

field for all providers and that the assessment criteria for quality must be consistent. Commercial providers should use GPs who hold the MRCGP diploma.

In conclusion, the College wishes to see a strong and vibrant general practice based primary healthcare system that is patient-centred, consistently of high quality, safe<sup>9</sup> and accountable. Values of interpersonal care<sup>10</sup> and continuity will remain central. We want care to be delivered by expanded and integrated primary health teams to well defined populations and offering a wider range of services in the community with access to diagnostic facilities. We suggest that virtually all health problems — including mental health — in the population will be dealt with in primary care — with short-term referral as needed, to maintain comprehensiveness. GP practices should be supported to become highly developed strategic learning organisations<sup>10</sup> collaborating with other practices and social care. Arrangements for public health, quality,

safety, and accountability will be integral to the future primary care system. The College will make it clear that good GPs will continue to be essential in any future configuration of primary care with the optimal role of the GP being that of the advanced medical generalist dealing with comorbidity,<sup>12</sup> diagnosis, and coordination of care.

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## Developing an evidence base for intermediate care delivered by GPs with a special interest

Although the delivery of specialised skills from GPs is not new, the NHS Plan formalised the role of the GP with a special interest (GPwSI) as part of a radical programme to reconfigure the healthcare workforce.<sup>1</sup> This development was part of a broader policy agenda to shift the balance of care towards the primary care sector, in order to deliver more patient-centred services and reduce waiting times and avoidable admissions to secondary care. However, against a background of increasing demands on limited resources and the need to maximise the benefits of additional health service investment, the focus has shifted to cost-effectiveness.<sup>2</sup>

Building on these developments, national frameworks were developed to define skills, competencies and

governance but primary care organisations were encouraged to develop innovations in service delivery based on local need.<sup>3</sup> However, despite the policy rhetoric, the initiative has developed considerable momentum without any evidence base.

The randomised controlled trial by Baker *et al*<sup>4</sup> in this month's Journal (page 912) showing no differences in clinical outcomes between orthopaedic hospital and practice-based clinics reflects an early and developing evidence base of the effectiveness of GPwSIs. With the shift in emphasis to decision making at a local level, a key question is how the evidence base can be developed to support policy decisions in a way that is relevant to local health economies.

The evaluation of public policy is set

across a spectrum of approaches.

#### RATIONAL DECISION MAKING

The dominant analytical framework for health policy research reflected in Baker *et al*'s study is known as a rational approach. In its broadest sense, this demands an explicit statement of objectives and values, and an examination of the costs and consequences of competing alternatives in order to provide a rigorous and generalisable evidence base. These demands present a formidable challenge to health service researchers<sup>5,6</sup>

A rational approach needs the purpose of investment in GPwSIs to be clear from the outset: whether GPwSIs are intended to be additional to and working in cooperation with existing secondary care services (increasing health care outputs more

efficiently from additional resources); or substituting for and therefore working in competition with existing services (achieving a desired output at minimum cost). Although some developments have been shown to be an addition,<sup>7</sup> within the context of a modernisation agenda that demands a balancing act between competition and cooperation, a more realistic perspective is to see them as a combination of both. This gives rise to conflicting economic perspectives; that is, different costs and benefits will be relevant from the perspective of the commissioning GP practice, the primary care organisation, the hospital trust or the NHS. The different answers can potentially destabilise local health economies.<sup>8</sup> For example, in Bradford where the PCT led the country in creating GPwSI posts the hospital trust ran into serious financial difficulties. The combined affect of GPwSIs skimming low cost work against a background of national tariffs is likely to reduce hospital incomes.

Other problems with a rational approach are well recognised and may prove insurmountable. For example, studies must control for referral rates increasing with better access; it is difficult to weigh and integrate the many relevant outcomes; there may also be important but unanticipated consequences in other parts of the system that are not captured; each GPwSI development will reflect different local health economies, historical contexts, case and intervention mix.

### DECISION MAKING IN A GARBAGE CAN

At the other extreme of the policy analysis spectrum is garbage can decision making.<sup>9</sup> Here, relating means to ends is highly problematic, and policy making is often arbitrary. Problems and solutions float around at random and their resolution depends on the time they are picked up and the availability of cans in which to put them.

For example, an intermediate care headache clinic led by one of the authors started as a chance encounter of a GP with an interest in headache, a senior PCT manager who had severe migraine and the availability of a small amount of soft money to pump prime an initiative that is now in its fifth year.<sup>10</sup>

### INCREMENTAL MODELS

This approach sits mid-way between the two extremes and recognises that there are limits to rational behaviour due to limited information and processing power.

Incremental models identify how we 'muddle through' and stress the importance of change by mutual adjustment and negotiation underpinned by pragmatism.<sup>11,12</sup> Such models emphasise the importance of the context in which economic transactions take place. The context, in turn, is influenced by culture and social norms, and the relative power wielded by different stakeholders.

If we accept this as a more accurate model of the world, an approach known as realistic evaluation may offer a more relevant framework within which to develop health service research.

### DEVELOPING AN EVIDENCE BASE IN INTERMEDIATE CARE — TOWARDS REALISTIC EVALUATION

Despite significant investment, the impact of health service research on service delivery has been disappointing.<sup>13,14</sup> Research is still viewed as a store in which researchers are busy filling shelves with a comprehensive set of studies that a decision maker might some day drop by to purchase.<sup>15</sup> The aim is to extend the notion of internal validity to all customers even in the presence of an increasingly heterogeneous set of confounding variables that begin as soon as the check-out is reached.

