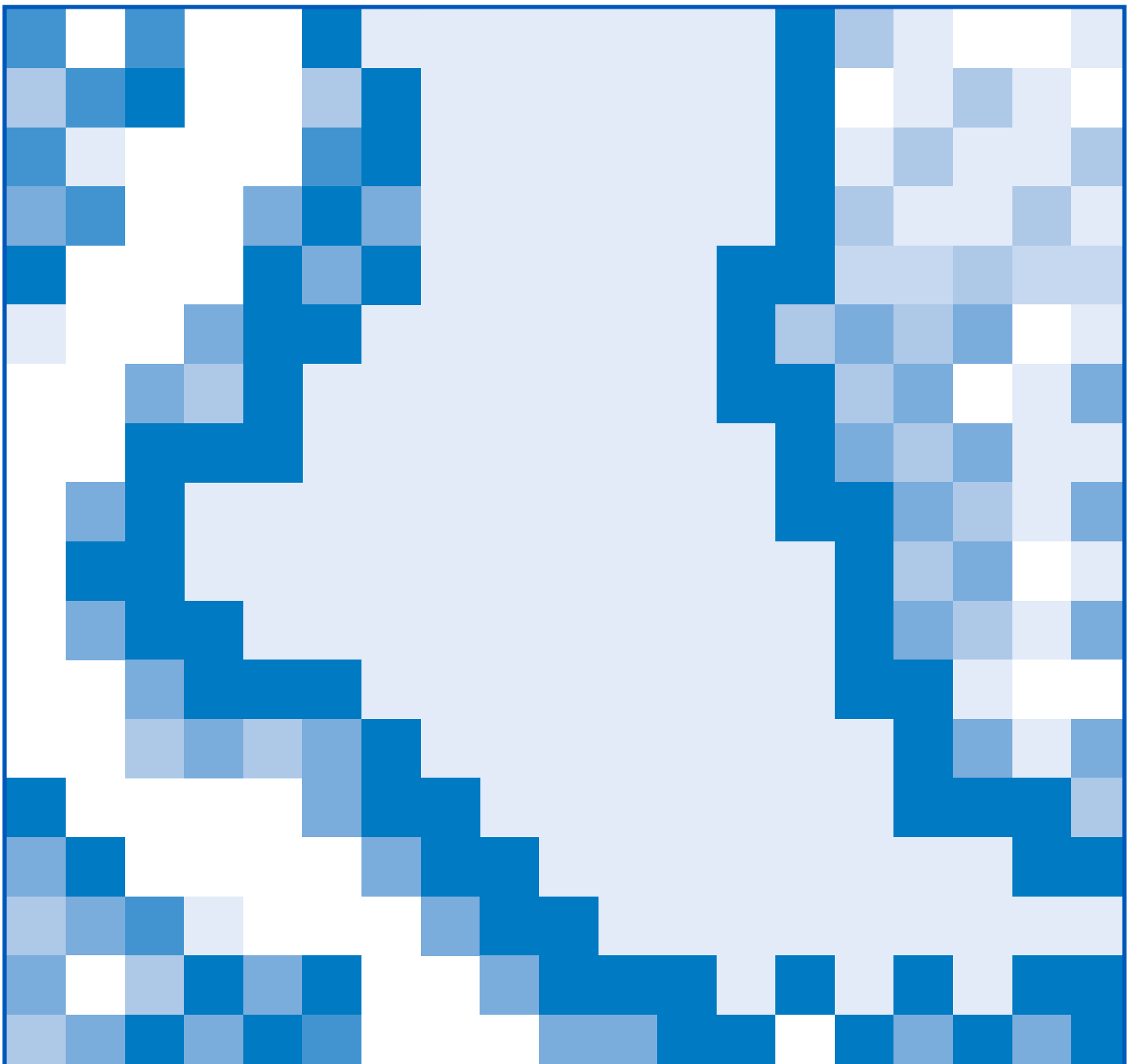


Practitioners with special interests

A Step by Step Guide to setting up a general practitioner with a special interest (GPwSI) service



Produced by Practitioners with Special Interest Team

April 2003

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Acknowledgements

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SETTING UP A GENERAL PRACTITIONER WITH A SPECIAL INTEREST (GPwSI) SERVICE

Experience has shown that a successfully implemented General Practitioner with a Special Interest (GPwSI) service will be a joint PCT and Acute Trust initiative.

Outlined in this document is a practical step-by-step guide to setting up GPwSI services. This is not prescriptive, but is a good starting point.



Definition

A recent document called "Implementing a Scheme for General Practitioners with Special Interests" (April 2002) gave the following definition of a GPwSI:

"General practitioners with special interests supplement their important generalist role by delivering a high quality, improved access service to meet the needs of a single PCT or group of PCTs. They may deliver a clinical service beyond the normal scope of general practice, undertake advanced procedures, or develop services. They will work as partners in a managed service not under direct supervision, keeping within their competencies. They do not offer a full consultant service and will not replace consultants or interfere with access to consultants by local general practitioners."

Department of Health,
RCGP 2002

Introduction

The NHS Plan has set out the target of creating 1000 new General Practitioners with Special Interests (GPwSI) and to continue to develop responsive services delivered closer to patients' homes. This initiative has been endorsed and supported by the Royal College of General Practitioners and the Department of Health who see it both as a way of boosting recruitment and retention into the profession and as an aid to delivering enhanced services within primary care.

Clinical Frameworks

In addition to the generic framework, it was recognised that it would be helpful to develop Clinical Frameworks in a number of key specialties where services were being developed. Whilst this list is not exhaustive, at the time of going to press, the following areas have been or are being developed and can be found at :

<http://www.doh.gov.uk/pricare/gp-specialinterests>

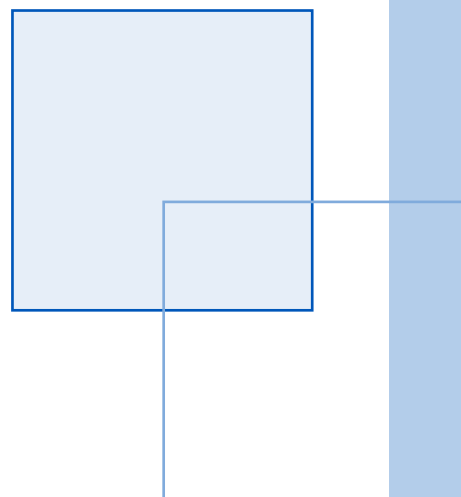
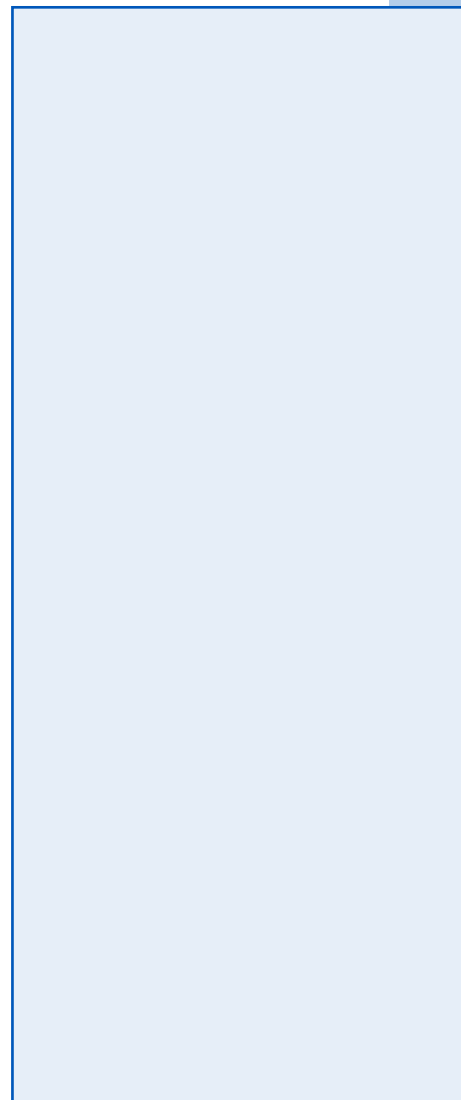
Care for older people	Epilepsy
Child Protection	Headache Service
Dermatology	Mental Health
Diabetes	Orthopaedics
Drug Misuse	Palliative Care
Ear, Nose and Throat	Respiratory
Echocardiography	Sexual Health
Emergency Care	



Although this document essentially concentrates on the development of GPs with Special Interests there are five essential caveats that need to be considered

Five essential caveats

1. Before embarking on the development of General Practitioners with Special Interests, there should be a strategic consideration of priority areas within the health community. Whilst it is acknowledged that the development of these roles may be career enhancing and provide additional interests to the individual practitioner: this must be balanced against the need to develop services in a strategic context
2. General Practitioners with Special Interests should be seen as only one of a number of options available to a PCT in designing services for their population. The role of nurses and allied health professionals must not be overlooked. The Department of Health will be publishing a generic framework for Nurses with Special Interests and Allied Health Professionals with Special Interests (see www.doh.gov.uk/pricare/gp-specialinterests)
3. Patient experience and public involvement are crucial when designing services and all opportunities should be sought to ensure that newly developed services reflect the needs of the local community. Consideration should also be given to the role of the Expert Patient and the role that they may have in sustaining chronic disease management in the community. PCTs and Acute Trusts have patient forums. Representation should be sought from these groups when designing a new service. See <http://www.healthvoice-uk.net> and <http://www.doh.gov.uk/involvingpatients> and also Appendix A. The NatPaCT Engaging Communities Learning Network gives PCTs opportunities to share and reflect upon emerging practice www.natpact.nhs.uk/connectors/ecln.php





