

GENERAL PRACTITIONERS WITH SPECIAL CLINICAL INTEREST

DRUG AND ALCOHOL MISUSE

Introduction

1. Policy background

1.1. General practitioners (GPs) undertaking special interest training, such as in drug misuse are at the leading edge in formal recognition as practitioners with special clinical interest (GPSI)¹, as defined by the NHS Plan¹. The Royal College of General Practitioners, recognizing that many general practitioners already have special clinical interests², has endorsed this initiative³ and has defined key principles that need to be adhered to by practitioners and PCOs if the use of GPSIs is too add value to patients and to local health service. This document gives a framework for PCOs who may wish to employ GP to provide a GPSI service.

2. Definition

2.1. A GPSI is a doctor who is qualified and competent to provide the full range of general practitioner services and has additional special interest training, expertise and knowledge in drug misuse. Such a doctor would be expected to work within a clinical governance framework, which includes, where relevant, access to specialist services, support or investigations. A GPSI would be expected too

¹ For the purposes of this guidance the term Intermediate Practitioner, General Practitioner with special (clinical) interest, Specialised-generalist are assumed to mean the same and be interchangeable terms. The term specialist general practitioner is a misnomer and care must be taken when using it.

accept referrals from colleagues in the PCO for assessment, treatment or review. Some GPSI may provide an extended service within their own practice, seeing large numbers of more complex patients. Who are registered with the practice?

2.2. In most circumstances a GPSI will work in a community setting, though circumstances will exist where a GPSI works entirely in an Mental health, Acute Trust or other setting, for example a GPSI in Accident and Emergency Care providing a drug and alcohol liaison service, or a GPSI providing care to drug users in a voluntary sector organizing. Different service models will be developed according to local need though in all circumstances clinical accountability rests with the GPSI who is responsible for their actions, including referral to more specialist care and the need to work with other professional groups where appropriate. Overall accountability rests with the employing authority. Quintessential to GPSI practice is that they work independently of direct supervision, accepting referrals, making diagnosis, supervising or administering treatment and discharging from care. This does not mean working in isolation from related acute trust services, with whom GPSIs may associate in a common venue, share clinical governance activities, and participate in joint organisation and professional development when appropriate.

2.3. A General practitioner with special clinical interest is a GP

- Of appropriate experience

- Independently delivering a defined service

- Outside the remit of 'normal' general practice as defined by the New General Practice Contract

- Under a fair contract

- In an appropriate venue

- Within a defined quality framework

3. Roles and responsibilities

3.1. Before appointing a GPSI it is advisable that the employing authority (usually the Primary Care Organisation) will need to satisfy them that certain criteria have been met. First and foremost, local health economies need to identify areas of need and also tasks for which a GP with Special Interest may be suitable to undertake.

3.2. Examples of areas that GPSIs may be used

- Providing care to homeless drug users

- Providing medical assessment/primary care clinic to out of reach users in a voluntary sector organizing

- Providing a pregnancy –liaison service to the local obstetric service

- Providing Personal Medical Services to Drug Users and their families

- Providing medical support to the local shared care service

3.3. The PCO or employing authority will appoint, support, monitor and remunerate a GP to undertake the tasks, and in doing so will wish to comply with best national and local practice. They will want to ensure that these posts bridge primary and secondary care, and that services become increasingly integrated and coherent.

General Practitioner Consultant/Specialist

In some instances GPs act as consultants – leading services and teams and taking full clinical responsibility. These practitioners as yet have no clear definition

4. Obtaining stakeholder involvement

4.1. Stakeholder groups

4.2. Before appointing a GPSI in drug and alcohol misuse it is important that relevant parties are involved in the development of the post with the formation of a key stakeholder forum made up of local representatives to help establish the need, core activities and overseeing mechanisms of the GPSI service. Beyond this a smaller group whose responsibilities would be to oversee the development, monitoring and clinical governance arrangements of GPSI service

needs to be established at local level. In most circumstances the membership of this later group should be

- Representative from the PCT
- Representative from the lead specialist medical provider
- Drug Action Team CO-coordinator

4.3. Level of specialist involvement

4.4. It is important that local specialist provider/s and their teams are involved wherever possible in the development of the GPSI service. Without specialist involvement there is a real danger of the GPSI service undermining the overall strategic direction of service provision and also of the GPSI not being able to access necessary secondary care specialist opinion, investigations and treatment. It is also imperative that the local specialists understands the vision of a GPSI service and that they are clear that this should be seen as a new form of delivering help to local colleagues and are not merely of creating training grade doctors in a community setting.

