Department of Health/ Royal College of General Practitioners

Implementing a scheme for General Practitioners with Special Interests

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Foreword

Improved access and consistently high quality services both lie at the heart of the Government’s vision of modern primary care. Patient surveys identify ready access to primary care as a key issue. The NHS Plan set out clear targets for improving access to and convenience of primary care services, by reducing waiting times in primary care and extending the range of services available in primary care and community settings.

There are many innovative developments in primary care providing General Practitioners (GPs) with additional opportunities for new ways of working that enhance their skills and improve career opportunities. One such development identified in the NHS plan is for up to 1,000 "specialist GPs" to take referrals from their colleagues for a range of conditions.

Since the publication of the Plan, I have been appointed National Clinical Director for Primary Care and inter alia was asked to lead on the development of the Specialist GP. We now refer to such GPs as GPs with special interests (GPwSIs) to reflect the view of General Practitioners that our main speciality is one of being a generalist.

There is already a great deal of very good work taking place across the country involving GPwSIs. This has recently been pioneered in the work of the National Primary Care Development Team and Modernisation Agency’s Action on Programmes e.g. as a means of improving pathways; PCG/Ts on the Collaborative have already created over 200 GPs with special interests and there are currently over 650 working in England.

What we have aimed to do with this paper is offer to the public, the health service and health professionals information on the issues that need to be considered when setting up such a scheme including how such a scheme will operate nationally and locally, contractual arrangements and to offer draft guidelines for different specialties and roles.

Progress to date suggests the introduction of GPs with special interests bring with them real and sustainable benefits for patients and the NHS. They are providing localised services, in familiar surroundings with easier access and speedier care for patients. In addition, this role will help support GPs in their professional development and allow GPs with specialist experience and expertise to apply their skills and knowledge to best effect for the benefit of patients and local services. It will also improve management of workload between primary and secondary care and enhance the quality of referrals to consultants.

The recently published "Delivering the NHS Plan" identified the need to develope a wider range of services in primary care. This document was backed with extra resources in the 2002 budget. New additional monies in the Primary Care Access Fund have been earmarked to boost primary care capacity and integrated whole system working. In the Department’s recently published document "Achieving and..."
sustaining improved access to primary care” PCTs are advised to consider whole system needs and how best to utilise and or/extend the contribution of other services available to them in their local health economy.

Finally, may I take this opportunity to thank all of those who have worked so hard to complete this piece of work, particularly Professor Mike Pringle, and the members of the National Development Group who have given both their valuable time and advice. I would welcome feedback on examples of good practice that we can add to the Department of Health web.

Dr David Colin-Thomé
National Director for Primary Care

There is nothing new in the concept of General Practitioners having special interests. For years GPs have had interests that have sometimes been clinical, sometimes research based, and sometimes educational. For example, the system of Vocational Training for General Practice has depended entirely on GPs who have developed a special interest in education. These doctors have been trained, assessed, and supported – the pre-requisite for any professional skill.

However, the NHS Plan has taken this concept a step further, by proposing the development of an extended scheme for GPs with special interests in clinical activities. These are not called “GP Specialists” for the very good reason that all GPs are specialists already – specialists in primary care and family medicine. Neither should such GPs be thought of as being Clinical Assistants who can take referrals from their colleagues. This is to underestimate greatly the added value that a trained generalist can bring to specific clinical areas.

The Royal College of General Practitioners has been pleased to work with the Department of Health to develop this paper which highlights the many issues which should be taken into account, both from a local and national perspective, when implementing this exciting new development in the NHS.

As with GP Vocational Training, standards for General Practitioners with Special Interests must be assessed and maintained, and doctors must be supported. But properly implemented, such a scheme will undoubtedly extend the range of services available to patients, improve access to care, and be of real benefit to the National Health Service.

Professor David Haslam
Chairman of Council
Royal College of General Practitioners
**Introduction**

**What are general practitioners with special interests?**

1. 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. Their roles will be circumscribed but within their role definition they should offer a high quality service.

**What does a Primary Care Trust need to do?**

2. PCTs review the needs of their local population and the health and social care provision to meet those needs. If they identify an area for service development they will wish to consider all the options available to them through their commissioning role. There is now one new option – the appointment of a general practitioner with special interests. If a PCT or group of PCTs identify this as the best way forward then they will need to do so with the support of the local community, those currently providing the service, general practices and their team members, Acute Trusts and their staff, and community and social care services. If the National Development Group has published guidance on the specific topic concerned then the PCT (or lead PCT if a group of PCTs) is advised to work within that guidance. If guidance is not available, the PCT is recommended to ask the National Development Group to develop guidance to meet their needs. However, PCT’s do not need to await the publication of these proposed guidelines. If a PCT wishes to appoint before guidelines have been developed they can choose to do so, subject, of course, to the normal performance management processes. They should also review their procedures in light of national guidelines as they become available.

