Briefing Paper

An assessment of the clinical effectiveness, cost and viability of NHS General Practitioners with Special Interest (GPSI) services

Key messages

- GPs with some additional specialist training were able to manage one in two patients who would normally be referred to secondary care – with only one in eight of these requiring further care in hospital.
- Those patients deemed suitable for referral to a GPSI clinic were equally satisfied with the clinical care provided in either type of clinic. For these patients, there was no evidence of a difference in clinical outcomes between care at a GPSI or hospital clinic.
- Patients referred to GPSI clinics were broadly satisfied with the service provided – though some had initial concerns about the quality of care and the possibility of longer waiting times for patients who eventually required a consultant appointment.
- Patients expressed a slight preference for the accessibility, convenience and shorter waiting times of locally-based GP clinics. However, a shorter waiting time and a convenient location were seen as less important to patients than the thoroughness of the consultation and the expertise of the doctor.
- The introduction of GPSI clinics did not reduce waiting times at any of the hospital outpatient clinics studied and in one instance, outpatient waiting times actually increased following the launch of a GPSI service.
- The total cost to the NHS of GPSI clinics varied widely but was always more expensive than hospital clinics, and in at least one case cost nearly twice as much as the hospital service. When patient costs were taken into account, GPSI clinics were still more expensive.
- Hospital consultants were generally sceptical about the value for money of GPSI clinics.
- The development and organisation of GPSI clinics varied, with an overall lack of uniformity in case mix, links with hospital clinics, supervision by consultants and arrangements for monitoring quality and safety.

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Background

The GP gatekeeper role between primary and specialist care is an important factor in managing cost-effectiveness in the NHS. Yet this referral system has been associated historically with long waiting times for consultant appointments. These have persisted despite several government initiatives to end the waiting list culture. It has also been claimed that many referrals made by GPs to specialists are inappropriate or unnecessary and that between 30 and 50 percent of referred patients could be managed in primary care, provided GPs had the necessary skills and equipment.

A policy of developing GPSI clinics was announced in the NHS Plan (Department of Health, 2000) with the aim of managing patients with uncomplicated problems in primary care and thereby speeding access to hospital consultants for patients with serious conditions. The NHS Plan proposed training 1000 GPs in specialties with long waiting lists. New primary medical care contracting arrangements, introduced in April 2004, proposed that GPSIs should provide one million more outpatient appointments in the community by 2006. The policy of providing a wider range of services closer to where patients lived was reinforced in the 2006 White Paper on care outside hospital.

So far, GPSI services have not been subjected to substantial scrutiny and where research has been carried out, the findings have been mixed. An assessment of GPSI services (Audit Commission, 2004) found that in eight out of ten primary care trusts (PCTs), these services made no impact on hospital waiting times.

Several studies of consultant outreach clinics, an alternative model of community specialist clinics held in primary care settings during the GP fundholding initiative in the 1990s, reported high levels of patient satisfaction with this model of care. But these clinics were more expensive than hospital outpatient clinics and had inconsistent impact on hospital referral rates and waiting times. The largest of these studies found that 38 outreach clinics were considerably more expensive to run than 38 hospital outpatient clinics, with patients having slightly better health outcomes when treated at the outreach clinics which they found slightly more accessible and convenient (Bond, 2000).

This briefing paper represents the main findings of two separate studies of GPSI services, funded by the NHS Service Delivery and Organisation (SDO) Research and Development Programme – with the aim of assessing the cost-effectiveness of GPSI services and their impact on hospital referral rates and waiting times for appointments.

Study 1 was a randomised controlled trial that compared clinical and cost-effectiveness of care provided in a GPSI dermatology clinic and a normal hospital outpatient clinic. The trial, carried out by Professor Chris Salisbury and colleagues at Bristol University Academic Unit of Primary Health Care, was completed on 1 December 2005.

Study 2 was a rigorous evaluation of access to, cost of and satisfaction with three GPSI dermatology clinics and a GPSI musculo-skeletal clinic. It was carried out by Dr Rebecca Rosen at the King's Fund, London, Professor Roger Jones at King's College London, and colleagues. It was completed in August 2005.

Practical *findings*

Potential for GPSI clinics

In Study 1, GPSIs with some additional specialist training were able to manage half of patients traditionally referred to a hospital outpatient clinic, with only one in eight of these requiring further hospital care. According to Study 2, this training most frequently involved hands-on experience as a hospital practitioner or clinical assistant. In at least one case, it consisted of completing a single diploma course.