5. Establishing evidence of need

5.1. This should take into account national and local policy and the need to improve access and reduce waiting lists.

5.2. National policy.

5.3. It is important that the GPSI service is congruent with national and locally determined policy areas and that the service meets the requirements of these areas. These include the NHS Plan, National Drug Strategy, Models of Care, DANOS, Quads and the National Clinical Guidelines on the Management of Drug Misuse.

5.4. Local needs assessment

5.5. Local knowledge underpinned by national and local information must determine the need for a GPSI service.

5.6. Factors to consider when determining the need for a GPSI service

5.6.1. Local: e.g. long waiting lists, high prevalence of certain morbidity groups, local primary care experts, and geographical problems in delivering an effective service, for example rural issues.

5.6.2. National: e.g. requirement to meet Drug Strategy targets of 30% GP involvement in the care of drug users.

5.7. How does the proposed GPSI service fit into local health economy

5.8. The service should be a coordinated approach to delivering care to patients across primary, secondary and community (and in some cases prison) health care where the most appropriate practitioner meets the needs of the patients at every level of service delivery. In all cases the GPSI should complement existing services and provide added value for the patient and the PCO. The GPSI service should be

set up in conjunction rather than in competition with local specialist drug and alcohol services. It is not only unhelpful but also potentially dangerous for different service providers to be acting independently of each other. The GPSI service must be seen as part of the overall service delivery package open to drug and alcohol users. A GPSI service must not be seen as a substitute to a specialist service. Where specialist care is absent then the PCO must ensure that a suitably trained practitioner is found to fill the treatment gap. In some cases, for example where there is a lack of specialist secondary consultants, it may be necessary to establish supervision with a neighboring consultant or other addiction provider.

6. Establishing the infrastructure for a high quality service

6.1. Drug and alcohol services work best where there is close cooperation between different providers and it is important that formal links between the GPSI service and the specialist service are built in. This issue will be discussed later.

6.2. Defining the purpose and aims of the service

6.3. This will be determined by the Stakeholder Group taking into account local and nationally determined priorities. The purpose of the service can be thought of in three main domains:

- Clinical

- Service Development

- Leadership

6.4. Defining the core activities

6.5. The core activities of the service will depend on the local need. In general GPs work best where they provide their skills and expertise across the primary care/community care interface.

6.6. Examples of core activities of GPSI service

- 6.7. Within a multidisciplinary framework provide support to GPs and others working in a primary care setting in the care of drug and alcohol using patients.
- 6.8. Work with DAT in the development of services at generalist and intermediate levels
- 6.9. In partnership with shared care providers, support the development of training for GPs and GP registrars and PCHT in drug (and/or alcohol) misuse.
- 6.10. Provide direct clinical care at an intermediate level to patients with Drug and/or Alcohol (D & A) problems either within their own practice or else where.
- 6.11. Develop pathways of care for patients with D and A problems
- 6.12. Develop clinical capacity for D and A patients in primary care
- 6.13. Support the development of harm reduction across the PCT
- 6.14. Provide a bridge between primary and secondary addiction services
- 6.15. Work with the local drug user/service users group and relevant National Groups, e.g. The Alliance, formally, National Methadone Alliance.

6.16. Contribute to the development of effective treatment pathways across primary and secondary care (including the development of local referral and treatment guidance)

6.17. **Case load**

6.18. The caseload will largely be determined by the number of sessions, location and support available to the GPSI but in all cases must be at a level to prevent undue pressure being placed on the GPSI.

For further examples see Audit Commission Handbook www.audit-commission.gov.uk and The Task Force Department of Health

6.19. **Arrangements for handling referrals**

6.20. Local guidelines, which are in line with National and local guidelines, with, for example, exclusion and inclusion criteria, type of patients seen, time to first appointment, number of follow up sessions will need to be drawn together for each special interest area.

6.21. **Geographical limits**

6.22. To be determined locally.

6.23. **Facilities needed**

6.24. The list below are suggesting for most PCOs. Obviously there needs to be some flexibility to take account of different areas needs and issues such as rurality. It is important though that the PCO is able to provide sufficient support for the GPSI to be able to provide a safe and effective service.

