The role of UK general practitioners with special clinical interests: implications for policy and service delivery

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SUMMARY

The development of specialist clinical interests by general practitioners (GPs) is currently receiving considerable attention in the United Kingdom. Although GPs have long been able to pursue such interests, it is only in recent years that they have taken on within primary care what were previously secondary care tasks, provided such services for patients outside their own practices, and received payment for them. The expansion of such services has been highlighted as a target in The NHS plan for England. Managerial and professional guidance is becoming available that seeks to clarify the role and nature of specialisation within general practice, to learn from the experiences of individuals who have embarked on specialist practice, and suggests procedures for future developments. Drawing on a range of sources, this paper builds on that burgeoning knowledge by setting the development of GPs with special interests in a broader policy context, highlighting the implications for the way that healthcare services are organised and delivered, and discussing their actual and potential impact on professional roles and practice.

Keywords: general practice; general practitioners with special interests; health policy; primary care.

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Introduction

THE past decade has seen an increasing emphasis on specialisation within primary care in the United Kingdom (UK). Although this paper is concerned with general practitioner (GP) specialisation, this trend has not occurred in isolation. Nurse practitioners and other nurses have often taken on responsibility for dealing with minor illness or for chronic disease management[1] and, with increasing numbers of specialist posts being established,[2,3] nurse consultants are taking on new clinical responsibilities,[4,5] and nurse prescribing is being extended.[6,7] Such developments involve changes in the boundaries between professionals as organisations take on new tasks and seek to deploy resources both efficiently and cost-effectively. For GPs, changes in the mix of skills within primary care teams have occurred in parallel with opportunities to extend the range of their own skills and interests in education, management, research, clinical governance, or clinical practice.[8-10] Such extensions of their generic general practice role have provided intellectual stimulation and an opportunity to develop careers through offering additional interest, personal development, and heightened self-esteem.[9] Traditionally, opportunities to develop specialist clinical interests have been provided through clinical assistantships within hospitals.[11] In accident and emergency departments, where GP input has increased in recent years, the role of GPs has not always been clear and GPs have varied in their wish to either provide a primary care service or focus on non-primary care patients.[12]

Recently, *The NHS plan* for England set a target of training 1000 GPs with special interests (GPwSIs) by 2004.[13] Jones and Bartholomew estimated that about 4000 GPs were undertaking clinical sessions in areas of particular interest.[14] Not all of these GPs had formal contracts to provide specialist primary care services to patients from outside their own practices. In their survey, 38% of the GPs with special clinical interests worked as clinical assistants, 19% as hospital practitioners, and 37% did not have a contract. Only 9% had contracts with primary care groups or trusts and 10% had private, health authority, or community trust contracts. However, proportions vary around the country: in Bradford South & West Primary Care Trust, nearly a third of GPs have contracts with the trust to provide specialist clinical services.[15] Colin-Thomé suggested that over 650 GPwSIs were working in England in early 2002.[16] Crucially, *The NHS plan* emphasises that GPwSIs will take referrals from other GPs, thereby distinguishing their role from GPs who provide a specialist service just for their own patients.[13]

This paper summarises the emerging guidance on factors to be considered when establishing GPwSI schemes.[8,32,38]

Given that such schemes have been in operation for a few years in some places, it is also possible to draw on these experiences and highlight both benefits and problems.

Methods

Three sources of data were used in this paper. Firstly, policy statements, both from central government and professional bodies, that set out the broad aims of GPwSI services as well as some pointers towards implementation. Secondly, we drew on the available research literature. Given that the development of GPwSIs is relatively recent, few research studies have been carried out and published. Some earlier studies did, however, examine the work of GPs who provided a specialist service for their own patients; although the context and organisational arrangements were different from those for GPwSIs, other aspects of their work are common to both. A few brief accounts of GPwSIs' work are mentioned in the professional press and, although lacking academic rigour, these too provide useful information. Thirdly, one of the authors was involved in a detailed evaluation of specialist primary care-based diabetes services. This evaluation highlighted both the benefits of GPwSI services and obstacles to be overcome.

