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Editorial

Otolaryngology in the GP Fundholder Practice

Since the introduction of the Health Service reforms in 1991, one of the more contentious issues has been the inception of the GP fundholder (GPFH).

This enlarging group of general practitioners has been empowered to manage their own budgets for proscribed areas of healthcare and drug expenditure. They have thus been able to shape and change the pattern of secondary care which is offered to their patients: in order to effect shorter waiting times for both outpatient and inpatient treatment, the GP fundholders have been able to purchase services from NHS hospitals which in the past would not have been considered as the geographically local provider.

In order to bridge the service between the GPFH surgery and the distant secondary provider Trust hospital, GP fundholders have contracted to have consultants hold regular clinics in the GPFH surgery. The majority of these clinics are probably held by consultants as part of a fixed session NHS contract, whilst less commonly, consultants are contracted independently by the GPFH practice to provide this service outside their NHS commitment.

Many of the hospital specialities including otolaryngology have been popular with GPFH practices because of the high outpatient workload and traditionally long waiting times for hospital appointments with local providers.

The attraction of having the consultant visit the GPFH clinic on a monthly or fortnightly basis is viewed by the GP's as a positive quality issue in terms of accessibility for their patients, shortened waiting times, and improved communications between general practitioners and hospital specialists.

Certainly where audit of patient satisfaction has been carried out, the attenders at the GPFH consultant clinic are wholly supportive of the service which they have received. Sixty-seven per cent of patients have waited four weeks or less to see a specialist and 75 per cent have waited 10 minutes or less beyond their appointment time. (Levack—personal communication).

From the GP's and patient's point of view, the service provision in this model is near-ideal. There are however actual and potential problems.

The system is labour-intensive in terms of travelling time and the number of patients who can be seen in a clinic session. Hospital junior staff are generally excluded from GPFH clinics with an opportunity for training lost and clinic attendance numbers necessarily reduced. Travelling to distant sites may result in a single clinic occupying two sessions of fixed NHS commitment.

As the number of GPFH practices expands rapidly and the number of ENT consultants more slowly, it will not be possible to meet the demand for outreach clinics in every practice.

The difficulties of locating specialized equipment at the GPFH surgery have been cited. Some of these however are not seen as a bar by the more innovative practices: microscopes and vacuum equipment may be purchased. A light source may be provided and a nasendoscope easily carried to the clinic. An audiologist can be armed with portable equipment, (as in the community), and offered a quiet, rather than sound-proof room which is perfectly adequate for the majority of routine audiometry.

Radiological support may be difficult although can often be arranged prior to the clinic attendance by scrutiny of referral letters in advance. Nursing and clerical support must be assured before agreeing the contract for the GPFH clinic (Robb, 1993a).

On balance, it seems that it is possible to provide an ENT clinic service on a peripatetic basis that will serve the majority of patients referred with routine ENT problems. The GP's and their patients see the facility as highly desirable while the consultants have reservations about the time and resources consigned to such a small number of patients distant from the hospital base.

There is a middle ground where the needs of all parties concerned may be met, and yet bring the services away from the hospitals where access is poor, parking impossible and despite the best efforts of all concerned, waiting times may be long.

In order to serve our patients well and to satisfy the increasing shift of emphasis from secondary to primary, commmunity-orientated "delivery of care", we must support the reinvention of the community hospital. The old style cottage hospitals, long since closed or sold-off to make way for the high technology district general hospital, now have a new role to play.

With the cooperation of general practitioners locally, the community hospital with fully equipped outpatient facilities, limited radiography and ample parking can bring the clinics closer to the community on a number of different sites around the catchment area of a general hospital acting as a mini-hub and spoke organization feeding in-patient work to the general hospital.

A number of general practices may feed to the local community hospital where fully equipped and staffed clinics may be run efficiently with many of the benefits of the single practice GPFH clinic.

Patients may also move in the opposite direction from the general hospital to the community hospital. Where post-operative convalescence or social pre-discharge planning is necessary, the community hospital can provide nursing care and liaison with the GP's and community nurses, relieving the pressure on reduced numbers of acute short-stay and day-case beds (Robb, 1993b).

There is no doubt that GPFH clinics are with us for the immediate future, and putting aside the logistical difficulties of organizing them, they are popular with patients and GP's alike. They have proved an immensely useful exercise in demonstrating how it is possible to shift acute speciality outpatient care into the community setting. I believe, however, that they are a springboard to the renaissance of the small community hospital and not the final turn of the evolutionary wheel.

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