6.25. Absolute

6.26. Access to multidisciplinary team support.

- 6.26.1. Access to specialist advice and regular meetings (at least monthly) with the specialist service.
 - 6.26.2. Access to specialist prescribing and assessment services
 - 6.26.3. Access to services for young people and patients with complex needs (e.g. DUAL diagnosis)
 - 6.26.4. Access to dose assessment and supervised ingestion services
 - 6.26.5. Mentoring/supervision
 - 6.26.6. Access to education and training
 - 6.26.7. Access to library facilities
- 6.27. *Desirable – though in time all PCOs should have access to these services*
- 6.27.1. Referral arrangements to in-patient services through specialist services
 - 6.27.2. Referral arrangements to rehabilitation services through social services
 - 6.27.3. Good links to support services, such as benefits, housing and employment services.

6.27.4. Other services needed to provide good quality care, as

listed in Models of Care. www.nta.nhs.uk

7. Induction, support and CPD arrangements

7.1. All GPSIs should have access to a locally based mentor support network.

8. Identifying suitably qualified GPSI

8.1. It would clearly be unhelpful to specify a universal standard of initial training that might discredit many GPs of substantial experience. On the other hand, the safety of patients must be safeguarded against incompetent practice.

8.2. Generic skills

8.2.1. It would be expected that the GPSI in drug misuse would be an experienced generalist practitioner, with MRCGP or equivalent and maintains their generalist skills through annual appraisal process to meet the requirements of revalidation.

8.3. Special interest skills and core competencies

8.3.1. These have been defined by the RCGP National Expert Advisory Group for the Certificate in Drug Misuse.

8.4. At minimum level the GPSI should have acquired -

8.4.1. The GP with a special interest in drug and alcohol misuse should be able to diagnose, assess and take care of patients with common substance misuse problems, to a high standard of care,

but recognizing their limitations of knowledge and competencies in this area. They would be expected to show knowledge and skills level reflecting a higher level than that acquired by non-specialist colleagues.

8.4.2. The minimum standards are those outlined within the Drug Misuse Clinical Guidelines and it is expected that all GPSIs meet these competency levels before proceeding to provide a GPSI service.

8.4.3. Beyond this the GPSI would be expected to

8.4.3.1. Provide safe, evidence based care to drug users, including complex drug users with co-morbidity, across a range of commonly used substances and using a range of commonly used treatment interventions including pharmacological (methadone mixture, Buprenorphine, lofexidine, naltrexone), Psychological (brief intervention, problem solving, motivational interviewing) and social treatments, such as benefit and employment advice.

8.4.3.2. In partnership with specialist services able to provide advice, supervision, teaching and training to primary care colleagues.

8.4.3.3. Work with community based drug and alcohol nurses and drugs workers in the shared care of drug and or alcohol

patients across the geographical area of the service. Different models will be used dependent on local needs.

8.4.3.4. Participate in the commissioning process within the PCO and have a broad understanding of the concept of needs assessment, service development planning, roles and responsibilities of DATs and others involved in providing and commissioning care to drug and or alcohol users.

8.4.3.5. Provide primary care substance misuse leadership to the PCO.

8.5. Evidence of training

8.6. A GPSI should present a portfolio with evidence of the following training

8.6.1. Acquisition of core competencies defined in the Drug Misuse Clinical Guidance. This can be through attendance at a recognized training course, certificate level qualification or through maintaining a logbook of patient's contacts to demonstrate management of the common substance misuse problems and their correct management.

8.6.2. A minimum attendance at 10 outpatient clinics or at least 2 years experience in drug and alcohol misuse field.

8.7. Evidence of reaching competency level

8.7.1. This can be undertaken through a number of means, including benchmarked accredited training courses, direct observation of skills, viva or interview by specialist provider. The evidence required will depend on the specific service/s provided by the GPSI. The table below gives some examples.

8.7.2. Signed portfolio of clinical attachment and direct observation of skills

8.7.3. Clinical assessment by either lead specialist clinician or RCGP Regional Lead

8.7.4. Certificate or Diploma in drug/alcohol misuse

These are examples of competencies and ways of meeting and maintaining them

COMPETANCY	EVIDENCE OF EXPERIENCE, SKILLS AND KNOWLEDGE	REQUIREMENT TO DEMONSTRATE COMPETENCY TO DESIRED LEVEL	EVIDENCE OF MEETING REQUIRED COMPETENCY	COMMENTS
Able to assess and plan the treatment of a patient with opiate addiction	Log book of 20 opiate dependent patients, including patients with different clinical needs Or Recognized bench mark certificate or Diploma Or Extended case histories Or Clinical placement	Direct clinical contact with opiate dependent patients with understanding of treatment modalities – methadone, Buprenorphine, naltrexone. Lofexidine at sufficient evidence based doses, regimes and understanding of the problems,	Signed portfolio by lead specialist or regional RCGP lead	

		complications and natural history of their intervention.		
Able to assess stimulant user	Log book showing contact with 10 stimulant users Or Recognized course, conference Or Period of personal study	Understanding of the complications, treatment of stimulant users. Knowledge of harm reduction opportunities in relation to stimulant users	Signed portfolio by lead specialists or RCGP regional lead	
Able to assess and plan treatment for pregnant users and child protection cases	Log book cases Attendance at local child protection training courses		Signed portfolio by lead specialist or regional RCGP lead	
Able to organize and plan education and training session on drug and alcohol misuse in primary care settings	Evidence of training provided through Post graduate training departments and local DAT training teams		Signed portfolio	

