

# Referrals from GP with special interest clinics should be adequately evaluated

With the goal of improving the provision of accessible services for patients and reducing the demand on secondary care it was intended that by 2006 'at least 1 million more outpatient appointments will take place in the community rather than hospital' (Department of Health, 2002).

The concept of GPs with special interests (GPwSI) was first proposed by *The NHS Plan* in 2000 (Department of Health, 2000). This was further formalized by a joint document from the Department of Health and the Royal College of General Practitioners that set out the key points for both the primary care trust and the clinician when instigating a GPwSI-led service (Department of Health and Royal College of General Practitioners, 2002).

The GPwSI was expected to 'deliver a clinical service beyond the normal scope of general practice' but at the same time would 'not offer a full consultant service and will not replace consultants' (Department of Health and Royal College of General Practitioners, 2002). These new services were commissioned by the local primary care trusts responsible for the provision of a full range of clinical services to the population they serve.

These extended roles were also planned for other health professionals such as physiotherapists, nurses or optometrists. Within the provision of care for musculoskeletal services, the enhanced roles for both physiotherapists and GPwSI led to the development of multiprofessional triage teams.

Thus, with significant policy rhetoric, the development of GPwSI clinics has gained momentum despite lacking any substantive evidence base. One of the few studies comparing orthopaedic services within GP-run clinics with those in hospital outpatient departments showed short-term outcomes (3 months) in health to be similar (Baker et al, 2005).

However, there were several problems with this study:

1. There was no comparison of the temporal delays for patients

2. There was no qualitative assessment of the diagnosis
3. There was no assessment of the patients seen in the GP-run clinic who subsequently needed referral to hospital outpatients
4. The SF36v2 health survey, a non-specific measure of general health outcomes, was used as the principal discriminating measure.

These are significant methodological deficiencies for a study aiming to compare the clinical outcome and patient satisfaction between GPwSI-led clinics and hospital outpatients.

The momentum behind the development of GPwSI clinics, such as the multiprofessional triage team clinic, was born out of a genuine requirement to improve patient services as well as a broader policy agenda to shift the balance of care toward the primary care sector.

It may be argued that the inception of such a radical change in the delivery of specialist care without a substantial body of supporting evidence was unwise. However, in practice generating an equivocal judgment on the benefits or costs of a GP-run specialist clinic would have been theoretically difficult before their introduction. This was highlighted in a *British Journal of General Practice* editorial in December 2005:

**'a key question is how the evidence base can be developed to support policy decisions.'** (Kernick and Mannion, 2005)

Scientific evidence must reflect unbiased facts and should not be developed to support policy decisions. Now that these clinics have been introduced, valid and unbiased evidence must be sought and reviewed with the relevant changes implemented.

Assessment of clinical outcome should include subjective patient questionnaires and objective clinical and often radiographic assessments. There are several non-clinical outcomes including time delays, training and education evaluation and the difficulties resulting from patients

who are uncertain of the health-care professional responsible for their care and the referral pathway. Benefit analysis is complex and determining the complete financial cost is very difficult and should ideally take into account more than just the NHS costs (Kernick, 2003). In view of the inherent difficulties in collating clinical, non-clinical and financial outcomes of a GP-lead orthopaedic clinic, especially with long-term data, it is unlikely that a fully comprehensive study will ever become available.

No published data have been produced analysing referrals made from a GPwSI-run clinic from the perspective of the hospital clinician. Data from a 6-month survey (BA Rogers and N Bradley, unpublished data, 2006) showed that patients seen by the GPwSI clinic and subsequently referred to a hospital consultant waited significantly longer (140 days to 62 days,  $P < 0.05$ ) to see an orthopaedic consultant compared to patients referred directly from their GP. Furthermore, over three quarters of this patient cohort incorrectly identified the health-care professional conducting their consultation, with an incorrect or absent diagnosis identified in 28% of the patients seen in the GPwSI clinic.

