

# GUIDANCE AND COMPETENCES FOR THE PROVISION OF SERVICES USING PRACTITIONERS WITH SPECIAL INTERESTS (PwSIs)

RESPIRATORY



**DH** Department  
of Health



English Pharmacy Board

**NHS**

Primary Care Contracting

# FOREWORD

The White Paper *Our health, our care, our say: a new direction for community services* ([http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4127453](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127453)), published in 2006, set out the vision for the future of care outside hospitals. It reinforced the importance of services provided by healthcare professionals working in community settings. The public involved in the consultation process that informed the White Paper made it clear that while convenient care was important, it must be of high quality and that a transparent process should underpin that quality.

In his interim review, Lord Darzi re-emphasised this need for quality, drawing on four overarching themes for the NHS over the next 10 years, where he describes the vision of a health and care system that is fair, personalised, effective and safe. Much of the vision continued in his main report, High Quality Care for All and in the primary and community care strategy] is underpinned by the movement of more complex care out of hospitals and into community settings – just the sort of services that PwSIs provide. *World Class Commissioning* (“Adding years to life and life to years”) will be the key vehicle for delivering a world leading NHS, equipped to tackle the challenges of the 21<sup>st</sup> Century. By developing a more strategic, long-term and community focused approach to commissioning and delivering services, where commissioners and health professionals work together to deliver improved local health outcomes, world class commissioning will enable the NHS to meet the changing needs of the population and deliver a service which is clinically driven, patient centred and responsive to local needs. PCT Commissioners will therefore be looking for PwSI commissioned services to link to the world class competencies which ensure the best value of service for patients

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_080956](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080956)

Many PwSIs in Respiratory Care have been established around the country and much has been learnt from examples of best practice. All those involved in the delivery of these services recognise the need to ensure that PwSIs are suitably qualified, with demonstrable competences, training and experience. These factors underpin the delivery of safe, high quality care. As we move steadily towards a regulated service, with registration of NHS organisations and increasing use of accreditation schemes, such as that currently being piloted by RCGP, there is increasing pertinence of the processes described in this document. Through implementation of this guidance, there will be a more vivid guarantee of quality.

This document, which should be read in conjunction with *Implementing care closer to home: Convenient quality care for patients* ([http://www.dh.gov.uk/en/Healthcare/Primarycare/Practitionerswithspecialinterests/DH\\_074419](http://www.dh.gov.uk/en/Healthcare/Primarycare/Practitionerswithspecialinterests/DH_074419)), describes different models of care and provides information about the competences, training, accreditation and assessment processes to support the accreditation of PwSIs in Respiratory Care. For Commissioners, this should be read in

conjunction with the World Class Commissioning Assurance Framework and associated competencies

<http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Assurance/index.htm>

# CONTENTS

Introduction	5
1. PwSI Service Provision	7
2. Infrastructure Required	10
3. The Competences Required	12
4. Teaching and Learning	14
5. Assessment	15
6. Accreditation, Maintenance of Competence and Re-accreditation	16
Appendix 1: Competences for a PwSI in Respiratory Care	19
Appendix 2: Assessment Tools	25
Appendix 3: Links to Other Resources	26
Appendix 4: Membership of Respiratory Care PwSI Stakeholder Group	28

# INTRODUCTION

Respiratory conditions are amongst the most common long term health conditions affecting adults and children and have a high impact on both morbidity and mortality<sup>1</sup>:

- Respiratory Conditions are the most common reason for general practice consultation or emergency medical admission to hospital
- Respiratory disease kills one in four people – twice the EU average
- COPD, pneumonia and chest infections account for more than 2.8 million hospital bed-days per year

The cost of respiratory disease to the NHS is higher than any other disease area with around 40% of these costs being for in-patient care.

Reports from the Chief Medical Officer in 2004<sup>2</sup> and by the Health Commission in 2006<sup>3</sup> outline deficiencies in access to local specialist services in Chronic Obstructive Pulmonary Disease (COPD). Similarly the House of Lords report on Allergy in 2007<sup>4</sup> highlighted deficiencies in local specialist allergy services.

Accredited general practitioners and pharmacists with a special interest in respiratory care can provide the clinical expertise and skills needed to bring these specialist services closer to the patient's home and potentially reduce the burden on secondary care.

This document represents an updating of *Guidelines for the appointment of GPwSIs in the Delivery of Clinical Services: Respiratory Medicine* published by the Department of Health in 2003. It provides detailed information to guide accreditors and practitioners towards the type of evidence and competences that may be expected to be seen and tested during the nationally mandated accreditation process set out in *Implementing care closer to home: convenient quality care for patients, Part 3: The accreditation of GPs and Pharmacists with Special Interests* ([http://www.dh.gov.uk/en/Healthcare/Primarycare/Practitionerswithspecialinterests/DH\\_074419](http://www.dh.gov.uk/en/Healthcare/Primarycare/Practitionerswithspecialinterests/DH_074419)).

This guidance, developed with the support of the General Practice Airways Group, relates only to the specific training and accreditation needs of general practitioners and pharmacists seeking accreditation as PwSIs in Respiratory Care.

