years a considerable amount of attention has been directed towards the feasibility and benefits of moving some services out of acute hospitals into primary care and community settings. To some extent this reflects the need to reduce the high costs of hospital treatment but it is also due to a genuine acknowledgement of the importance of treating people as close to their own homes as possible. There is also a growing recognition that much care currently provided in acute hospitals would be more appopriately provided in other settings.

A number of official and other reports have identified the need to change the balance between acute hospital care and primary and community care, to allow effective health care to be provided in the future (1). Although this movement is seen to be particularly urgent in London it is reflected in most other major cities in the UK.

In 1992, the King's Fund documented a number of iniatives which had been introduced to improve the appropriatness and effectiveness of acute and primary health care (2). A year later, we investigated the extent to which these kinds of initiatives had been taken up on a wider front. The methods used included a literature search, discussions with experts, and an analysis of London Family Health Service Authorities (FHSAs) development plans.

This review uncovered few further examples where services have moved from hospital into primary or community care, over and above those already acknowledged and reported as successful and innovative. What did emerge however, was that there is much interest, discussion and, to a lesser extent, planning for services to be moved out of hospital into other locations. Certainly, changes are taking place within the hospital environment with a growth in day surgery, shorter inpatient stays, a decreasing number of acute beds and recognition that those acute beds need to be used more effectively.

The movement of services from hospital into primary or community settings is happening in a number of ways: from hospital to general practice, from hospital to home and to a lesser extent, into community hospitals and clinics. Certain factors have influenced these changes, particularly technological advances, the development of new drugs and the emphasis on making health care more accessible to patients. In addition, the introduction of fundholding for GPs in 1990 has enabled some GPs to expand the services they provide to include some which are traditionally provided in hospitals.

This article considers the extent of movement away from traditional acute care in hospital into the following settings: **1. general practice; 2. home settings; 3. community hospitals and clinics.** The final part discusses developments in the provision of care in hospitals.

MOVEMENT OF SERVICES INTO GENERAL PRACTICE

General practitioners and practice nursing teams are undertaking more acute treatment, and care, as well as providing services traditionally found in hospitals, in the practice premises. Minor surgery, shared care schemes, outpatient clinics held within the practice and GPs working in hospital accident and emergency departments are all happening to some extent across the country.

Minor Surgery

Since the introduction of the GP contract in 1990, minor surgical procedures by general practitioners have increased (3). There is some debate however, as to whether this increase has had any impact on levels of referral to hospital. For example, Rotherham FHSA reported a dramatic increase in the number of minor surgical procedures done by GPs in the first year of the contract (from 230 to 2670), but claim that this has had no notable effect on referral levels to hospital. What they found was that most cases of minor surgery resulted from patients who would not have sought treatment if it had not been provided by their GP (4).

Many regions experienced an increase in the number of GPs on their minor surgery list and, subsequently, an increase in the number of procedures carried out. Whether they had the same results as Rotherham has not been determined. The general view is however, that most GPs who received payments for minor surgery, were largely claiming for injections and truly minor operations (especially cryotherapy for warts), which would seem to confirm Rotherham's findings.

Despite this, minor surgery in general practice is quicker and more convenient for patients and will no doubt increase further. Plans like those of Kensington, Westminster and Chelsea health authority which aim to increase the number of practices offering minor surgery from 10% to 50% over the next five years, are not unusual.

Shared/Integrated care

Shared care schemes, using agreed protocols, are becoming more widespread both in where they are found and in the conditions they are used for. Shared care is most common for ante-natal care, but more and more shared care is being developed for chronic diseases. Shared or integrated care involves hospital and primary care staff collaborating in the clinical care of patients. Protocols provide strict procedures on how a particular treatment must be administered, with information on dosages and possible side-effects. In Nottinghamshire, protocols are being developed for a range of what used to be hospital-only treatments, so that they can be provided at home. These include erythropoietin and lithium therapy in psychiatry (6). They may also provide guidance to a GP on diagnosis and referral. In Portsmouth, for example, a protocol for the management and investigation of urinary tract infections among children includes agreements on GP arranged urine culture and ultrasound scanning, so that children are referred to a clinical department only when they need more invasive investigation (7).

