Community nursing – a forgotten element in systems reform: the London polyclinic experience

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ABSTRACT

Internationally, the polyclinic has been a feature of many health systems. The recent UK policy shift towards enhanced coordination of care closer to home resulted in the development of polyclinics most notably in London. This paper explores the background to the development of polyclinics and draws on the early experience of developments in London to explore what their impact has been, and is likely to be, on community nursing. Emerging findings from an evaluation of 4 pilot polyclinics suggests that rather than one model, polyclinics evolved in distinctively different ways more appropriately labelled as polysystems. Although policy makers clearly identified community nursing as being one of the key components of integrated, community based care, the evaluation suggests that a focus on high level organisational restructuring and system change can in fact shift attention from what many would consider core activities such as community health services.

KEY WORDS

- POLYCLINICS

- COMMUNITY NURSES

- HEALTH POLICY

- HEALTH SYSTEM REFORM

KEY POINTS

1. Polyclinics have recently been developed as a response to the policy shift towards co-ordinated care closer to home.

2. Because of the population density and ease of transport links, London was identified as an area that would benefit from the development of polyclinics.

3. There is no one model of polyclinic and they have evolved into a number of different polysystems.

4. Community health services were seen as a core component of the shift to coordinated care closer to home and yet they play little, if any part, within the emerging polysystems.

5. Whether a focus on high level structural reorganisation of services moves the focus away from frontline services such as community nursing needs to be explored further.

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Introduction

The introduction of polyclinics and renewal of the concept of the GP-led health centre in recent years has sparked much debate about both the concept and also their place in the UK NHS. Much discussion has focussed on the relationship between polyclinics, general practice and secondary care. Less attention has been paid to examining the way such centres are being developed and given the idea of polyclinics as community health care hubs, their relationship to community health services and the roles of community nurses.

This article explores the background to the development of polyclinics and draws on the early experience of developments in London to explore their potential and impact on community nursing. The article draws on the findings of early phases of research on the development of polysystems in a number of locations in London being undertaken by a research team led by the London School of Hygiene and Tropical Medicine commissioned by Healthcare for London. Interviews were carried out with key commissioning and provider staff and where relevant, local authority staff and patient representatives. It was confirmed that this was a service evaluation and as such did not require NHS Research Ethics approval.

Polyclinics, polysystems and the community nursing role

The strategic document *Healthcare for London: A Framework for Action* (Healthcare for London 2007) set out the need to develop a new model of care which included elements of primary and community care, current GP practice, elements of the traditional district general hospital and local government services. In line with the vision set out in *'Our Health, our Care, our Say'* (Department of Health 2006) this new model of care was to provide services to a critical mass of the population,

making it possible to provide both a greater range of services and to offer improved access. The model built on recommendations in Lord Darzi's *A Framework for London* that polyclinics should be established in each Primary Care Trust (PCT) in NHS London (Healthcare for London 2007).

Polyclinics were expected to provide a wide range of services, including GP and pharmacy services and some diagnostic services traditionally carried out in hospitals. *A Framework for Action* also suggested that polyclinics could house other services such as dentistry, physiotherapy, family planning and mental health services, although there was little detail about what could be provided and at what cost. The range of services could also be integrated non-health services such as social care, the voluntary sector and other care providers, and the creation of new services to promote health and wellbeing. Lord Darzi argued that London was suited to such a concentration of services owing to the ready availability of public transport that enabled patients to travel easily to the polyclinics (Healthcare for London 2007).

Interest in polyclinics and care closer to home was stimulated in the UK by the experiences of services in mainland Europe that provide enhanced co-ordination of care and Kaiser Permenante, an integrated managed care consortium in Oakland, California (Department of Health 2006). *'Our Health, our Care, our Say'* envisaged a substantial expansion of community based services including *"expanding the provision of community nursing services to support people at home"* (DH 2006:7.46). The focus on developing care closer to home with improved primary and community health care services was a key element of the Darzi Report *"High Quality Care for All"* (Department of Health 2008b). This led to the launch in 2008 of the care closer to home initiative by the government. There was not one blueprint for developing such care but it was envisaged that it would be system wide and delivered by enhancing the local workforce, working in partnerships with patients and communities, investing in better community facilities and be delivered through stronger commissioning (Department of Health 2008a). The main focus of *High Quality Care for All* was on the

need to develop stronger community health services with a key role for GP-led health centres or polyclinics (table 1).