The competency framework is designed to help practitioners understand and develop the extended knowledge and skills they will require to provide services beyond the scope of their generalist roles. Such developments are expected to occur within a negotiated local framework. It is not intended that PwSIs in Respiratory Care have all the competences listed in this document. Commissioners will need to identify the specific competences (detailed in Chapter 3) required by the practitioner in order to meet the service specifications. An appropriate competency framework, related to the job role would need to be developed.

**Commissioners should note that the training and personal development of PwSIs will need to be ongoing and will require support from specialist practitioners and / or access to relevant peer support.**

This framework does not preclude commissioners from developing specialist services using other practitioners, eg, nurses and other health care professionals. Competences for NHS-employed staff providing specialist care in community settings may be assessed through the knowledge and skills framework.

Specialist practitioners are expected to operate within the local clinical governance framework and within their scope of professional practice. They must be able to demonstrate relevant expertise when moving into new areas and commissioners will need to take a more competence-based approach to reflect the current work on modernising healthcare careers.

#### **IMPORTANT NOTE FOR COMMISSIONERS IN RESPECT OF RESPIRATORY CARE**

Many GPs and pharmacists who do not consider themselves to be special interest practitioners are currently providing services within their practice or locality, perhaps acting as the practice lead in respiratory care.

This guidance does not intend to undermine these clinicians. It is provided for doctors and pharmacists whose objective is to extend their competences and skills within a formally accredited PwSI framework.

# 1. PwSI SERVICE PROVISION

## 1.1 DEFINITION OF A PwSI

**PwSIs supplement their core generalist role by delivering an additional high quality service to meet the needs of patients. Working principally in the community, they deliver a clinical service beyond the scope of their core professional role or may undertake advanced interventions not normally undertaken by their peers. They will have demonstrated appropriate competences to deliver those services without direct supervision.**

## 1.2 LOCAL SERVICES THAT CAN BE PROVIDED BY A PwSI

The needs of the local population will inform the services to be provided. PwSIs will form one of a series of integrated options for the delivery of these services. The specific activities of the PwSI will depend on the service configuration, and may include providing advice and raising awareness of the primary and community practitioners' role in the prevention, detection, identification and care of respiratory conditions.

It is very important that all service providers and patients and carers are involved at every stage of service development.

The following points should be considered by commissioners when establishing a service, and by referring clinicians:

- Who will be referred to the service, including inclusion and exclusion criteria
- Type of service(s) being delivered
- Referral pathways
- Response time
- Communication pathways
- Consent
- Confidentiality and information sharing
- Multi-disciplinary working
- Caseload / frequency

## EXAMPLES FOR A PwSI SERVICE IN RESPIRATORY CARE

The table below gives examples of different types of services that a PwSI could deliver:

### **Liaison**

- Liaison with the following groups to help improve the provision of respiratory care in a locality:
  - Between primary and secondary care health providers
  - With health service managers and commissioner
  - With local patient groups in providing local respiratory services

## Clinical Services

- Consultation with patients referred by other practitioners for advice on diagnosis and clinical management for defined respiratory problems falls under clinical services
- Health promotion and Prevention eg, smoking cessation
- Diagnosis, eg, spirometry, skin prick testing
- Disease Assessment, eg, oxygen assessment in COPD
- Pharmacological management
- Non-pharmacological management, eg, Pulmonary rehabilitation in the management of COPD and Immunotherapy in the treatment of allergy

## Education

- Provide support, advice and training for local health professionals involved in the delivery of respiratory care
- Provide education and support for local patient groups
- Act as a source of local expertise in prevention, detection and treatment in respiratory care for patients, health professionals and health care managers
- Provide support for other Practitioners with a Specialist Interest in Respiratory Care, eg, mentoring
- Provide / support research and development into respiratory disease in the locality

## Service Development and Leadership

- Preventative Services:
  - Smoking Cessation
  - Immunisation against respiratory disease.
  - “Early warning” campaigns, eg, weather warnings by the Met Office
- Diagnostic and Assessment Services:
  - Allergy testing
  - Lung function testing and oxygen assessment in COPD
  - COPD case finding or detection
- Disease Management:
  - Pulmonary rehabilitation
  - Community Care of Acute Exacerbations of Respiratory Disease
  - Immunotherapy in allergic disease
- Provide Leadership (support) for the development and implementation of local respiratory services and Guidelines
- Monitoring of quality standards of care (in liaison with the clinical governance lead), benchmarking with other PwSI providers and providing feedback to primary and intermediate care health professionals on quality performance
- To lead / advise primary care commissioners on the commissioning of respiratory services in a locality
- Identifying and addressing the needs of vulnerable and disadvantaged groups

### 1.3 PRINCIPLES OF SERVICE DELIVERY

Models of service delivery are expected to reflect the important principles outlined in the *Implementing care closer to home: convenient quality care for patients* documents ([http://www.dh.gov.uk/en/Healthcare/Primarycare/Practitionerswithspecialinterests/DH\\_074419](http://www.dh.gov.uk/en/Healthcare/Primarycare/Practitionerswithspecialinterests/DH_074419)).

