‘Somehow the wheels on the bus stayed on’ – Managing change, reformation and revolution in primary care.

Jennifer Gosling, Andrew Wallace, Dorota Osipovic, Stephen Peckham and Pauline Allen (London School of Hygiene & Tropical Medicine).

Introduction

In recent years, NHS Managers have faced waves of centralised policy changes coming from both Government and NHS London, whilst also negotiating the resulting organisational re-structuring, rising demand for services and an impending cash-limited environment. This paper explores some of the issues that have confronted Primary Care Trust (PCT) managers in London, identified during an evaluation of one of those policies: the polyclinic/polysystem programme.

Background

In 2007 NHS London decided to undertake a ‘whole system transformation’ of the way it delivered health services in the capital. This followed on from the ‘Darzi Report’ (‘A Framework for Action’, NHS London, 2007) and an internal report undertaken by the management consultancy McKinsey, which measured likely resources against future increases in demand and demonstrated a significant financial challenge for London PCTs. One aim was to pursue the Labour Government’s commitment to providing care closer to home (DoH, 2006), meaning that services could be delivered locally and, in theory, more cheaply than in large centralised hospital buildings. The vehicle for delivering this shift was the polyclinic, broadly speaking an enhanced health centre, containing a multi-disciplinary team of clinicians and a wide range of services, with extended diagnostics, such as x-ray, as well as treatment facilities. The aim was to provide a ‘one stop shop’ and seamless care for the patient. There is some logic to this approach, as in many ways the structures of the NHS have not caught up with improvements in medical technologies, with many procedures and treatments no longer needing patients to be in hospital overnight. However, while treatments have improved, the best location for delivering it is still open to debate. Shortly after the programme was announced, the landscape was further complicated by the creation of the term ‘polysystem’.

There has also been some confusion over the exact definition of a polyclinic, but it is important to remember that the concept of a polyclinic is not a new one, nor has it had a uniform definition. 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 general practitioners (GPs), as UK family doctors are called, 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 (Lewis & Brookes, 1983). More recent 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 by Kaiser Permanante in the USA (Department of Health, 2006). 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 (Immison et al, 2008; Meads, 2006). 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 (Meads, 2006). 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 (Meads, 2006), which is possibly more in line with the polysystem concept.

The Darzi polyclinic model, which included services such as x-ray, implied the building of new premises (it is extremely difficult, for example, to install x-ray into an existing building). However, political and financial reality caught up with these plans before they could be properly rolled out, so while 30 polyclinics should have been open by 2010, in fact only 17 were in existence before the programme was ended by the new Secretary of State. Many PCTs did not have the resources to enter into contracts for new buildings in their areas, yet each PCT was expected to open at least one polyclinic, preferably more, in order to cover their whole population. Thus rather than form following function the necessary use of existing estate and re-badging of existing clinics meant that function inevitably followed form, compromising the core polyclinic ideal. Nor were the polyclinics themselves uncontested, with many GPs in London resisting the creation of a polyclinic in their area, fearing that they would be forced to sell their own premises and move into the new buildings. In several of the case study sites PCTs struggled to find a practice to take on the contract for providing general practice services in their polyclinics. There was a clear dissonance between PCT managers and GPs over this issue, with one Chief Executive stating, when interviewed: ‘the whole point ... was to reduce the number of places that you’d provide primary care from.’

Partly to allay these concerns, the term ‘polysystem’ was coined. There is some dispute about the origin of the term, but broadly, it is a geographically defined area, which contains a polyclinic hub, with the polysystem practices as spokes, creating a self-contained locality, with patients being referred to the polyclinic, rather than a hospital to receive treatment (where clinically appropriate). In some places, this served to reassure GPs about their continuing independence, whilst allowing the polyclinic programme to roll out.

Methods

The evaluation was commissioned by NHS London in 2009. Using 'early adopters' as case study sites, the evaluation was asked to assess the operation of polyclinics under the headings of access, clinical quality, value for money and patient experience. The research team was led by a team at the London School of Hygiene & Tropical Medicine, who undertook the qualitative data collection, while colleagues at Imperial College, London, undertook the quantitative analysis of clinical data and the Picker Institute in Oxford designed and administered the patient experience surveys. The qualitative side of the research involved semi-structured interviews with key informants, observation where possible and documentary analysis.

There were significant methodological problems in undertaking the research, not least the fact that this was a real-time rather than retrospective evaluation. Thus polyclinics and polysystems were still developing and bedding down as the fieldwork was being undertaken and most were working below intended capacity because of the lead time involved in transferring services across. Following the general election in 2010 the coalition Government's White Paper, 'Equity and Excellence: Liberating the NHS' was published (7 months after the field work began), which foresaw the abolition of Primary Care Trusts. Thus an unstable research environment became a turbulent one as swathes of staff were made redundant and we found ourselves trying to locate key informants who had moved to new jobs during re-structuring, or who had taken redundancy and disappeared altogether, along with the posts they had previously inhabited. The research field of polyclinics and polysystems themselves also partially disappeared as the term polyclinic was dropped. Some polysystems were re-branded as Integrated Community Health Networks, whilst in other PCTs they were so unpopular with GPs, who saw them as centrally imposed, they were rapidly discarded as the GPs began to establish the new GP Commissioning (now Clinical Commissioning) Groups.

Results

When undertaking the qualitative fieldwork on the ground, the research team found PCT managers grappling with a shifting policy environment, trying to balance on-going strategic planning and service delivery, in line with local needs assessments, with top-down policy and organisational prescriptions – the top being both NHS London and central Government. The impact on colleagues was keenly felt as this commissioning manager explained:

'I interviewed, for a relatively junior commissioning manager [post], 14 senior managers; and in the feedback to those... the only thing I could say was, there were 14 of you, and 13 of you couldn't get the job...'

