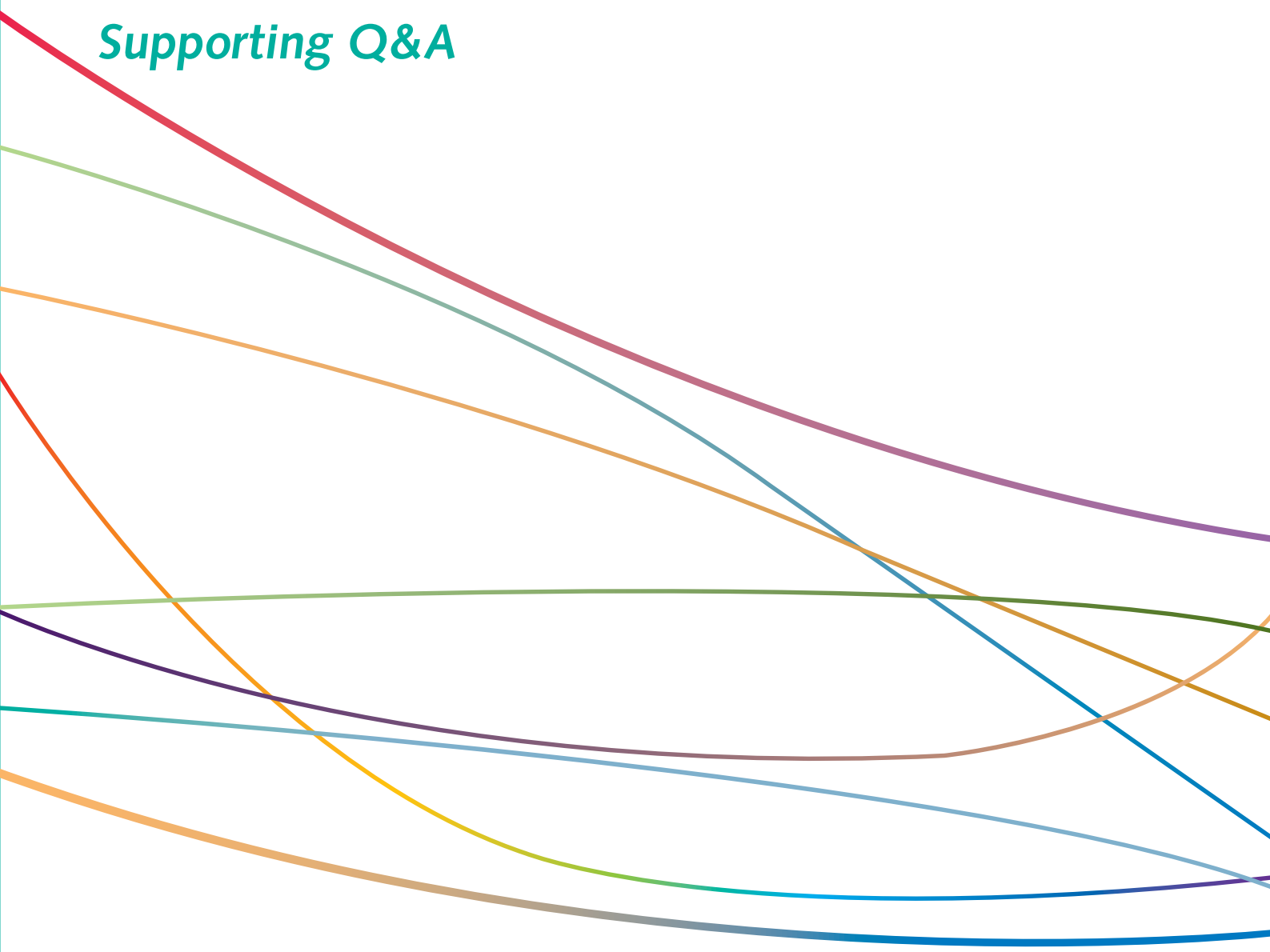
Implementing care closer to home: Convenient quality care for patients

Supporting Q&A



Q: What is a Practitioner with a Special Interest?

A: Practitioner with a Special Interest (PwSI) has in the past been used as a general term covering all primary care professionals working with an extended range of practice (as opposed to the normal scope of that role).

This included:
GPwSI – GP with a Special Interest
NwSI – Nurse with a Special Interest
AHPwSI – Allied Health Professional with a Special Interest
DwSI – Dentist with a Special Interest
PMwSI – Practice Manager with a Special Interest
PhwSI – Pharmacist with a Special Interest

However, some of these groups – namely nurses, allied health professionals, and healthcare scientists – have moved away from the term PwSI and have developed new approaches through their own professional development review processes, such as the Modernising Nursing Careers programme. As a result, similar guidance is available or currently in development for these professions.

