ResearchSummary

NHS
National Institute for Health Research

Planning, developing and implementing a General Practitioner with Special Interest (GPwSI) service

Meeting the needs of people with long-term conditions (LTCs) is an increasing challenge for the National Health Service (NHS). A consistent priority is the shift from provision of hospital-based acute care to care delivered in the community. New professional roles are emerging to meet this policy imperative, including GPs with Special Interests (GPwSIs).

This research summary, based on research led by Dr Hilary Pinnock at the University of Edinburgh, on behalf of the NIHR Service Delivery and Organisation Programme (SDO), reports on a study which explored changing clinical roles as Primary Care Organisations (PCOs) in England and Wales developed services for people with long-term respiratory diseases (Pinnock *et al*, 2008).

The findings have implications for policy makers, commissioners and managers charged with developing care within their locality, primary and secondary healthcare professionals seeking to improve the services they offer, patients' organisations campaigning for better care, and health service researchers.

Key findings

- Workforce reconfiguration is strongly influenced by negotiation of professional boundaries. Developing constructive, trusting relationships between primary and secondary care clinicians and managers is crucial to integrated service development.
- Clinicians and commissioners need training to develop the interpersonal and management skills required to work effectively within networks.
- Policy makers should review the impact of commissioning processes on services for people with LTCs.
- Patients with LTCs value flexible access to professional advice to support self-care. Increasing diversity of professional roles and commissioning of packages of care introduces complexity for both patients and clinicians. Simplified systems, clear sign-posting and coordination of individual patient care by a key trusted professional are essential.
- Patients need support to enable them to contribute meaningfully to service development.

Background

Long-term conditions and new ways of working

Policy underpinning cost-effective reconfiguration of care for people with LTCs has promoted a shift in provision of care from hospitals into the community and the evolution of an increasing number of specialist medical and nursing roles, including GPwSIs. The merger of PCOs and establishment of stronger PCO commissioning structures has resulted in a period of unprecedented organisational change.

Provision of care for people with LTCs is often addressed within the framework of the pyramid of care (LTC pyramid) (Department of Health,2004). It is argued that the responsibilities of specialist services extend beyond provision of clinical services for the minority of patients with complex needs to encompass strategic and educational roles in order to improve the quality of care at all levels of the LTC pyramid (Gask, 2005). GPwSIs, originally conceived as providing a clinical role within a narrowly defined specialty, have adopted this broader remit – including strategic, educational and clinical roles – in the provision of care for people with LTCs (Williams *et al*, 2002).

Patients are increasingly seen as partners in their care. Self-care is promoted both in recognition of patients' pivotal role in the care of their condition, and to enable healthcare services to meet the challenge of providing care for people with LTCs. Policy dictates that patients should actively contribute to decisions about reconfiguration of services.

What is already known

Existing research provides some evidence on individual roles, (e.g. GPwSI, or specialist nurses), but little is known about how these novel roles integrate and evolve within a local healthcare economy as services are reconfigured.

What we aimed to find out

Using respiratory services as an exemplar, we sought to explore the process of workforce reconfiguration within PCOs, and the impact on patient experience. Although the role of the respiratory GPwSI was a key focus, we aimed to understand this development in the context of the range of new professional roles and services. Our specific questions were:

- What are the key drivers of respiratory service reconfiguration in PCOs?
- What are the factors which shape the planning and implementation of workforce change?
- What infrastructure, support and training are required to achieve successful workforce change in delivering respiratory care?
- What is the patient experience when respiratory services are reconfigured?
- How aware are patients, and what is their perception of workforce changes in the context of overall management of their respiratory disease?

Our study comprised three phases: screening interviews with 30 PCOs to understand broad trends in workforce change, detailed case studies in four PCOs to examine workforce change in context, and a patient study to explore how patients perceived and managed service change. Finally we discussed our findings at a national workshop at which diverse participants provided feedback on the emerging analysis.

