General practitioners' plans for developments in the inner city: a review by a primary care project

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SUMMARY. This paper describes part of the work of a development project, working in Tower Hamlets in east London in 1983–87, with the wider remit for facilitating primary care development in the inner city. Thirty-nine of the 43 practices in the district were visited and general practitioners discussed their plans for development and the problems they encountered. The paper presents the results of the discussions and the follow-up work, which explored how further developments could be brought about. It concludes that many general practitioners are considering and introducing a wide range of new developments in their inner city practices. Planning for development of primary care in the inner city should focus more closely at local levels on what practices are already planning and provide more encouragement and practical help than at present.

Introduction

PRIMARY health care in the inner cities continues to be a cause for concern. Many reports have focussed on the difficulties and 'shortcomings' of inner city general practice and the proposals in the white paper[1] have led to renewed debate about future developments. Recent studies have reviewed progress 'after Acheson'[2] and there are hopes that the establishment of family practitioner committees as independent authorities with major responsibilities for planning will have a beneficial effect on the quality of primary health care.[3] However, to date there has been little work reported which explores at a local level whether development is actually happening in inner city general practices, and how general practitioners themselves plan to develop their services.

The Tower Hamlets project

The Tower Hamlets primary care development project was established in 1983 jointly by the health authority and family practitioner committee, with the support of the King's Fund, and ran for four years. Drawing on the earlier general practice facilitation work of Dr Arnold Elliott in Islington[4] the project aimed, more ambitiously, to work across the professions and structures of primary care to help find solutions to some of the practical problems of primary care in the inner city and to support and encourage those working in the field to develop new initiatives. The project worker would work with general practitioners, community health staff, social services and appropriate statutory and voluntary organizations and act as a focal point for feeding ideas about necessary developments to decision-making bodies.

When the project was set up in 1983, the Acheson[5] and Harding[6] reports had already drawn attention to a wide range of practical problems of inner city primary health care, and it was argued by Jarman[7] that social indicators relating to the local population could be used to measure the need for primary health care services. In addition, the interrelationship of social factors with the high levels of morbidity and mortality in Tower Hamlets had been highlighted both in the appendix to the Black report[8] and in a number of local studies.[9,10] An initial study by the project in 1983 of information currently available on general practitioner services in Tower Hamlets and visits to nearly all practices confirmed many of the earlier findings.[11] Some major developments had taken place in a few locations, through the determination of the doctors and with the support of the health authority and family practitioner committee. Services in these practices were well developed and there was close working with health authority services. However, generally there were widespread problems with premises, very low levels of attachment of health visitors, low numbers of ancillary staff employed, and a higher than average number of elderly and of single-handed general practitioners. A contemporary study by Bowling and Betts[12] again emphasized the many practical problems general practitioners were experiencing.

The project began working closely with local general practitioners, the family practitioner committee and community health service staff to tackle some of the specific problems, including improving premises, providing information for patients in leaflets, assembling information for general practitioners on open access and community health services and producing lists of general practitioner services for use by other health professionals, and community and voluntary groups. Meetings were held with a wide variety of community and voluntary organizations, as well as general practitioners and health professionals to discuss how new approaches to joint working could be developed.

Survey of development plans of general practices in Tower Hamlets

During the course of the project, it became increasingly clear that joint planning with health authority services to meet local needs was hampered by the lack of structured information on what general practices themselves were planning.

It was on this basis that the project decided to collect detailed information from all Tower Hamlets general practices on their plans for the next two, five and 10 years. The aim was to gather information of use to both the family practitioner committee and the health authority, and, just as important, to provide an opportunity for general practitioners to consider and report the general direction and future plans for their own practice so that help and support could be provided where possible.

During 1985 and early 1986 interviews were requested with one or all of the partners in the 43 practices in Tower Hamlets. In some instances a measure of persistence was required while in others the practice not only invited the project officer, but also requested further visits and the project followed up areas of

concern. Of the 43 practices four did not take part, but two of these had been seen on other occasions. Using a semi-structured questionnaire questions were asked about practice catchment areas and these were mapped; organization of services and plans for development; aspects of practice management; present and proposed staffing and training needs; reception cover and information for patients; liaison arrangements with community health, hospitals, social services and voluntary organizations; existing premises; and plans for the future. Discussions lasted from half-an-hour to three hours.