Study 2 found that GPSI services varied considerably in content and organisation reflecting the substantial variation in the arrangements for the training, accreditation and continuing professional development of GPSIs between the four sites and between individual GPs. They also found that referral criteria sometimes changed as a result of GP turnover, contributing to reported uncertainty among referring GPs about which conditions were suitable for referral to the GPSI clinic.

The impact of GPSI clinics on hospital referral rates and waiting times

There was no evidence that setting up a GPSI clinic reduced hospital referral rates or waiting times. In Study 2, the establishment of a GPSI clinic in one area was associated with a statistically significant increase in hospital referral – apparently because GPs were able to refer patients directly to both services, thereby encouraging them to address unmet need. In Study 1, there was less improvement in waiting times for hospital outpatients in a PCT with a GPSI clinic than in neighbouring PCTs.

Study 1 noted: "If it is necessary to increase capacity, the evidence of this study suggests that the most efficient way to do this might be to provide more appointments at the hospital outpatient department... by GPSIs working at the hospital, specialist nurses or more non-consultant grade doctors."

Patient outcomes and experience

Study 1 reported that patients seen in the GPSI clinic did not have significantly differing clinical outcomes compared to those receiving normal outpatient care. GPSI care was preferred by patients and was considered to be more accessible. In Study 2, GPs who referred patients to GPSI clinics were also satisfied with the quality of care provided. Both studies reported, however, that accessibility and waiting times were less important to patients than the thoroughness of the consultation and the expertise of the clinician.

The cost of GPSI clinics

The cost of a GPSI appointment varied between clinics although this may be explained by differences in the way that the cost was estimated and in the resources that were included. The introduction of Payment By Results (Department of Health, 2002), encouraging all NHS providers to collect more detailed information about the true costs of providing different types of services in different settings, should make the cost of GPSI services more transparent. In comparing costs, it is important to consider all relevant factors including: training, follow-up consultations, administration, facilities, investigations, treatments and (if relevant) locum payments. These costs were not always transparent in the services studied.

Study 1 found no evidence that GPSI clinics could save the NHS money by transferring patients away from 'more expensive' hospital outpatients clinics. On the contrary, an episode of GPSI care was always significantly more expensive than the equivalent provided at a hospital outpatient clinic. This was partly due to lower patient throughput due to longer consultations. Salary costs of GPSIs were higher as they were paid more on average than hospital doctors who included less costly staff grade doctors and clinical assistants.

Hospital consultants were unanimous in considering that the GPSI service was not cost-effective and this scepticism was clearly justified in some cases. In one PCT, savings were made when a higher paid consultant replaced a GPSI temporarily, according to Study 2, because the consultant saw twice as many patients per session. Another factor, according to Study 1, was the double payment that some PCTs were obliged to make: GP locum fees on top of GPSI salaries.

Siting of GPSI clinics

Both studies found that GPSI clinics were usually more accessible than hospital outpatient clinics – although this was largely related to access to parking and did not apply to urban residents who lived nearer the hospital.

However, GPSIs who were located in hospital clinics had more opportunity for regular contact with hospital consultants, enabling them to receive advice and mentoring and thereby preventing the sense of isolation that was reported by GPSIs working in the community. Consultants reported feeling more confidence in GPSIs when able to work alongside them in the same place. Co-location of GPSI and consultant clinics also allowed for easier onward referral of patients with complex problems.

Training, accreditation and clinical governance

Both studies reported significant variation in the training and clinical governance of GPSIs and Study 2 identified the following reasons for this continuing lack of uniformity.

1. The shortage of suitably qualified GPs meant that PCTs could not be 'too stringent' about the competencies or accreditation process of the doctors they recruited.
2. There was a lack of consensus on whether hospital consultants or established GPSIs should take responsibility for 'signing off' newly recruited GPSIs.
3. Robust clinical governance arrangements were seen as an important way to ensure quality and safety in the absence of routinely collected clinical outcome data. Yet there was continuing uncertainty over whether the PCT or NHS trust was responsible for clinical governance. One PCT was still deliberating on which organisation should have ultimate responsibility for the GPSI service two years after it was set up.
4. One consequence of this uncertainty was that at three sites, significant events occasionally went unreported to the employing authority. The exception was the GPSI clinic where the employing authority was the NHS trust. Here, there was a consensus that GPSIs were under the supervision of the hospital management.
5. While all GPSIs undertook some kind of continuing professional development, the content varied. Most GPSIs attended multidisciplinary hospital clinical departmental meetings either infrequently or not at all. The exception was those GPs employed by the hospital trust, who attended courses laid on for hospital practitioners.
6. There was no uniform procedure for GPSIs to engage in routine clinical audit, for complaints or for obtaining consent for treatment involving surgical procedures. Requesting patients' hospital notes in advance was possible only at the hospital-based clinic.