Practical findings

Findings from the screening interviews

'Mind the gap'

For many of our interviewees, there was a large gap between policy rhetoric and practical reality. Against a backdrop of uncertainty due to the impending reorganisation and, in some cases, large financial deficits, the 30 PCOs interviewed in the first phase of our study were seeking to marshal their resources to develop new services to shift care for people with LTCs cost-effectively into the community. However, the design and implementation of new services were subject to a broad range of local, and at time serendipitous influences which could, and often did, derail the process. Some interviewees described teams of clinicians and managers able to balance policy requirements and local needs in order to develop innovative care, albeit limited by financial restrictions and often with an uncertain future. Most, however, highlighted the many barriers to progress, describing initiatives suddenly shelved for lack of money, progress impeded by reluctant clinicians, plans for reducing hospital care thwarted by 'Payment by Results' and a PCO workforce demoralised by the upheaval and job insecurity of repeated reconfigurations.

A narrow focus on short-term gains at the 'top of the LTC pyramid'

The services currently being developed by PCOs were driven by the need to reduce the cost of chronic obstructive pulmonary disease (COPD) admissions and were therefore inevitably focused on the care of people with high-risk, complex needs. Despite universal awareness of the LTC pyramid, only a minority of the PCOs had a coherent long-term strategy to ensure that all patients with respiratory disease had access to a high quality service. The specialist services, most commonly nurse-led intermediate care, had a limited remit to provide education for primary care and few were actively involved in the strategic planning of services.

> *"Well the top priority, I am sure you are going to hear this everywhere, is financial, absolutely nothing to do with redesign, but that is the absolute top."*
> **PCO 3: GPwSI-led team, Interviewee: Commissioner**

The benefits of teamwork

Where successful teamwork was achieved it was valued and seemed to result in a fruitful alignment of objectives and broader more integrated approach to services. In stark contrast, in other PCOs, the challenge of overcoming lack of interest, antagonism, and entrenched attitudes could appear to be insurmountable.

PCOs commonly turned to the hospital trust for expert advice on developing 'hospital at home' services, but active involvement of clinicians from both primary and secondary care was less common. We identified an association between, on the one hand, collaborations involving both primary and secondary care clinicians and PCO managers and, on the other, the provision of specialist services with a broader remit of clinical, strategic and educational roles in order to improve standards of care for patients at all levels of disease severity.

> *"What was very unique about our project team was the fact that we had clinicians and managers working very closely together across primary, secondary care. And I think that established the right team structure to actually get things done."*
> **PCO 17: GPwSI-led service, Interviewee: GPwSI**

Findings from the case studies

Key features of the case studies

The four case study areas were selected from the screening interview PCOs to reflect a range of approaches to delivering respiratory services (see Box below).

'Team' PCO

GPwSI (in training) service.

Development driven by a local Team with a 'diagnosis to death' vision of respiratory services. The team actively involved GP, PCO and hospital interests.

'Merged' PCO

Established GPwSI service.

Roll out of the established GPwSI referral service to the enlarged PCO driven by a 'turnaround' team's stringent financial measures, exacerbating tensions in the already complex relationships between PCO, primary and secondary care.

'Commissioning' PCO

Nurse-led community respiratory service.

Intermediate care service commissioned by PCO primarily to reduce hospital admissions. Good links with secondary care, but little involvement of primary care clinicians.

'Rural' PCO

One specialist respiratory nurse supporting GP and community nurse care.

Development was focused on using existing primary care resources, supported by the appointment of a charity-funded second community specialist respiratory nurse.

Impact of change, uncertainty and contextual factors

The planning process in all case study settings was diffuse, serendipitous and often interrupted by financial circumstances, local policy and/or changes in personnel.

The substantial changes following reorganisation could offer new opportunities for service reconfiguration and workforce change. However, more often the effect was disruptive as managers and clinicians worked around unfilled posts and job losses. Financial constraints and uncertainty about the future favoured short-term planning (for example: reductions in referral to acute care by the end of the financial year) at the expense of the longer-term system change that was needed to provide care and support for patients with different levels of need and complexities of condition.

Commissioning and functions of the services

Commissioned services tended to concentrate on the provision of intermediate clinical care and on the needs of patients at the top of the LTC pyramid. Education and training, initiatives aimed at longer-term prevention (e.g. pulmonary rehabilitation) and strategic planning tended to be squeezed out when resources were scarce.