The policy background

Within primary care, some GPs have taken lead roles in their practices for specific clinical areas. These roles have usually centred on general practice tasks. One exception to this has been in minor surgery, where GPs have, for many years, carried out surgical procedures, albeit initially without payment. Increasingly, calls were made for such procedures to become more readily available in primary care, not least to relieve hospital departments from having to perform minor procedures.[17-19] The 1987 white paper on primary care noted that such availability would also allow patients to receive a quicker and more convenient service.[20] Importantly, it suggested that approved GPs should be paid for such surgery, a suggestion that was incorporated into the 1990 GP contract.[21] The types of procedures eligible for payments were set out, with the number of such sessions limited to three per quarter, although eligible GPs could use the quotas of other GPs in their practice.[22,23]

The 1990s saw an explicit policy shift towards primary care.[24] The introduction of fundholding, followed by total purchasing,[25] together with the growth of near-patient testing, led to the expansion of outreach clinics led by consultants.[26] Despite the clinics' popularity with patients, some evidence of shorter waiting times for first appointments, and fewer follow-up appointments than in outpatient departments, important concerns remained about their cost-effectiveness and the lack of realisation of their educational potential for primary care staff.[27,28] Nevertheless, consultants' clinics formed part of the service configuration envisaged by *The NHS plan* within one-stop primary care centres.[13]

In 1996, a working group established by the chief medical officer reported that some GPs had the skills to carry out a wider range of tasks than were currently included within their contract. This led to the production of a set of health service guidelines (*A national framework for the provision of secondary care within general practice*, HSG[96]31) whereby health authorities could authorise the provision by GPs of some secondary care services within a primary care setting.[29] Over the following 5 years, Bradford Health Authority approved over 200 applications, although other authorities approved far fewer (M Purvis, seminar presentation, 2001).

The NHS plan sets out a number of service principles, including the removal of demarcations between groups of professional staff, extending the roles of staff, and developing primary care services. GPwSIs are mentioned in the context of reducing waiting times for treatment; this provides a clear objective against which performance might subsequently be measured, although they potentially offer additional benefits as well. Setting a numerical target also highlights the political recognition given to GPwSIs and indicates the need for primary care trusts to work towards this goal.[30] The establishment of GPwSIs accordingly forms part of the remit of the NHS Modernisation Agency, charged with implementing *The NHS plan*. *Action on ENT*, for instance, adopts a range of methods to improve patients' access to ear, nose and throat (ENT) services, including a GPwSI development project encompassing six sites.[31,32] The Changing Workforce programme focuses on role redesign within primary care for 13 sites, and GPwSIs represent one way in which such redesigns can be carried out.[33] In order to draw together and build on these developments, the Department of Health and the Royal College of General Practitioners (RCGP) jointly produced a guidance document outlining the issues to be considered when GPwSI schemes are being established.[8] More recently, the move towards GPwSIs has been supported by generic guidance on how to set up and run GPwSI services,[34] together with more detailed clinical frameworks for individual specialisms.[35] The frameworks cover issues such as service design, skills and competencies, and clinical governance, as well as giving an indication of the sorts of conditions that GPwSIs can be expected to deal with. To add further to the increasing amount of documentation about and for GPwSIs, the Modernisation Agency has published a step-by-step guide to setting up GPwSI services, which includes advice on how to review current service provision, requirements and service design, clinical governance issues, audit, and evaluation.[36] The new GP contract encompasses GPwSIs as 'enhanced' services and states that 'these might include more specialised services undertaken by GPs or nurses with special interests', and that 'primary care organisations will be free to commission whatever enhanced services they consider appropriate to meet local need', so setting GPwSIs firmly within the remit of the primary care trusts.[37]