Realistic evaluation reflects a foundation in scientific realist philosophy. It seeks to understand the ways in which mechanisms, such as GPwSI clinics, interact with contextual factors, such as local professional networks, history and culture, to bring about unique outcomes. In contrast, the currently prevailing approach minimises contextual factors in order to identify more direct and universal relationships between mechanisms and outcomes.<sup>16</sup> Although this approach has been used widely in education and criminology research, we are only aware of one study published in health care where realistic evaluation was used to complement a randomised controlled trial investigating the impact of mental health link workers in primary care.<sup>17</sup>

A realistic evaluation promises the opportunity of more useful insights into

specific interventions, shifting the question from 'what works?' to 'what works for whom in what circumstances?' The starting point is to generate a number of theories of how mechanism, context and outcomes may inter-relate. For example, one theory would be that the mechanism of shared discussion and support operating in a context of a history of good relationships between GPs and consultants leads to better health outcomes. Other examples are shown in the Journal's online supplementary information.

Such hypotheses then frame the research strategies to test possible configurations of context, mechanism and outcome to provide results that may be transferable rather than generalisable. Statistical significance is replaced by 'likely to be of importance.' Although evidence from randomised controlled trials is not excluded, the importance of qualitative, ethnographic and case study research is elevated and can provide a richer understanding of local contexts and contingencies.

Baker *et al's* paper represents an important first step in the development of an evidence base to support GPwSI expansion. Realistic evaluation can offer an analytical framework to complement the randomised controlled trial that takes stock of social structures, local cultures and institutions, reflecting the reality that there are no idealised solutions but that it is the actions of stakeholders that are triggered in conducive circumstances that can lead to relevant outcomes. The research task is to identify, articulate, test and refine configurations of mechanism, context and outcome rather than assuming it is a specific intervention that gives the desired results.

A broader evidence base supporting the right thinking is more likely to get us to an approximation of where we want to be rather than attempts to engineer health economies to defined outcomes underpinned by rational analysis. Realistic evaluation offers an important framework that can facilitate this process in a way that is accessible and acceptable to local policy makers.

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## Supplementary information

Additional information is available online at <http://www.rcgp.org.uk/journal/supp/index.asp>

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# Triage and remote consultations: moving beyond the rhetoric of access and choice

Bunn *et al*, in their systematic review published in this issue of the Journal,<sup>1</sup> review the evidence underpinning the role of telephone consultations in triaging access to health care.<sup>1</sup> Remote consulting, however, has the potential to impact far more broadly on clinical practice than simply facilitating triage, and, in so doing, raises important issues around the political imperatives of access and choice. In this editorial, we consider these issues and discuss a number of practical points that need to be resolved.

The telephone is increasingly used to access advice from both general and disease-specific helplines (for example, NHS Direct, Terrence Higgins Trust and Asthma UK) and there is also growing interest in telephone consultations as an alternative to traditional face-to-face reviews of people with long-term diseases.<sup>2,3</sup> 'Texting' may encourage teenagers and young adults, to use the health service.<sup>4</sup> Although use of e-mail consultations is currently limited, the majority of people with internet access (now approximately 60% of the UK population) express interest in using it to communicate with their healthcare provider.<sup>5–7</sup> Plans for electronic patient records, linked with the

patient's personal internet account (available to UK residents at [www.healthspace.nhs.uk](http://www.healthspace.nhs.uk)) will offer further innovative possibilities for interacting with healthcare professionals.

In parallel with the imperative to improve access, policy rhetoric implies that alternative modes of consultation will offer patients choice about when, with whom, and how they consult.<sup>8,9</sup> This may not always be the case. Telephone triage may actually reduce choice as requests for face-to-face appointments or home visits are intercepted by a clinician (usually a nurse) who may address the problem or allocate 'appropriately', potentially overriding the patient's original choice of provider and mode of consultation. In such scenarios it is not surprising if telephone calls increase re-consultation rates and may not always be acceptable to the patient.<sup>8,9</sup> Similarly, incoming e-mails and text messages are sorted into prescription requests, appointments, and clinical queries and then forwarded to the 'appropriate' member of the team.<sup>6</sup> From the patients' perspective the 'dragon at the door' reputation of receptionists may be being replaced by the 'triage genie', ensuring that the doctor

remains hard to reach. Real choice of when, where and how a patient is treated,<sup>8</sup> requires breaking the link between 'telephone' and 'triage' — exemplified by Bunn *et al*<sup>1</sup> who observed that the 'terms were used interchangeably' — and inviting patients to select the mode of consultation appropriate to their presenting problem and personal preference. Reassuringly, early experience does not suggest that this will 'flood' the service with additional work,<sup>1,3,6,11,12</sup> but trials incorporating patient preference will be needed to examine the overall effect on workload.

Patients and clinicians should be free to choose and mutually agree the mode of consultation most suited to the task and personal circumstances. Email consultations may be ideal for seeking health information and text messages may economically communicate progress with an understood condition. People with asthma may choose the convenience of a telephone review when their asthma is controlled, but a face-to-face consultation for the assessment of a problem. Preferences may not always coincide, and clinicians must be free to arrange a timely face-to-face consultation if