4. Patients view their conditions in terms of the pathways they take to be treated. When designing services, the entire patient pathway should be considered. For example, when redesigning services in dermatology, the team involved in the planning of this service should include patients, GPs, consultants, managers, nurses and allied health professionals from across primary and secondary care. The importance of gaining support from all parties should not be overlooked and the most successful examples of practice have been demonstrated where the relationships between the GPwSI, local GPs and a consultant are strong and continually maintained
5. This guide focuses on the GPwSI in the role of providing a clinical service to patients. However, we acknowledge that this is only one aspect to the role of GPwSI. Equally important are the roles of GPwSI as a trainer, educator and coach of other healthcare professional colleagues in raising overall standards of care. The GPwSI may also play a significant part in the strategic planning of services across a health economy

How to use this Guide

This Guide is not meant to be prescriptive or exclusive. It is an advisory document and has been designed through experience from working with teams. It will help you to work through some of the issues and learn from the experience of others. Contact details for the team and further support is available at the end of this document

Please note that *Practitioners with Special Interests, a guide for PCTs on the role of “nurses with special interests” in primary care* will be available on Department of Health website in Spring 2003

Step One

Reviewing the current services

1

- 1.1. Set up a working group with representation from primary and secondary care clinicians and managers
- 1.2. Establish that the service in question is a local priority for the redesign and development of additional capacity. This is particularly important if the interest in establishing a new GPwSI service is in response to a GPs' existing skills or enthusiasm. Public health colleagues can provide a health needs assessment to assess whether the service is a priority for development
- 1.3. The next step is to consider whether the service you are designing requires a GPwSI or another health care professional. If so, does it fit with the local health economy's strategy to improve access to services? (*See Liberating the Talents (Department of Health, 2002b) for further information:*
www.doh.gov.uk/cno/liberating_talents.htm)
- 1.4. Be very clear about the objectives of using a GPwSI (or other clinician)

These may include:

- i. To add capacity
 - ii. To be part of redesign or modernisation
 - iii. To change the dynamics of the secondary care system
 - iv. To provide feedback and education to primary care colleagues
 - v. To provide a strategic overview and development of a service
 - vi. To improve the quality of services for patients
- 1.5. Remember that more staff is not always the answer. These services may be provided through the reallocation of existing resources
 - 1.6. Map the current patients' journey across both primary and secondary care to identify bottlenecks and waits in the system. See the example process map Figure 1 on page 2 and refer to the Modernisation Agency's Improvement Leaders' Guide to process mapping,

Health Needs Assessment

Health needs assessment is the systematic approach to ensuring that the health service uses its resources to improve the health of the population in the most efficient way. It involves epidemiological, qualitative, and comparative methods to describe health problems of a population; identify inequalities in health and access to services; and determine priorities for the most effective use of resources (Wright et al, 1998).

The Health Development Agency has produced a Health Needs Assessment Workbook, which takes you through the process of undertaking such an assessment. See:

<http://www.hda-online.org.uk/documents/hna.pdf>



Example of Process map - traditional pathway

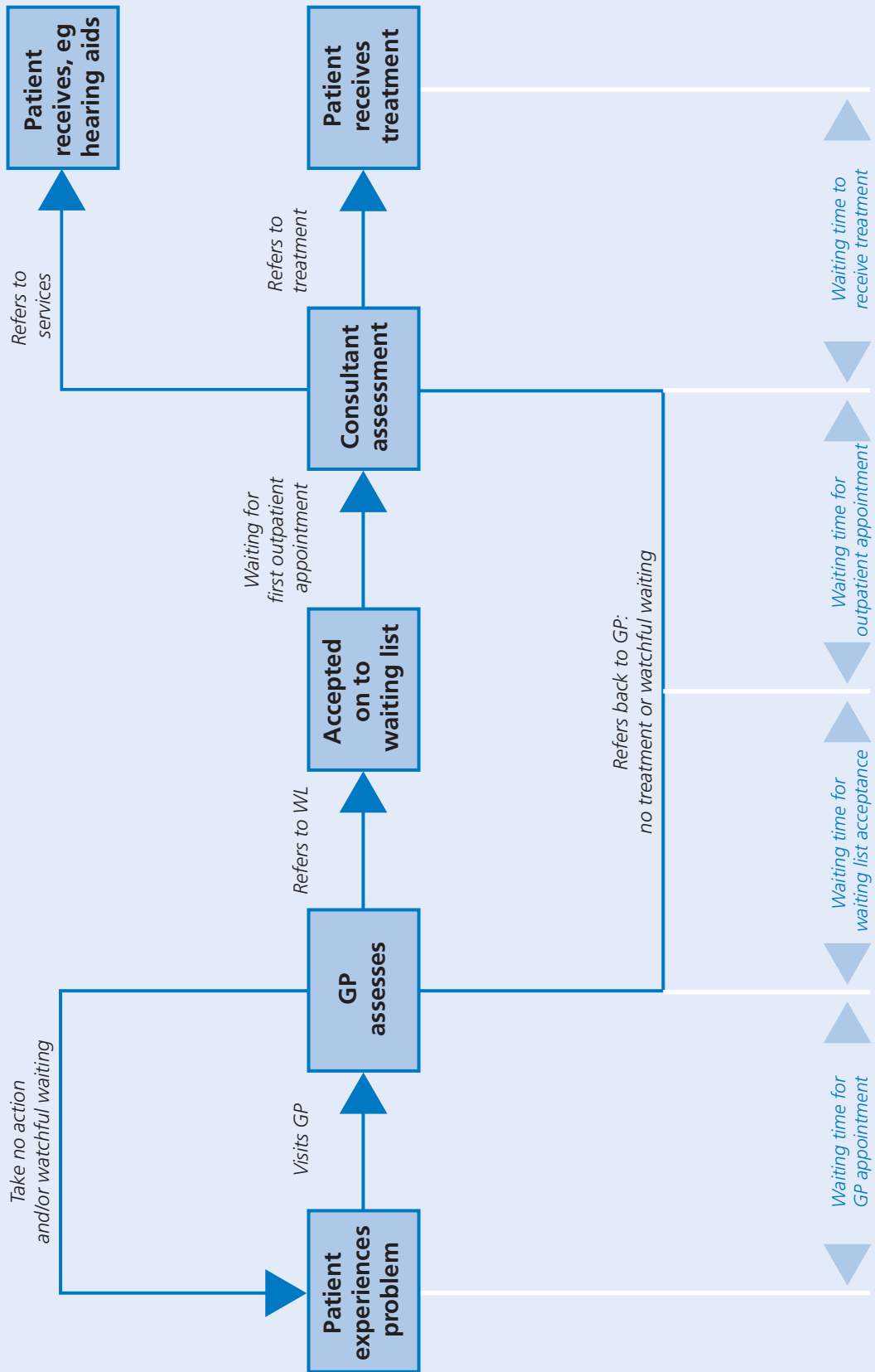


Figure 1

analysis and redesign for further information (*NHS Modernisation Agency, 2002a*) www.modernnhs.nhs.uk

- 1.7. Consider evidence from this guide or other sources about what works before designing your system
- 1.8 Measure and analyse the capacity, demand and activity of this service. Please refer to the Modernisation Agency’s Improvement Leaders’ Guide to matching capacity and demand for further information (*NHS Modernisation Agency, 2002b*). See also the Demand Management website: www.demandmanagement.nhs.uk
- 1.9 Audit and analyse the case mix of referrals into secondary care to identify suitable conditions that an appropriately trained GPwSI could see. The audit needs to identify which practice or PCT each referral is from. This will allow you to work out at a later stage the number of sessions that are required for each local population. This is best done as a joint exercise between primary and secondary care clinicians
- 1.10 Survey local GPs to build up a register of interest, skills and experience (see website for sample document)

Capacity and demand in brief:

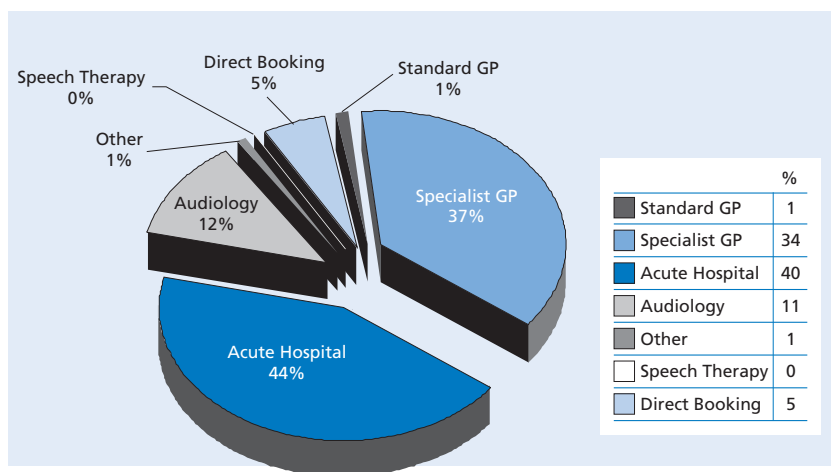
Measure demand, capacity, backlog and activity at the bottleneck in the process. Measure each in the same units for the same period (e.g. in minutes over seven days).

Make improvements at the bottleneck by reducing demand or increasing capacity, including reducing all unnecessary waits and delays.

Aim to match capacity to demand on a daily basis; plan capacity at 80-85% of the fluctuation in demand to ensure that queues and waiting lists do not build up.

For a case study in capacity and demand see Appendix B

GP ENT Referrals to Ealing Hospital NHS Trust - 16th July 2001 to 20th July 2001



Audit of Referrals

In an audit of pilots as part of *Action On ENT*, consultants from six sites came up with almost exactly the same percentage of ENT cases which could be seen by a GPwSI – between 35 – 40%.

This figure has been mirrored in other specialities.