There was some evidence that formalising the commissioning process and increasing competition between providers had an adverse effect on the conditions for development. In particular, it could disrupt relationships and effective networks which hitherto had allowed a longer-term strategic approach to service and workforce reconfiguration.

"It was quite difficult you know, with all the changes that had gone on. Whereas before we worked much more as a partnership with the [..] Hospital, you know, from a commissioning basis, now... there has been this talk about new providers and... in many ways our relationship has become more difficult... There is more conflict of interest and things like that, so sometimes I just stay out of it."
Commissioning PCO: PCO manager

Professional boundaries

A key factor shaping service reconfiguration was negotiation of professional territories among clinicians moving into new specialist roles in the 'intermediate' sector that was opening up between secondary and primary care. Where it was possible to align interests and bring benefits for all parties, new services were able to develop. However, where new services were perceived to threaten existing professional interests without providing compensating factors, they were strongly resisted and development stalled.

"I think the current structure of the health service has introduced, I think unhealthy, competition, you know, in the past you wanted to I think be more positive about these initiatives whereas now, because with the one hand if PCOs do this they're taking away your own service you're much more concerned about it."
Merged PCO: Respiratory consultant University Hospital

Networks and relationships

Some PCOs were able to form service planning teams, encompassing primary care, PCO and secondary care clinical and managerial interests. Good relationships between individuals could mitigate some of the adverse effects of the long-standing unhelpful professional contests, and allow individuals (e.g. GPwSIs and specialist nurses) to be accepted by their peers as able to extend their previous roles and to work in new ways. The effectiveness of the teams was dependent on a range of factors including the team membership, the personalities of individuals (particularly the team leader(s)) and the resources available to support the team (e.g. time and training). These relationships could allow service development to continue at times of rapid change when familiar arrangements were sometimes being dismantled before new and transparent structures and processes had been put in place.

"I felt very much, a big sense of loyalty to [GPwSI] because we'd all gone off and done this leadership programme and we'd got [the 'Inspire' team] up and running and I actually still attend those meetings sort of out of hours in my own time. I'm not sure how helpful I am but I think it helps them to feel they've got support from senior managers at the PCO."
Team PCO: PCO manager

An important resource for clinicians moving into new roles was their personal contacts and networks which provided access to people, committees and organisations where key decisions were made about resource allocation for service development. Many GPwSIs were particularly effective at using these networks. They were able to shape decisions and lead developments because of their relationships with managers who could argue 'the business case' to the PCO, and with colleagues involved in Practice Based Commissioning. The GPwSIs also had access to a national network providing information, contacts and support, and lobbying for GP interests. By comparison, nurses only had limited access to decision-making groups and their support networks were local and informal. They therefore had fewer opportunities to shape service development and their own roles.

"...you need these clinical champions and people with clout like the [senior PCO manager], like a consultant physician because lone GPs and nurses make no impact at all. And then you need people in the PCO who understand the structure of the PCO and who are the influencers..."
Team PCO: PCO manager

The role of the GPwSI

The GPwSIs in our screening interviews and case study PCOs undertook clinical, strategic and educational roles within their PCOs. They were all involved in the strategic reconfiguration of local services, some directly leading service development and sometimes acting as 'champions'. Most of the GPwSIs had a clinical role, although often leading a clinical team rather than providing a clinical service themselves. Most GPwSIs also had an educational remit, providing informal teaching for members of the respiratory team, and working to raise standards of respiratory care amongst their GP colleagues, by whom they were often valued as credible sources of advice and education.

"We developed sort of a vision ... that envisaged basically utilising the services of a GPwSI with a community respiratory specialist nurse as a support and also filtering down to all the other support staff as needed ...to improve the care that's given in primary care through education."
PCO 14: GPwSI service, Interviewee: GPwSI

Training and accreditation

Training and accreditation for GPwSIs were seen as important, both to satisfy governance requirements and also to provide credibility for the GPwSI as a local specialist. Some GPwSIs were undertaking formal training courses to gain accreditation and some were being accredited by portfolio on the basis of their experience. GPwSIs valued mentoring by a secondary care consultant not only to complement formal study, but also to build relationships between primary and secondary care. Both GPwSIs and specialist nurses identified that there was a range of generic skills (e.g. team-building, financial planning, negotiating, service development) that they needed to acquire to be effective in their new roles and that such generic training was not readily available.