Accordingly, *Implementing care closer to home: Convenient quality care for patients* relates principally to those professionals who are individually accredited at a local level to provide a specific specialist service. Presently these are GPs, dentists and pharmacists, and could potentially include community optometrists in the future.

Q: Doesn't PwSI work detract from primary care?

A: Not at all. Most GPwSIs, for example, spend just one or two half-days per week on their Special Interest. The continued maintenance of generalist skills and practice is essential.

Q: Why does the accreditation process focus only on GPs and pharmacists?

A: Similar arrangements have already been published or are in development for other health professionals. (National guidelines for the accreditation of Dentists with Special Interests are available at www.dh.gov.uk/en/policyandguidance/Healthandsocialcaretopics/Dental/DentistswithSpecialInterestsDwSIs/index.htm.) In 2003, a document (*Implementing a scheme for Nurses with Special Interests in primary care*) was produced on the role of Nurses with Special Interests that demonstrated how nurses were working in new roles. Agenda for Change and the knowledge and skills framework are also tools with which individual practitioners will be performance-managed through the professional development review process. A similar document was published for AHPwSIs in 2003 (*Implementing a scheme for Allied Health Professionals with Special Interests*) to support commissioners developing community services as alternatives to hospital-based care.

Nonetheless, commissioners may wish to consider following a similar process to that for GPs and pharmacists when accrediting any other health professionals who work without the need for direct supervision and are providing convenient quality care for patients in community settings.

Q: How much does a GPwSI cost?

A: Pay should always be subject to local negotiation to allow flexibility in the way in which services are provided. There are no national rates for GPwSI remuneration, as each service will differ and depending on local circumstances the scope and level of the service being provided. These will vary from specialty to specialty. Typically, a GPwSI would be paid the costs of locum cover on a sessional basis, but local payments should always reflect the nature of the service.

Q: If a PwSI who is accredited through one process, say in Bradford, moves to Bristol, does his accreditation remain valid or should he be required to go through the local process prior to setting up as a PwSI again?

A: The philosophy underpinning the recommendations for accreditation is that the context of service delivery is fundamentally important. While an individual who has been through an accreditation process will have generated a portfolio of evidence to support them in a new PwSI role in a new health economy, the new service delivery and clinical governance context will not have been tested by the original accreditation. Our recommendation in such circumstances is that the individual is supported through an accreditation process in their new health economy. This process will be facilitated by the evidence presented in the individual's portfolio relating to their previous role, but will necessarily be supplemented by a description of the relevant referral pathways, clinical governance and peer support arrangements.

Q: I am planning to register myself as a GP and I am currently doing a Masters in Respiratory Medicine. Will this help me to become a GPwSI in Respiratory Medicine according to new DH plans?

A: There is a difference between qualification and accreditation. Accreditors will seek the demonstration of appropriate knowledge, skills and experience – coupled with evidence of a commitment to ongoing quality improvement and personal development. While a qualification alone is unlikely to provide sufficient evidence for accreditation, it is likely that the accreditors will be looking for a recognised qualification as part of a portfolio of evidence.

The specialty-specific guidance will address this type of issue. Part 3 of this series of *Implementing care closer to home* documents, *The accreditation of GPs and Pharmacists with Special Interests*, considers the generic issues around the accreditation of GPwSIs and PhwSIs. Commissioners, accreditors and prospective GPwSIs and PhwSIs should meet the standards outlined in both documents.

Accreditors should have the appropriate understanding of the curriculum that a qualification represents. It is beyond this piece of work to quality assure the increasing number of

qualifications available. Those qualifications kite-marked by the relevant professional representative bodies and Royal Colleges are appropriately quality assured.

Q: I am an accredited GPwSI working six sessions per week in dermatology and three in general practice. My PCT has asked me to increase my time commitment to the dermatology pathway because of waiting-time pressures. The only way I can do this is to give up my GP time and focus exclusively upon my GPwSI role. How should I respond to my PCT?

A: There are two reasons behind the recommendation that individuals from GP roles maintain an element of their core role within their portfolio. The first relates to the concern that, without the appropriate structure for professional training and development, there is a risk that individuals in such roles could become professionally isolated and their practice could become out of date. No formal professional development infrastructure exists for these individuals, and therefore it would be entirely inappropriate to advocate this way of working.

The second reason is that the generalist perspective which such individuals bring to patient management adds immensely to the value of the dialogue between clinician and patient and it is this added value that is promoted in this guidance.