**What does a GP need to do?**

3. If a general practitioner has a special clinical interest that they wish to offer to PCTs, they should make themselves known to local PCTs. PCTs may wish to include information on the availability of skills in deciding how best they can develop services locally, but the appointment of a general practitioner with special interests should follow a review of health needs, local service provision, and commissioning options.
Background

4. The NHS Plan stated that by 2004 “up to 1,000 specialist GPs will be taking referrals from fellow GPs for conditions such as ophthalmology, orthopaedics, dermatology and ear nose and throat surgery. They will also be able to undertake diagnostic procedures such as endoscopy” (paragraph 12.7).

5. Since the NHS Plan was published, specialist or intermediate practitioners have become known as general practitioners with special interests the term used in this document. This is intended to recognise that all GPs are specialists in the generalist discipline of family medicine. Many GPs have special interests beyond their clinical general practice, for example in teaching, management, research, leadership or in clinical areas. This document only relates to clinical special interests.

6. The implementation of this scheme is occurring against the new structures and roles set out in Shifting the Balance of Power (StBOP) in the NHS. Under these reforms Primary Care Trusts will lead on the commissioning of appropriate local services, and their new roles are reflected in this advice. One of the aims of StBOP is to develop a new and more patient centred service. This new service will be delivered by PCTs who will be responsible for securing the provision of a full range of services for their local populations.

7. Although this advice deals with general practitioners only, there are many other health professionals such as nurses, optometrists or dentists who adopt similar enhanced roles. Many of the principles in this paper will apply to them, and Primary Care Trusts will wish to review the whole range of options, including enhanced secondary care, before deciding to appoint a general practitioner with special interests. Further, many general practitioners currently work, and will continue to work, offering enhanced care as hospital practitioners or clinical assistants. Although outside the remit of this advice, such posts will continue to offer valuable services.

8. An independent survey undertaken on behalf of the Department of Health by Professor Roger Jones (Guys, Kings and St Thomas, Kings College) suggests that there could be as many as 4,500 GPs with clinical special interests in England, often working as practice leads in defined clinical areas, clinical assistants or hospital practitioners. Many of these posts will continue, but some GPs will wish to enter a scheme which offers an appropriate contract, facilities, support and professional development. They will wish to work to break down the primary-secondary care barriers and to ensure faster and more convenient access to high quality care close to the community.
9. GPs with special interests will be either employed by Primary Care Trusts or Acute Trusts, usually on a sessional basis, or will deliver services as independent contractors. The contract that is used needs to be congruent with that of mainstream hospital practitioners, in particular around annual and study leave entitlement, audit, clinical governance and appraisal arrangement.

10. General practitioners with special interests will be principals in general practice or be eligible to be so (including PMS equivalents). They must be generalists first and foremost who undertake their special interests in addition.

11. The service provided by general practitioners with special interests will not be equivalent in breadth to those of a consultant in the same service area. General practitioners with special interests are not consultants or specialists. However within the terms and conditions of the post the general practitioner with special interests will nevertheless provide a service of as high quality in process and outcomes as the equivalent service in other settings.

12. The contract between the Primary Care Trust (PCT) and the GP will specify as appropriate:

- The core activities and the competencies required
- The types of patients suitable for the service including age range, symptoms, severity, minimum caseload/frequency, and reasons for referral
- The facilities that must be present to deliver that service
- The clinical governance, accountability and monitoring arrangements, including links with others working in the same clinical area in primary care, at PCT level and in acute trusts
- The level of payment. This should be determined through discussion with key representative bodies but as a guide should be sufficient to fully replace that doctors time in practice.
13. In appointing a general practitioner with special interests, the PCT will consider:

- The views of key people in delivering the service locally, including clinicians and managers in other relevant Acute and Primary Care Trusts, and local GPs and nurses. It is important that a general practitioner with special interests commands the support and respect of the others involved in delivering the relevant service and of potential service users.

- Evidence of successful acquisition of the competencies. While an appropriate diploma or similar formal qualification would usually be a credible source of evidence of the acquisition of competencies, many applicants will be able to offer other experience based evidence. It is important that the service provided meets local needs and that courses and qualifications are appropriate to the service requirements. Nationally the Royal College of General Practitioners will advise on the suitability of courses and diplomas for general practitioners with special interests. Locally the Postgraduate Deans will be able to give advice.

14. Before the service can be delivered, the following must be in place:

- The support of the local population, health professionals and health and social care organisations

- Induction, support and continuing professional development arrangements for the GP

- The facilities to allow satisfactory delivery of the service

- Local guidelines on the use of the service that are widely disseminated

- Monitoring and clinical audit arrangements

- Appropriate indemnity cover.
15. In reviewing the service and the GP’s work (through clinical governance, annual appraisal and revalidation), the following will be sought:

- Evidence that the guidelines for use of the service are being followed
- Evidence that the caseload is appropriate
- Evidence of relevant continuing professional development, clinical audit, exploration of the views of patients, carers and other health professionals, peer observation and revalidation
- Evidence of involvement in appropriate clinical governance arrangements, including when appropriate in the local Acute Trust(s)
- Evidence of satisfactory process and outcomes of care, including patient views
- Evidence that the generalist service is not being adversely affected.