A variety of shared care schemes for diabetes exist and have done for some time. These range from GP schemes, GP run mini-clinics to the more recent district diabetes centres which integrate both medical and personal

services considered important for the management of diabetes. Over 20 GP run schemes were reported in the literature and one report indicated that there were thirty to forty district diabetes centres, suggesting that shared care for diabetes is already well-established (8).

The St Vincent Declaration in 1989 and the Health of the Nation document in 1992, highlighted diabetes as a key health care target. As a result more and more health authorities are making the routine care of diabetes in primary care settings, a priority. For example, Kensington, Chelsea and Westminster Health Authority are planning to increase the number of practices offering diabetes shared care from 10% to 50%, and East London, Camden and Islington and Waltham Forest Health Authorities also have plans to increase the diabetes care in primary settings. In addition, the employment of a practice nurse, often a key member of the team in shared care, is on the increase.

Shared care for asthma is also developing, with much of the routine care being provided in the community by GPs and acute episodes only being dealt with in hospital. A comprehensive study in Scotland compared the effectiveness of integrated care and continued conventional outpatient care. Overall it was found that 'integrated care patients for asthma were at no clinical, psychological or social disadvantage through membership of such a scheme' (9). They benefitted financially and in their perceived level of asthma control. Three quarters of the patients wanted to continue with the scheme. It was also found that the reduction in direct specialist contact was not associated with worse asthma management and that regular GP contact with distant consultant supervision, provides care as effectively as a more conventional out-patient clinic attendance (10). As with diabetes, a number of London health authorities stated in their primary care plans that they intend to increase shared care for asthma in general practice.

It has recently been reported that epilepsy is to be recommended for shared care, with GPs and practice nurses at the centre of such schemes (9). Isolated schemes do exist for epilepsy, for example in Doncaster (9) but it is not as widespread as diabetes and asthma. Other conditions reported to be suitable for shared care are HIV/AIDS and hypertension.

Outpatient Clinics in General Practice

The extent to which outpatient clinics are held in general practice, and whether there has been an increase since the introduction of the GP contract is difficult to measure accurately. The literature suggests that among fundholding GPs the range of outpatient clinics has grown and that in the future, more and more clinics will be held in general practice. It is generally recognised that many outpatient clinics, currently held on main hospital sites, could be provided in primary care settings. Traditionally this happened in only a few specialties, like psychiatry, geriatrics and obstetrics, but this appears to be changing to include specialties like gynaecology, ophthalmology, orthopaedics, dermatology, rheumatology and ENT. Many examples of such clinics held in general practice premises are to be found: a practice in Rochester, Kent holds 8 clinics a month, including medical, surgical, gynaecological, orthopaedics, ENT and dermatology (10) and in Merseyside, clinics are held for colcopscopy, ophthalmology and sigmoidology in order to reduce waiting lists (11). A GP in Hertfordshire, holds outpatient clinics at his practice, and is planing to open a day surgery unit with 4 beds at his practice and employ local consultants to perform hernia operations (14). Amongst the London health authorities, Waltham Forest are planning to move such clinics into primary settings and Islington and Camden plan, over the next year, to have 10% of their practices offering at least one regular consultant session. The benefits of holding outpatient clinics in primary care are recognised as:

* patient access may be improved and non attendance rates reduced;
* extension of opportunities for GP involvement and improvements in continuing care and training of primary care staff;
* reduction of follow up clinics and more rapid discharge of patients to their GP;
* improved communication between GP and consultant.