Defining the GPwSI role

The Department of Health and RCGP paper suggests three components to the GPwSI role: they may 'deliver a clinical service beyond the normal scope of general practice, undertake advanced procedures, or develop services'.[8] Not all definitions include the service development role: the *Action on ENT good practice guide*, for example, refers solely to assessment and treatment.[39] It goes on to describe four GPwSI models that are already in existence in ENT services: fully independent from secondary care; based in primary

care but with close support from secondary care; primary care-based, with triage by consultants in secondary care; and based in secondary care. Crucially, GPwSIs play an intermediate role between primary and secondary care. Although providing a specialist service, they do not represent a replacement for consultants or 'interfere with access to consultants by local general practitioners'.[8] The primary care trust role in GPwSI development is not limited to reactive responses to individual GPs' requests for funding, as was generally the case under the previous guidelines (HSG[96]31). The Department of Health and RCGP document specifies at the outset that GPwSIs are designed to meet the needs of one or a group of primary care trusts.[8]

The clinical services provided by GPwSIs can include triage, diagnostic tests, surgery, and chronic disease management (B Hakin, workshop presentation, 2001), within a wide range of specialties.[9] The Department of Health and RCGP guidance highlights 11 key areas, selected as having significant access problems or likely to be priorities in terms of national programmes. These are cardiology; care of older people; diabetes; palliative care and cancer; mental health (including substance misuse); dermatology; musculoskeletal medicine; women's and children's health, and sexual health; ENT; care for homeless people, asylum seekers, travellers and others with problems accessing traditional services; and other procedures such as endoscopies, cystoscopies, echocardiography, and vasectomies.[8] This list, however, is not exhaustive. At a local level, primary care trusts will also take account of the prevalence of particular conditions, the nature of the interventions required, shortcomings in existing services that can be addressed within a primary care setting, and local GPs' interests and skills.

Promoting GPwSIs

The policy reasons for encouraging the development of GPwSIs can be broadly summarised as:

- reducing waiting times for treatment,
- meeting needs in primary rather than secondary care,
- enhancing the quality of primary care services,
- enabling secondary care to concentrate its efforts and resources where its skills are most needed,
- and improving career opportunities for GPs.[8,13,40]

A further reason is to reduce costs by using primary rather than secondary care services, although this objective is more problematic.

At a local level, primary care trusts frequently hope to reduce waiting times and costs, and to provide more local services to patients.[15,43] (D Rout, conference presentation, 2001.) Recently, it has been reported that more patients are being treated in their local surgery with reduced waiting times[41] and practices have been encouraged to develop GP-to-GP referrals via the GPwSI scheme to reduce waiting times for secondary care (RILA Conference, 2001). GPs refer to increased job satisfaction and the acquisition of enhanced skills;[43] at a time of recruitment problems, the opportunity to specialise may make general practice more appealing to students and junior doctors.[44] (D Rout, conference presentation, 2001.) Some GPs argue that specialisation will provide better services for their patients; in-house services are seen as avoiding long waiting times and high non-attendance rates in hospitals. The ageing of the population itself brings an increased need for healthcare services, with primary care offering a setting where these might be delivered (T Stern, conference presentation, 2001).

GPwSIs can be seen to be addressing problems at the interface between secondary and primary care, particularly in relation to the knowledge gap between GPs and consultants. This gap, according to Rout, leads to the following problems (D Rout, conference presentation, 2001):

- Inappropriate referrals: 40–80% of ENT referrals could potentially be dealt with by GPs, provided they acquire additional expertise.
- Unnecessary appointments with hospital consultants: for some patients, tests may be necessary but treatment could then be carried out in primary care.
- Long waiting times, dissatisfied patients, and the prolonging of symptoms that could be dealt with more promptly.

All of these problems could be addressed by GPwSIs.

GPwSI schemes in practice

Needs assessment

Before setting up local schemes, an assessment is required of local service needs. Where several GPwSIs are considered necessary in a given speciality, strategic planning is needed to ensure that the service will be evenly distributed and accessible throughout a locality; a lack of such planning can lead to inequalities of access, over-supply in some areas and over-demand in others, resulting in some of the problems the service was intended to address, notably long waiting times.

Skills and training

Clarity is needed to determine the skills that are required, and available, to meet the identified needs. Early research found that a lack of appropriate skills or expertise on the part of GPs was causing concern,[22] yet there was no national system for training or accreditation.