Local guidelines for the service should reflect and incorporate nationally agreed guidelines. Both the commissioner and PwSI should demonstrate awareness of relevant national advice issued by organisations such as:

- The General Practice Airways Group (GPIAG)  
<http://www.gpiag.org>
- Scottish Intercollegiate Guidelines Network (SIGN)  
<http://www.sign.ac.uk/index.html>
- The British Thoracic Society (BTS)  
<http://www.brit-thoracic.org.uk>

**In addition:**

The service model should take account of nationally agreed guidance, in particular:

- SIGN / BTS Asthma Guidelines
- Locally agreed care pathways
- NICE Guidance on COPD  
<http://www.nice.org.uk/guidance/index.jsp?action=byID&r=true&o=10938>
- Department of Health – new NSF for COPD will be published in 2008

The model should incorporate examples of nationally agreed good practice such as care closer to home demonstration sites:

[www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Modernisation/Ourhealthourcareoursay/DH\\_4139717](http://www.dh.gov.uk/en/Policyandguidance/Organisationpolicy/Modernisation/Ourhealthourcareoursay/DH_4139717)

## 2. INFRASTRUCTURE REQUIRED

### 2.1 SERVICE LEVEL AGREEMENTS

It is important that the commissioned service meets the agreed specifications as set out by the employing authority.

This will include, for example:

- Type of service to be delivered including the type of respiratory condition (COPD, asthma allergy etc) and patient age group (children or adults or both)
- Joint working arrangements, eg, with statutory or third sector agency
- How referrals are received
- The scope and criteria for further access to specialist advice for acute and chronic care
- Waiting times
- Means of communication between referrer, PwSI and other specialist health care professionals
- Confidentiality / information sharing
- Number and composition of sessions to be worked by PwSI
- Location of the service, suitability, accessibility and support
- Contact with other health professionals, specialists in respiratory care or other PwSIs
- Direct access to diagnostic provision (including reporting)
- Review / process for following-up patient
- Communication / updating medical records
- Reporting mechanism for activity data
- How the service links with the commissioner's requirements
- Administrative and support staff available to provide the service
- Developmental support to be provided by other health professionals, eg, mentoring
- Diagnostic facilities available to the clinician
- Prescribing responsibilities (and limitations)

### 2.2 SUPPORT AND FACILITIES

Facilities will vary according to the commissioned service. The basic requirements for a PwSI in Respiratory Care include the following:

- Direct access to support and supervision from respiratory care specialists
- Clinical and administrative support staff available as required for each service
- Adequate means of record keeping
- Education mentoring support and clinical network facilities
- Appropriate support to facilitate effective clinical audit and performance monitoring
- Access to educational material / clinical reference databases, events and conferences to ensure they are undertaking appropriate CPD

NB: Facilities must be kept up to date in keeping with national guidance. Such facilities are to be accredited and should take account of the Government's *Standards for Better Health*:

## 2.3 CLINICAL GOVERNANCE AND STANDARDS

PwSIs will operate within the local clinical governance framework and within their scope of professional practice.

Mechanisms of clinical governance need to be agreed as part of the service accreditation. This will ensure maintenance of local and nationally agreed standards in respect of patient care and patient safety. Nationally agreed standards for the provision of facilities exist, and are referred to in *Implementing care closer to home: convenient quality care for patients* ([http://www.dh.gov.uk/en/Healthcare/Primarycare/Practitionerswithspecialinterests/DH\\_074419](http://www.dh.gov.uk/en/Healthcare/Primarycare/Practitionerswithspecialinterests/DH_074419)).

The commissioner should give consideration to the following aspects of the PwSI service:

- **Lines of responsibility:** Accountability for overall quality of clinical care.
- **Monitoring of clinical care:** Patients' and carers' experience to be included in patient surveys. Staff to be encouraged to participate in clinical governance programmes.
- **Workforce planning and development:** Continuing professional development, which may include peer review, support and mentoring, will be built into organisations' service planning. Succession and contingency plans will be in place and service users will be involved and their opinions taken into account.
- **Risk management programmes:** Included in clinical risk management and in protocols on good record keeping, patient safety, confidentiality and handling complaints.
- **Poor performance management:** All organisations should have systems in place for identifying and managing poor professional performance in line with professional organisations and national bodies, eg, NCAS.
- **Linked to this is reporting of critical incidents:** Such as medication errors, which should be mandatory for all settings, not just the NHS.
- **Adherence:** To the requirements set down by the Accountable Officer in relation to controlled drugs.

# 3. THE COMPETENCES REQUIRED

## 3.1 GENERALIST COMPETENCES

The PwSI will be required to demonstrate that he / she is a competent generalist.

