

# General practitioners with a special clinical interest: a model for improving respiratory disease management

Siân Williams, Dermot Ryan, David Price, Carol Langley, Monica Fletcher and Paul Everden

## SUMMARY

*Health care technology is continuously moving forward with great advances in all fields of medicine. The way in which health care is delivered has been stuck in a primary care/secondary care model, which is failing to meet patients' needs. Existing structures are inefficient because they do not maximise use of skills. A new way of delivering services is proposed using an intermediate level specialist — a general practitioner with a special clinical interest (GPSCI), to increase access at a location close to the patient while giving support to the wider primary health community. We explore how the role of GPSCI might work using the field of respiratory medicine as an exemplar. The concept is transferable to other therapeutic areas.*

**Keywords:** *general practitioner with a special clinical interest; service model; primary care; secondary care; respiratory medicine.*

## Introduction

THE NHS Plan proposes up to 1000 general practitioners with a special clinical interest (GPSCI) in the NHS by 2004.<sup>1</sup> It also suggests that GPSCIs might have a role in shaping local services.<sup>1</sup> Various policy-making bodies have begun to define what the whole purpose and impact of GPSCIs might be.<sup>2,3</sup>

A number of significant gaps appear in the current discussions. First, there has been little discussion yet about the GPSCI as physician and clinician, rather than technician. Secondly, what really makes the difference between a GPSCI and a GP acting as a clinical assistant to a hospital consultant? Thirdly, how are the health benefits of specialist practice in primary care achieved without undermining the holistic, generalist strengths of British general practice? Finally, how do the roles of other healthcare professions as specialists link together?

This paper proposes a model of a GPSCI as part of a broader primary care team, to improve respiratory disease management in primary care. We are committed to promoting high quality respiratory care management in primary care; we discuss the rationale for the GPSCI role, models of how this role could be developed, what training might be needed, barriers to such service provision, and how such a service should be evaluated.

## Rationale for specialist services in primary care

Respiratory disease is a substantial burden for patients, the health service, and society. It is the third highest cause of mortality in the United Kingdom, accounting for one-quarter of all deaths and is a substantial cause of morbidity,<sup>4-7</sup> with most of this burden falling on primary care.<sup>8</sup> The dynamics of health care commissioning and delivery are changing rapidly with changes in primary care, including the commissioning role for primary care organisations (PCOs) and support for GPSCIs, presenting excellent opportunities to create new models for the management of chronic disease (Box 1).

The practice in primary care of exercising a specialist interest alongside generalist work has existed since the inception of the NHS. Individuals have sought support for their special interest by setting up specific interest groups, such as the General Practice Airways Group<sup>9</sup> and others.<sup>10,11</sup> These initiatives provide a firm platform for the introduction of a high-quality primary care service.

At the same time there is increasing recognition by secondary care physicians that hospital-based respiratory specialists have insufficient capacity to meet the needs of those suffering from respiratory disease.<sup>12</sup>

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- Inadequate service provision and resulting morbidity
- Changing dynamics of health care delivery
- Primary care solutions for primary care problems

Box 1. Rationale for GPSIs in respiratory disease.

There would be a potential role for the GPSCI in helping to design and implement local disease management systems appropriate to chronic respiratory illness that would help meet the primary care clinical governance agenda.<sup>13-16</sup>

Current measures of outcome in respiratory disease are often not applicable to individual clinical situations, as they are extrapolated from secondary care settings to the primary care population, whose needs are often different. A network of GPSCIs around the UK has the potential to do research and development, both into service delivery and into patient-centred outcomes, identifying primary care solutions for primary care problems.<sup>15,17</sup> This may include new methodologies to identify high-risk patients, to help us to target resources more appropriately.<sup>14</sup>

### Models of service

Models which could be adapted at a local level include two traditional options: GPs with special interest working autonomously and GPs with special interest working as part of the respiratory service headed by the secondary care consultants. We are proposing an innovative model, where GPs with special interest work as part of a specialist primary care team.