Table 1: The Focus of the Next Steps Review (Department of Health 2008b)

Focus of the *Next Steps Review* was to:

- increase the capacity of primary community services and thereby improve access;

- provide more choice for patients;

- tackle some of the inequalities in healthcare; and

- encourage team working between a range of health care professionals located in one building.

In response the Government published "*Our vision for primary and community care*" (Department of Health 2008c), which placed the application of "choice" and "personalisation" at the centre of their proposals with a vision for primary care which was to be shaped by and around individuals. This would be achieved by giving patients more rights and control over their own health and care and by the NHS providing them with more information and choice to make the system more responsive to their personal needs.

Polyclinics: influences and forerunners

The lack of an exact definition for a polyclinic has led to some uncertainty about what it exactly is with a diverse range of both services and organisational models. At the same time, it is important to remember that the concept of a polyclinic is not a new one. The polyclinic has been a standard feature of many international health systems, not least in the Eastern Bloc. Although some former Eastern Bloc states are moving towards a more pluralist or market model, the UK is not the only country to be now adopting the polyclinic model (Imison *et al.* 2008). None of the newer international adoptions of the polyclinic as a site for healthcare are uniform, with differing numbers

of doctors and specialists and some with close links to social services, rather than being exclusively medical. Naturally, each polyclinic is also planned through the prism of national cultural and political history as well as attempts to meet particular health needs. In Singapore and Brazil, as in the UK, the polyclinics were created as part of a deliberate policy, in Sydney, Australia, on the other hand, the polyclinic is a more diffuse network of sites (including multi-cultural styles of medical practices) within an area, rather than a single building, which grew organically in response to a national Government strategy to improve integration of services (Department of Health 2008b). The success of the polyclinic and the model adopted also depends on historical professional boundaries, hence in Finland there are few specialists in the clinic, because they are perceived to be a low status place to work (Ettelt *et al.* 2006).

Even in the UK, before the NHS was created, multi-disciplinary health centres were already in existence. The 1920 Dawson Report anticipated two types of Health Centre: "primary health centres" in which GPs would have access to diagnostics such as radiology and laboratories as well as operating rooms, dispensaries and other services; and "secondary health centres" staffed by consultants offering specialist services, which they named 'polyclinics' (Lewis & Brookes 1983). When the NHS itself was established in 1948, the original idea was to have GPs (as employees of the NHS, rather than self-employed) working in newly built multi-disciplinary health centres (Meads 2006). Today's polyclinic it could be argued, is a re-working of the same idea, with advances in treatments and the technologies relating to treatment and diagnosis meaning that more sophisticated and complex procedures can be done outside hospital, because the treated patients no longer require in-patient stays. However, the polyclinic vision seems very distinct from recent policy initiatives such as Healthy Living Centres and more community based primary car centres such as the West End Centre in Newcastle and Bromley by Bow Centre in London (Kai & Drinkwater 2004).

Community nurses were seen as playing a key role in Darzi's vision of the community and primary care sectors, particularly as the profession has a dual focus on personal health care and community

health (Department of Health 2008d). However, while it was assumed that this central role would play an important part in the integrated and broad ranging functions of the polyclinic, there was also concern that it was unclear who would undertake much of the work envisioned in the polyclinic (Independent Nurse 2008). If the range of diagnostic, assessment and treatment facilities were to be realized then there would need to be an associated investment in workforce development (Sines 2009). Concerns at the time regarding dwindling numbers of nurses (Independent Nurse 2008) are now compounded by financial constraints within the health service.

The London developments

Following the publication of *Our Health Our Care Our Say* and *A Framework for London,* NHS London took the opportunity to consider a whole system transformation of the delivery of its health services, particularly in the primary care. The subsequent report *Healthcare for London: a Framework for Action,* set out a vision to deliver care closer to home and more cost-effectively than in major secondary care centres (Healthcare for London 2007). Beginning with a programme to introduce polyclinics into every PCT, the proposals developed into the intention to create locality based polysystems – mini health economies and service delivery structures either focused round a polyclinic hub or a via a 'virtual polyclinic' networked between existing service providers and locations. The polysystem programme was ambitious and provided a unique opportunity to deliver a step change in patient care. It is a new type of healthcare delivery model that aims to improve health outcomes and reduce health inequalities in London (table 2).