Figure 2

2

Step Two What you will need

Joint Working

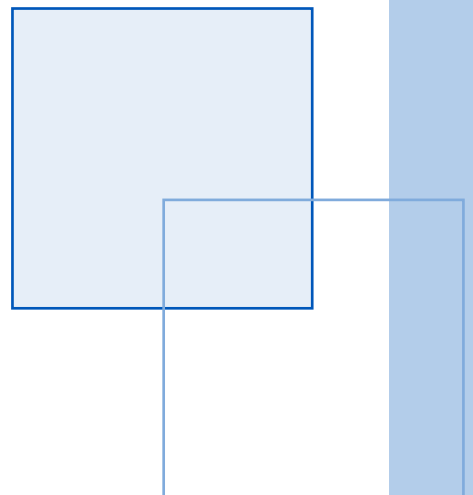
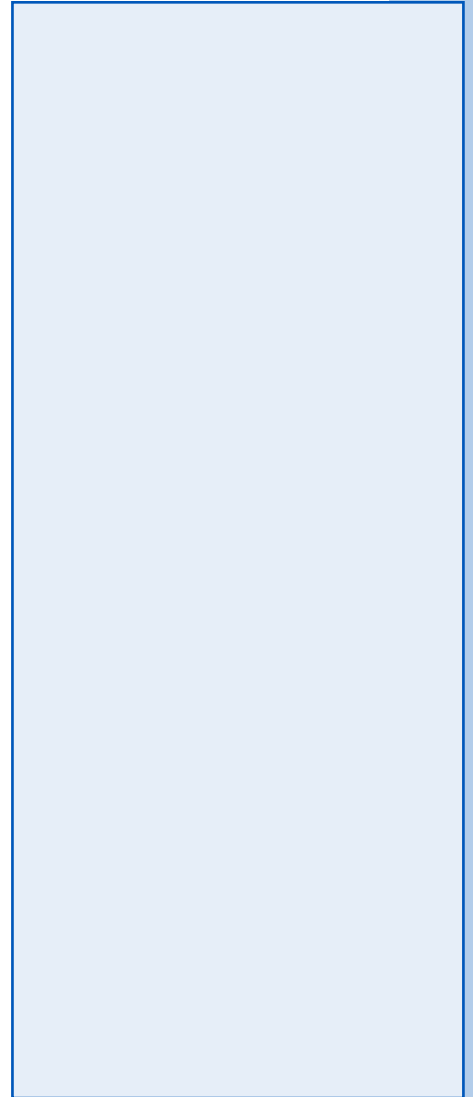
Providing the best service for the patient should be the main driver when designing the service. Experience has shown that a successfully implemented General practitioner with a Special Interest (GPwSI) service will be a joint PCT and Acute Trust initiative.

- 2.1 High level support from all organisations involved
- 2.2 A working group, that includes: a GP, Consultant, managers from the Primary Care Organisation (PCT), the Acute trust (and other health professionals depending on the service) and patient representatives. In addition the Access, Booking and Choice programme should be involved and/or the local modernisation lead
- 2.3 An impact assessment will ensure that resource issues are considered (staffing, facilities etc) and that a wider appraisal of the proposal can be undertaken to take account of the extent to which the development:
 - i. Is part of an integrated commissioning strategy, linked to the Local Delivery Plan
 - ii. Has taken account of Patients Choice and Booked Admissions
 - iii. May affect current primary and acute sector services locally
 - iv. May have an impact on prescribing (this is discussed later in the document)
- 2.4 It is also important to consider the extent that development may be needed to support the proposal
- 2.5 Identify sufficient funds on a recurring basis and funding for capital outlay. A GPwSI is not necessarily a cheap option. See Appendix C for examples of capital costs



- 2.6 Access to appropriate premises. When developing an enhanced range of services within primary care there may be an opportunity to bring these together and to take a strategic view on the development of primary care services. This may be in the form of new buildings, changes to existing premises, using community hospitals or developing Diagnostic and Treatment Centres, which could provide a range of services

- 2.7 The realisation that a GPwSI service is not a 'quick fix' and cannot be set up immediately but potentially an integral part of the provision of enhanced primary care. Even with an experienced GP, from the point of deciding to set up a service, it is likely to take a minimum of three months, but if the GPwSI requires training it will take eighteen months to two years



3

Step Three Design the service



Reminder: multiple secondary care providers

Where a GPwSI is going to link to more than one acute provider it will be more complex and it will be essential that everyone concerned is involved.

This will be particularly important when agreeing:

1. The conditions to be seen by the GPwSI
2. The referral processes

- 3.1 The scope of the service will be determined either by the number of sessions the GPwSI can provide or the resources available (financial, premises or equipment). Alternatively, if these are not constraints, use the audit of referrals from the population that the GPwSI will be serving to help to define the scope of the service
- 3.2 It is important that the appropriate clinicians are fully involved in the service design process

The following factors need to be considered:

- i. Type of conditions the GPwSI will see
- ii. Exclusions of patients with defined conditions (e.g. children)
- iii. Length of session (including time for administration). An average session lasts for three and a half hours including 30 minutes per session for administration
- iv. Length of appointments: use secondary care appointment times as a guide for new appointments and follow ups
- v. Estimate the ratio of new to follow up appointments
- vi. Number of sessions per year

New to follow up ratios

Typically new to follow up ratios for GPwSI are different from secondary care outpatients. Examples from Action On can be found at www.modern.nhs.uk ENT pilot sites indicated that GPwSIs discharge 70 – 80% of patients back to the care of their GP. The data below is from a GPwSI who sees all routine ENT patients. The new to follow up rate is 3:1.

Total consultations	413
New patients	311
Follow ups	102
Referral to consultant	46
Discharged	252 (81%)



The GPwSI was able to provide 2 clinics per week with approximately 9-10 patients seen per clinic
 = 18 patients per week x 40 working weeks = 720 appointments. With a 3:1 follow up ratio, this equates to 540 new appointments per year.

In the first 12 months of the service the GPwSI saw 36% of total ENT routine referrals from the PCT.

Example from an ENT GPwSI Service calculating the demand, capacity and activity of the GPwSI clinic

One PCT with 110,00 patients has generated demand for approximately 1000 routine ENT appointments. An audit undertaken by the consultants in secondary care indicated that approximately 37% of referrals could be seen by a GPwSI = 370 referrals per year.

3.3 If the referrals are sent directly from GPs to the new GPwSI service, there will be a lead-in time for the referrals to reach the anticipated level. This needs to be taken into consideration when planning the first few months of anticipated activity - Figure 3 shows data from the first 12 months of a gpwsi service in ENT

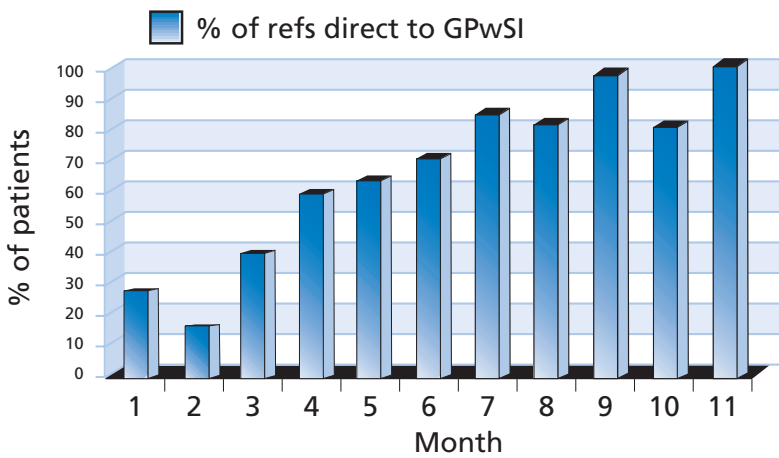
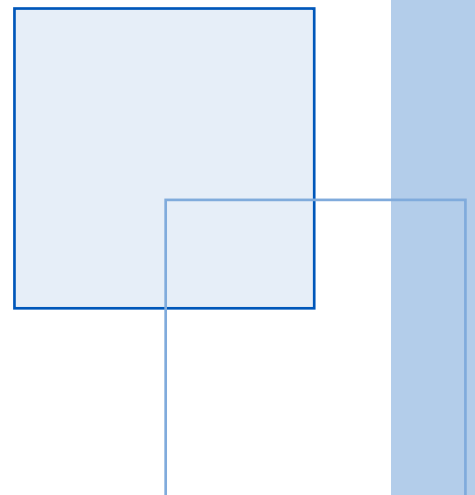


Figure 3



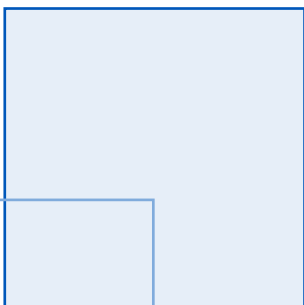


Reminder: access

If the service is provided in secondary care you need to consider that patients' access may not be improved. It may be more difficult for the GPwSI to work autonomously and this model does not help to provide more outpatients in primary care.