Administration of change

While the establishment of GPSI services provided an opportunity to re-evaluate primary and secondary care services, Study 2 described the stress that may be caused by testing the traditional roles of GPs and consultants.

Both PCT staff and GPs reported finding that negotiating GPSI terms and conditions of service was both difficult and uncomfortable. Study 2 identified some suspicion that PCT motivation for developing GPSI clinics was a means of gaining control of the waiting list rather than for clinical reasons. Some PCT personnel admitted frankly that locating GPSI clinics within the community would ease the moving of investment from secondary to primary care, enabling managers to control referrals and referral data and thereby access to health services.

Establishing a GPSI clinic proved a strain on relations between PCT staff, GPSIs and hospital consultants on occasions. In one PCT, consultants reported feeling that their views had not been taken into account in designing the service. The determination of another PCT to press ahead with a GPSI clinic, despite a lack of consultant support, led to a near complete breakdown in relations between consultants and managers and a failure to agree key operational details relating to competencies, accreditation and support.

Only when hospital consultants acted as local champions for the new services, could negotiations with PCT staff and potential GPSIs focus on operational details for the services.

Questions that need answers before deciding *the best way forward*

1. Why set up a GPSI service?

Managers seeking to introduce GPSI services should be clear, following discussions with local key stakeholders, whether the objectives are to:

- improve accessibility and convenience through a more local service
- provide a different type of service
- increase capacity in order to address unmet need
- reduce waiting times
- increase career opportunities for local GPs.

It may be that trade-offs between the key advantages and disadvantages of GPSI services will be required to make the services feasible.

- Reducing the costs associated with the GPSI services may be possible by increasing throughput – though this may involve losing the benefits of shorter waiting times and longer consultations which are associated with greater patient satisfaction.
- Costs could be reduced by providing a GPSI service within a hospital outpatient setting – though this would reduce the benefit of local accessibility.

The relative importance of accessibility, waiting times and costs in relation to GPSI services needs to be decided in the context of the geographical area and the specialty.

2. Where should GPSIs practice?

Should GPSIs work in stand-alone clinics or alongside consultants in hospitals? The findings of this research suggest that the latter is likely to be more cost-effective in real terms and that the health service would need to place considerable value on accessibility and convenience in order to justify the extra cost of GPSIs in small local clinics. At the same time, the question of whether other proven benefits of GPSI clinics, such as better patient choice and convenience would persist in a hospital setting, should also be considered.

However, the incentives in practice-based commissioning, where tariffs for hospital-based services are fixed and do not necessarily reflect the true cost of providing care, may mean that it is cheaper for practices to commission services from GPSIs.

3. How should GPSIs develop further?

The following questions need to be addressed:

- Should minimum standards for training, accreditation and facilities for GPSI clinics be set, in addition to what the Royal College of General Practitioners (RCGP) has already established (RCGP, 2004)?
- What role will GPSIs have within the White Paper proposals for piloting the large-scale provision of six specialties in the community?

Future *research*

Studies are urgently required to investigate:

- whether the findings from this study apply to GPSI clinics in other suitable clinical specialties including ear, nose and throat (ENT) (Sanderson, 2002) and epilepsy (Mills, 1999) – as well as in other geographical areas
- whether increasing service capacity by providing GPSI clinics inevitably leads to increased demand or whether particular systems of referral prevent any such expansion
- how the comparative costs and benefits of GPSI services compare to other models such as increasing capacity in existing outpatient services or employing specialist nurses or non-consultant dermatologists.

PCT evaluation of emerging services should involve careful consideration of four issues: clinic activity; impact on waiting list; comparative costs (taking account of all costs including those hidden in other budgets); and patient experience assessed using questionnaires or local interviews.

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Further *information*

The full report, this briefing paper and details of current SDO research in the field can be downloaded at www.sdo.lshtm.ac.uk

Further reading

National Primary and Care Trust Development Programme
www.natpact.nhs.uk
(see *A step by step guide to setting up a GPSI scheme locally*)

Implementing a scheme for general practitioners with special interests.
DH/RCGP 2002
Available to download from www.dh.gov.uk

About the SDO Programme

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For further information about the NCCSDO or the SDO Programme visit our website at www.sdo.lshtm.ac.uk or contact:

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Addendum

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