Competent practitioners will be able to demonstrate:

- Good communication skills with patients, carers and colleagues
- The ability to explain risk and benefits of different treatment options
- Skill in involving patients and carers in the management of their condition(s)

---

### GENERAL PRACTITIONERS

Generalist skills can be assessed in a number of ways including:

- Meeting the competences set out in the new RCGP curriculum ([www.rcgp-curriculum.org.uk](http://www.rcgp-curriculum.org.uk)) together with a holistic understanding of primary care practice
- Obtaining a pass in the examination of the Royal College of General Practitioners or equivalent and being a Member of Good Standing
- Evidence of critical appraisal skills
- Engaging in active clinical work

---

### PHARMACISTS

A generic PhwSI competence framework was published within the national framework for PhwSIs (<http://www.primarycarecontracting.nhs.uk/246.php>). It is recommended that this is used to assess generalist (practitioner-level) skills and experience. CPD records are expected to form a significant part of this evidence. This framework may also be used to identify skills and experience that go beyond the core role.

## 3.2 SPECIFIC COMPETENCES

The PwSI will demonstrate a knowledge and skills level higher than those acquired by non-specialist colleagues.

It is not intended that a PwSI in Respiratory Care will necessarily have all the competences listed in this document. The commissioners need to ensure that the practitioner has the specific competences, drawn from the overall list in Appendix 1, to meet the requirements of their service specification.

This same principle applies to the differing clinical roles of GPwSIs and PhwSIs; while some competences may be relevant for both GP and pharmacist services, there may be others which

relate only to a GP or pharmacist role. The competences for both roles can be drawn from the same overall list in Appendix 1.

---

*It is important for commissioners and practitioners to note that not all of these competences will need to be demonstrated before appointment. The specific competences that can be developed after appointment depend on the roles and responsibilities expected from the practitioner.*

The competences for a PwSI in Respiratory Care are summarised below:

- Asthma
- Drug therapy for respiratory disease
- Health promotion and prevention
- Respiratory infection
- Allergic disease of the respiratory tract
- Chronic Obstructive Pulmonary Disease (COPD)
- Other respiratory disease
- Acute respiratory disease

The full guidance can be found in Appendix 1.

# 4. TEACHING AND LEARNING

## 4.1 TRAINING FOR PwSIs

PwSIs are expected to demonstrate that they have completed recognised training which may include acknowledgement of prior learning and expertise.

Training can be acquired in several ways and would be expected to include both practical and theoretical elements.

For example:

- Experience (current or previous) of working in relevant departments
- Self-directed learning with evidence of the completion of individual tasks
- Attendance at recognised meetings / lectures / tutorials on specific relevant topics
- As a trainee or other post under the supervision of a specialist or consultant in respiratory care in the secondary care service
- As part of a specialist training programme
- As a clinical placement agreed locally
- As part of a recognised university course
- A postgraduate qualification, eg, Joint Programme Board postgraduate diploma in general pharmacy practice with a defined area of practice (DAP) in respiratory care
- Experience of delivering a full clinical medication review service
- As part of accredited training as a non-medical prescriber
- Evidence of working under direct supervision with a specialist clinician in relevant clinical areas. The number of sessions should be sufficient to ensure that the PwSI is able to meet the competences of the service requirements

Many universities are developing training modules that include theoretical training followed by supervised practice and formal competence-based assessments. Such courses use many of the assessment tools described in this framework. While these courses are no substitute for clinical experience, the use of supervised practice and formal competence-based assessment is likely to become widely accepted, mirroring the robust assessment processes used in undergraduate and post-graduate training. This type of training module would therefore be useful in supporting the training and accreditation process for PwSIs.

Consideration should be given to the successful completion of a Diploma in Primary Care Respiratory Care. This may assist with the collation of the PwSI portfolio which is detailed in chapter 6.

## PHARMACISTS

The precise nature and duration of supervised practice will depend on the specific service requirements. Pharmacists with a special interest in respiratory care are expected to demonstrate a range of evidence in line with the generic PhwSI competency framework in addition to providing a structured reference from an objective, relevant and independent clinician which confirms their competence to take on the new role. It is anticipated that this evidence will include formal learning, supervised practice and the recent application of relevant expertise in the special interest area. Pharmacists applying for accreditation as a PwSI in Respiratory Care will need to draw on support from respiratory care specialist services and hospital pharmacy colleagues to develop this range of evidence, including periods of supervised practice.

For all PwSIs the most suitable teaching and learning and assessment methods will vary according to individual circumstances and it is recommended that these are agreed with an educational supervisor and / or trainer in advance.

## 5. ASSESSMENT

The most suitable teaching / learning and assessment methods will vary according to individual circumstances and should be agreed between trainee and trainer in advance. The PwSI can be assessed across one or more of the competences listed in Appendix 1, and it is expected that this process will be tailored towards the service that the PwSI will deliver.

The assessment of individual competences can be undertaken by a combination of any of the following:

- Observed practice using modified mini clinical examination
- Case note review
- Reports from colleagues in the multi-disciplinary team using 360-degree appraisal tools
- Demonstration of skills under direct observation by a specialist clinician (DOPS)
- Simulated role-play objective structured clinical examination (OSCE)
- Reflective practice
- Logbook / portfolio of achievement
- Observed communication skills, attitudes and professional conduct
- Demonstration of knowledge by personal study supported by appraisal (+/- knowledge based assessment)
- Evidence of gained knowledge via attendance at accredited courses or conferences

Further information regarding the above assessment tools can be found in Appendix 2.