Redesign the process

- 3.4 Design the ideal process for the GPwSI service including the clinical parameters of the service and the competencies required. Please refer to the clinical frameworks on the website www.gov.uk/pricare/gp-specialinterests and see Figure 4 on page 9 for an example from an *Action on ENT* pilot site
- 3.5 However, when implementing the service, you may need to adjust the process to take into account the skills, confidence and experience of the GPwSI and the views of the secondary care consultants. It may be necessary to take an incremental approach to implementing the ideal service
- 3.6 The GPwSI clinics can be located in a number of places in primary or secondary care, but consideration needs to be given to the following:
 - i. Primary care surgery: if the GPwSI is employed, funding for clinic on-costs need to be agreed. If the GPwSI is commissioned these costs will need to be covered by the service level agreement
 - ii. If the clinics are held in GP owned premises, then the notional rent that GPs may receive will be abated by any rent they get for use of the premises. This can be avoided by paying the practice a 'service charge' rather than rent
 - iii. Trust owned premises: the costs for the premises should already be covered
 - iv. Secondary care outpatients: costs associated with the clinic will need to be agreed with the acute trust





Example of process map - *Action On ENT* GP to GPwSI pilot

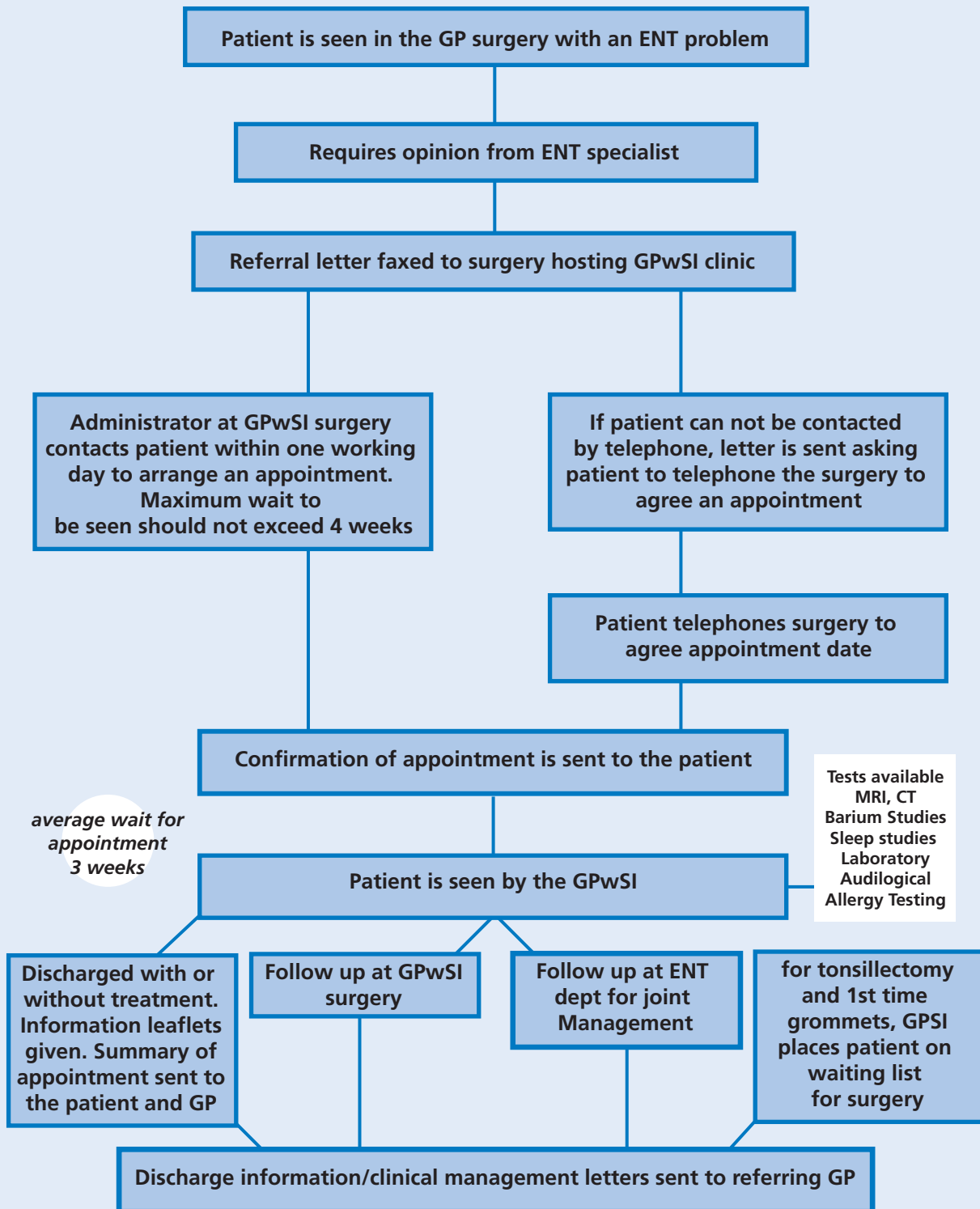


Figure 4



Budget for Patient Transport

North Bradford PCT provides approximately 4,500 GPwSI clinic appointments per year and has a high proportion of elderly patients. It has allocated a budget of £2,000 per year for transport and has an arrangement with the local taxi firm, which charges £1 per mile. NB just over half the sum allocated for this was spent in the year.

The criterion for using the taxi is that all other avenues must be explored first, eg family and friends. The patient must be able to make their own way from their home to the taxi (it is not the job of the taxi driver to assist patients). If assistance is needed then an ambulance is used. The taxi company invoices the PCT monthly.

The PCT signed an agreement with the taxi firm, which includes a confidentiality clause, because occasionally they also use the taxi to transport patients' notes to clinics.

An Access database has been developed for GPwSIs in ENT. This is currently being adapted for use in other specialties and will be available on www.gpws.org and www.natpact.nhs.uk/special_interests. See website for examples of the reports available from the ENT database.

- 3.7 The PCT needs to consider what funding will be available for the patients who are not able to arrange transport to attend the clinics (see to box to the left)
- 3.8 Patients in receipt of Income support or Job Seekers Allowance are entitled to claim for legitimate transport costs for attending hospital appointments. Details are available at local benefit agency offices (*leaflet HC11*) or by accessing the benefits agency website on www.dwp.gov.uk. If it is decided that attendance at a GPwSI clinic is classified as an outpatient appointment, then the patient would be entitled to reclaim travel expenses under this scheme. Consideration should be given to local voluntary schemes that may be operating locally
- 3.9 Identify the equipment required (see Appendix C for some examples). Capital costs will vary depending on the speciality and any alterations that may be required to the clinic room and waiting room
- 3.10 The medical records from the GPwSI clinic are the property of the PCT. There is no reason why computer records can not be held on the medical system used by the practice for their own patients. However, if the GPwSI holds clinics in other practices, or provides a peripatetic service, the records may be best kept on a laptop computer. Consideration needs to be given to what data will be held on computer, which will permit audit and evaluation of the service. Data protection principles also apply
- 3.11 There should be a separate budget and prescribing code issued by the Prescription Prescribing Authority (PPA) for prescribing within the GPwSI service. To estimate the budget, the GPwSI should look at the conditions to be seen, the drugs which will be prescribed and the likely frequency of prescribing



- 3.12 Prescribing costs will vary depending on the type of service offered
- 3.13 Referral guidelines can be introduced as part of the new service if local GPs agree. The advantage of using guidelines is that they can help to clarify which patients GPs should refer to the GPwSI. This is not relevant if referrals continue to be sent to secondary care and the consultant decides which patients will be seen by the GPwSI. A barrier to this may be the reluctance of GPs to use guidelines, particularly those that are paper based. For an example of a referral pro-forma see the website
- 3.14 An alternative is to give clear guidelines about which conditions the GPwSI can and can not see.
See website for sample document

Example of GPwSI Prescribing Costs

The prescribing costs for a GPwSI offering a medical dermatology service, seeing around 500 new patients was £4,500.

The prescribing costs for a GPwSI providing ophthalmology services, seeing 128 new patients is anticipated to be £250 .

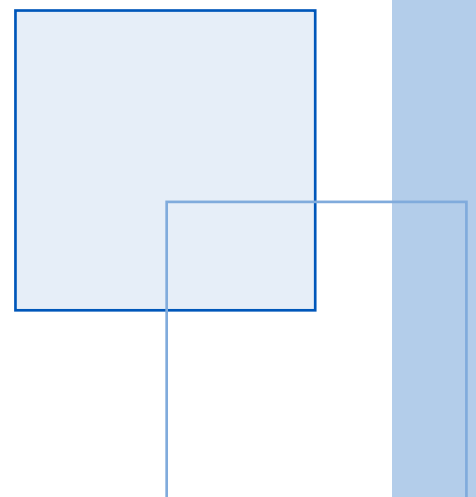
Administrative arrangements

- 3.15 There are three main models for referral, the choice of which will vary with local circumstances:
 - i. GP refers directly to GPwSI
 - ii. GP refers to PCT based triage and the patient is referred on to GPwSI or secondary care
 - iii. GP refers to secondary care, and consultants select patients to delegate (not refer) to GPwSI. (This may raise some issues re accountability, which are discussed later -see page 18)

In terms of the patient pathway the first model is the most efficient, but there may be good local reasons (e.g. when establishing a new service with an inexperienced GPwSI), to use one of the other models

- 3.16 Depending on the booking arrangements for outpatients locally, the referrals can either be sent by letter, phone call, a web-based system or by email

Ideally, referring GPs should be able to book a date for a GPwSI appointment from their surgery, just as they make referrals to hospitals. This will either be through an electronic link, fax or email





Example: Greater Manchester Tier 2 model

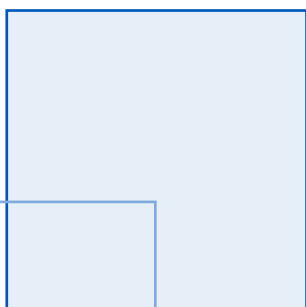
The Tier 2 strategy is piloting the use of Referrals and Booking Management Services to provide single assessment through referral management for specified clinical areas. Where services are developed using the wider skills of multidisciplinary professions, centralising the referral and booking management could provide a more systematic and integrated model of referral triage. www.gmsa.nhs.uk

Electronic booking will allow GPs to log directly into appointment systems. Faxes or emails will go either directly into the relevant clinic or via a contact centre into hospital appointment systems. If the referral has been sent by email or fax to a contact centre, the patient should be given a unit booking reference and information about telephoning the Contact Centre to arrange the booking