"You're actually implementing it as you go along and trying to work out the best thing to do at each step and having never had any formal management training it's quite challenging and doing it outside the sphere of, the comfort zone of my practice as well."
Merged PCO: GPwSI

Findings from the patient phase

Awareness and involvement

The patients in our study were acutely aware of changes that affected their own experiences of care. They also noticed changes in the availability and type of providers and in their own relationships with clinicians. Patients recognised what was happening at regional and national level and took great interest in the causes behind the developments, though none were actively involved in service redesign. Many contextualised their personal experiences of changes in their care in the light of national developments, often explaining changes and developments in terms of financial cutbacks in the NHS.

"I think so much is happening these days and so much is financially based you think to yourself, 'Hang on a minute, are they really qualified to take some of this work or is it just a financial get out?' We can't find enough doctors, so we'll say that some of these nurses are qualified enough to be able to do some of those things and it's purely a financial get out. And that's always at the back of your mind."
70–79 year old man with COPD, Merged PCO

Fragmentation of care

Several patients experienced their care as fragmented as they found the increasingly complex systems difficult to navigate and new services hard to access. For some patients, the access to health professionals in new coordinating and supportive roles in the community (e.g. specialist respiratory nurses and community matrons), seemed to be a matter of chance.

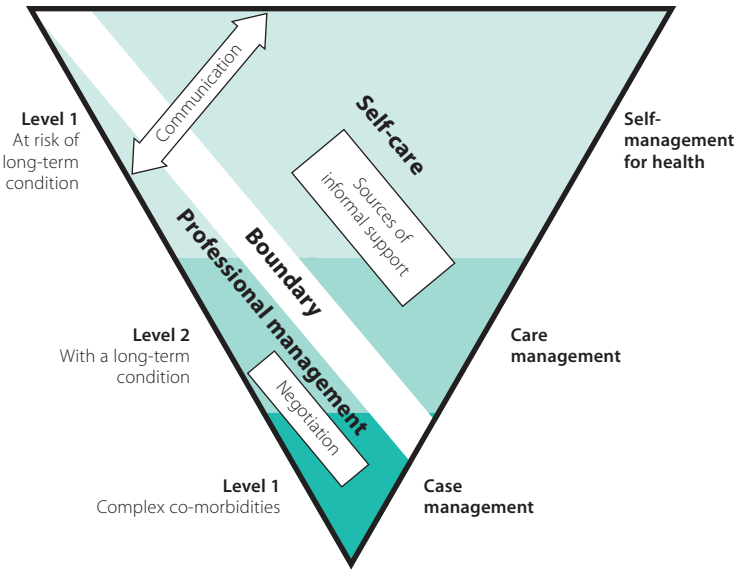
"In the olden days, you know you saw your GP and I think that was the role that tied things together. Now, but now, there are so many specialist clinics and, you know, you go to the asthma clinic at the surgery, you go to the diabetic clinic at the surgery, you see? You know, they're all compartmentalised I think."
40–49 year old woman with asthma, Team PCO

Self-care and the boundary with professional care

Patients in our study were aware that professionals are increasingly promoting patient involvement in their own care and self-management. Our data illustrate not only the complexity of self-care, but also the fluidity of patients' care needs throughout the illness experience, the thin line between feeling empowered and feeling abandoned, and the importance of the relationship

between patient and provider (see Figure below).