Table 2: The polysystem vision

The polysystem vision will be achieved through:

- Making a greater range of services available in the community in a polyclinic hub building and networked GP practices

- Delivering patient-focussed, integrated services based on the latest clinical evidence and best practice pathways

- Ensuring services and individual polyclinics meet the needs of the local population

- Developing a sustainable model of care which provides value for money, and will continue to evolve and innovate

- Upgrading the primary care estate so that services in the hub and spokes are delivered from fit-for-purpose buildings.

- Resources would be made available via demand management programmes?

The initial two year programme was for the establishment of 20-30 polyclinics across London by 2012. However, the subsequent financial crisis before the 2010 general election and dire public spending predictions following it have potentially compromised NHS London PCTs' ability to follow through on the re-design of its delivery systems. The development of polysystems in London since April 2009 illustrates both the diversity of plans for their structure and organisation but also highlights the difficulties that have been faced. The shift from polyclinic to system infused the development agenda with added complexity and scope for fairly wide interpretation, and each PCT has implemented the polyclinic/system policy against a backdrop of different local patient demographics and strategic care priorities, varying organisational legacies and uneven commissioning expertise. However, it was clear from the outset that the 'ideal-type' polyclinic outlined in the Darzi review (Department of Health 2008b) was unlikely to materialise, not least because of the level of investment implied by that report, even before the advent of a stringent

public sector financial climate, appeared unrealistic. From the outset there was substantial diversity of interpretation which was then further exacerbated by the strategic policy shift from polyclinic to polysystem as some PCTs were already developing plans for new stand alone service entities, whereas others, not so far advanced in the polyclinic agenda, were able to progress to a more systemic approach as the political and policy pressure for new high-impact, statement buildings and services receded.

Method

In 2009, NHS London commissioned an evaluation of the commissioning and operation of eight polyclinics across London. An independent research team, led by the London School of Hygiene and Tropical Medicine and in collaboration with Imperial College, London and the Picker Institute was mandated to undertake a 2-stage evaluation over 24 months which would provide on-going learning and an evidence base for PCT commissioners implementing the polyclinic agenda across London. The research focus subsequently developed to an examination of polysystems rather than specific polyclinics. For the first phase of the evaluation, four 'early implementer' sites were selected as initial case studies and the data presented here are based on interviews with 41 interviews across these four sites (See table 3) and an analysis of documents from NHS London, PCTs and provider organisations.

Table 3: Interviewees

Interviewee role	Number (n=41)
PCT manager	12
Service manager	3
Clinician (provider)	4
GP	3
Nurse manager	3

Primary care manager	6
PbC manager	2
Patient representative	2
Polyclinic/polysystem lead/manager	5
pharmacist	1

Another three PCTs have since been selected for phase two, which began in September 2010. The seven polysystems together cover a large section of London, being in both inner city and outer suburban PCTs. The research team were asked to focus on key areas in their evaluation of these polyclinics, identifying the key drivers, barriers and enablers in the restructuring of primary and acute care. The study involves a 'mixed-method study design' (Byng *et al.* 2008), combining both qualitative and quantitative approaches to collecting, analysing, interpreting, and reporting data. For example, selected patient outcomes are being examined by using quantitative data analyses together with patient surveys and insights gained from in-depth interviews on specific aspects of service delivery. Each polysystem forms the basis of an individual 'case study' (Yin 2003), which also comprises the agreed organisational and service delivery features of each site. The research is taking the form of documentary analysis, interviews with key stakeholders in commissioning and provision, analysis of performance data and a wide-ranging consultation with patients using each service. The evaluation is distinctive because it is designed to be embedded within, and inform the ongoing commissioning decisions of PCTs, rather than looking retrospectively at a completed service development.

Results

Commissioners and providers in our initial interviews often spoke of the difficulty in reconciling local organisational realities with imposed policy expectations. This was even more pronounced in

relation to polyclinics/systems which had become politicised innovations with a degree of baggage and pressure attached, not to mention significant resistance from GP organisations. Having completed the first phase of evaluation, the most striking finding has indeed been to identify the variation in polyclinic/system models implemented by PCTs. Of the four initial sites, one polyclinic evolved out of pre-existing plans to manage Accident and Emergency attendances by procuring a GP practice and an 'urgent care centre' staffed by GPs and nurses to triage or 'stream' all but the most urgent cases into a primary care setting. This service 'became' a polyclinic midway through a competitive tendering process as commissioners devised a contract that met the necessary quality and service criteria. Similarly, a second case study site grew out of a programme to create neighbourhood resource centres where primary medical services would share space with the local authority, with an opportunity to move to a broader conception of public health. This only 'became' a polyclinic then a 'hub' after a substantial amount of planning and organisation had already been undertaken and the strategic decision had been made to have health and social services dispersed to and structured around a network of community facilities. Another site has been billed as one of the first purpose built polyclinics but again, plans were already in place to create a, less ambitious, GP-led Health Centre on the site; whilst the final case study site had decided to make better use of an existing building when creating their polyclinic.