#### The respiratory GPSCI (Figure 1)

The advantages of this option are that it provides a clear peer support system to generalist GPs; it is set apart from secondary care, thereby acknowledging that most of the burden of care for respiratory disease falls in primary care, and also builds on much current practice where individual GPs have developed a leadership role in certain specialties or functions, so will require little change. Disadvantages include potential isolation and lack of involvement from other potential primary care specialists, such as nurses, and extended scope practitioners, such as physiotherapists, and

potential alienation from secondary care. This model may also be perceived as adding another tier of care between primary and secondary care with no clear guidance as to who goes where, acting as a hindrance to improved care.

#### The GPSCI as part of service led by secondary care (Figure 2)

This option is the most familiar, since it builds on the practice of clinical assistants and hospital practitioners, but based in the community rather than in traditional outpatient settings. It has the merit of joining up primary and secondary care services and encouraging the use of shared protocols, standards, and guidelines for delivery of care education, training, and supervision, i.e. a seamless service. The demerits include reinforcing a secondary care model for predominantly primary care conditions. Currently, many GPs engaged as clinical assistants feel that this limits, rather than enhances their role, in part because their usual levels of autonomy are reduced.<sup>18</sup>

#### The GPSCI as part of a specialist primary care team (Figure 3)

This option involves a multi-disciplinary team providing a primary care service in primary care settings. It meets those primary care needs that are currently unmet or inappropriately met by secondary care outpatient or outreach provision. Each team would cover a Primary Care Organisation (PCO) and be accountable to, as well as requiring support from, that PCO. Patient-held records or smart cards might facilitate shared records.

The primary care respiratory team would perform many different functions involving many professionals, with the overall aim of improving existing service provision and developing new services close to the patient.<sup>19,20</sup>

It would not be intended as a new tier of service but a massive enhancement of existing arrangements (Box 2).

Traditionally, many primary care-based specialists in other professions, such as diabetic liaison nurses or pulmonary rehabilitation therapists, are trained and accountable to secondary care. This model creates an opportunity to improve interprofessional working, by training them in primary care

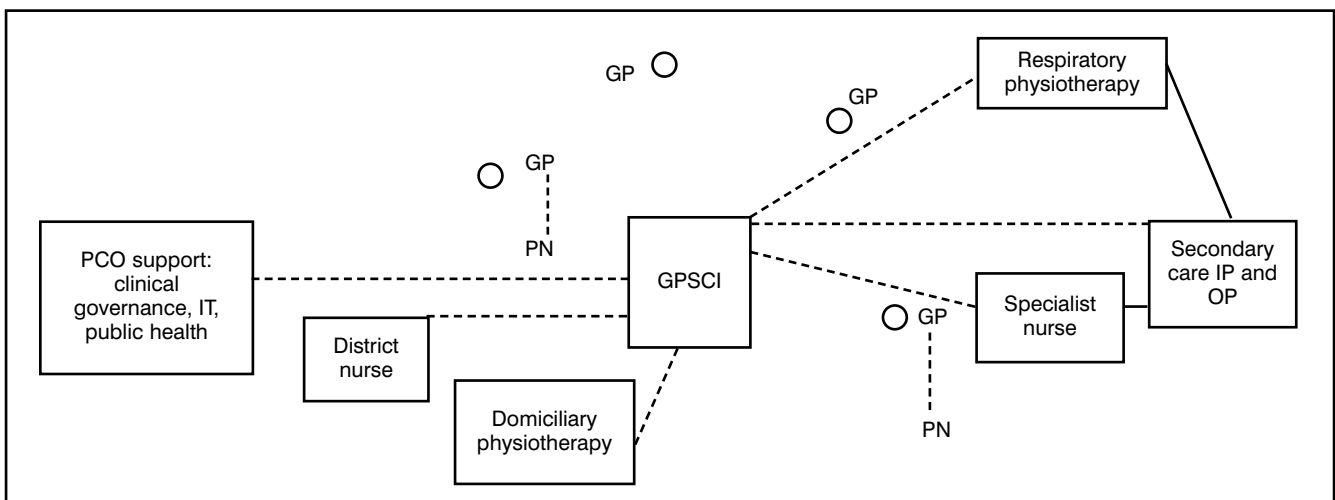


Figure 1. The respiratory GPSCI.

