Summary of
"Guidance on developing new ways of working in primary care services including the development of GPs and Practitioners with Specialist Interests"
30th May 2006

This document was produced by Severn and Wessex Deanery in collaboration with Avon, Gloucestershire and Wiltshire Strategic Health Authority Workforce Development Confederation. The document is intended as a guide to Commissioners and Providers of care pathways and particularly those involving GPSI and PSI. As this summary is prepared for the LMC, the paper focuses on the GPSI parts of the guidance.

In brief, this document provides a step by step guide:

1. Identify health need:
2. Establish likely patient preferences and choice:
3. Identify options for service delivery:
4. Explore the options, examining closely workforce implications including training requirements, availability and skill mix:
5. Undertake a relative cost analysis:
6. If a GPSI is to be employed, it will need to be ensured that:

    a) Initial training has taken place and appropriate competencies are demonstrated
    b) An appropriate level of remuneration has been identified using consultant pay scales.
    c) Provision for CPD and appraisal has been made
    d) Adequate indemnity cover is in place
    e) Provision for clinical governance has been made

7. A mechanism for evaluation of the service has been made.

Research indicates that the current workforce have very different views and aspirations to previous generations of medical professions and to meet them careers are changing to take into account a range of non-traditional working practices, in particular portfolio working, specialisation and skill mixing. The paper discusses both skill mixing through delegation and substitution and skill mixing to enhance services.

Skill mixing through delegation/substitution

In terms of skill mixing through delegation/substitution, evidence suggests that there is quite a degree of latitude in the nature and range of tasks that can be transferred in this way and that nurses can provide similar levels of quality of care and achieve similar health outcomes for patients of doctors. It is unclear however, whether such skill mixing serves to decrease a doctors' workload as the nurse may be serving a previously unmet need or delivering an additional service. The cost effectiveness of substitution/delegation is also unclear as an unintended consequence can be the greater use of resources, though evidence does suggest that in a well defined business plan, there are benefits to be had. There is a dearth of research describing the range and type of tasks that can be delegated by doctors to nurses and other AHPs.

Skill mixing to enhance services

Reviews of research concerned with skill mixing to enhance the range of services offered, is less clear cut in its findings. In recent times this type of skill mixing has seen growth in the area of 'intermediate care' where the doctor workforce has developed through enhancing the skills of GPs in certain areas of illness common to general practice, in order to create a team of what *The Plan* refers to as 'specialist GPs'. 16% of GPs have forged roles in secondary care specialities as clinical assistants or hospital practitioners. The research evidence is contradictory in regard to the cost effectiveness and savings to be delivered from diversification of this type. The main positive outcomes were found to be increased patient accessibility and satisfaction. Clinical outcomes were similar as for hospital based care, however, the financial costs were higher. All-round benefit should therefore not be assumed as has been the tendency. The cost of GPSI services seems to vary depending on specialties and there is also variation depending on geographical location and local circumstances. One reason for variation would seem to be the lack of national rates of pay, or conditions of service for GPSIs. The benefits of a GPSI service to the community are also unclear. Evidence into the effectiveness of GPSI services has generally been derived from small-scale case studies and detailed evaluations which look to longer-term outcomes or compare hospital and GPSI clinics are few in number. The lack of research evidence-base and the variation across GPSI services therefore makes it difficult to draw absolute conclusions about their effects at present. Enough evidence exists however, to suggest that such services are not necessarily as cost or service-effective as they may appear at face value.

Professional issues

The chief professional issue arising from the research literature concern the broad areas of:

- ensuring the competence of the practitioner and
- ensuring mechanisms for monitoring the quality of care and patient safety.

Service design and resources

Clinicians drawn from both primary and secondary care representing those using and delivering the service, should be engaged in the service design stage. The following will need to be taken into account:

1) The role of the GPSI
2) The type of conditions the GPSI will treat (an estimation of the number and type of patients to be seen and their profile)
3) Exclusions from the service
4) The management of referrals in terms of process and type
5) Length of appointments (new / follow-ups)
6) Estimate ratio of new to follow-up appointments
7) Length of session (including time for administration)
8) Number of sessions per year
9) Prescribing arrangements:
10) Lines of communication regarding the treatment patients receive:
11) The location of the service centre:
12) An assessment of the likelihood of being able to match the recruitment needs from local resources or from open competition and a broad costing of the relevant option.

Training, accreditation and CPD

Training:

There is a need to standardise these requirements. As a first step prior to undertaking a specialist role, practitioners must be able to demonstrate

competence and experience in their profession. Training needs should be identified by specialist clinicians in the field at the service design phase. It may be appropriate to set-up formal training posts in specialist areas, or it may be delivered through formal postgraduate courses, the number of which is growing.

Accreditation:
There is currently no national system of accreditation, leaving requirements and systems to be decided at a local level between the provider and commissioner. There is also little consensus on accreditation structures, although the emerging model looks set to be a two path process:

- accreditation of skills by postgraduate award or training and
- by portfolio of evidence and experience.

The robustness of the appointment system rests with the employing organisation, however case study evidence drawn from a range of specialities, indicated that cross organisation working in this area, can enhance the robustness of the process.

CPD:
GPs will require some protected time to engage in audit, attend relevant courses / conferences and undertake study in order to maintain competence and fitness to practice in the specialist area. The RCGP recommendation for instance, is that 15 hours protected time per year should be identified for regular training and professional development in the specialist interest. The development of a portfolio as a record of this activity should be encouraged, and in additional the support of a mentor supervisor can assist. In terms of appraisals for GPs with specialist interests there is scope to bring a third party into the appraisal process in order to ensure that specialist skills and performers are given appropriate consideration.

Clinical Governance

Responsibility in clinical governance arrangements should be identified at the service planning stage. As a rule the practitioner will be subject to the clinical governance requirements of the employing organisation. It will be the responsibility of all practitioners to ensure good practice with the systems and procedures relating to the service.

Indemnity

In all cases it is the responsibility of both the practitioner and the employer to ensure that the appropriate indemnity cover is in place.

Contractual arrangements and remuneration

Formal guidance on contractual arrangements should be sought from the appropriate HR or legal representative. As an outline GPSIs may be commissioned to provide through a Service Level Agreement or may deliver the service as an independent contractor. Whichever route is chosen, the contract / service level agreements should be for a fixed term with built in review points. The remuneration of GPSIs has, up to now, been left to local negotiation. The new consultant contract where sessions are fixed at four hours in length and costs calculated on a basis of experience, may offer a way of addressing variations in pay. It is therefore suggested that this is used as the basis for negotiation remuneration for GPSIs.

Service Evaluation

Regular evaluation and review of the service will close the loop of service development by providing data on the benefits to patients, its value for money

and whether it is addressing the care needs of the community. Typical data to assist in this process concerns:

1) Referral data to the service, including change in the pattern of referrals to secondary care:
2) Process and outcome data for the service:
3) Costs per patient seen and overall costs for the service:
4) Change in waiting times and list sizes:
5) Effect on consultant caseload and case-mix
6) Views of patient and local clinical service users on the service and its impact
7) Overview of complaints about the service and adverse event data
8) Impact on workload of other primary care members in the locality
9) Comparison data on GPSI capacity.

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10.7.06