Many healthcare communities around the country are beginning to develop electronic booking and contact centres. GPs should check local availability for booking their patients, with the aim of giving them maximum choice

For further information about booking, go to www.modern.nhs.uk/booking or email booked.admissions@npat.nhs.uk where your queries can be answered or be put in touch with your local Access, Booking & Choice Manager

- 3.17 Referrals can be sent to where the administrative support is located, to the local health economy's booking service, or a PCT central referral office
- 3.18 To make the booked appointment, the options are:
 - i. the patient contacts the GPwSI – contact details will need to be provided by the referring GP or their administrative staff
 - ii. the GPwSI booking service contacts the patient
 - iii. the referring GP makes the appointment, either by telephone or electronically while the patient is present
- 3.19 It may be necessary to form a clinic template with the number of new and follow up appointments in each clinic, although this will vary with the type of GPwSI service to be provided, (particularly the proportion of chronic conditions that may be involved)



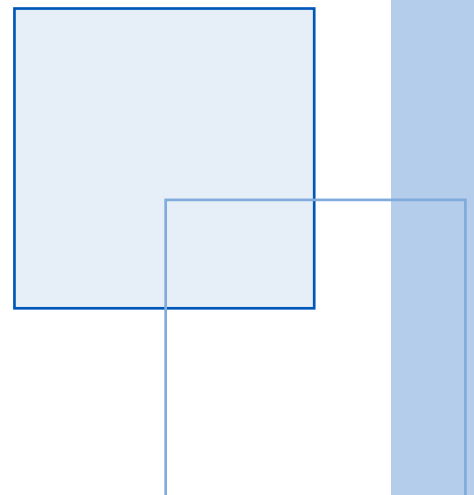


- 3.20 If the responsibility is given to the patient to make the booking, consideration needs to be given to what will happen to patients who do not make an appointment: a reminder letter can be sent to the patient, or the referral can be returned to the GP
- 3.21 At the point a decision is made to refer it is good practice for the GP to give the patient information about the GPwSI service, a map and information about how the booked appointment will be made. However, this could be provided by the GPwSI booking clerk when an appointment confirmation is sent
- 3.22 Consideration may need to be given to interim measures until GPs change referral habits. For example, take patients from secondary care waiting lists. If you do this, who will be responsible for the patients originally referred to secondary care? Will patient records for those patients be held in primary care and copied to consultants? How will you inform/gain consent of patients originally referred to secondary care? Telephone booking is useful in this context – it provides an opportunity to inform the patient and give them the choice of being seen by the GPwSI or retaining their secondary care appointment
- 3.23 You may consider sending a letter to GPs in the locality to inform them that for a short period of time patients originally referred to the consultant may be referred on to the GPwSI. Ask GPs to contact the acute trust if they are not happy with this arrangement
- 3.24 If the GP has not given information to the patient about the GPwSI service and the patient does not want to see a GPwSI, the referral should be forwarded on to secondary care and the patient's GP should be notified of this action. As far as possible patients should not be disadvantaged because they prefer to be seen at the hospital. The use of an electronic referrals system or fax will ensure any delay is minimised

Reminder: Booked Admissions Service

Link with the local booked admissions service to ensure it is integrated with local development and for practical advice. Also see the Ready, Steady, Book guide to implementing booked admissions (NHS Modernisation Agency, 2002c).

www.modern.nhs.uk/booking





- 3.25 If the secondary care outpatient waiting times may exceed the maximum waiting time, patients on the secondary care waiting list could be reassessed to see whether any could be referred to the GPwSI service

Access to secondary care

- 3.26 The GPwSI should have direct access to appropriate tests carried out within secondary care that are appropriate to the speciality e.g. in ENT, - Audiology, MRI, CT and X-ray and in dermatology, phototherapy. The PCT will have to give consideration to the access times for these services and how they will be funded
- 3.27 The GPwSI needs rapid access to formal and informal second opinions from secondary care consultants; this needs to be considered in planning from the outset. Care needs to be taken to ensure patients are not disadvantaged because they have first waited to see a GPwSI

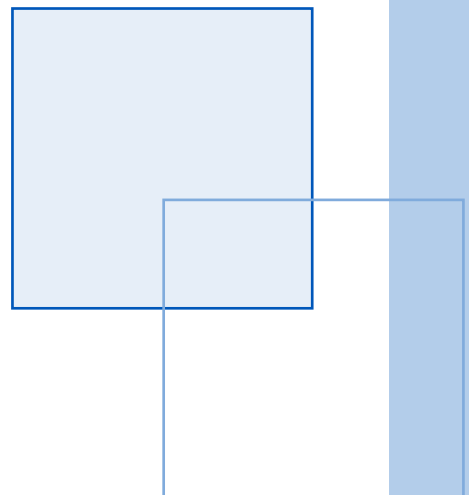
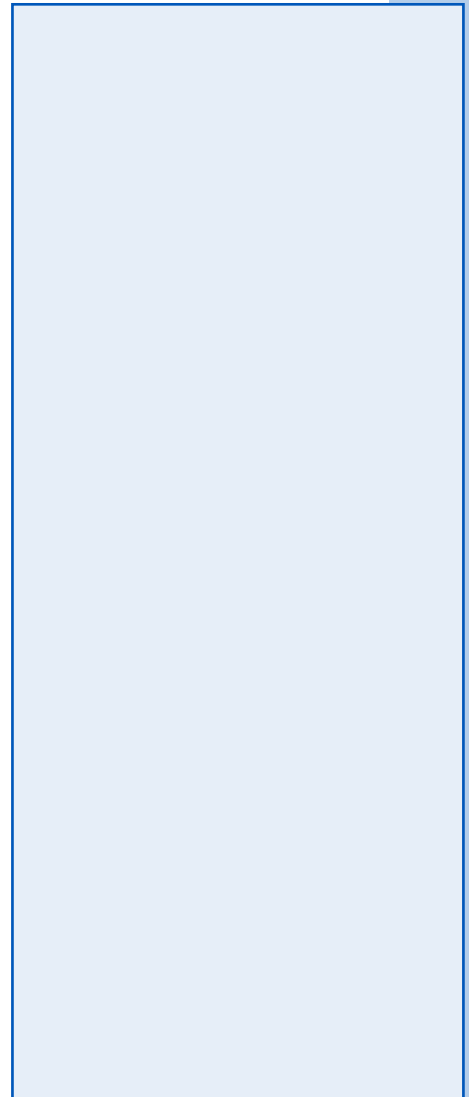
Remuneration

- 3.28 The Department of Health generic framework (*Department of Health, 2002*) indicates that remuneration of the GPwSI is a matter for local negotiation, but GPwSI should not be out of pocket. Some PCOs have taken the decision to pay all GPwSI sessions at the same rate regardless of the specialty. Rates vary from £150 to £400 per session, with the majority in the range of £180 - £200
- 3.29 Agree the method of payment, either direct to the GPwSI or to the practice



Commissioning or appointing a GPwSI

- 3.30 A GPwSI service would usually be commissioned or appointed by the PCT. However, a GPwSI could also be employed by the Acute Trust. Whichever applies, HR procedures, standing financial instructions and current legislation will need to be taken into account
- 3.31 There are circumstances in which what appears to be a “contract for services” could be construed as a “contract of employment”, thus bringing in the complications which may arise from an employer/employee relationship. As this is a continuing area of the law, it is advisable to take advice on proposed contractual arrangements from an appropriate professional, such as an employment lawyer or human resources professional
- 3.32 A sample service level agreement can be found on the website
- 3.33 The commissioning or appointment of the GPwSI should be a partnership between primary and secondary care, usually led by the PCT
- 3.34 The evidence of the GPwSI’s competence to provide the service should be assessed against agreed local criteria. Specialty or condition based national frameworks with defined competencies are being developed. Please refer to <http://www.doh.gov.uk/pricare/gp-specialinterests> for the latest frameworks
- 3.35 PCTs may wish to support training, either in part or completely. In addition to the cost of the training, locum cover needs to be considered (will the PCT cover all or part of the costs?)





- 3.36 The local Workforce Confederation is a potential source of funding for GPwSI training as the Confederations hold the budget for medical education
- 3.37 It is possible that the Deaneries may become involved in supporting the GPwSI role, by bringing the education and training system to bear appropriately. For example, current initiatives in GP education and training include extended (senior) GP registrar, Higher Professional Education (HPE) programming and the Prolonged Study leave system (PSL) for established GPs
- 3.38 In addition, the revised RCP competency based curricula for specialist registrars www.jchmt.org.uk/curricula/curricula.htm may be a valuable resource for PCTs and GPs in determining GPwSI training needs

Launching the Service

- 3.39 GPs and practice staff will need to be informed about the new service. Follow-up your initial publicity with reminders and include details in the PCT prospectus
- 3.40 You need to manage expectations (GPs and patients) and try to change the concept from 'a consultant referral' to 'a referral for a second opinion'

Define the lines of accountability

- 4.1 The GPwSI is fully responsible for the clinical service they provide. A confirmation letter from the Medical Defence Organisation should be provided to support the accreditation proforma and confirm that they are covered. This cover is at no additional cost to the standard fee for GPs. NHS indemnity will apply to GPs who are directly employed by an NHS body, but will not apply to those GPs who are engaged under contracts for services
- 4.2 A decision needs to be made about whether the clinical governance arrangements are through the PCT or the local NHS Hospital Trust. The GPwSI service may be provided alongside a service provided by the acute trust i.e. within the clinical governance of that department and sanctioned by the Medical Directors of the department and Trust
- 4.3 A PCT may make a considered judgement to commission a service without the approval of the Hospital Trust. In this case clinical governance would be the responsibility of the PCT Board
- 4.4 Any complaints from patients should be handled in accordance with the PCT complaints procedure. The clinical standards/governance function within the PCT should also play an active role in the management of complaints
- 4.5 PCTs should ensure that the quality of the service to be provided is of a consistently high standard. Relevant quality markers should be discussed with the service provider, together with audit and reporting requirements demonstrating the agreed standards are being met (see the website for a sample audit form)



