

Executive summary

**Cooperatives and their primary
care emergency centres: organisation
and impact**

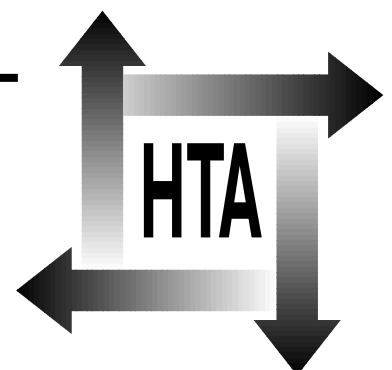
Combined report on seven case studies

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**Health Technology Assessment
NHS R&D HTA Programme**





Executive summary

Objectives

This study aimed to describe:

- the development of cooperatives, their structure, organisation and finances
- the patterns of care provided
- the attitudes and experiences of service providers and users
- stakeholders' views of the strengths and weaknesses of cooperatives.

Methods

Case studies were conducted in seven cooperatives between July 1996 and April 1997. Sites were selected to reflect diversity in number of members, scale of operations, organisational features and nature of area covered. Interviews were conducted with key informants, general practitioners (GPs), cooperative staff, and representatives of health authorities, accident and emergency (A&E) departments, ambulance trusts and community health councils. Six of the seven cooperatives provided details of all consultations over a 4-week period. From these, 400 patients in each were randomly selected to receive a postal questionnaire covering their expectations, experiences and satisfaction.

Selected cooperatives

Membership numbers ranged from 26 to 186 GPs, serving 45,000–400,000 patients. The selected sites included urban, rural and mixed areas, and patient populations covered a broad spectrum of socio-economic groups. The cooperatives had been established from between 1 and 5 years at the time of the study and operated from a total of 16 emergency centres.

Results

Reasons for establishing cooperatives

Most members established and joined cooperatives with the aim of reducing their hours on call. GPs viewed the change as essential to: improve their quality of life; meet the rising demand;

increase the attraction of general practice as a career choice; and aid recruitment in their own practice. Their concerns included: heavy workload for the duty rotas; increased travel distance resulting in delays in reaching patients; and varying standards of care.

Organisational features

The 16 emergency centres were located in community hospitals (5), A&E departments (2), other hospital departments (2), GP health centres (2), community health clinics (2), purpose-built/converted premises (2), and an ambulance station.

Average shift commitments ranged from 1.5 to 4.2 per month. It was usual to have only one GP on duty a night in each centre, covering 30,000–180,000 patients, though a second GP might be on call if needed.

Costs and funding

Annual operating costs varied widely between cooperatives, with gross cost per GP ranging from £1000 to £3800; the major source of variance was support staff costs.

Patterns of work

On average, the cooperatives studied visited 26% of callers, saw 30% at the centre, and advised 40% by telephone.

Conclusions

Cooperatives have improved the quality of life for GP members by reducing out-of-hours commitments and professional isolation. Patients attending cooperative centres are as satisfied with their treatment as those visited at home and more satisfied with response times.

However, rising demand means that co-operative members fear a step towards 24-hour access to routine care with associated problems of increasing rota commitments for GPs. Wide variations in patterns of care and response

times lead to questions of equity and safety and this is clearly an area that needs to be addressed. At present there is no single model for the future to which all stakeholders in emergency care would subscribe.

Publication

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NHS R&D HTA Programme

The overall aim of the NHS R&D Health Technology Assessment (HTA) programme is to ensure that high-quality research information on the costs, effectiveness and broader impact of health technologies is produced in the most efficient way for those who use, manage and work in the NHS. Research is undertaken in those areas where the evidence will lead to the greatest benefits to patients, either through improved patient outcomes or the most efficient use of NHS resources.

The Standing Group on Health Technology advises on national priorities for health technology assessment. Six advisory panels assist the Standing Group in identifying and prioritising projects. These priorities are then considered by the HTA Commissioning Board supported by the National Coordinating Centre for HTA (NCCHTA).

This report is one of a series covering acute care, diagnostics and imaging, methodology, pharmaceuticals, population screening, and primary and community care. It was identified as a priority by the Primary and Community Care Panel and funded as project number 93/20/01.

The views expressed in this publication are those of the authors and not necessarily those of the Standing Group, the Commissioning Board, the Panel members or the Department of Health. The editors wish to emphasise that funding and publication of this research by the NHS should not be taken as implicit support for the recommendations for policy contained herein. In particular, policy options in the area of screening will be considered by the National Screening Committee. This Committee, chaired by the Chief Medical Officer, will take into account the views expressed here, further available evidence and other relevant considerations.

Reviews in *Health Technology Assessment* are termed 'systematic' when the account of the search, appraisal and synthesis methods (to minimise biases and random errors) would, in theory, permit the replication of the review by others.

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The editors have tried to ensure the accuracy of this report but cannot accept responsibility for any errors or omissions. They would like to thank the referees for their constructive comments on the draft document.

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