The LTC pyramid with the boundary between professional and self-care (adapted from Degeling *et al*, 2006)



Many patients in our study were relatively comfortable self-caring, especially when experiencing less severe symptoms. They relied on their own knowledge of the condition or accessed support from alternative sources, such as complementary therapists, information from the Internet and their friends and relatives. Patients seemed to be more content to self-care when their relationships with clinicians were based on trust, confidence, familiarity, mutual respect and good communication. A fundamental requirement for feeling confident about managing the disease seemed to be achieving the right balance between self- and professional care:

"You know, and the thing there is that it's a peculiar feeling. You want somebody to be there, but you want to be left alone, if you can understand what I mean. [...] it's nice to know that there's somebody there if I need them, but I don't need them until I shout, you know?"
60–69 year old man with COPD, Team PCO

Patients wanted flexible access to a health professional enabling them to cross the boundary between self-care and professional management when they needed to and using a choice of face-to-face, telephone and e-mail communication:

"He said if I have any problems just ring either him or the nurse up and they would sort it out, which I knew I could do. [...] Yeah they're really good."
50–59 year old woman with asthma, Team PCO

"We use the email sometimes, if I'm going to see him I'll email him and tell him why I'm coming so he can check into anything that's necessary and so on and I think we have a good working relationship."
50–59 year old man with asthma and COPD, Team PCO

Without this flexibility, some patients felt abandoned:

"...I said, 'Well why are you only seeing me every month or two?' 'Oh well, you always seem to be able to manage'. And so well, I can, but should I be, should I be just doing it all on my own, do you know what I mean? I don't know, the more independent and able to manage you are the less keen they are to see you sometimes."
40–49 year old woman with asthma, Team PCO

Some patients in our study had gone a step further and had become involved on the professional management side of the 'boundary' as they negotiated their care and made decisions on their treatment and medication intake.

"If my breathing is not so good then the doctor's quite happy for me to increase that [inhaler] and to use that as and when required. [...] I don't know if it's because I understand my complaint quite well and can manage it and seem to be responsible."
70–79 year old man with COPD, Merged PCO

Conclusions

For long term benefits, there needs to be investment in the care of patients at all tiers of the LTC pyramid

Patients valued flexible access across the boundary between professional and self-care and emphasised the dangers of fragmentation of care. However, the increasing diversity of professional roles and tendency for commissioning to create services targeted at separate 'packages' of care, introduces complexity for both patients and clinicians. Financial imperatives to reduce hospital admissions, and policy directives to move care closer to home have focused most attention on the few patients with complex needs.

- Policy makers should review the incentives that have led to a narrow focus on admission avoidance in people with complex needs, and address the potentially disruptive impact of a commissioning process that emphasises short-term contracts and prioritises contestability.
- Commissioners should recognise that systems of care for people with LTCs need to encourage flexible access and movement between self-care and professional services.
- Simplification of systems, clear signposting and co-ordination of individual patient care from a key trusted professional are essential.

Local networks of primary and secondary clinicians and managers need to be encouraged and facilitated

Development of services and provision of care are strongly influenced by relationships and alliances which are not only based on professional group identities, but also evolve around shared interests and visions. In our study, relationships based on professional and collegial interests were an important resource protecting service development in periods of instability and change. Understanding and harnessing this process is crucial to successful service innovation and workforce change.

- Policy makers should consider and, if necessary, address the infrastructure required to enable PCOs to develop effective local networks.
- Commissioners should harness local skills and broker productive relationships with and between healthcare professionals from both primary and secondary care in order to build effective and sustainable networks.
- Primary and secondary care clinicians need a detailed understanding of the commissioning process, in order to fulfil a strategic role.

The workforce profile and training needs required to fulfil the broad clinical, educational and strategic functions of a specialist service must be addressed

With a broadening of the remit of specialist services to encompass strategic and educational responsibilities new skills will be needed. In addition to specialist clinical training, GPwSIs and other professionals in new roles highlighted the need to learn management and leadership skills. Mentoring developed relationships and mutual understanding, while access to local and national networks could provide support for clinicians in new specialist roles.

- A core skill for commissioners is the ability to engage with all stakeholders, broker negotiations, identify potential leaders and support the development of the necessary skills.
- Commissioners should ensure that service specifications explicitly address the training and support needs of personnel in specialist services to equip them to fulfil the broader clinical, educational and strategic roles.
- Patients need to be supported so that their awareness of and interest in the changes in delivery of their care can be harnessed enabling them to contribute meaningfully to decisions about service development.