- 4.6 When a GP refers a patient to a GPwSI, the GPwSI becomes responsible for the care of the patient in the same way that a patient normally referred to secondary care becomes the responsibility of the consultant for that aspect of care
- 4.7 If referrals are made to the GPwSI via secondary care (ie the consultant triages referrals to decide which referrals are appropriate to be passed on to the GPwSI), the consultant does not become responsible for the patient unless he/she directs the GPwSI to pass back the patient to the consultant after seeing or treating the patient

Continuing professional development

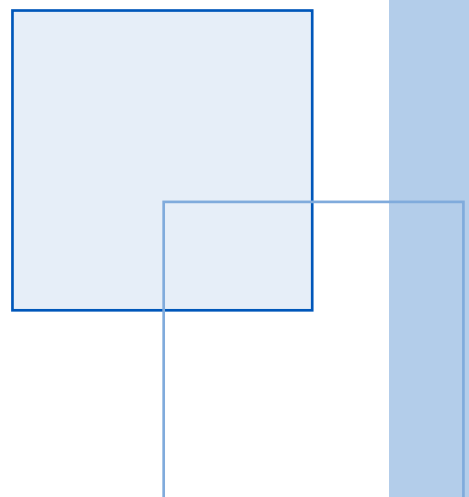
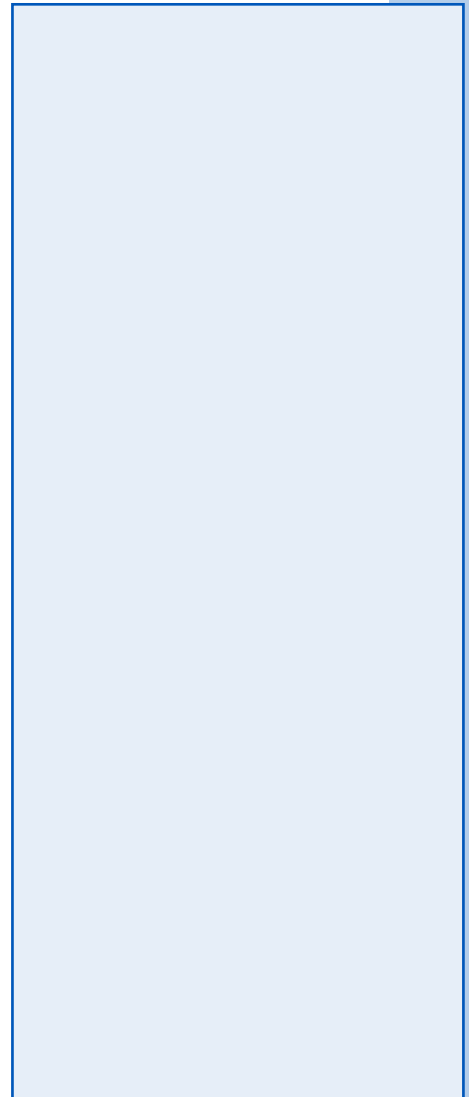
- 4.8 Each GPwSI should have a consultant mentor who provides advice about the service provision and ongoing professional development
- 4.9 The GPwSI should receive regular training and professional development amounting to approximately 15 hours a year. Regular time must be allocated for clinical sessions with a consultant. These sessions could take place in either primary or secondary care
- 4.10 A PCT may decide to meet the cost of any formal training courses/conferences
- 4.11 The GPwSI should be appraised for their GMS or PMS work. This appraisal should cover all of their clinical work, including that undertaken as a GPwSI
- 4.12 The GPwSI does not need to have a second appraisal for their GPwSI role
- 4.13 The appraiser should have a good knowledge of the work of the GP they are appraising. Before the appraisal the appraiser should discuss the GPwSI's work with the local clinicians who work with the GPwSI – for example the consultant at the local acute trust



- 4.14 When allocating an appraiser to a GPwSI the PCT needs to consider which appraisers are able to adequately discuss the specialist clinical work of the GPwSI
- 4.15 A toolkit to guide GPs through the appraisal process is available at www.appraisals.nhs.uk.
- 4.16 Further information on appraisal can be found at www.appraisaluk.info

Accreditation

- 4.17 For a GP to work formally as a GPwSI there needs to be a process of accreditation by the employing /commissioning organisation. This would usually, but not always, be the PCT
- 4.18 The accreditation process involves determining core competencies for the specialist interest area, the evidence required to meet these competencies and criteria for maintenance
- 4.19 The process should be as simple and non-bureaucratic as possible, but with the purpose of ensuring that the practitioner can demonstrate the necessary competencies for the role they are undertaking
- 4.20 The mechanism for this process can be determined at local level, though ideally this should be through appraisal of the practitioner's personal development portfolio. This should include local appraisers (eg medical director, local specialist) and/or national appraisers from the relevant specialist interest group





- 4.21 Although many GPwSIs undertake training courses, this should not be seen as the only way to develop and demonstrate competency. Indeed, however good the training may be, there is no guarantee that the competencies gained are relevant to the role the GPwSI will be undertaking. The emphasis, therefore, needs to be around the competencies and the role
- 4.22 Where clinical frameworks have been developed and are published, they may prove helpful in identifying some of the competencies for specific roles or specialties
- 4.23 Whilst accreditation of the practitioner is crucial, it is also important to ensure that the infrastructure, such as administrative support is available and that premises are fit for purpose
- 4.24 For a sample accreditation process see *Figure 5* on page 22



Risk Assessment

Premises

- 4.25 Within the clinical frameworks (www.doh.gov.uk/pricare/gp-specialinterests) there are sections dealing with the necessary facilities to support GPwSI services
- 4.26 Sample guidance documents for the accreditation of premises and decontamination assessment can be found on the website

Maintaining records

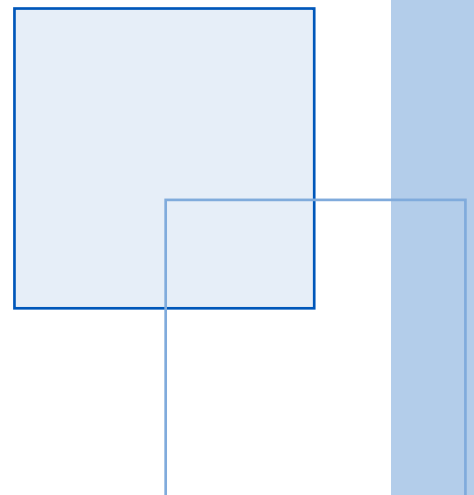
- 4.27 The GPwSI should maintain all patient records relevant to the service
- 4.28 The GPwSI should forward all correspondence, detailing outcomes etc, to the patient's registered GP
- 4.29 Copies of correspondence to the referring GP need be forwarded to secondary care only when the patient was transferred from the hospital waiting list
- 4.30 Data collection should meet the minimum standards required for local development plans and be in accordance with the Data Protection Act and all relevant codes and guidance

See Health and Safety Direct website

www.hsedirect.com

This offers useful check lists for hazardous materials and how they should be stored and used and links to updated leaflets and current information and advice for staff and organisations.

Example: Consideration needs to be given to floor coverings to reduce infection and ensure easy cleaning in areas where minor surgery or invasive techniques will be carried out.