In late 2001, GPwSIs generally received between 5 and 8 days additional training; usually taking the form of workshops led by local hospital consultants (RILA Conference, 2001). However, national courses are now being offered in some specialities, which provide a year's part-time training involving 1 day a week: this comprises academic study, written assignments, and clinical supervision by local consultants. Some GPwSIs may argue that they have many years' experience in dealing with a particular condition and should be allowed to choose the form of continuing medical education that they consider most suitable. Such arguments need to be balanced against the expertise and quality assurance, not least in the eyes of other GPs and patients, that are offered by more formal accreditation.

Links with secondary care

The views of local hospital consultants about GPwSIs are crucial. Some consultants see GPwSIs as encroaching on the

preserve of secondary care without equivalent skills (B Hakin, workshop presentation, 2001). Others see the advantages of being able to concentrate on more challenging problems or better quality referrals in smaller clinics of their own.[32] (RILA Conference, 2001.) Although time consuming, consultants' involvement in drawing up GPwSIs' job specifications and training, together with regular joint working, serves to break down the barriers between primary and secondary care.[9,32,45,46] It also helps to create an integrated system that offers better opportunities for ensuring high quality clinical care, smooth care pathways, and overall service coordination.

Implications for non-specialist GPs

Other GPs may be reluctant to refer to colleagues, whom they perceive as generalists with much the same level of skills as their own, and there may well be a prolonged introductory period during which GPwSIs receive few referrals. According to Limber, it is the combination of quick access to a specialist service, together with favourable outcomes, that leads to more referrals (C Limber, conference presentation, 2001). The nature of GPwSIs' relationships with GPs needs to be set out: some GPwSIs, for example, may be willing to provide advice and discuss cases over the phone, without the need for a formal referral. Clear policies are needed about patients who wish to re-register with the GPwSI's practice. The quality of feedback to GPs is crucial, particularly where patients' GPs need to take over the management of longer-term problems; the responsibility for different aspects of concurrent care also needs to be clear, to avoid both duplication and omission.

Implications for patients

For patients, information is needed about the availability of GPwSIs and the extent to which they have a choice between a GPwSI and a hospital referral. Not all patients prefer to see a GPwSI rather than a hospital consultant. Those who do see GPwSIs tend to report satisfaction, with short waiting times, ease of access, a more congenial environment than in a hospital, ample time to discuss problems, and sufficient explanations and advice.[32,47,48] It is not known whether GPwSIs' responsibilities increase waiting times for routine primary care consultations with those GPs and whether this creates difficulties for patients.[32] The lack of transport means that GPwSI services may not be equally available to patients with mobility problems (C Limber, conference presentation, 2001).

Staffing

As well as nursing and administrative back up, GPwSIs may need support from teams that include specialist nurses or other healthcare professionals; for example, podiatrists or dietitians. The nature of team working needs to be set out too, including aspects such as access to records and the extent of joint decision making. Other staffing issues concern the fulfilment of the GPwSI's general practice responsibilities, implications for the workload of other primary healthcare team members, and whether locum cover is required.

Costs

Funding for GPwSIs can come directly from primary care trusts, personal medical services (through salaried GPs), local development schemes (under section 36 of the NHS [Primary Care] Act 1997), earmarked funding for the implementation of particular national service frameworks, resources resulting from a shift from secondary to primary care, or growth funds. Although payment is agreed at a local level, account needs to be taken of the basic sessional payment, the number of clinical sessions in a year (including time for ongoing training and annual leave), pension contributions, nursing support, administration, equipment costs, laboratory tests, and locum costs. Sessional costs in 2002 generally varied between £160 and £200, leading to annual costs of £7000–10 000,[32,38] although considerable variations can occur, particularly in older schemes with more unusual historical or financial underpinnings. The total annual cost of a weekly GPwSI ENT clinic has been calculated as between £11 500 and £18 400, depending on local circumstances.[32,39,46]

Comparisons with hospital costs are not always easy, due to differences in case mix, but Sanderson estimated that GPwSI ENT consultation costs were about half those for outpatient consultations.[32] However, this included hospital overheads but no specific overheads for GPwSIs and excluded the costs of support for GPwSIs provided by hospital trusts. As she points out, cost comparisons are fraught with difficulties and must be approached with considerable caution. Moreover, the figures available represent average, not marginal, costs; thus the transfer of a patient to a GPwSI would not entail a saving to a primary care trust's overall budget.