There was also recognition of the pressures placed on those who deliver services, whilst these different reforms and changes were being undertaken, as this quote, from which the title of the paper is drawn, from a commissioning manager illustrates:

'I mean, somehow the wheels on the bus stayed on; yes, and actually we got a bit better. But a lot of that has to do with your front-line staff who are keeping the wheels on the bus whereas the rest of us highly paid bureaucrats are trying to work out a system and a... And specifically about polyclinics, poly-systems... and now we're calling them community networks.'

The final part of the quote also illustrates the constant churn of policies – Darzi's report, which introduced the modern polyclinic concept, was published in 2007; polysystems emerged in 2008, by early 2011 they had all but disappeared. There was also a lack of patience with some of the reforms and the haste with which they were being introduced, rather than with consideration and planning:

'We're not having the strategic debate about what it is we're trying to achieve in outcome terms ... So in actual fact, we are… for reasons that have largely to do with cost at the moment, we are squeezing the system without reference to where do we want to get to in terms of outcomes...'

Imposed definitions of what constituted the criteria for a polyclinic also caused problems, with some PCTs finding it difficult to successfully source practices to provide general practice services in the polyclinics. In one case study site it took two rounds of the tender process before a private provider successfully bid for the contract. In another, the PCT was about to resort to the local Out of Hours provider, as a temporary stop-gap, when a local practice volunteered to provide a small surgery in the polyclinic. It is not clear whether this operates as a second, standalone practice, or is in fact a branch of the parent surgery.

The concept of the 'hub and spoke' model, also threw up some anomalies. An organisational diagram of this would naturally put the hub in the middle, with the spoke practices radiating out uniformly in a circle. However, in several case studies, because of the convenience method of selecting locations, the polyclinic was geographically to one side of the polysystem. Thus in one case study site while the practice in the polyclinic itself had significantly reduced unnecessary A&E attendance by its patients, it still made sense for the patients of practices in the wider polysystem to travel to the local hospital A&E department, because it was closer and transport flows made it a more logical destination. This particular polyclinic was a new build, but the original plan had been for a Primary Care Resource Centre in an under-doctored part of the borough, and was perhaps not the location that would have been chosen specifically for a polyclinic. This again

underlines the anomalies which can be created when one policy is laid on top of another.

Similarly, patients use the polyclinic services as they want to, not as PCT managers might wish. So whilst the ideal of the polyclinic is that patients should be able to move from one service to another, seamlessly, during one visit, in fact patient data showed that less than 2% of patients accessed more than one service during their visit and most stated that ease of access was more important.

Discussion

NHS London aimed for a 'whole system transformation' of the way services are delivered in the capital. However, in the NHS as in other public services, one is rarely, if ever, beginning with a blank sheet of paper. Change is always on a continuum and the polyclinic/polysystem policies were over laid on other pre-existing policies, making it difficult to untangle cause and effect from previous and overlapping policies within this complex system. Sometimes these policies worked against each other: for example, GPs and PCTs worked together in some polysystems to redesign patient pathways which aimed to refer patients to a consultant's outpatient clinic only when clinically necessary. However, this contradicts the parallel policy of patient choice, under which patients should be allowed to choose where they go for treatment.

PCT managers found themselves caught between the implementation of top down policies imposed from the centre and GPs on the ground who, as independent practitioners, were in a position to resist and obstruct unpopular organisational restructuring. Managers in most case study sites were also trying to negotiate and balance NHS London's proposed solutions to the impending financial constraints (pre-2010 comprehensive spending review and coalition budget) within a context of growing demand, with their own on-going strategic and service delivery planning, based on local needs analyses.

Much seemed to depend on the pre-existing relationship between PCT and the local GPs. If this was a good working relationship, PCT managers were able to negotiate the creation of polysystems and in some cases build on practice based commissioning systems to enhance the organisation and delivery of services to the local population. Where relations had historically been poor, PCTs struggled to gain GP engagement with both the polyclinic and polysystem processes. This was evidenced by the difficulties some PCTs had in successfully locating a practice to move into the polyclinic and in the immediate collapse of polysystems in other areas, when the policy was superseded by GP Commissioning.

Conclusion

The research results illustrate the difficulty of imposing top down organisational solutions and the pressures this can exert on managers who are tasked with

implementing policies on the ground, particularly when the NHS is shifting from a time of plenty to one where budgets are static or decreasing. This is even more problematic across an area as diverse as London, where demographics and morbidities can vary widely across a single PCT as well as between the 31 PCTs in the capital. Consequently, polysystems were executed in different ways and with different levels of success in different localities, with some PCTs or GPs seeing them as uncalled for intrusion into autonomy, whilst others embraced them as a useful template for organisational reform and improvements in service delivery, with managers caught in the middle, attempting to negotiate change and improve services in an unstable and uncertain environment.

References

Department of Health (2006) *'Our Health Our Care Our Say'* TSO: London

Healthcare for London (2007) '*A framework for action'* Healthcare for London: London

Imison C, Naylor C & Maybin J (2008) *'Under one roof – will polyclinics deliver integrated care?'* Kings Fund: London

Lewis, J. and Brookes, B. (1983) 'The Peckham Health Centre, "PEP" and the Concept of General Practice During the 1930s and 1940s' *Medical History,* Vol 27, pp. 151 – 161

Meads, G (2006) '*Primary Care in the Twenty-First Century, an international perspective'* Abingdon: Radcliffe Publishing