As well as holding consultant run outpatient clinics, GPs are beginning to extend the services they provide by employing physiotherapists, chiropodists, occupational therapists and dieticians. For example, a Hertfordshire GP employs a physiotherapist when direct access to hospital is unavailable or waiting lists are too long (15). Chiropodists and dieticians are often employed as part of diabetic shared care schemes.

Direct Access to Diagnostic Procedures

Direct access by GPs to diagnostic equipment and therapy is becoming more widely available either in hospital premises or, in some cases, within general practice. In Waltham Forest, in 1993, a GP radiology unit was opened with the range of services set to develop beyond X-ray and ultrasound to include contrast and invasive procedures (endoscopies) under direct visualisation. A Practice in Princes Risborough has X-ray and ultrasound services on site, as does the South Westminster clinic. In Merseyside, a mobile theatre and mobile scanner were introduced to assist in reducing waiting lists and Waltham Forest plan to provide direct access to stress testing and ECGs in the hospital as well as training and support for practice teams to provide this service in the community.

GPs in Accident and Emergency Departments

It is widely recognised that many attenders at A&E departments have problems which could be treated by their GPs. An experiment in Kings College Hospital which started in 1988, employed GPs on a sessional basis to see those patients identified by the triage process as having such problems. Following the success of the scheme, which is still running, a number of other London health authorities are planning to introduce similar schemes. These include Whipps Cross hospital in Waltham Forest, St Georges hospital in Wandsworth, West Middlesex and Ealing Hospitals in Ealing, Hammersmith and Hounslow, St Marys Hospital (started in Feb 1993) and Chelsea and Westminster Hospital (in Kensington, Westminster) and Chelsea and University College Hospital, the Whittington and Royal Free hospitals in Camden and Islington.

Clearly, from this sample, it can be seen that the issue of primary care attenders in A&E departments needs to be and is being addressed. Putting GPs in A&E departments is one solution currently being adopted, but others include minor injury clinics in primary care settings and extending the opening hours of general practices.

MOVEMENT OF SERVICES INTO HOME SETTINGS

Developments in providing acute services at home, similar to those provided in hospitals, can be found in the provision of high technology equipment and drug administration at home and where the provision of intensive home nursing allows very early discharge from hospital or prevents hospital admission (or as is often the case, a combination of both). In addition, home care developments, can also reduce the inappropriate use of acute hospital beds particularly by elderly, handicapped and mentally ill people.

High Technology Home Care

It is estimated that there are about 8,000 people in the UK who, without a homecare scheme, would have to spend long periods of time in a hospital acute ward receiving treatment (16). The majority of these are patients with kidney failure, receiving haemodialysis or peritoneal dialysis (CAPD) in their own homes. Home dialysis started in the 1970s and is now the preferred form of treatment for patients with kidney failure. Other treatments at home include lintra-venous (IV) therapies, chemotherapy for cancer, antiviral therapy for HIV, antibiotics for cystic fibrosis, chelation therapy for thalessemias, enzyme therapy for gauchers syndrome, and immunoglobin), enteral and parenteral nutrition, respiratory therapy and home monitoring of patients during pregnancy and for individuals with heart disease. The fastest growing of these, according to Barbara Stocking (17) is intravenous infusion, but there seems to be no central drive to encourage more widespread homecare therapy despite the fact that it can improve the quality of life of a patient and can be cost effective (16).

It is difficult to determine the extent of these treatments at home because there appears to be no statistics for many of them. It is known that there are 2300 patients receiving long term enteral feeding at home with 210 patients receiving parenteral feeding but not what proportion this represents of those suitable for home nutritional support (18).

'Hospital at Home' schemes

The term 'hospital at home' is used to cover intensive home nursing support provided either by community nursing teams or hospital outreach teams.

They serve to enable shorter stays in hospital or prevent hospital admission at all, by providing care at home equivalent to that usually provided in hospital. The most famous scheme is the Peterborough hospital at home scheme and it is on this that most other schemes are based.