Advice to clinicians who find themselves in the position outlined above would be to maintain a regular commitment to their generalist role, and to work with their PCT to develop their service through skill mix and the use of other professionals to support service delivery.

Q: This accreditation process looks expensive. How is it all going to be paid for?

A: The accreditation process is based upon well-established principles of clinical governance. It is our belief the process set out in Part 3 of this series of *Implementing care closer to home* documents, *The accreditation of GPs and Pharmacists with Special Interests* represents a reasonable expectation on service providers to underpin their roles and their services with evidence of good governance and that it is in line with the Government's *Standards for Better Health*. Commissioners have always had a responsibility to ensure that resources are used cost-effectively and this framework provides a mechanism to support decisions about individuals and the services they provide in a consistent way. When developing and commissioning new community-based services, commissioners and providers must take into account the costs of delivering appropriately high standards of governance.

It is imperative that high quality processes are developed to support applicants through accreditation. This needs to be a developmental process rather than exclusively summative. It is inefficient for a panel to be forced into a situation where an unsatisfactory application keeps bouncing back. Our objective must be to arrive at a situation where only those applicants and applications that are likely to satisfy the panel are submitted.

There are no new resources available to support accreditation. The costs of this process need to be built into the financial assumptions which are made in support of service redesign initiatives. Commissioners will need also to take account of the costs of the necessary support of hospital-based specialists in providing overarching clinical governance and peer support to PwSIs. This is not currently reflected in the tariff.

The benefits of implementing schemes for PwSIs are not about financial savings. The emphasis should be on improving the patient experience by providing localised services, in more familiar surroundings, that give easier access to traditional secondary care. In addition, this role helps support staff in their professional development and allows those with specialist experience and expertise to apply their skills and knowledge to best effect for the benefit of patients and local services.

Q: Will extending services delivered in primary care compromise the quality of care patients get?

A: Not at all. A PwSI has extensive experience or training in their specialty – this is always a prerequisite of the service. They should also be closely supported by a local consultant in their relevant specialty, have regular contact and, where appropriate, training with them. The new approach to accreditation set out in Part 3 of this series of *Implementing care closer to home* documents, *The accreditation of GPs and Pharmacists with Special Interests*, will ensure that both GPwSIs, PhwSIs and the services in which they work are safe, of a high quality and better able to meet patients' needs in the communities in which they are located.

Q: What would be described as a significant shift in service specification to require re-accreditation?

A: Service providers are reminded of their responsibilities to meet the Government's *Standards for Better Health*. Where new funding flows and new referral pathways are developed, commissioners are responsible for ensuring that care is delivered in the right environment and by individuals who are competent to deliver those tasks. They are expected to work in partnership with providers to develop systems that work in support of these requirements. Judgement needs to be made at the local level to enable minor changes in specification and the natural evolution of service development to occur without unnecessary bureaucracy, and at the same time to ensure that if there is an increase in the level of risk to patients, appropriate steps are taken to reduce that risk.

Q: What processes are available if a clinician wishes to appeal against an unsuccessful application?

A: Generally speaking, while an unsuccessful application for accreditation is uncommon, the experience of members of the PwSI Steering Group suggests that there are two issues that can lead to an unsuccessful application. The first relates to the overall quality of the application. Where applicants fail to provide appropriately detailed or comprehensive documentation, then

the panel is likely to reject the application and suggest that the applicant is supported more actively through the process of accreditation. Some PCTs may wish to support the development of PwSIs and identify managers with a specific responsibility to support the process of accreditation. It is expected that as such support posts become established, and as PwSIs become aware of the support available, failure to achieve accreditation for this reason will become increasingly uncommon.

The second, and potentially more significant, reason for unsuccessful accreditation relates to mentoring, support and participation in appropriate clinical governance activities, or to the applicant, failure to reassure the panel during the process of accreditation that appropriate governance is in place. Ultimately, the panel is required to make a judgement based upon the evidence presented through documentation and, where necessary, at interview, that an applicant is competent to practise independently in the chosen area of Special Interest. While the quality of documentation may be an issue here also, it is likely that panels will encounter applicants who simply fail to meet the required standards of governance. It is the responsibility of the chair of the panel to ensure that the reasons for an unsuccessful application are clearly communicated to the applicant. The applicant then has two choices. The first would be to approach the chair or the relevant commissioning lead for appropriate support through the process. The second choice would be to appeal to the chief executive of the PCT. Chairs of accrediting panels should be reminded that the panel is empowered to exert appropriate judgements and should be constituted to ensure that membership is of sufficient seniority and experience to exert that judgement. Appeals will relate to the question of process rather than outcome – in other words, applicants should reflect upon their responsibility to demonstrate appropriate governance through the accreditation process and ensure that they present information in such a way as to help the panel to arrive at an appropriate decision rather than relying upon an appeals process to rescue their application. Chief executives are likely to allow an appeal only if there has been a failure of process, rather than in circumstances where the applicant wishes that the outcome had been different.