Impact

An evaluation of GPwSIs working in ENT found that between 30–40% of patients who are referred to secondary care could be seen by GPwSIs instead.[32] Others reported that GPwSIs in some areas could carry out much minor surgery (including almost all elective endoscopy, gastroscopy and cystoscopy), a wide range of chronic disease management, and extensive triage work.[44] Reductions in waiting times were a common finding, with many patients seen within 2 weeks of referral.[32,38,44,48-50]

Information was generally collected about the numbers of patients seen by GPwSIs and the numbers of procedures carried out. Little information is available, however, about subsequent outcomes, such as impacts on patients' health, or comparisons with hospital performance. Similarly, only limited data are available about adverse events. One study reported poor standards of infection control by GPs carrying out minor surgery,[51] but earlier research found no difference in wound infection between GPs and a hospital.[50] Nevertheless, the latter study found that GPs in one district sent fewer specimens for histopathology testing than did hospital doctors, they incorrectly diagnosed a larger proportion of malignant conditions as benign, and inadequate excisions were made of malignancies. However, in both instances the studies were of GPs carrying out minor surgery on patients in their own practices. Further comparative data

are needed about both positive and negative outcomes for hospitals and GPwSIs treating patients from outside their practices and across a range of specialties.

The impact of GPwSIs on secondary care appears to vary. In one ENT scheme, referrals to secondary care were reduced in line with the increase in GPwSI activity (C Limber, conference presentation, 2001). This was not the case in a dermatology clinic, where no reduction took place in referrals (G Lewis, conference presentation, 2001). In the case of minor surgery, too, earlier studies found that, although the number of procedures carried out by GPs increased, hospital waiting lists remained high; some of the problems referred to GPs may not have been sent to hospital departments previously.[22,49]

Clinical governance

The growth of GPwSI schemes has coincided with that of clinical governance, clinical audit, and revalidation. While earlier schemes placed little emphasis on formal accountability and monitoring arrangements and relied instead on professional independence and integrity, more formal arrangements are now expected, including distinct clinical and contractual accountability, and regular audit and appraisal. Alongside the assurance of high clinical standards and adherence to established protocols, data need to be systematically collected about outcomes for patients.

Monitoring and evaluation

Although GPwSI arrangements are now well established in some geographical areas, few have been independently evaluated. While there may be sound reasons for promoting an expansion of GPwSI schemes, this should be informed by an understanding of their operation, benefits, and any shortcomings that might need to be addressed. Some of the issues that need to be considered in relation to each GPwSI speciality within a locality are set out in Box 1. Furthermore, monitoring and evaluation of GPwSI schemes will have specific data collection requirements, as shown in Box 2.

Conclusions

GPwSI schemes embody a number of key features of current NHS policy. They reflect, primarily, a move towards specialisation in primary care, which also encompasses specialist nurses at locality or primary care trust level, practice nurses with specialist responsibility for particular clinical areas, dentists, optometrists, and physiotherapists, who can, for example, carry out orthopaedic triaging.[8,44,52] Rather than patients having to go to hospitals, such schemes bring specialist skills closer to them in community settings. They offer GPwSIs the opportunity to develop new interests and gain further expertise. At a time of difficulties in recruiting and retaining GPs, specialisation offers an incentive that may attract more family doctors and improve morale within the service.

The schemes reflect a change in the overall configuration of services; in the respective roles of primary and secondary care and in the relationship between them. On the one hand, they help to build a more integrated health service. On the other, they change the balance between primary and secondary care, with primary care now playing a much greater