9. Monitoring and maintenance of GPSI

9.1. CPD requirements

9.2. Each GPSI is expected to maintain their competency level and to keep a portfolio with evidence of such. The type and level of evidence will vary with each GPSI though it is recommended by the NEAG that GPSIs in Drug Misuse completes a minimum of 15 hours per year of CPD in areas relevant to Drug Misuse and matched against their identified learning needs. It is also recommended that the GPSI

undertake a validated mechanism for identifying and meeting their learning needs, such as through a Personal Development Plan or Modified RCGP APD Programme². It is also useful to maintain close contact with the specialist provider and the GPSI may wish to attend the regular multidisciplinary or audit meeting. What is important is that the CPD requirements of the service meet the learning needs of the GPSI.

9.3. CPD arrangements

9.4. These need to be locally determined, though should be integral to the overall service configuration with identified funding and time allocated.

9.5. Appraisal

9.6. This needs to meet the requirements for revalidation. The appraisal mechanism needs to meet the approval of the PCO.

9.7. Examples of appraisal mechanism

9.7.1. PCT Appraisal mechanism

9.7.2. RCGP APD Programme

² The APD programme developed by the RCGP with support from the Medical Defence Union can be used as evidence for revalidation. APD helps the clinician to collect and organise over a five-year period information and evidence that is required for annual appraisal and revalidation. The APD programme has mechanisms for quality assuring the practitioners personal development portfolio using both peer, independent and lay facilitators. The APD programme incorporates five rotating modules over a five-year period underpinned by one continuous module. The current APD programme will be adapted 2002-2003 to meet the explicit needs of the GPSI in drug misuse

9.8. *Revalidation*

9.9. This must meet the GMC requirements

9.10. *Clinical Governance framework*

9.11. Practice

9.12. All clinical practice must be evaluated and audited to identify errors, ensure safety, and raise standards.

9.13. The audit methods used to assess GPSI care must be appropriate to the service defined, and be properly resourced as part of the work specification. They should include consideration of significant events, review of caseload, and evaluation of clinical outcomes.

The regional leads will support the development of audit tools to assist busy practitioners to undertake this part of their work so it becomes integral to their service commitment

9.14. The RCGP has developed the Quality Team Development Programme (QTD) which provides a framework for Primary Care Teams and their Trusts to assess the quality of the services they provide for patients and the way the team functions. It promotes quality improvement, team development, and primary care development planning. It is an extremely important tool to facilitate clinical governance agenda in primary care. Areas of QTD can be

used to ensure that the Clinical Governance arrangements for the GPSI are met.

9.15. Quality assurance mechanisms can include annual reviews of the service through an external examiner/peer reviewer or through an annual report. Whatever mechanism is chosen the overall Clinical Governance framework should ensure that patients receive a safe and effective service delivered by the most appropriate practitioner.

9.16. Practitioner

9.17. For the practitioner a quality assurance mechanism should include annual appraisal involving both peer appraisal and where possible, lay involvement. The RCGP APD mechanism involves both these as well as quality assurance of a sample of personal portfolio by an independent panel

9.18. *Monitoring arrangements*

9.19. Summary of Clinical Governance arrangements

9.20. Quality framework (clinical audit standards, communication standards)

9.20.1. Risk Management system (significant event monitoring, complaint handling)

9.20.2. Quality assurance mechanism for the GPSI service.

9.20.3. Accreditation

9.20.4. Accountability arrangements

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1. Department of Health *the NHS Plan*. 2000. London: The Stationary Office
 2. Jones R., Bartholomew J., and General Practitioners with special clinical interests: a cross –sectional survey. *BJGP* 52:483; 2002
 3. Royal College of General Practitioners. *General Practitioners with Special Interests*. 2001. London: RCGP
 4. www.rcgp.org.uk/rcgp.corporate/gpspecial_menu.asp
 5. Good Medical Practice for General Practitioners. RCGP 2002