The New Interface Between Primary And Secondary Care?

The traditional model of community based Generalist and hospital based Specialist has served the NHS well for the last 50 years. However, the demand on both sectors is potentially infinite. New models of care provision are needed if the NHS is to remain modern and dependable and maintain the hard won confidence of the general public.

In Primary Care, initiatives such as NHS Direct are an attempt to cope with the burgeoning expectation of rapid access to high quality care. Waiting list initiatives have been a vehicle for coping with an increased demand for secondary care, but from the perspective of Primary Care they usually give the impression of being stopgap palliatives. What is needed is a re-think that takes the best of what already exists and uses it to make systemic changes that will really make a long-term difference. To do this, we need to challenge some basic assumptions.

Figure 1.

Figure 1 shows the traditional referral model. This could be any specialty. As the problem becomes more complex the primary care doctor reaches the limits of what is possible/appropriate for management in this setting, a well-defined referral threshold is reached and the patient is sent to see the appropriate specialist.

In reality, it is often not like this.

Figure 2.

Figure 2 is closer to the reality. No two GPs are the same. There is considerable variation between GPs in their knowledge, skill, experience and interests. Many have had extensive training within particular hospital disciplines before coming into General Practice. Point ?a? in figure 2 represents the minimum standard that one might reasonably expect all GPs to reach in their management of any particular problem. However, there is a significant minority who may be sufficiently skilled, enthused and resourced to reach point ?b?, and for the patients of these doctors with these problems this can have considerable consequences.

For instance, if a patient has a frozen shoulder it has been shown that the benefits of local corticosteroid injection administered by a GP are superior to physiotherapy (1). If the GP can make an accurate diagnosis and inject joints, then the patient can receive a cost effective evidence-based treatment at the earliest possible opportunity. However, if the GP lacks the diagnostic skill, is technically incapable of injecting or is simply not interested very much in musculoskeletal problems (perhaps they are far better at skin disease or gynaecology) then the patient may receive suboptimal management in primary care or face a long wait for a hospital specialist opinion.

Even then, they may not be referred to the most appropriate specialist. For example, the patient with chronic back pain and sciatica might be referred to any number of different specialties. How does the GP know which one to choose? Even within specialties, different consultants have different interests. As a GP, there is no bigger dis-service that you can do your patient than to connect them to the wrong specialist in the wrong specialty.
Many larger GP practices have recognised this problem and use intra-practice referrals to overcome it. In my practice we have GPs with a special interest in Musculoskeletal Medicine (of which back pain makes up a large part), Family Planning, Minor Surgery, Cardiology, ENT, Dermatology, Infertility, Diabetes and Ophthalmology.

For some specialties the area of overlap in figure 2 may be relatively small. Intrapartum obstetric care is an example of an overlap area that was once huge but is now almost non-existent. Similarly, a hospital specialist will manage almost all fractures. On the other hand, the potential overlap in Dermatology is considerable. Unfortunately, the training of many doctors in this area is poor, but there is now a postgraduate training programme and qualification (the Diploma in Practical Dermatology from the University of Wales) which may help to equip GPs to exploit the overlap. Similarly, the training of many GPs in the diagnosis and management of musculoskeletal problems is poor, and yet these problems make up 15 - 25% of General Practice. At one of our local trusts, 70% of referrals to the Orthopaedic Surgery department do not result in an in-patient episode, i.e. they are not surgical problems (Mr. P Sell, personal communication).

For ten years I have provided an intra-practice Musculoskeletal Medicine service for my patients and my partners who refer on to me. At one point we tried a dedicated clinic with a set day and fixed appointments, but this proved too inflexible and so we just book longer appointments in my ordinary surgeries. For four year, under GPFH and with the approval of Leicestershire Health, I have also provided an inter-practice referral service for other GP Fundholders. All I did was to offer them exactly the same service that I offered my partners. There is no reason why this could not happen at PCG level. It would create an intermediate referral tier between primary and secondary care, for which I would suggest the term "Community Specialist".

The pivotal role of the Community Specialist

- Screening of all referrals to hospital with a view to seeing those patients who might fall into the "overlap? area and managing them without referral to secondary care. Suppose this reduced the overall volume of hospital referrals by just 10% - what would this translate into in terms of resources freed up for something else?

- Identifying patients who would benefit from a more thorough "work up" before being referred on to hospital (using locally agreed protocols) in order to speed up the hospital throughput (e.g. by giving the Community Specialist greater access to specialist investigations).

- Acting as a conduit between Primary and Secondary care. There often appears to be a long lead time before best evidence based practice makes it out from the centres of excellence and into the community. A specialism advocate nearer the "coal face" may be a better way of disseminating best practice than the rather uncertain "professional osmosis" that we seem to have at the moment.

- Identifying local educational needs within the specialty. A Community Specialist, especially with the appropriate infrastructure support to collect some basic data about what is being referred, would be in an absolutely key position to identify the postgraduate educational requirements of the PCG within their own specialty. This would turn the threat of de-skilling GPs, by providing them with easier access to a
specialist opinion, into an opportunity to re-skill them, based on their real life needs. The Community Specialist would also be an important educational resource for the local GP vocational training scheme.

- Acting as a specialist resource to inform PCGs about prescribing issues related to their specialty. As a PCG board member, it has become rapidly apparent that prescribing is the one of the most critical areas with which PCGs will have to grapple.

- Research, audit and specialty related clinical governance issues.

One model for producing Community Specialists might involve identifying existing GP experts within a specialty and attaching them to clinical directorates at their local hospital trust. The GP might then have one session per week as a hospital based Clinical Assistant or Hospital Practitioner and one session as a community based Specialist to fulfill the role outlined above. The hospital attachment would allow for ongoing education, clinical supervision and quality control by the local consultants while creating a post that allows a GP to straddle the often enormous gulf between primary and secondary care. The GP could rotate between different consultant units with different areas of interest within the specialty. It would give the specialty clinical directorate an "ear to the ground" that would help it to identify issues of local importance and prevent an "ivory tower" mentality from developing.

As Medicine becomes more complex and specialised we are in danger of seeing the hospital specialist as the doctor who knows everything about nothing, while the GP knows nothing about everything. In figure 2, as the right hand boundary of Secondary Care expands to the right and secondary care specialists increasingly develop tertiary hyperspecialisms it is vital that we expand the size of the overlap and move it to the right as well. This implies that the baseline standard of care amongst GPs improves and that as they gain in confidence and experience the Community Specialists take more and more straightforward work off the hospital consultants to allow them to develop the tertiary interests while ensuring that they stay connected to the real world.

One door closes, another one opens. The passing of GP Fundholding is seen by many ex-GPFH practices as a threat to community based services. PCGs are an unknown quantity. Here is an opportunity to learn from the cutting edge of GPFH and apply the benefits as widely as possible. It would, of course, be vital that any such initiative was thoroughly evaluated and this would have resource implications. It would be money well spent.

Reference