# 6. ACCREDITATION, MAINTENANCE OF COMPETENCE AND RE-ACCREDITATION

The mandatory processes for accreditation and re-accreditation are set out in *Implementing care closer to home: convenient quality care for patients, Part 3 The accreditation of GPs and Pharmacists with Special Interests*. During the accreditation process, the PwSI is expected to provide evidence of his or her acquisition and maintenance of appropriate competences in respiratory care.

A practitioner should only be employed to work as a PwSI once his or her competence for that service has been assessed and confirmed against the standards described in this document.

## 6.1 MAINTENANCE OF COMPETENCES

Practical arrangements for the maintenance of competences should be agreed by all key stakeholders as part of the service accreditation.

PwSIs are expected to maintain a personal development portfolio to identify their education requirements matched against the competences required for the service and evidence of how these have been met and maintained.

This portfolio can act as an ongoing training record and logbook and should be countersigned as appropriate by an educational supervisor. The portfolio should also include evidence of audit and continuing professional development (CPD) and, for GPs, would be expected to form part of their annual appraisal. Pharmacists will be expected to include evidence relevant to their PwSI role in CPD records and in any regular appraisals.

To develop and maintain skills it is important to see sufficient numbers of patients in a clinical setting in accordance with the scope of the commissioned service.

It is recommended that PwSIs:

- Work regularly within the specialist area in order to obtain adequate exposure to a varied case mix to support CPD
- Undertake a joint clinic or clinical supervision session on a regular basis commensurate with the number of sessions worked by the PwSI. These should be with a more specialist practitioner for the discussion of difficult cases and as an opportunity for CPD. In the absence of this there should be evidence of working and / or learning with peers

It is also expected that practitioners will:

- Be actively involved in the local respiratory care specialist service(s)
- Contribute to local clinical audits

Active membership of an appropriate faculty, professional group and / or a primary care organisation for respiratory care will provide further opportunities for PwSIs to develop their knowledge and skills through attendance at educational events and update meetings.

For example:

- The Respiratory Group within the UK Clinical Pharmacists Association
- General Practice Airways Group (GPIAG)

## PwSI IN RESPIRATORY CARE PORTFOLIO

The portfolio should provide a track record of providing high quality respiratory care in line with national guidelines. Examples of the sections that could be included in the portfolio include:

- Assessment of practical skills relevant to the service being commissioned (in adults and children)
- Evidence of high quality clinical audit, research, training and teamwork in respiratory care
- Personal development through analytical reflection on clinical events, appraisal of three significant events, case history analysis detailing the decision-making rationale
- Evidence of educational skills via video, records or learning aims and outcomes achieved, feedback from audiences at educational sessions

An outline portfolio to support the accreditation of pharmacists with a special interest has been developed and is available at <http://www.primarycarecontracting.nhs.uk/246.php> and can be supported by CPD. This provides a guide to the range and types of evidence that will need to be included.

Pharmacists working as non-medical prescribers are also expected to fulfil the requirements of the competency frameworks described in the National Prescribing Centre documents, *Maintaining competency in prescribing. An outline framework to help pharmacist prescribers*, October 2006 ([http://www.druginfozone.nhs.uk/Documents/NPC\\_pharmacist\\_comp\\_framework\\_Oct06.pdf?id=575074](http://www.druginfozone.nhs.uk/Documents/NPC_pharmacist_comp_framework_Oct06.pdf?id=575074)).

## 6.2 MONITORING

Mechanisms of clinical governance need to be agreed as part of the service accreditation. This will ensure maintenance of local and nationally agreed standards in respect of patient care and patient safety.

PwSIs are expected to be involved in the monitoring of service delivery, which incorporates the following:

- Clinical outcomes and quality of care
- Access times to the PwSI service
- Patient and carer experience questionnaires

- Prescribing and medicines management

### 6.3 RE-ACCREDITATION

PwSIs must maintain their specialist skills and competences on an ongoing basis as outlined in national PwSI accreditation guidance (<http://www.primarycarecontracting.nhs.uk/173.php>).

The recommendations for re-accreditation are set out in *Implementing care closer to home: convenient quality care for patients*, Part 3: *The accreditation of GPs and Pharmacists with Special Interests*.

# APPENDIX 1: COMPETENCES

It is not intended that PwSIs in Respiratory Care have all the competences listed in this document, rather that commissioners ensure that the practitioner has the specific competences, drawn from the overall list, to meet the requirements of the service specification. This same principle applies to the differing clinical roles of GPwSIs and PhwSIs; while some competences may be relevant for both GP and pharmacist roles, there may be others which relate only to GPwSIs or PhwSIs.