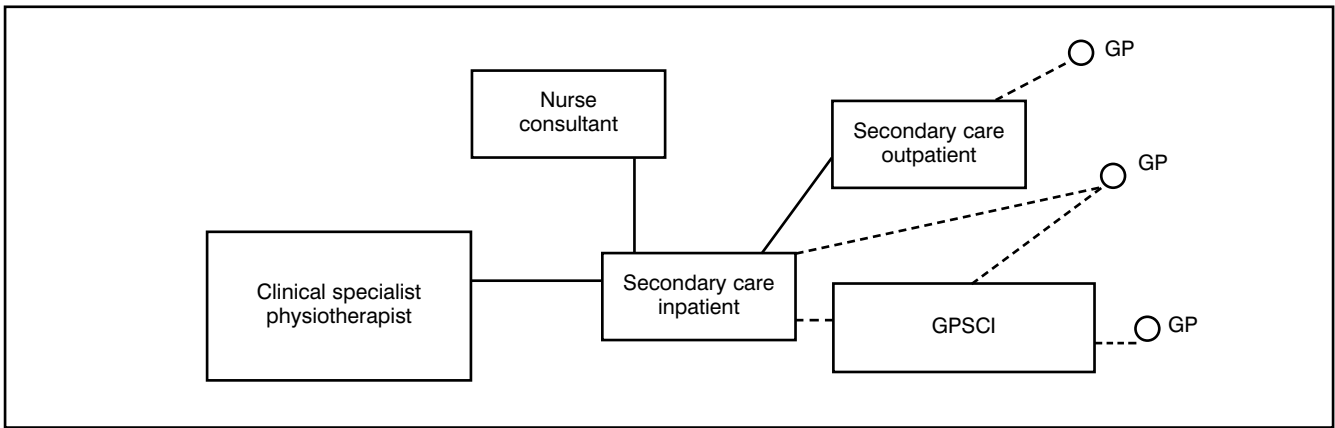


Figure 2. The GPSCI as part of a service led by secondary care

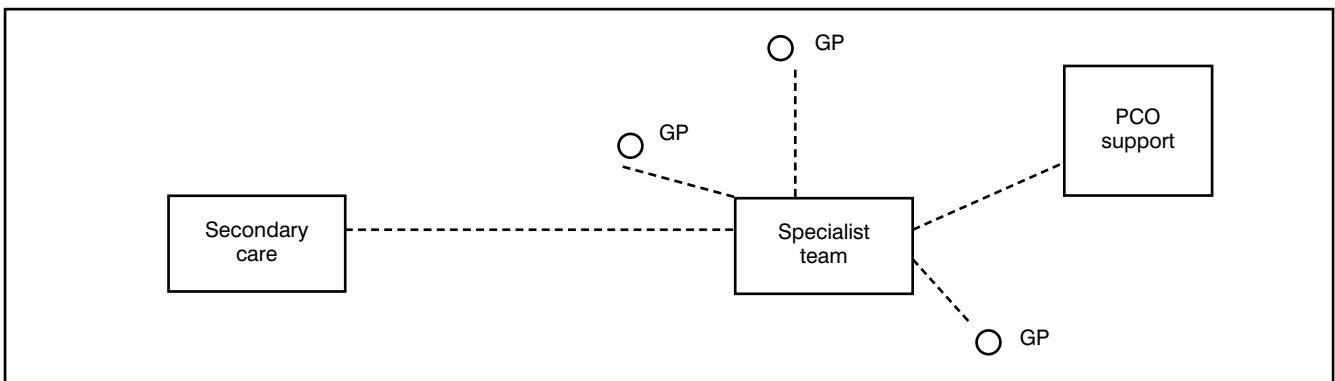


Figure 3. The GPSCI as part of a specialist primary care team.