All of these facilities have different central foci and whilst they share some services in common, are intended to serve and reflect the different needs of each local population. It has been assumed that polyclinics/systems can be treated as unified entities or models to be evaluated and challenged (Hutt et al 2010). Our evaluation has discovered that these innovations are better understood as instruments for service delivery with some common features, but diverse in nature dependent on their local contexts. Perhaps most strikingly, given the fact that polyclinic and polysystem developments were embedded in the London Darzi review (Healthcare for London 2007) and *Care Closer to Home* (Department of Health 2008a) is the absence of community health services as an

integral part of their development. In the interviews little reference was made to the inclusion of community health services as the focus, driven by financial imperatives, was primarily on outpatient services. The broad vision of networked community services has, as yet, not materialised.

Concurrent community health services (CHS) development

Alongside polysystems developments there are major changes in the organisation and structure of community health services in London. The development of new service models – whether vertically integrated with acute trusts or new CHS provider organisations (Community Foundation Trusts, social enterprises etc) – need to be considered alongside polysystems developments. Clarity about the organisation and role of polysystems will help identify the type of relationship. Despite the focus in polysystems development on developing community based services there was little evidence of polysystem investment in community nursing services or wider community health services. Much of the focus, mainly driven by financial models, was on developing outpatient clinics and shifting such activity out from secondary care and 'off-tariff'. It is clear that commissioners need to consider the role of community health services and wider primary care services in the development of polysystems.

While some of the initial aspirations about polyclinics and the development of polysystems identified the need to integrate health and social care services only one of the initial polysystems in the evaluation cohort of four had developed this to any degree. The main reason here was, however, due to historical factors relating to the PCT/Council relationship and the previous strategy for developing neighbourhood resource centres. In other systems integration with social care is slow and not always evident. Similarly the broader health and well being agenda is not strong within system developments. In these case studies there was little reference to inequalities as a driver or staying healthy, despite huge policy emphasis.

Implications for Community Nurses

Despite the key role envisioned for community nursing and community health services by Darzi (Department of Health 2008c), one of the more striking emerging findings of this evaluation is the lack of investment in weaving community nursing into the polysystem. This was in part due to the concurrent externalisation of community nursing services from primary care trusts and the development of arms length provider services. In addition, this lack of investment has also partly arisen by the narrow commissioning focus as opposed to the broad ranging, integrated health service provision originally described. Nevertheless, critics have also alleged that regardless of the lynchpin rhetoric (Department of Health 2008d), community nurses have yet again had difficulties in maintaining visibility in the eyes of commissioners (Edwards 2008). Edwards (2008) argues that although highly valued by patients, the generalist nature of much of community nursing makes it increasingly difficult to survive within the proliferation of specialists. It would seem that community nursing and community health services would most closely fit with a polysystem based on principles of integration, public health and services designed to meet the majority of needs of a local population ranging from enablement of self-management to end of life care.

Conclusion

Within London, polysystems could be seen as having been a necessary correction to practice-based commissioning by re-aligning non-geographic groups into more logical, geographically oriented local commissioning organisations, thus enabling a more coherent service delivery model for specifically defined local populations. The impact of the White Paper on these plans, with its emphasis on GP-led commissioning consortia, is as yet, of course, an unknown quantity although there are indications that consortia will differ from Practice Based Commissioning groups in size and coverage (Department of Health 2010). To some extent polysystems have provided an impetus for taking forward or challenging pre-existing plans. For example, plans to move more treatment and consultations out of acute hospital sites to dispersed localities – an agenda that it had been hoped

the polyclinic/system policy might shape and hasten. Nonetheless, in seeking to assess the impact of polyclinics/systems on organisation and delivery, there is a need to situate that assessment within the what, why and how of primary care restructuring. To what extent community nurses will play any significant role in these developments is not as yet clear. However, the initial findings from this research suggest that a focus on high level organisational restructuring and system change can in fact shift attention from what many would consider core activities such as community health services.

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