## ASTHMA

<b>Objective</b>	<b>Knowledge</b> Can demonstrate understanding of	<b>Skills</b> Is able to
To successfully diagnose asthma in the different age range groups	The various diagnostic methods and criteria for all age groups and trigger types, to include occupational factors	Examine the respiratory system
		Interpret chest X-rays
		Perform skin prick testing
		Carry out and interpret spirometry
To manage asthma in the individual and be conversant with the range of treatment therapies available	The various treatment / management options (cost, efficacy, safety), and the variances that can occur (pregnancy, children, occupational sufferers) Factors influencing concordance with treatment	Take and teach peak flow measurements
		Use and teach the use of inhaler devices
		Manage routine asthma care in practice to promote adherence and foster concordance
		Support personalised asthma action plans (PAAPs)
	The pertinent trigger factors and role of allergen avoidance	Identify and discuss trigger factors and their impact with the individual as appropriate
	The indications for appropriate referral to other disciplines and / or secondary care	Refer as necessary and effectively facilitate the interface between primary and secondary care.
The history and changing prevalence of asthma, possible causes and impacts (both to health and economy)	Signpost resources and effectively communicate national guidance to peers and patients / carers as appropriate, eg, NICE, SIGN, BTS	

## MANAGEMENT OF DRUG THERAPY FOR RESPIRATORY DISEASE

<b>Objective</b>	<b>Knowledge</b> Can demonstrate understanding of	<b>Skills</b> Is able to
To manage drug treatment for patients with respiratory disease	Drug therapy in respiratory disease	Assess, prescribe or supply and monitor response to treatment
	Specialist pharmaceutical knowledge of care of patients with respiratory disease	Be accountable for the pharmaceutical care of a group of patients with respiratory disease
	How to achieve shared decision-making with patients with respiratory disease	Personalise treatment goals based upon national therapeutic targets whilst recognising the individual patient's circumstances
	Drug treatment for common co-morbidities in respiratory diseases	Monitor, review and adjust drug treatments effectively including for complex medication regimens
	Adverse reactions to drug treatments	Manage and report adverse drug reactions

## RESPIRATORY INFECTION

<b>Objective</b>	<b>Knowledge</b> Can demonstrate understanding of	<b>Skills</b> Is able to
To take a detailed history and conduct appropriate tests	The clinical presentation of respiratory infection	Take an accurate history and carry out and interpret screening tests to national / regional standards
To diagnose and manage respiratory infection and be conversant with the range of treatment therapies available	The range of differential diagnoses	Interpret chest x-rays showing common respiratory pathologies
	The indications for hospital admission of: Upper/lower respiratory tract infection, COPD, Community acquired pneumonia, TB, Childhood infections, and Influenza	Refer as necessary and effectively facilitate the interface between primary and secondary care
	Working knowledge of national guidelines eg, BTS Guidelines for the management of community acquired pneumonia, cough, and TB	Lead on the organisation of care in the areas of: Influenza, pneumococcal immunisation, diagnostic services for TB, planning of services in influenza outbreak
To support appropriate use of antibiotic therapy in respiratory infection	Appropriate selection and use of antibiotics in respiratory care. Evidence of current antibiotic resistance Use of sputum culture and its interpretation	Monitor and audit antibiotic usage Contribute to development of local antibiotic guidelines

## ALLERGIC DISEASE OF THE RESPIRATORY TRACT

<b>Objective</b>	<b>Knowledge</b>	<b>Skills</b>	
	Can demonstrate understanding of	Is able to	
To take a detailed history at initial presentation and conduct appropriate examinations	The timeliness and indications for taking an allergy history	Take an accurate history and carry out a competent examination, to include the respiratory tract and ENT examination	
To diagnose and manage the individual with allergic disease of the respiratory tract and be conversant with the range of treatment therapies available	Knowledge of diagnostic techniques such as skin prick testing, blood testing etc, their indications and limitations	Discuss with the patient / carer the incidence, prevalence (including co-morbidity with asthma), risk factors, allergies, intolerances and natural history associated with the condition	
	The various management types, allergen avoidance measures, immunotherapy, drug therapies, and complimentary therapies		Use and teach the use of inhaler devices
			Carry out immunotherapy
			Ensure that the patient understands their therapy regime and so promote adherence and foster concordance
	The indications for appropriate referral to other disciplines and / or secondary care	Refer as necessary and effectively facilitate the interface between primary and secondary care	
	Theory and management of anaphylaxis	Teach the use of epinephrine pen	
A working knowledge of national/international guidelines, eg, Allergic Rhinitis and its Impact on Asthma (ARIA), European Academy of Allergology and Clinical Immunology (EAACI)	Act confidently in the organisation of care, eg, setting up allergy services, immunotherapy service		
To contribute to education initiatives for children and adults	Educational resources on asthma and anaphylaxis	Educate school staff and pupils on appropriate management of allergic disease and anaphylaxis	

## CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

<b>Objective</b>	<b>Knowledge</b> Can demonstrate understanding of	<b>Skills</b> Is able to
To take a detailed history and conduct appropriate examinations	The pathology, pathophysiology and systemic effects of COPD and how it presents in individuals	Take an accurate history and carry out competent examination
	An awareness of the history, prevalence, morbidity, mortality and economic effects of COPD	
To successfully diagnose COPD in the individual	The diagnosis techniques: spirometry, x-ray interpretation and basic secondary care diagnostic knowledge such as symptoms and risk factor identification	Carry out respiratory and cardiovascular examination
		Carry out ECG procedures and interpret traces illustrating common pathologies found in general practice
		Interpret normal and abnormal volume-time and expiratory flow-volume traces
		Carry out and demonstrate spirometry procedures including reversibility testing
		Interpret chest x-rays illustrating common chest pathologies found in primary care
To manage COPD and support the individual with the range of treatment therapies including the appropriate management of co-morbidities available	Management techniques, outcome measures (disability, dyspnoea scales, walking and health status measurements)	Discuss different therapy options, economics, compliance and complications with the patient / carer as appropriate
	Pulmonary rehabilitation	Ensure that the patient understands their therapy regime and so promote adherence and foster concordance
	Oxygen therapy	Understand different modalities of oxygen delivery Refer to Arterial Blood Gases Use pulse oximetry
	The benefits, problems and methods of smoking cessation	Provide level 2 or 3 advice on smoking cessation
	The indications for appropriate referral to other disciplines and / or secondary care	Refer as necessary and effectively facilitate the interface between primary and secondary care
	Basic knowledge of secondary care, assessment and management (including care pathways, models of care, and	A working knowledge of national / international guidelines, eg, NICE / GOLD

	support groups)	
	Have a working a sound knowledge of the common co-morbidities associated with COPD and its management	Able to assess and manage appropriately common co-morbidities as well as empower patient to seek further help when appropriate

## ACUTE RESPIRATORY DISEASE

<b>Objective</b>	<b>Knowledge</b>	<b>Skills</b>	
To successfully assess the acutely breathless child and adult	The clinical presentations common in the acutely breathless child and adult	Is able to	
		Take an accurate history and carry out competent examination	
		Use pulse oximetry	
		Interpret ECG traces	
To diagnose and manage acute breathlessness	Differential diagnosis of the adult and child presenting with acute breathlessness	Distinguish the normal from abnormal chest x-ray	
		Manage the acutely breathless patient in primary care with specific reference to: <ul style="list-style-type: none"> <li>• Acute asthma</li> <li>• Acute exacerbation COPD</li> <li>• pulmonary embolus</li> <li>• pneumothorax</li> <li>• foreign body inhalation</li> <li>• acute adult and childhood infection including bronchiolitis and croup</li> <li>• anaphylaxis</li> </ul>	
		The appropriate use of oxygen therapy in acute situations	Remove a trapped upper airway foreign body in a child or adult
		The indications for appropriate referral to or secondary care	Refer as necessary and effectively facilitate the interface between primary and secondary care
	National guidance including: BTS Acute Oxygen Guidelines and Resuscitation Council Guidelines	Apply Basic and Advanced (Defibrillator) Resuscitation Skills	

## LOCAL SERVICE DELIVERY

<b>Objective</b>	<b>Knowledge</b> Can demonstrate understanding of:	<b>Skills</b> Is able to:
To work in partnership with others eg, public health physicians to develop the skills and knowledge of primary (and secondary) care to manage patients with respiratory conditions	Effective interventions to prevent and treat respiratory disease	Communicate effectively with healthcare professionals and patients, especially those from minority and vulnerable groups
	The needs of patients with respiratory care	
	The role of patient support organisations	Able to teach and train other Trainee doctors/GPs Nurses within the clinics Provide information about support organisations Conduct an educational meeting with referring practices to maximise their potential

## CLINICAL LEADERSHIP AND CO-ORDINATED CARE

<b>Objective</b>	<b>Knowledge</b> Can demonstrate understanding of:	<b>Skills</b> Is able to:
To identify the need, and lead on the development, for shared care and other respiratory care services across the locality. This may be in partnership with public health teams	The principles of service and clinical leadership	Promote primary and secondary prevention of respiratory disease in primary care; work for prevention in high risk groups
	Service configuration and the role of local trusts and government organisations such as DH	Act as a champion, advocate and leader for respiratory health in primary care to raise understanding of causes, preventions and treatment of respiratory disease
	The structure of local primary care organisations and the role of Practice Based Commissioning Groups	Develop and maintain links with local trusts and practices

# APPENDIX 2: ASSESSMENT TOOLS

It is expected that, as part of the accreditation process, the assessment of individual competences will include observation of clinical practice. The recommended clinical assessment tools are the modified mini-CEX (mini clinical examination) and DOPS (direct observation of procedural skills).

A series of assessment tools suitable for use by PhwSIs are available at:  
<http://www.primarycarecontracting.nhs.uk/246.php>.

**The following notes are intended to support the effective use of these assessment tools as applied to the field of respiratory care:**

- It is strongly recommended that a series of clinical assessments (eg, using a modified mini-CEX or video assessment or other face-to-face assessment) takes place four times during the period of training prior to the PwSI becoming accredited.
- Each clinical assessment is expected to take the equivalent of one session and should be performed by a specialist clinician, consultant or clinical pharmacy lead, ideally an alternative to the educational supervisor.
- The assessor is expected to be present throughout the session and to make assessments, covering different clinical domains, from a number of patient interactions.
- Several assessments covering different areas are expected to be performed during each of the clinical assessment sessions.
- The subject / areas covered will depend on the type of service the PwSI is going to offer. This will be agreed at the start of the training.
- The assessment outcome will be 'satisfactory' or 'unsatisfactory'. Time will be allocated for feedback.
- It is expected that one of the assessments should include a review of case notes.
- It is expected that PwSIs will need training in the recognition and management of conditions normally seen / managed in secondary care and that this knowledge will be acquired via continuing education.
- Logbooks – there will be other competences that are not included but desirable; these can be documented in the PwSI logbook and signed off by the trainer. This will probably differ for the individual PwSI and the detail will need to be agreed with the trainer at the beginning of training.
- For PwSIs who have not completed a specialist qualification, it is envisaged that a formal test of knowledge should be included and submitted as evidence to the accreditation panel.
- Practitioners will be expected to demonstrate evidence of 360-degree review.