- Autonomy, but with strong links to secondary care
- Multi-professional, including respiratory nurses
- Information technology and administrative support from PCO
- Strong links with other GPSCI services
- Support clinical governance
- Provide a 'one-stop shop' service for clinical problems, e.g. respiratory diagnosis
- Promote patient-centred care
- Improve interprofessional working, e.g. using shared records
- Update other GPs on best practice
- Encourage primary care colleagues to engage in research

Box 2. Key features of a GPSCI as part of a specialist primary care service.

and linking them directly to the GPSCI team.<sup>21,22</sup>

The advantages of this model are that it reinforces the team management of chronic disease and sets a strong role model for other generalist practices.<sup>23,24</sup> While appropriately trained GPs may provide a new specialised service, this option proposes that they will do so as part of a specialist team in the community. It does not take over the care of individual patients, except where their needs are too complex to be managed easily by the GP, and only sees individual patients where GPs have asked for assistance in their management.

Potential disadvantages are the amount of change it would require to set up and the level of additional resources required, so that the substitution of the specialists in their existing generalist posts was properly resourced. There may

be lessons that can be learnt from primary care mental health teams. These have set out to create a new holistic model of care involving the patient and the carer network, and a team approach based in general practice rather than outreaching from secondary care psychiatric services.<sup>25</sup>

### How might enhanced service provision make a difference?

The aim of the NHS Plan is for GPSCIs to improve local services. If this ambition is to be realised, then we need clarity about what improvements might be observed, what levels of resource will be provided, and what the training needs are. Where evidence is currently lacking, pilot schemes could be set up and evaluated using these parameters.

### Re-skilling of generalist primary care

Evidence suggests that there is scope for improvement in the way that common respiratory diseases are managed in primary care.<sup>26</sup> The GPSCI and other extended scope practitioners may enable the re-skilling of the generalist primary care teams by offering audit tools, encouraging them to review their practice, and offering appropriate feedback.<sup>27-29</sup>

### Rebalancing waiting lists for secondary care

Secondary care specialist time is best spent on managing less common or more severe respiratory illness. GPSCIs should enable the management of those common illnesses which, given appropriate resources,<sup>19,20,30</sup> could be man-

aged in the community. While this should lead to improvements in the quality of care and potential cost savings,<sup>31</sup> the effects on waiting list length are less certain. Research on referrals suggests that increased interest by GPs may raise rather than lower demand for diagnostic and secondary care treatment services.<sup>32</sup> This has been found within the existing system, where such services are only available within the secondary care sector. Making them available to primary care might well avoid this effect.

### *Improved prescribing*

The Prescription Pricing Authority has found that respiratory drugs account for one of the top four categories of prescribing in both usage and costs.<sup>33</sup> More appropriately focused prescribing might improve outcomes.<sup>34-38</sup> For example, oxygen therapy costs the NHS over £29 million per year, including a 29% increase in prescriptions for oxygen cylinders in the past five years<sup>39</sup> and yet is often subject to delays in assessment, variation in prescribing, and lack of follow-up.

### *Fewer exacerbations and emergency admissions*

In addition to the emotional cost, each admitted patient consumes a disproportionate amount of resource,<sup>40-41</sup> thus prevention of acute respiratory admissions would be an important goal; for example, by increased use of self-management plans for asthma and provision of pulmonary rehabilitation in the community.<sup>42,43</sup>

Also, most importantly, the quality of life of patients with respiratory conditions should improve, as measured by individual patient-determined outcomes.<sup>44-46</sup>

### *Provision of services that are not possible for every practice*

Spirometry is the gold standard for the diagnosis of chronic obstructive pulmonary disease (COPD)<sup>47</sup> but is not uniformly accessible in the UK. Pulmonary rehabilitation for COPD has been shown to achieve clinically significant improvements in functional capacity and health-related quality of life beyond those achieved through conventional care.<sup>31,48,49</sup> There are insufficient skilled people or equipment to provide these services at practice level; a skilled team working at PCO level might be able to achieve desired improvements in people's quality of life and deliver these, in a convenient way, closer to the patient.<sup>19,20</sup> Allergy testing is an area that could also be improved, as an aid to the management of asthma and rhinitis.