Summary of Accreditation process Special Interest Area

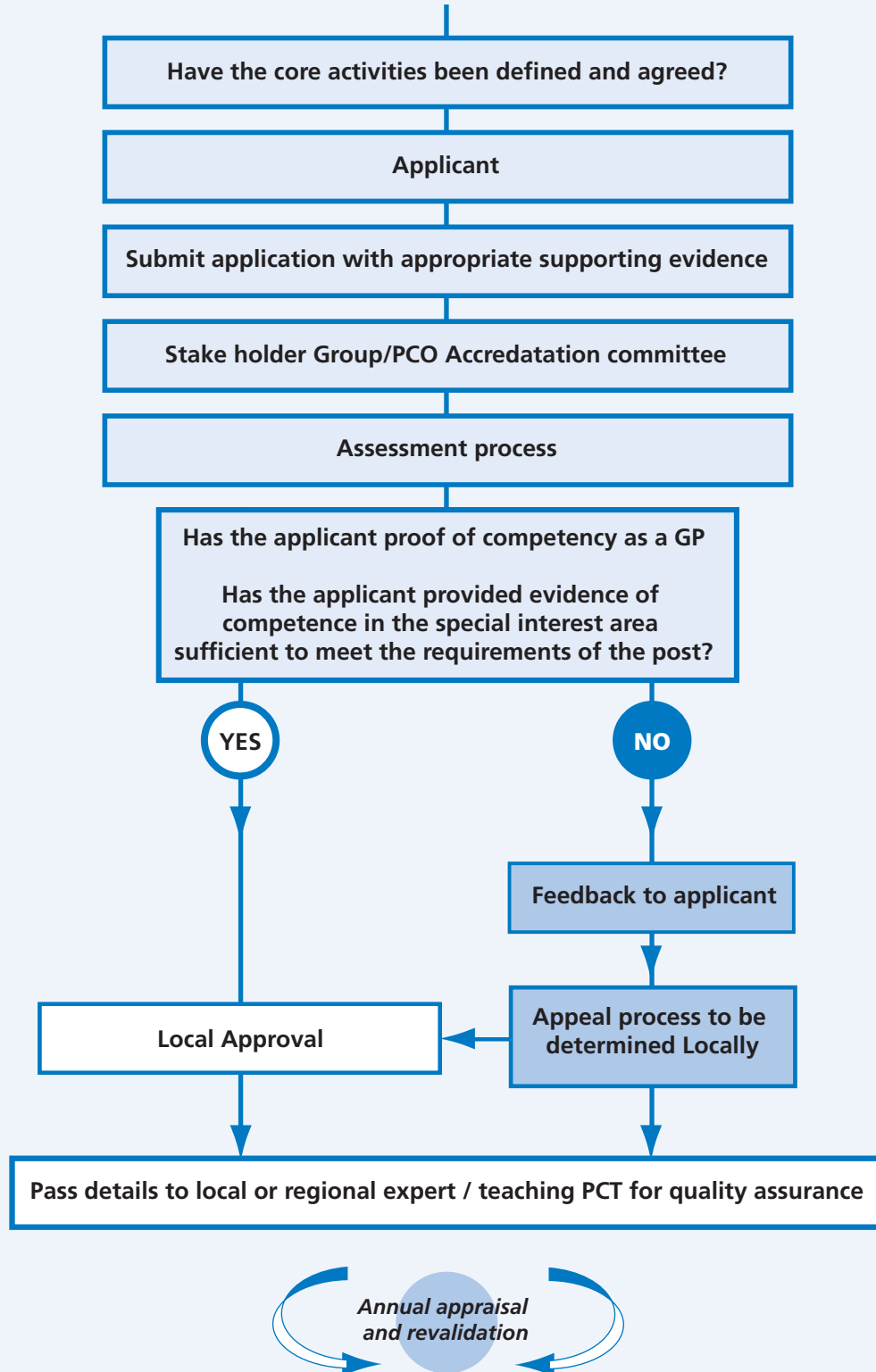


Figure 5

Step Five

Audit and evaluation

5

- 5.1 PCTs have a duty to ensure that the services they commission represent value for money and that the commissioning process provides the opportunity for open competition. It is important to ensure that the costs compare favourably with those available locally from other providers, taking into account the added value of the service for patients
- 5.2 It will be important for the PCT to consider the likely effects of a GPwSI service on existing services, and to discuss the change in commissioning arrangements with the existing local providers
- 5.3 Patient and GP satisfaction questionnaires are an important tool in evaluating the service. Sample questionnaires can be found on the website

Audit the referrals patterns of GPs to the GPwSI and to secondary care to see if there has been an impact on demand and on the patterns of service delivery. At a minimum, PCT's should monitor the following, comparing the results against the objectives identified in developing the GPwSI service :

- i. Local GPwSI capacity (how many GPwSIs are available providing how many sessions in what specialities?)
- ii. The change in referral patterns (how many specialist consultations that would have taken place in an acute setting are now being undertaken in Primary care settings? How many GPwSI referrals result in a further referral for a consultant intervention)
- iii. Any change in the relevant waiting times
- iv. Any change in demand for specialist consultations (is the availability of a GPwSI service driving up demand?)



- v. The effect on the relevant consultant caseload (has the GPwSI service resulted in the release of capacity (or a significant change in case-mix) in the consultant clinic?)
- vi. The views of patient and local health professionals on the GPwSI service and its impact

Measuring Performance, Outcomes & Best Value using a balanced scorecard

- 5.4 Stakeholders will put increasing pressure on new models of healthcare provision for measured performance, demanding data on quality and patient satisfaction, while simultaneously pressing for sensible and prudent cost structures
- 5.5 In response to demands for accountability and performance, there is a requirement for a broader set of measures to be put in place that not only capture cost and activity, but also the value. The framework most commonly used to build these more broadly based measurement systems is the concept of the balanced scorecard
- 5.6 The scorecard is built around four perspectives which allow for a balance between short-term and long-term, outcome measures and performance indicators, qualitative and quantitative. These are underpinned by an understanding that each is linked by a sense of cause and effect relations
- 5.7 Appendix D gives an example of a balanced scorecard for a GPwSI service



Plan for the future

- 5.8 You may need to set up a GPwSI service where the GP can only see a limited range of conditions at first. Ongoing mentoring and professional development may mean that the range of conditions suitable to be seen by a GPwSI can expand over time
- 5.9 Consideration to succession planning is necessary to sustaining service delivery – do not underestimate how long this will take, particularly if potential GPwSIs do not have experience in their chosen area of interest

Further assistance

Sample documents, which may be of assistance, can be found at www.natpact.nhs.uk/special_interests. These include accreditation process, service level agreement, local framework, patient satisfaction surveys, and GP surveys.

Where to go for more help?

WHAT	WHO	WHERE
Implementing a Scheme for General Practitioners	Department of Health, RCGP April 2002	www.doh.gov.uk/pricare/gp-specialinterests
Clinical Frameworks	Department of Health, RCGP	www.doh.gov.uk/pricare/gp-specialinterests
Information on Schemes locally	Modernisation Agency	www.natpact.nhs.uk/special_interests www.gpws.org (currently under development)
Developing Nurses with Special Interests	Department of Health	www.doh.gov.uk/pricare/gp-specialinterests
Redesigning Services	Modernisation Agency	www.modern.nhs.uk
Expert Patient Programme	Modernisation Agency	www.doh.gov.uk/cmo/progress/expertpatient/index.htm
Information on the deaneries		www.jchmt.org.uk



References

Department of Health the NHS Plan. 2000. London: The Stationary Office

Department of Health (2002) **Implementing a scheme for GPs with special interests and clinical frameworks.** London: Department of Health

Department of Health (2002b) **Liberating The Talents: Helping Primary Care Trusts and nurses to deliver the NHS Plan.** London: Department of Health

NHS Modernisation Agency (2002a) **Improvement Leaders' Guide to Process mapping, analysis and redesign.** Leicester: NHS Modernisation Agency.

NHS Modernisation Agency (2002b) **Improvement Leaders' Guide to Matching capacity and demand.** Leicester: NHS Modernisation Agency.

NHS Modernisation Agency (2002c) **Ready, Steady, Book: A guide to implementing booked admissions and appointments for patients.** Leicester: NHS Modernisation Agency.

Wright J, Williams R, Wilkinson R (1998) Health needs assessment: Development and importance of health needs assessment. *BMJ* 316:1310-1313.

Other sources of information:

Greater Manchester Strategic Health authority has been working with 14 PCTs to develop Tier 2 services, many of which will be provided by GPwSIs. Details can be found on their website: www.gmscha.nhs.uk

The Action on Programme guidance for ENT and dermatology both contain a lot of information on developing GPwSI services. They are available on the Action On website: www.modern.nhs.uk/action-on

Bradford South and West Primary Care Trust is a beacon site and has a number of GPwSI services. For more information see www.bradfordswpct.co.uk

The Improving practice questionnaire developed by the University of Exeter has been widely used in both primary and secondary care and can be found at : <http://latis.ex.ac.uk/CFEP/IPQ%20UK%20questionnaire%20V2.pdf>

Engaging patients and the public

Section 11 of the Health and Social Care Act 2001 – the new duty to involve and consult patients and the public – *is now in effect.* Details at:

www.doh.gov.uk/himp/himplegislation.htm#hea

Contact: Jenny de Ville 020 72105841 or: jenny.deville@doh.gsi.gov.uk



Contact us

The team are keen to offer bespoke support to designing a range of services in your area. If you wish to speak to them individually or would like more support please contact us.

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Appendices

Additional material



Appendix A

Involving Users and Patients

Appendix B

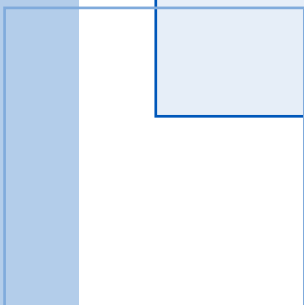
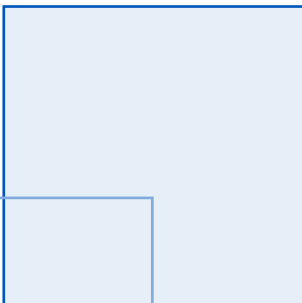
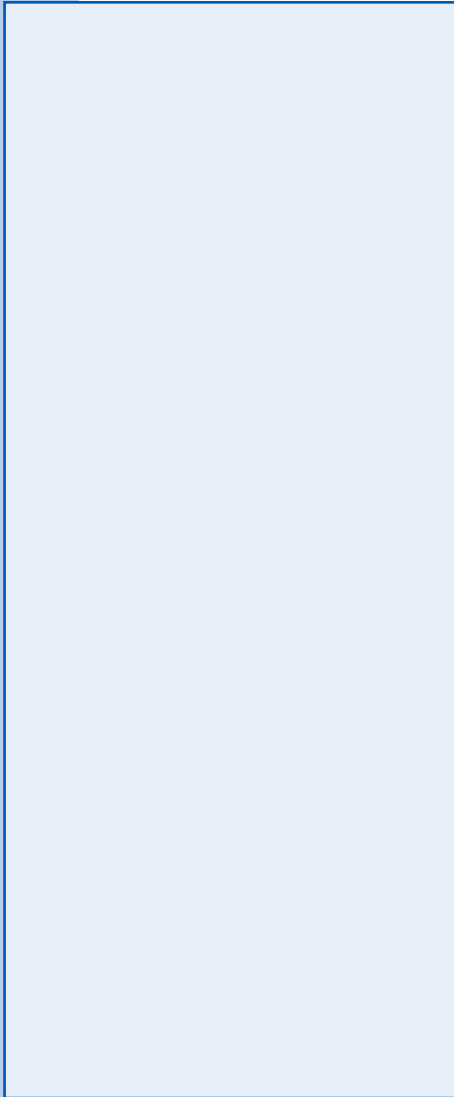
Management of Demand and Capacity

Appendix C

Example of capital costs to setup a GPwSI service

Appendix D

Balanced Scorecard





Patient and Public Involvement in the NHS

“Shift in Balance of NHS Power”

The Community Health Councils, which previously provided the “watchdog” service for users and carers, within the NHS, will cease on 1 September 2003. These will be replaced with 5 new groups to ensue patient and carer involvement in the planning, monitoring and delivery of services.