Of the London health authorities consulted, many are planning to introduce hospital at home schemes. These include one in Waltham Forest, where existing community nursing service will be extended to provide 24 hour cover to any patient who is chronically ill, acutely ill or physically handicapped; one in Wandsworth where the intensive nursing scheme will offer a multi-agency input; two in Hammersmith and Fulham, one of which is due to start in July 1993, initially for early discharge of patients following fractures and hip and knee replacements, but if it is successful it will extend to other specialties, for example gynaecology, and the other which was due to start in September 1993 for acute mental illness and offering an alternative to inpatient treatment at Charing Cross hospital; one in Ealing planned for 1993/4 and Hounslow in 1994/5; one is planned by Riverside Community Trust for orthopaedics, gynaecology and care of the elderly (those areas with particularly long waiting lists), which expects to have an annual intake of 200 patients; one in South East London which will aim to prevent re-admission and provide and alternative to admission. Others are also planned.

The most frequently reported 'hospital at home' schemes at the moment, are for children - usually community based paediatric nursing teams providing care following early discharge from hospital. There are currently said to be over 50 such teams operating in England (19).

Acute home care for children looks set to increase, following the Department of Health report in 1991 which stated that "children should only be admitted to hospital if the care they require cannot be as well provided at home, in a day care clinic or on a day basis in hospital." Paediatrics as a whole, can be seen as a target for shifting services out of hospital into primary and community settings. In fact, during the course of researching this article it was the specialty most frequently referred to as moving into primary and community care, with more GP involvement and surveillance.

Acute care for elderly people at home is also regarded as an area which needs development. As one report says "Much acute care of elderly people, traditionally provided in hospitals would be better provided outside of the hospital" (20). However change has not been extensive so far, particularly if hospital at home schemes are taken as indicators. Only seven schemes were identified, the majority of which enable early discharge following orthopaedic surgery. These schemes are in Peterborough, Essex (COPE), South Derbyshire, North West Surrey, Pembrokeshire, Seaton in Devon and Croydon. Apart from the specific hospital at home schemes however, much of the care provided by community nurses, care workers and community based therapists probably enables elderly people to avoid hospital admission and while the care may not always be considered as acute, it is still important in enabling people to remain at home.

Acute care at home of terminally ill people is more developed, with a network of groups provided by the voluntary sector, like the Macmillan Nurses for cancer care. There are over 950 Macmillan nurses, the majority of whom provide nursing care and support to cancer patients at home. Many hospices too, provide home care schemes - over 300 of the 383 hospices in the UK are reported to do so (21). There are also two Hospice at Homes schemes, one in Tonbridge Wells, the other covering the Chiltern area, to which patients are referred by their GP in the same way as they might be referred to an inpatient hospice, but all the care is provided in the patients own home. These two Hospice at Homes are believed to be the only two in the UK (22). Whether care at home for the terminally ill has increased over the last few years and as a result had an impact on acute services in hospital has not yet been determined.

One area where the emphasis on care can be seen to be shifting from hospital into primary or community settings, is in the care of people with HIV and AIDS. As more is known about HIV, it is increasingly recognised as a chronic disease for which care could be shared to a far greater extent with primary care teams. In addition , it is believed that the majority of people with HIV and AIDS prefer to be cared for in the community and at home. Increasingly, health authorities are seeking to involve GPs and district nurses in the care of HIV and AIDS patients to lessen the pressure on hospital services. Bloomsbury and Parkside have developed multi-disciplinary teams whose primary aim is to activate local services, especially outside their

district where many of their patients live. Bloomsbury report that the involvement of primary health care teams in providing domiciliary care for people with HIV has risen form 35% at beginning of 1988 to 90% in 1990 (22). As well as these developments, care at home is provided by St Marys Hospital through a home nursing service (which also seeks to involve local primary care staff) as does the London Lighthouse, a voluntary organisation.