### *Overcoming lack of clear guidance for important respiratory conditions*

In the UK, professionals managing people with asthma and COPD tend to follow evidence-based guidelines that lay out standards of diagnosis, care, and record keeping. However, not all common respiratory conditions have guidelines; for example, childhood wheeze.<sup>50</sup> As the understanding of respiratory disease increases, new models of illness are proposed and experts at local level can relay and implement evolving practice. This is of particular relevance when new treatments become available between revisions of guidelines, e.g. the use of leukotriene receptor antagonists.

## *Education*

GPSCIs will necessarily have a key role in the education of their GP colleagues and the wider primary health care team,<sup>24,27-29,51</sup> using their understanding of both general practice and respiratory medicine to give detailed, individualised feedback to their peers on either the management of an individual patient or, as a new service, on a type of patient.<sup>51</sup> This latter service would be more personal than a helpline and would take into consideration local issues and be tailored to the needs of individual practitioners. They might also work with local patient groups from the National Asthma Campaign or the British Lung Foundation. It is possible that enhanced disease management in primary care may lead to de-skilling of trainees and specialists in secondary care. This could be countered by having trainees spend a period of time training with primary care specialist teams.

## *Training requirements*

Apart from the existing expertise of its individual members, the individual specialist or team would need to meet, on an ongoing basis, a set of national standards that were taught and monitored by accredited universities. This would require a new modular postgraduate education programme that is built on a specified level of prior experience. The modules could also be designed to meet the identified learning needs of non-specialist primary care practitioners and be accredited at diploma level.

## *Disease-specific training*

This would include core skills in diagnosing and managing common respiratory diseases, such as asthma and COPD, and training in allergy-based respiratory care.

## *Generic training*

Other therapy areas, such as cardiology and psychiatry, might also wish to establish training programmes for primary care specialists, with potential for joint training in such areas as setting up structured recall, clinical governance support, and providing locally based education.

## *Evaluation*

Any new initiative needs to be evaluated for its benefits and disbenefits. These should be evaluated in terms of their impact on the patient, the professional, and the service. In respiratory medicine it would appear that patients' needs are not being met: this is partly because they are not being identified and partly because of a failure to use different therapeutic options.<sup>7,28,52,53</sup> New tools are being developed to measure patient benefit at an individual and population level, including simple measures of quality of life.<sup>15,17,54</sup> It is important to develop indices to evaluate the impact of GPSCIs, on both patients with acute presentations of asthma and COPD and those with stable conditions. Such indices might include:

- The percentage of patients who, having experienced an acute asthma episode, can be considered to be self-managing six months later, with improved self-confi-

dence and self-dependence.<sup>55</sup>

- The percentage of those with stable conditions on the relevant disease register who use their medication and devices effectively, and the improvements in their quality of life.

This could be complemented by qualitative exploratory techniques, to learn more about the patient's perspective.

Service outcomes might include: emergency admissions; readmission rates or repeat unscheduled healthcare utilisation rates for respiratory disease; and prescribing trends, such as the use of nebulisers and spacers.

Professional outcomes for GPSCIs and generalists could include changes in job satisfaction and sense of control.

Structural and process measures appropriate for study might include the presence and accuracy of disease registers and identification of high-risk patients.

## Conclusion

It is an exciting vision for primary care that recognises the existing strengths of general practice and the roles of the wider healthcare team, but also seeks to remedy known shortfalls in current care, evidenced by unacceptable levels of hospital admissions for respiratory care and inappropriate prescribing for many people with treatable conditions. Patients with chronic conditions deserve better care and this model suggests how that could be achieved through the government policy of primary care specialists, including GPSCIs and specialist teams. It may not lead to cheaper care, but it should lead to more effective care and enhance the role of the primary care team, rather than diminish it.

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