Future research

Professional boundaries: We have captured the way that professional boundaries are being redrawn as new roles are emerging to provide intermediate care services.

- There is a need for further research to understand the longer-term impact as these new professional roles evolve and become established, and involve a more diverse range of professionals.

Clinical networks: We have highlighted the importance of teamwork, and also the skilful management involved in overcoming the challenges of local circumstances, existing relationships and personalities to build effective teamwork built on collaborative advantage.

- There is a need for further research to understand how networks can be facilitated, their optimal membership, at what level they should operate within the NHS and to understand the impact on services commissioned for LTCs.

Commissioning: We observed that commissioning, with its targeted focus on cost effectiveness of services, could disrupt the existing local relationships which underpinned overall service arrangements.

- There is an urgent need for further research to understand the immediate and long-term impact of the current formal commissioning (including practice-based commissioning) and contracting processes on workforce reconfiguration and service provision, including their impact on workforce morale and social capital.

Training: We have shown that, in addition to the currently available specialist clinical training, GPwSIs and other professionals in new roles have identified the need to learn strategic and leadership skills. We also suggest that training for commissioners should include an emphasis on brokering relationships and nurturing teams.

- There is a need for further research to understand the training needs of both specialist healthcare professionals to enable them to fulfil clinical, educational, and strategic roles and of commissioners to enable them to build effective local clinical networks.

Flexible support for self-care: Patients emphasised the need for flexible support at the boundary between professional and self-care.

- There is a need for further research to explore ways of providing flexible support to enable people with LTCs to self-care, and to understand how such support may be commissioned and evaluated.

Involving patients: Patients in our study were aware of how their own care was affected by changes in the availability and type of providers and interpreted these changes in the light of regional and national events. However, none of the patients in our study were actively involved in service redesign.

- There is a need for further research to develop strategies to address the widely acknowledged barriers to patient and public involvement in order to harness this untapped resource.

About the study

Our study proceeded in three phases:

I. We carried out semi-structured interviews during the first six months of 2006 with a representative from each of a nationwide purposive sample of 30 PCOs with varying approaches to developing respiratory services.

II. We conducted a comparative prospective case study in 2006-2007 in four PCOs selected to show variation in respiratory services workforce change. Each case study was constructed around a description of the planning process, both historically and as it unfolded over time, focusing on the way local service histories and organisational dynamics shaped the planning and implementation of services.

III. We used illness diaries and serial telephone interviews to explore patients' understanding and knowledge of the service system and the way they used the system to manage their illness in the context of their overall life situation. The themes identified were further explored in focus groups.

Data analysis was iterative and continued throughout the phases of the study.

National workshop: In order to derive models of good practice in planning and implementation, we convened a national workshop in February 2008 with 30 participants selected to represent a range of perspectives on the key themes identified by the case studies. Feedback was provided on the issues raised by our findings and four multidisciplinary break-out groups focused on specific emerging themes.

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Further information

The full report, this research summary and details of current SDO research in the field can be downloaded at: www.sdo.nihr.ac.uk

For further information about anything included in the report, please contact lead researcher Dr Hilary Pinnock, Allergy and Respiratory Research Group, Centre for Population Health Sciences: GP Section, University of Edinburgh: hilary.pinnock@ed.ac.uk

Feedback

The SDO Programme welcomes your feedback on this research summary. To tell us your views, please complete our online survey, available at: www.sdo.nihr.ac.uk/researchsummaries.html

About the SDO Programme

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The NIHR SDO Programme improves health outcomes for people by:

- commissioning research and producing research evidence that improves practice in relation to the organisation and delivery of healthcare; and
- building capacity to carry out research amongst those who manage, organise and deliver services and improve their understanding of research literature and how to use research evidence.

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Addendum

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The management of the Service Delivery and Organisation (SDO) programme has now transferred to the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Prior to April 2009, NETSCC had no involvement in the commissioning or production of this document and therefore we may not be able to comment on the background or technical detail of this document. Should you have any queries please contact sdo@southampton.ac.uk.