16. If the general practitioner is employed directly by the Primary Care Trust or Acute Trust, they will be covered by the Clinical Negligence Scheme for Trusts run by the NHS Litigation Authority. The PCT should notify or discuss their proposed scheme with the NHS Litigation Authority and their own legal advisors. If the general practitioner is an independent contractor, then they will normally be covered by their professional indemnity provider. However, in all circumstances the general practitioner is advised to notify their medical defence organisation.

17. Doctors who are appropriately registered in EU countries and who apply for GPwSI posts or contracts will need to demonstrate the competencies but may not need to go through the accredited diploma route.
Delivering the Scheme

Nationally

18. A National Development Group will publish advice for the commissioning and appointment of general practitioners with special interests in specific areas. It will approve guidance in new areas and update existing guidance over time. For examples, see the Annex.

19. When designing or reviewing such guidance the National Development Group will normally ask the RCGP to consult with other relevant Colleges, specialist societies, professional organisations, appropriate parts of the Modernisation Agency and key stakeholders including any appropriate National Director and relevant patient advocacy groups. They will design a guidance that, as far as possible, achieves wide professional support. The National Development Group will make the final decision on the content of guidance.

20. The role of the National Development Group will be reviewed in a year and it will be disbanded when there is no further need for its input.

Primary Care Trusts

21. Primary Care Trusts will identify their priorities in the context of key national policies (e.g. NHS Plan, NSFs) local needs and local service delivery. If they decide that in order to meet a priority a service requires reconfiguration, the Primary Care Trusts in an area, together or singly, will consider the options for service development. These options will include, for example, hospital outreach, community based clinics or the appointment of a general practitioner with special interests. In deciding how to develop the service the Primary Care Trust will consider the views of other trusts and of the current service providers.

22. The following are the areas considered most likely to be priorities in terms of national programmes or services with significant access problems:

- Cardiology
- Care of the elderly
- Diabetes
• Palliative care and Cancer
• Mental health (including substance misuse)
• Dermatology
• Musculoskeletal medicine
• Women and child health, including sexual health
• Ear, nose and throat
• Care for the homeless, asylum seekers, travellers and others who find access to traditional health services difficult
• Other procedures suitable for community setting (endoscopy, cystoscopy, echocardiography, vasectomy etc)

These will therefore be the areas in which the national guidelines will be first prepared. This list is not intended to be exhaustive but to reflect national priorities. The topic to be addressed by a general practitioner with special interests will depend on local needs.

23. If it is decided to appoint a general practitioner with special interest as part or all of a service development, then the Primary Care Trust (acting singly or as a lead PCT for local PCTs) will make an appointment after due process bearing in mind the guidance for the appointment of general practitioners with special interests to the service concerned. If no guideline exists for the service concerned, then the Primary Care Trust can request a new guideline from the National Development Group.

24. However, PCT’s do not need to await the publication of these proposed guidelines. If a PCT wishes to appoint before guidelines have been developed for a specific service or outside any guidelines from the National Development Group, they can choose to do so, subject, of course, to the normal performance management processes. They should also review their procedures in light of national guidelines as they become available.

25. As in all commissioning decisions, the Primary Care Trust should review the appointment regularly. In the case where the Primary Care Trust is both commissioner and provider, there is a special responsibility to review service quality rigorously. In doing so, it will wish to take into account the views of the local health community and service users, clinical governance and audit data, and the outcomes from annual appraisal. It will need to be satisfied that the post continues to meet a local priority.
Figure 1 – Flowchart of the Process

24. The Department of Health GPwSI National Development Group (NDG) Secretariat can be contacted via its mailbox - www.gpwsi@doh.gsi.gov.uk.
Guidelines for Specific Services

27. There are two broad categories of activities that may be undertaken by general practitioners with special clinical interests:
   • delivery of a clinical service
   • undertaking of procedures

28 Information will be made available through the National Development Group to cover a wide range of services within these two broad categories. It is also recognised that some GPs have special interests beyond their clinical general practice, for example in service development. For this reason examples of strategic and implementation roles for GPwSIs in key NSF areas have also been developed (CHD, MH, cancer, diabetes). These can be found on the web together with contractual models, job descriptions etc. A number of other examples have been developed or are being developed and these will also be added to the DH web at: www.doh.gov.uk/pricare/gp-specialinterests/index.htm

29. The “Action on” teams and the collaboratives within the Modernisation Agency, the National Directors and the National Service Framework teams will also offer advice on the ways in which general practitioners with special interests can be used to enhance local services. In addition, useful links can be found on the DH Primary care web:

   • Modernisation Agency (including Action on Teams) www.modernnhs.nhs.uk
   • National Primary Care Development Team www.npdr.org
   • National Primary Care and Trust Development Team www.natpact.nhs.uk
   • Royal College of General Practitioners www.rcgp.org.uk
   • Department of Health, Primary Care www.doh.gov.uk/pricare
   • Department of Health National Service Frameworks www.doh.gov.uk/nsf