Findings of the survey

A major finding was that two-thirds of the practices had plans for development of services and therefore the discussion with the project worker and the follow-up work was genuinely useful to many practices. For some it offered an opportunity to review the direction of the practice and to help turn tentative ideas into firm plans. For general practitioners new to the district it also was an opportunity to find out about local contacts and groups. In other practices major changes were discussed and further contacts arranged, to discuss, for example, practice nurses, new premises, use of the community mail run which called at a few practices, or long term retirement plans. The project was also able to follow up many of the problems identified by general practitioners.

The main findings of the interviews with the 39 practices are listed below and related to statistics about all 43 practices where appropriate.

Plans for development

Twenty-six practices, 67% of those surveyed, had plans for service development. These varied widely and included developing preventive and practice nurse activities — such as geriatric screening, a hypertension clinic and child health sessions — and new initiatives to meet ethnic health care needs. These practices included the larger practices which had already made major changes, but also several small practices, some of which were not well known to community health staff. In addition, 21 practices (54%) were planning to move or to improve their current premises.

Practice organization

There was considerable variation in practice organization within Tower Hamlets. In 1986, 67% of the 43 practices (29 practices) had a walk-in, wait-your-turn system which some practices thought was appreciated by patients while other practices said an appointment system would not work for organizational reasons. Four practices had no receptionist and a further 17 (40%) had limited part-day reception cover. In discussion with the practices, some had not realized that these arrangements might make communication more difficult with other health staff whose daily timetable was different.

Thirteen practices had age–sex registers and two had a computer. Five of the 43 practices (12%) had attached health visitors and another five practices employed a practice nurse. Over half the practices (21) said they would like clearer arrangements for attachment of or liaison with nursing staff, and this was an area in which considerable concern was voiced.

Practice premises

Over half of the practices visited were planning to move or to improve their current premises. In fact, problems with small, poor quality rented premises were seen as the major stumbling block to further developments. There was often little waiting space, cramped examination facilities, no treatment room or office space and poor toilet facilities for both staff and patients. The general practitioners had real difficulties in acquiring new sites and in dealing with the local authority, who owned over 80% of the land, and who had little understanding of possible financing mechanisms. The active help of the family practitioner committee and the Medical Architectural Research Unit's practice premises unit was much valued. Over two-thirds of premises were owned by the local authority, and the majority of these practices had full repairing leases which meant that the leaseholder, the general practitioner, was responsible for structure, maintenance and any improvement. This was not conducive to the optimum use of existing financing arrangements. In particular the improvement grant system was often not seen as appropriate when the premises were, for example, a small local authority flat in a block, held on a short-term lease.

Personnel

Major personnel changes were taking place in many practices, in particular the appointment of young, locally trained general practitioners, with the formal policy support of the family practitioner committee. This was leading to new developments and new ways of working in many practices and to interest in developing clearer protocols for joint working with hospital and community health services. Several practices were growing rapidly and major changes had taken place since 1979. In particular there were more women doctors, a lower average age, and more group practices (Table 1).

Table 1. Changes in partnership size and age and sex of general practitioners in Tower Hamlets between January 1979 and January 1987.

	Percentage of GPs	
	1979 ($n=82$)	1987 ($n=91$)
Number in partnership		
One	*27*	*16*
Two	*37*	*18*
Three	*24*	*36*
Four	*5*	*18*
Five	*0*	*5*
Six or more	*7*	*7*
Age (years)		
Under 30	*1*	*3*
30–39	*14*	*36*
40–49	*23*	*20*
50–59	*26*	*21*
60–69	*27*	*11*
70+	*9*	*9*
Sex		
Men	*84*	*76*
Women	*16*	*24*

Source: City and East London family practitioner committee.

Facilities and services

Facilities and services available to patients in Tower Hamlets varied greatly. In part this was said to reflect differences in need. Providing appropriate services for the inner city population was recognized as especially difficult. Very high consultation and visiting rates were recorded in some practices: some general practitioners reported regularly seeing 30–40 patients per morning surgery. Annual turnover rates of over 15% were reported because of high mobility and this added to the difficulty of maintaining record systems and communicating with hospitals.

Language and cultural difficulties were frequently mentioned, and no official interpreting service for general practitioners was available, although the health authority provided a service in some community health clinics.

