

# **Evaluation of General Practitioners with Special Interests: Access, Cost Evaluation and Satisfaction with Services**

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# Executive Summary

## ***Introduction***

Policy to develop general practitioner with special interest (GPSI) clinics was announced in the NHS Plan (2000). They are intended to divert patients with un-complicated problems to intermediate practitioners, speed up access to specialists and improve convenience for patients. To date there has been no formal evaluation of their impact.

## ***Aim***

To evaluate the impact of general practitioners with special interest (GPSIs) services on access to specialist care, user satisfaction and costs.

## ***Methods***

The study used an observational comparative cohort design, combining quantitative and qualitative methods. The research was conducted in four sites: three with Dermatology GPSI services and one in which a GPSI musculoskeletal service has been developed as part of a wider re-organisation of orthopaedic, rheumatology and physiotherapy services.

Quantitative analysis of GPSI clinic and hospital outpatient activity data was used to measure changes in activity, referral rate and waiting times over two six-month periods before and after the introduction of GPSI services. Referrals were compared from GP practices that had access to GPSI clinics and those that did not.

Self completed postal questionnaires were used to assess patient experiences of GPSI clinics and to assess the views of GPs referring patients to GPSI clinics. Costs were assessed using a template of costs incurred in setting up and running the service from the perspective of PCT or hospital trust. This data was used to calculate costs per patient appointment in GPSI clinics.

Qualitative data combined interviews with key stakeholders and document analysis. to explore the rationale for establishing each GPSI service; the processes involved in setting up the clinics, the organization of GPSI services; the recruitment and appointment of GPSIs, clinical governance and quality monitoring, service impact, perceptions of cost-effectiveness and views on the value and future status of the service.

## **Results**

Quantitative results summarising the impact of GPSI clinics on activity and waiting times, costs and patient and referring GP views are presented in chapters four, ten, 11 and 12 respectively. Results of the qualitative analysis are organised and presented thematically covering:

the definition of an 'intermediate' case mix (chapter 5);  
clinical quality and safety in GPSI services (chapter 6);  
change management and the acceptability of GPSI services (chapter 7);  
determinants of the impact of GPSI clinics (chapter 8) and  
stakeholder views on GPSI services (chapters 9 & 13).

### **Key findings**

#### ***The association between the introduction of GPSI clinics and hospital referral rates was variable and unpredictable.***

We were unable to detect significant changes in hospital referral rates following the introduction of GPSI clinics in any of the sites studied. Data gaps precluded calculation of new hospital referrals in two sites. Overall referrals to hospital and GPSI clinics combined increased in the three sites for which data were available.

Our hypothesis that a GPSI clinic would reduce hospital referrals from practices with access to that clinic relative to control practices was not supported by the data. The likelihood of referral, calculated as the relative risk, adjusted for baseline and linear time trend, did not change after the launch of the GPSI clinics in any of the sites studied. Small changes in risks of referral from studying control practices did not reach statistical significance. In the musculoskeletal site, where all practices had access to GPSI clinics, there was a significant ( $p=0.08$ ) 13 per cent increase in overall referrals.

The association between the launch of GPSI clinics and hospital outpatient waiting times was variable

After adjustment for secular trends, there was evidence of decreased waiting times for hospital appointments after the introduction of the GPSI service in two sites and of increased waiting times in two sites. Interview data revealed that changes in the staffing and organisation of each clinic may also have influenced these findings.

In all dermatology sites, waiting time in days was shorter for GPSI clinics than for hospital clinics, although the difference was non-significant in site three.

Variability in methods for attributing costs to GPSI clinics precluded reliable comparison of the costs of GPSI appointments

There was no consistency across sites in the methods used to monitor and evaluate the costs of establishing and running GPSI clinics. Using available data, the cost per GPSI appointment in each site ranged from £35 to £93. Data was not available to compare the costs of hospital and GPSI clinics.

***Patient satisfaction with both GPSI and hospital clinics was high with significantly greater satisfaction with GPSI clinics in some domains***

There were no significant differences in reported overall satisfaction between GPSI and hospital patients. The majority rated both services either excellent or very good. But GPSI patients were more satisfied than hospital patients with the time they waited for an appointment, the ease of getting to the clinic and the time waited once there.

***Most GPs were aware of the GPSI service, had referred to it and were satisfied with the quality of care provided;***

The majority (94 per cent) of GPs who were able to refer to GPSI clinics were aware of the service and 73 per cent had referred to it. Referring GPs were broadly satisfied by the range of services provided by the GPSI clinic, but few had been offered any training or education by the GPSI, as proposed in Department of Health (DH) policy documents on GPSIs

Key benefits of GPSI services in the eyes of referring GPs were shorter waiting times and diversion of patients away from hospital outpatient clinics and access to other staff such as specialist dermatology nurses. Perceived problems with GPSI clinics were knowing which patient to refer, concerns about quality and the possibility of longer waits for patients who subsequently needed to be seen by a consultant.

The development and organization of GPSI clinics varied, with consequences for case mix, links with hospital clinics, supervision by consultants and arrangements for monitoring quality and safety.

Clinical referral guidelines and triage arrangements were different for each clinic and tailored to the skills of each GPSI, raising questions about the nature and definition an appropriate 'intermediate' case mix. We noted elasticity of referral triage

criteria in response to a range of external influences that also influence case mix.

Arrangements for accreditation, appraisal and continuing professional development, varied between sites and there were no standard arrangements for record keeping, significant event audit, complaints, obtaining consent or accessing hospital records.

Relationships between GPSI, PCT staff and hospital specialists varied from near universal support to outright hostility and resistance. This was a key determinant of the acceptability of the service. There was concern among GPs about the knock on consequences on the practice of GPSIs taking time out of their surgeries.

A range of key issues were identified that need to be resolved for the future, including standardisation of pay levels and contracts, premises development and locum arrangements; The need to train sufficient GPSIs to maintain the workforce in a steady state, IT support for GPSIs; Clinical governance arrangements and demand management

### ***Discussion and conclusions***

Our discussion acknowledges methodological limits to this study including the constraints arising from our inability to collect a full data set from each study site. Differences in basic data sets, coding, and the capacity to extract data on GPSI clinics limited the extent of statistical comparison between GPSI and hospital services.

Despite this, the study provides rich detail about the impact of GPSI clinics and about the many factors shaping their development and continued existence. Not least among these were the unpredictability of GPSI impact on referral rates and waiting times (see above). Yet patient and referring GP views about GPSI clinics were remarkably positive.

The further development of GPSI service will create a number of challenges for PCTs. Important among these will be;

- ensuring consultant engagement with GPSI services and managing the struggle for control over access to specialist care between doctors and managers
- recognising the fluidity of referral and triage decisions and the variability of the 'intermediate case mix' and developing the best possible guidance to ensure patients see a clinician with the necessary skills to treat their condition

- workforce development for GPSI roles with sufficient, standardised training and accreditation to produce a stable workforce that merits the trust of its users. Current training and accreditation processes are very variable and with a limited workforce, recruitment is proving difficult when established GPSIs leave.
- monitoring the whole system impact of GPSI services, their impact on the generalism, of the primary care and the effect on whole system equilibrium

**Disclaimer**

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**Addendum**

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