MOVEMENT OF SERVICES INTO COMMUNITY HOSPITALS AND CLINICS

Community hospitals are cited as being ideally placed to provide the intermediate level of care required by patients who do not need the high-tech specialist facilities of district general hospitals but are unable to be cared for at home. Many patients in acute beds could be more appropriately managed in low technology community hospitals under the care of a GP (one report claimed up to 25% (24)). It is suggested that local hospitals are capable of being expanded to deal with more acute cases for such things as acute episodes of chronic illness and to enable early discharge from acute beds (25). A few community hospitals are already expanding their roles to provide such services but the literature indicates that this is not widespread. The Lambeth Community Care centre is most frequently cited. The St Charles development in the Kensington, Chelsea and Westminster FHSA is set to provide, (in addition to the minor injuries unit which opened in February 1993), 10 - 15 community beds, GP out of hours service, direct access services and outpatients clinics. The community ward will be for acute medical conditions where home nursing is insufficient, post operative patients transferred from acute general hospital, terminal illness and rehabilitation.

The development of primary care centres or polyclinics is one of the recurring themes in the primary care development plans of the London Iniative Zone. All authorities cited plans to develop such centres which would provide a wide range of services in addition to general medical services, such as minor injuries, physiotherapy, counselling advice, and outpatient services. The benefits of such centres are clear, nevertheless, it will be interesting to see how successful these centres are in providing services outside of acute hospitals. The provision of a minor injuries service in a community clinic has proved successful in North Manchester where it was opened following the closure of the Ancoats general hospital accident and

emergency department. The service operates from 9.00am to 9.00pm seven days a week and is run by nurses.

DEVELOPMENTS IN THE PROVISION OF CARE IN HOSPITAL SETTINGS

It is worth looking briefly at the developments in treatment and care in acute hospitals which have, or are beginning to occur. These include day surgery, the use of nursing beds/wards and the introduction of 'patient hotels'.

Day Surgery

Day surgery has developed in recent years due to major advances in surgical techniques like minimally invasive surgery and to a lesser extent in an effort to reduce waiting lists. It is cheaper than in patient stays and often more convenient for the patient. Whilst many procedures are already carried out on a day basis it is thought that the number and range could increase. An Audit Commission report estimated that 95,000 patients could be treated as day cases rather than in-patients if all hospitals achieved minimum conservative target proportions of day surgery (26). One of the reasons why this is not happening is because not all districts have the appropriate day surgery facilities (25%) and those that do are not using them to their full capacity. Nevertheless, day surgery is a major development in changing the way treatment is provided in acute hospitals and will inevitably increase in the future. It can be supposed that any increase will put more pressure on GPs to care for those convalescing, but no research has been here on how this has or may affect GPs' workloads.

Nursing Beds

The use of nursing beds is perhaps more suited to community hospitals, however examples were found where a nurse-run ward admitted patients soon after the acute stage of their illness to enable them to receive the nursing care required without using an acute bed. The most recent example is the Byron ward in Dulwich hospital which has 17 beds and was opened in February 1993.

Patient Hotels

A number of references were found to the building of patient hotels which would act as a 'half-way house' between the acute district hospital and primary care. So far, the only one in existence is in Kingston but plans are in place for others. The idea of using a hotel is not new: in Worthing in-patients who have cataract operations, spend the night prior to the operation and up to four nights after the operation in a local hotel. A team of nurses, assisted by volunteers provided 24 hour nursing care and support at the hotel and patients were transferred to and from hospital by ambulance. The scheme was a great success and has been repeated since.

CONCLUSION

It is difficult to conclude confidently on the extent of change in the movement of acute services out of hospitals. The London primary care development plans show that a great deal of change in this direction is planned for the next few years and discussions with NHS personnel show that there is much interest in achieving change. However, at this stage, the conclusion must be that the movement of acute services from hospital into primary care and the community is just beginning. The examples found indicate that the extent to which it has happened is limited and at this stage, no clear trends have emerged.