# APPENDIX 3: LINKS TO OTHER RESOURCES

## REFERENCES

Holmes S, Gruffydd-Jones K., *A proposal for the annual appraisal of, and developmental support for General Practitioners with a Specialist Interest (GPwSIs) in respiratory medicine.*  
Primary Care Respiratory Journal 2005 14:161=165

Gruffydd-Jones et al., *What standards and terms of employment should respiratory PwSIs expect from an employing organisation?*  
Primary Care Respiratory Journal 2007 16(3) 182-187

## LINKS, RESOURCES AND REPORTS

### Links:

British Thoracic Society  
[www.brit-thoracic.org.uk](http://www.brit-thoracic.org.uk)

Royal Pharmaceutical Society  
<http://www.rpsgb.org.uk>

Department of Health  
<http://www.dh.gov.uk/en/index.htm>

General Practice Airways Group  
<http://www.gpiag.org>

Allergic Rhinitis and its Impact of Asthma  
<http://www.whiar.org>

Scottish Intercollegiate Guidelines Network (SIGN)  
<http://www.sign.ac.uk/index.html>

National Institute for Health and Clinical Excellence  
<http://www.nice.org.uk>

European Academy of Allergology and Clinical Immunology  
<http://www.eaaci.net/site/homepage.php>

Healthcare Commission  
<http://2007ratings.healthcarecommission.org.uk/homepage.cfm>

Public health skills and career framework, 2007

[http://www.phru.nhs.uk/Pages/PHD/public\\_health\\_career\\_framework.htm](http://www.phru.nhs.uk/Pages/PHD/public_health_career_framework.htm)

UK Clinical Pharmacists Association

<http://www.ukcpa.org>

**Resource Packs:**

*Learning from the experience of GPs and other PwSIs in Respiratory Medicine.*  
General Practice Airways Group, available via [www.gpiag.org](http://www.gpiag.org)

*Chronic respiratory disease*, Centre for Pharmacy Postgraduate Education, 2005  
[www.cppe.manchester.ac.uk](http://www.cppe.manchester.ac.uk)

**Guidance and Reports:**

Chief Medical Officer's Annual Report, *It Takes Your Breath Away*, 2004

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4115786.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4115786.pdf)

NICE Guidance on COPD

<http://www.nice.org.uk/guidance/index.jsp?action=byID&r=true&o=10938>

Report, *Clearing The Air*, 2006

[http://www.healthcarecommission.org.uk/db/documents/COPD\\_report1.pdf](http://www.healthcarecommission.org.uk/db/documents/COPD_report1.pdf)

House of Lords Report, *Allergy*, 2007

<http://www.publications.parliament.uk/pa/ld200607/ldselect/ldsctech/166/16602.htm>

*Burden of Lung Disease*, London, 2006

[http://www.brit-thoracic.org.uk/Portals/0/Library/BTS%20Publications/burdeon\\_of\\_lung\\_disease2007.pdf](http://www.brit-thoracic.org.uk/Portals/0/Library/BTS%20Publications/burdeon_of_lung_disease2007.pdf)

# APPENDIX 4: MEMBERSHIP OF PwSI RESPIRATORY CARE STAKEHOLDER GROUP

**We appreciate and are grateful for feedback from the following people and organisations that have commented or contributed to the development of this document:**

## **Clinical Lead**

Dr Kevin Gruffyd-Jones	General Practice Airways Group (GPIAG)
Dr Steve Holmes	General Practice Airways Group (GPIAG)
Sian Williams	Executive Officer (former NHS Manager)
Chris Town	Former CEO Peterborough and Cambridge PCTs

## **Royal College of General Practitioners**

Dr Clare Gerada	RCGP Vice Chair
Colette Marshall	RCGP Head of Clinical and Research
Layla Brokenbrow	RCGP Project Manager, Clinical Innovation and Research Centre

RCGP Professional Development Board

## **Pharmacy**

Brian Curwain	English Pharmacy Board, RPSGB
Meghna Joshi	Practice and Quality Improvement Directorate, Royal Pharmaceutical Society of Great Britain
Anna Murphy	Consultant Respiratory Pharmacist, Glenfield Hospital Groby Road, Leicester
Beth Taylor	National Development Lead, Pharmacists with Special Interests, NHS Primary Care Contracting Team

Public Health Unit  
General Practice Airways Group  
British Thoracic Society  
Education for Health (Formerly National Respiratory Training Centre)  
Asthma UK  
International Primary Care Respiratory Group