One may view these data as partially calling into question the professional capacity of primary care clinicians. However, in this study many patients seen in the GPwSI clinic had the same diagnosis made by both the initial referring GP and the hospital consultant, suggesting the GPwSI clinic was a superfluous tier of care for this patient cohort.

The benefit of a reduction in the waiting list time for surgery to less than 6 months is lost for those patients referred to the GPwSI clinic who subsequently require surgery because of the inherent delay.

A good rapport and patient confidence being essential for all surgeons and the doctor-patient relationship and consultation, the bedrock upon which general practice is based, must not be overlooked within the hospital outpatient setting. The

addition of another layer of professional consultation may easily lead to the patient receiving mixed messages and also lead to heightened concerns and unrealistic expectations. This not only risks a sub-optimal standard of patient care but may have future medicolegal implications.

Within the context of the state of flux in which the NHS exists today, the laudable goal of improving patient services is frequently coloured by non-clinical factors that make true evidence-based decision making difficult. The ongoing role of the GPwSI, either complementing or substituting secondary care, has not been defined and their benefit not clearly evaluated. Within the field of musculoskeletal medicine, all studies to date focus on and compare patient care up to, but not beyond, the hospital consultation. Responsibility rests with hospital-based orthopaedic clinicians to provide long-term evidence detailing the impact of changes in service provision, such as GPwSI clinics, in conjunction with their primary care colleagues.

There is a significant geographical variation in the organization of GPwSI clinics. For musculoskeletal medicine, some regions have developed GPwSI clinics running fully independently from orthopaedic consultants. Other regions have a consultant clinic running concurrently within a health centre, resulting a more consensual professional opinion while at the same time affording the opportunity for both the GP and the consultant to learn from each other.

### Conclusions

It is important that both hospital and primary care clinicians evaluate the impact and costs of developing a system where GPs have an extended role. It is essential that steps are taken to create a complete and reliable evidence base on which to effectively evaluate these new procedures. Currently, all the policy statement and published studies have originated from primary care clinicians and research groups.

Innovation frequently necessitates changes which lack comprehensive evidential

support. To this end, continual evaluation and audit are essential to ensure an accurate cost-benefit analysis. Such an evaluation and audit has yet to be conducted for GPwSI clinics. **BJHM**

#### Benedict A Rogers

*Specialist Registrar in Trauma and Orthopaedics  
St Peter's Hospital  
Chertsey  
Surrey KT16 0PZ*

#### Neil Bradley

*Consultant Orthopaedic Surgeon  
The Royal Surrey County Hospital  
Guildford  
Surrey*

- Baker R, Sanderson-Mann J, Longworth S, Cox R, Gillies C (2005) Randomised controlled trial to compare GP-run orthopaedic clinics based in hospital outpatient departments and general practices. *Br J Gen Pract* **55**: 912-17
- Department of Health (2000) *The NHS Plan: a plan for investment, a plan for reform*. The Stationery Office, London
- Department of Health (2002) *Improvement, expansion and reform - the next 3 years: priorities and planning framework 2003-2006*. The Stationery Office, London
- Department of Health and Royal College of General Practitioners (2002) *Implementing a scheme for General Practitioners with Special Interests*. The Stationery Office, London
- Kernick DP (2003) Developing intermediate care provided by general practitioners with a special interest: the economic perspective. *Br J Gen Pract* **53**: 553-6
- Kernick D, Mannion R (2005) Developing an evidence base for intermediate care delivered by GPs with a special interest. *Br J Gen Pract* **55**: 908-10

### KEY POINTS

- Despite little evidential support, GP with special interest clinics have been introduced to improve the access to secondary care.
- The few studies performed to evaluate their impact have been conducted from a primary care setting and have methodological deficiencies.
- Further hospital-based evaluation, including comparative clinical outcomes, is required to justify GP with special interest-led clinics in the modern NHS.