Q: Is there a timescale for the accreditation process, from the initial application to the point where accreditation is granted?

A: This has been intentionally omitted to allow a degree of local flexibility. Nevertheless, the consensus of opinion is that it should not exceed eight weeks.

Q: The definition for PhwSIs includes both pharmacists who are independent contractors and those who are directly employed by practices or NHS organisations. Where pharmacists employed by NHS organisations or practices are delivering more specialised services in community settings, should they always become accredited as PhwSIs?

A: As for all PwSIs, the PhwSI model may be particularly suitable for health professionals who work without the need for direct supervision and are providing convenient quality care for

patients in community settings. For these pharmacists, a range of commissioning models exist including PhwSI, and it will be a local decision as to the most appropriate commissioning route.

Q: Will the development of GPwSI services make hospital consultants redundant by moving their work into the community?

A: GPwSIs and other PwSI services are only one of a number of options available to commissioners of NHS services help deliver one of the objectives of the White Paper: to deliver more convenient and accessible services closer to where patients live. There are other options available to PCTs, including hospital doctors working in a community setting where this is appropriate to do so. Most services delivered by GPwSIs or other clinicians are set up to meet an identified clinical need – for example, to reduce secondary care waits or, to improve the patient experience.

GPwSIs, for example, supplement their important generalist role by delivering outpatient consultations and procedures in primary care and community settings, which would otherwise have taken place in a hospital. They do not offer a full consultant service and do not interfere with access to consultants by local general practitioners, nor are they intended to replace consultants, or to carry out the major part of the work of a consultant. The services they provide always rely on the maintenance of good working links with secondary care.

In addition, GPwSIs have extensive experience and training in their speciality – this is a prerequisite of the service. They should always be closely supported by a local specialist or consultant in their relevant speciality and have regular contact and, where appropriate, training with them.

Q: I am a community pharmacist and would like to become accredited as a PhwSI so that I can provide a more convenient anticoagulant monitoring service for local patients. Our commissioners have recently indicated their intention to expand this type of service using accredited PwSIs. However, I will need to undertake some further training and also work for a period alongside specialists in a clinic setting, but cannot do this without funding for locum cover and course fees. How can I fund this preparation for a future PhwSI role – there seems to be a 'chicken and egg' problem here.

A: As part of the development process, commissioners may need to work with all potential providers to ensure that the required skills and competencies will be available at the appropriate stage. Step 5 in Part 2 of this series of *Implementing care closer to home* documents, *Step-by-step guide to commissioning services using Practitioners with Special Interests (PwSIs)* includes advice on developing the competencies of practitioners prior to accreditation. Where care pathways include significant changes to practitioner roles, commissioners may need to consider 'pump priming' training and development resources, and other strategies required to prepare individuals for successful accreditation as PwSIs.

Q: Why doesn't the accreditation process specify more clearly which 'senior clinician' should assess the competency of individual PwSI applicants? Surely this will normally be a hospital consultant?

A: There are circumstances where an alternative clinician other than a hospital consultant may be the most appropriate option and local flexibility should be exercised. An example might be where an identified group of pharmacists are trained to provide a new anticoagulation or substance misuse service. The competencies required, while beyond their core role, are at a level that may be assessed by an appropriate clinician who is not a consultant. We believe that local commissioners and clinicians are best placed to specify any parameters for supervision and assessment within agreed care pathways.

We would like to reinforce the fundamental importance we attach to the role of hospital-based specialists where competencies are most appropriately assessed by them, but also want to support other approaches where it is agreed locally that different clinicians possess the skills to assess appropriately. One important facet of this whole approach is that applicants ensure that they have strong evidence from their supporting senior clinician, and that accrediting bodies assure themselves that the supporting clinician understands their role in this process and the content of the specialty-specific guidance.

Q: When you refer to local lists in Part 3 of this series of *Implementing care closer to home* documents, *The accreditation of GPs and Pharmacists with Special Interests*, do you mean the PCT performers list?

A: No. This is a separate list that consists solely of accredited PwSIs. It should include details of dates and duration of accreditation, the relevant specialty (eg dermatology or ENT) and be made available for public inspection.

Produced by COI for the Department of Health
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