Thirteen practices had a card or some written information for patients but 26 of the practices surveyed (67%) had no written information about services to give to their patients. No practice or health centre had a patient participation group.

Practice areas

Attention has been focussed in the past on the overlap of practice areas in the inner city. We found there was considerable variation in practice catchment arrangements. Ten practices had clearly defined local boundaries for new patients, in some cases marked on maps by street, 18 had defined but less discrete areas within part of Tower Hamlets and 11 had wide practice limits. Some practices said they wished to provide continuity of care for patients of high mobility. Others wished to provide care for specific needs: the homeless, students or those with particular language needs. Fifteen practices, some on the borders of the district, might retain long-term patients who moved outside the health district even if this were a considerable distance. In two areas in particular there was little choice of doctor for patients. A few general practitioners were unclear about which area their practice covered and some did not know the location of other neighbouring practices and had not met local colleagues or other health care workers.

Contact with other organizations

There seemed to be confusion in many practices about what the health authority policies and plans were for local services, and in addition a perceived lack of regular information about secondary care services, including names of consultants, changes in services, open access services available and waiting times. Many practices still worked without close contact with other community health staff, social workers or voluntary organizations. Thirty-three practices, 85% of those surveyed, said they had little or no contact with voluntary organizations. Others mentioned a total of 14 local voluntary organizations. One health centre had a social worker located in the building on a part-time basis.

Facilitating development

During the survey the project followed up many of the practical needs put to it, and the main findings were presented to general practitioners at a postgraduate centre seminar and at a meeting attended by over 60 general practitioners, family practitioner committee and health authority members and senior staff, community council representatives and others. The meetings discussed possible recommendations for improving communication and planning. The findings and recommendations were also put to the community unit management team.

The aim was to discuss how general practices and community health services could develop joint approaches and to identify how statutory health authorities could work with primary care providers to meet inner city health needs.

Conclusions

A number of important conclusions can be drawn from this survey and the follow-up activity. First, many developments being planned for inner city general practices are not adequately discussed or supported. Many have major implications for the future joint planning of primary and secondary care. In its reports the project has outlined some of the recent changes known to have taken place in general practice organization, age structure and service development in Tower Hamlets. This survey revealed that broad statistical overviews are likely to miss many planned local developments and therefore give a misleading picture of the state of primary health care in inner cities. In this context too, the policy of encouraging change by exhortation and financial incentives, some of which may be inappropriate, is somewhat misleading: the desire to change is often already there. What is lacking, rather, is the necessary practical support, resources and encouragement to enable plans to be carried through.

A second major conclusion is the need to draw this kind of information together for use as a tool for health authorities when planning secondary care services as well as community health services. It is vital that collaboration is developed at local levels if real improvements in local health care services, in which inner city general practitioners play a major part, are to be achieved.

The final conclusion concerns the considerable variations between practices noted above. Although the majority of the practices worked to provide a higher quality service for their patients, they varied in their ideas of how to do this and their practical knowledge of the mechanisms — principally organizational and financial — by which desired goals might be achieved. In practical terms, this highlights the crucial importance of ensuring an equitable dissemination of support and resources between different practices. Development of policies to address this issue can only be made easier by the collection and use of the kind of information assembled in this survey.

The context

All these points need to be considered in two contexts: one is the constant day-to-day pressure, heavy workloads and poor working conditions that often allow the inner city general practitioner little time, energy or encouragement for further development. The second is the enormous scope for clearer thinking and joint strategies to link primary and secondary care in the inner city, and in relation to this the important role that health authorities and family practitioner committees have in supporting developments and change.

Some major studies have shown that change and development in general practice may come about as a result of peer influence[13] and review.[14] The influence of feeding back some available indications of work patterns and performance has been noted.[15] Local groups are obviously valued.[16] Stocking, looking at the process of innovation and change in the NHS, identified the importance of a 'product champion',[17] from whatever source and combination of circumstances, and there are obvious examples in some inner city general practices. However, Horder and colleagues in their review of influences on general practitioners,[18] pointed out that a variety of factors may be relevant. This project in Tower Hamlets and others such as the Camberwell project have found that many inner city practices are planning developments, but what is needed is practical and acceptable facilitation and encouragement, backed by joint policies and resources, to combat the inner city deprivation that can affect practices as much as patients.

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