Patient Advice & Liaison Services (PALS)

Based within PCTs, these provide on the spot help to patients, carers and families to resolve concerns quickly and efficiently. They also provide information on the NHS Complaints Procedure. A good first contact to consider if there are any particular local issues and/or themes where improvements could be developed.

Commission for Patient and Public Involvement in Health (CPPIH)

Established from January 2003 and chaired by Sharon Grant, this will support and develop patient forums and Independent Complaints Advocacy Services (ICAS). It will appoint members to the **patient forums, and set standards for these and ICAS**, and then have a monitoring role. In addition, the Commission will submit reports to the Secretary of State on progress of patient and public involvement, along with making reports to other national bodies on these issues. (see www.doh.gov.uk/involvingpatients)

Patients' Forum

Supported by CPPIH, every PCT and Acute and MH and Social Care Trust will have a Patient Forum. It is hoped that, as for CHCs, members will have attending and speaking rights at Board meetings for their organisations. Effective from **1 January 2003**, these forums would be the best route to find public involvement and representation, when planning and designing any new services. Their remit is:

- Monitor and review from the patient's perspective, the operation and range of services provided or arranged by the Trust
- Seek the view of patients receiving the services
- Inspect premises where HS Services are provided or arranged by the trust
- Refer matters of concern to relevant bodies and to other people deemed appropriate, including the news media

Overview and Scrutiny Committees

All local authorities with social services responsibilities, will have powers (as CHCs previously) to scrutinise NHS services, and call on NHS managers to give information about services. They need to be consulted by NHS where there are to be major changes to health services, and are able to refer contested service change to the Secretary of State

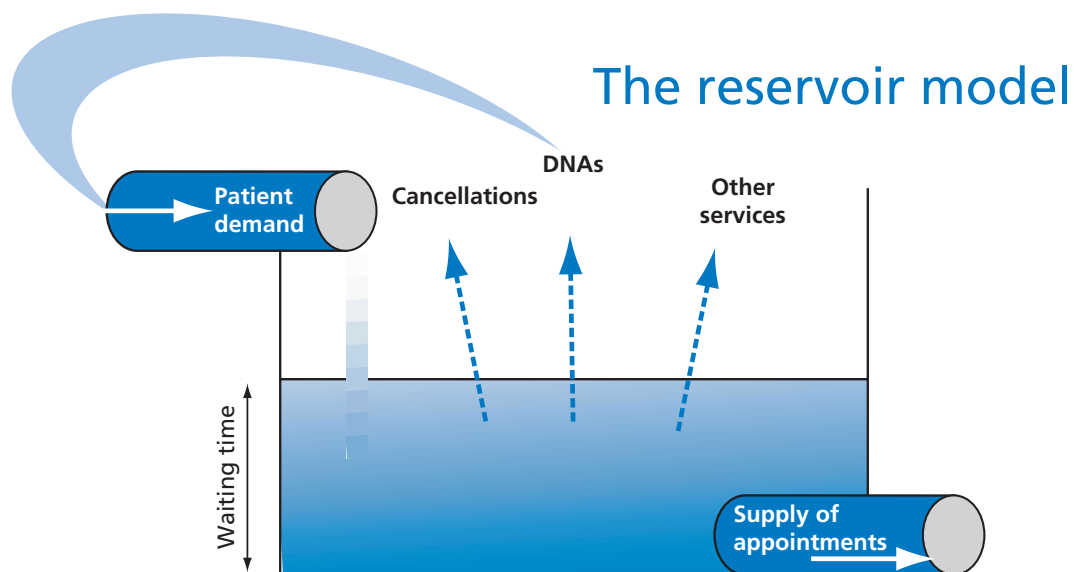


First Steps in Matching Capacity and Demand

This is not a science, but involves discussions and consultation with the frontline staff and people involved with the whole process of booking appointments, working in out patient departments, and seeing and treating patients.

Retrospective information is not as valuable as taking a snap shot of what is happening now!

- Step 1:** Ask out patient clinic to count total new referrals arriving between an agreed start and end date (*say 2 weeks*)
- Step 2:** Count up number of available new appointment slots available for these new referrals across the same period.
- Step 3:** Match demand (*step 1*) to capacity (*step 2*) and measure differences. Note: often capacity matches demand, if it wasn't for the booked appointments. These are the backlog (*See "reservoir model" below*)



Mark Murray/National Primary Care Development Team

Advantages of mapping a process

A process map event can also help inform this, by working through the process involved in a referral letter arriving and the patient attending at clinic. Using some dedicated time, with as many representatives as possible, this process is mapped out, by “walking the journey”. With post-its and one long piece of wallpaper, staff are invited to think through the steps, and place them in order along the route; this is when unnecessary loops and delays are identified, and become visually obvious.

Apart from the opportunity to have protected time to work as a team, one of the many advantages is that members of the same team, supporting the same patients, often realise that they and their colleagues are not aware of duplications or unnecessary steps that are occurring in the process!

Appendix C

Examples of capital costs to set up GPwSI service



Capital Costs associated with developing services in Primary Care

ENT

Costs are approximately £25,000 which includes microscope for dealing with ear problems and nasendoscope for diagnosing throat problems.

A full breakdown of costs and benefits are in the YHEC report, which can be seen on www.gpws.org

Ophthalmology

Costs are approximately £15,000 for slit lamps and lenses

Urology

Costs

£18,000 for cystoscopy equipment.

This includes the cystoscope (£12,000), washer (£4,000) and adequate bed, lighting etc.

£3-4000 for flow-rate analysis and handheld urology equipment

Cardiology

Costs of echocardiogram in primary care are in the range of £30,000-£35,000, used to diagnose and review heart failure, which accounts for a large percentage of admissions and readmissions, in the over 65 age group. Dr Huw Williams, who is a GPwSI in Cardiology based in Trowbridge explained that this should preferably be a portable machine to ensure it can be used across more than one PCT and/or sites. Very little maintenance costs are involved.

Training was highlighted as important, particularly of a specialist nurse role, to support the ongoing management, which ensures patients stay out of hospital, and these may need to be considered as part of “set up costs”.

Dermatology

Cryosurgery Equipment (inc liquid nitrogen supplies)	£3000
Storage Dewar	£300
Secure Storage Cabinet	£300
Digital camera (inc software)	£700
Computer Equipment (record & store clinic data)	£2000
CD-ROM MedicalText Book	£400
Increased cost of Insurance (for capital equip)	£100
Dopler Machine (if service includes leg ulcer)	£1000
Secure Drug Cabinet	£300
Microscope	£400
Resuscitation Equipment	£500
Total	£9000



Orthopaedic Medical Service

Traction Couch	£1000
Orthopaedic Examination Couch	£800
Secure Drug cabinet	£300
Computer Equipment (Record & Store Clinic data)	£2000
Medical textbooks (poss CD Rom)	£400
Secure Storage Cabinet	£300
Theraband	£500
Resuscitation Equipment	£500
*Treatment room alterations	£1000
Increased cost of Insurance (for capital equip)	£100
Total	£6900

Nurse / Optometrist led Stable Glaucoma Monitoring

Humphrey Analyser (inbuilt data collection & recording)	£30000
Tonopen	£3500
Increased cost of insurance	£200
*Digital Imaging System	£5000
Total	£38700

* Optional & not always required for each satellite clinic

GPwSI Ophthalmology

Definitive list of equipment to be obtained.	
Costs in the region of	£20000
Including items such as slit lamp & minor surgery equipment.	
Also including generic items such as insurance, storage, resus equip etc.	

GPwSI Rheumatology

Definitive list of equipment to be obtained.	
Costs in the region of	£4000
Also including generic items such as insurance, storage, resus equip etc.	

Primary Care INR Monitoring (using near patient testing) GPwSI or PharmacistwSI

Capital costs (inc vat) for 3 year contract providing 20000 patient tests, this includes all extras (lancets & quality control tests)	£49000
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Additional Coagucheck Monitor £1000 (each)

These would have previously been carried out within secondary care outpatient clinics.

Appendix D

Example of a balanced scorecard



Financial

- Return on capital employed
- Cash flow statements
- Prudent, sensible costing structures
- Activity forecast
- Sustainable demand forecasting
- Best value probability

Stakeholder (patient / PCT / strategic partners etc)

- Patient satisfaction
- Service uptake
- Referral rates
- Changing patterns of service delivery
- Quality of service provision (inc, length of consultation / waits etc)
- Outcome analysis

Process

- Effectiveness of booking systems
- Effectiveness of service management systems
- Number of complaints & actions taken
- Effect on whole system referral rates
- Effect on whole system waiting times

Learning

- Effect on commissioning / LDPSwAFF cycle
- Continuous improvement
- Actions for CPD
- Number of referrer / patient suggestions
- Effect on organisational culture
- Whole system clinical opinion
- Effect on expectations
- Effect on patient pathway & whole system

Further examples of factors influencing performance, outcomes and best value are detailed below. Local circumstances will dictate the range of performance indicators and outcome measures applicable.

- Clinical case reviews
- Clinical outcome measures: objective and subjective
- referral audit
- patient satisfaction
- referrer satisfaction

External assessment

- Clinical Governance audit
- Service management review – whether right conditions and case mix
- Systems audit including administrative and booking systems
- Clinical outcome, case mix evaluation
- CME / CPD assessment
- Objective analysis of feedback to GP

NB add need to audit the potential for GPs to refer patients to GPwSI to avoid prescribing high cost drugs where there is a separate drug budget

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