- How is the distribution of GPwSIs planned? Is the GPwSI service equally available and accessible throughout the locality?
- Are referrals obligatory, voluntary, triaged by hospital, or distributed from a central office (if there is more than one GPwSI in a speciality)?
- Can patients choose whether they go to a GPwSI or to a hospital?
- Do GPwSIs carry out a specific, tightly defined set of tasks; undertake triage for secondary care; provide a local source or centre of excellence, offering advice and support to other primary care practices?
- What staff are involved? What is the nature of any teamworking (access to records, contributions to decision making)?
- How often do the clinics take place? At what times of day? Are they open on weekdays or weekends?
- How do potential GPwSIs demonstrate their expertise? What training is required?
- What do the protocol and quality standards entail?
- How much integration is there with secondary care? Who provides the clinical coordination and overall responsibility for the GPwSI service?
- What are the referral pathways from GPwSIs to secondary care (via referring GP or direct, is there any means of compensating for time the patient has already waited)?
- What are the referring GPs' and GPwSIs' respective responsibilities (particularly in relation to long term care)?
- What data are collected to monitor waiting times, process, and outcomes?
- What audit mechanisms are required; for example, to ensure appropriateness of referrals and long-term care responsibility (in the case of chronic disease management)?
- For medical specialties, which processes will avoid caseload saturation through routine monitoring?

Box 1. Issues to be considered in the setting up of GPwSI services.

- Number of referrals to GPwSIs and to secondary care, broken down by referring practice
- Numbers of patients seen by GPwSIs, by clinic session
- Non-attendance rates (both for GPwSIs and secondary care)
- Characteristics of patients seen by GPwSIs and in secondary care: age, gender, and reason for referral
- Process and outcome data
- Workload trends for GPwSIs and secondary care
- Other GPs' views about the GPwSI arrangements
- Impact on workload of other primary care staff in the GPwSI's practice
- Impact on the GPwSI's practice patients; for example, on waiting times
- Impact on primary care staff in the locality, such as provision of advice/training and de-skilling; for example, through inappropriate referrals
- Costs per patient seen, with and without overheads, and overall service costs
- Patients' views regarding the pros and cons of GPwSI and secondary care services, including extent of knowledge of the two services and amount of choice available

Box 2. Data requirements for the monitoring and evaluation of GPwSI schemes.

role. While the remit of secondary care is thereby reduced, the advantages are that waiting times may, at least sometimes, be reduced and secondary care can concentrate on more complex problems. This is welcomed by many consultants but may reduce training opportunities for junior doctors through a reduction in more routine work.[32]

The change in the balance of power between primary and secondary care is facilitated by the new role given to primary care trusts. As well as having a remit to develop services, particularly with a primary care focus, their budgetary responsibility for both primary and secondary care means that they have the wherewithal to change the balance between the two, notably through the allocation of growth monies. It is no longer left simply to professionals to change their practices; primary care trusts also have the organisational and financial backing to do so. Although other financial commitments mean there may be relatively little room for manoeuvre, GPwSIs nonetheless represent one area in which primary care trusts can exercise their new powers to bring about change.

It is not clear that GPwSIs are cost-effective. What is clear, is that they are additional to, rather than a substitute for, secondary care; allocations to secondary care can rarely be reduced at the margins as a result of GPwSI provision. Were any such reductions to be considered, the objections raised by hospital consultants would very likely be so strong as to jeopardise their support for GPwSI schemes.[32] In any case, a key driving force behind GPwSI policy is the reduction of waiting times. Evidence of cost-effectiveness may be less important than policy objectives and professional interests.[52]

The emergence of GPwSI schemes represents a substantive change to primary care delivery that, if handled correctly, is likely to continue for the foreseeable future. Fears that GPwSIs might undermine the value of generalism have been voiced in some quarters[9,53] with a warning that they should continue to deliver their specialisms within general practice. Similarly, GPwSIs should not be regarded as second class to secondary care services, making training and accreditation particularly important. Although some hospital consultants have voiced their opposition, the schemes that are already in existence receive general support from consultants, as well as other local healthcare professionals. They form part of broader trends in service organisation and professional development, and address policy needs, notably in relation to waiting times. Were those needs to change, their role would undoubtedly be revisited. Financial considerations might then call their continuation into question. Even then, however, professional interests, and the possibility of aggravating recruitment difficulties, might militate against a major reversal of their role. Provided that a balance can be achieved between policy, professional, and financial considerations, the new breed of GPwSIs are likely to become a substantial feature in primary care.

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