The role of a GPSI in changing times

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Along with the newly proposed changes to the organisation of care from the coalition Government (Department of Health [DH], 2010), the way that diabetes care is being delivered in the UK is changing dramatically. In England and Wales, the National Service Framework for diabetes (DH, 2003) signalled a shift in the delivery of diabetes care from secondary to primary care, and this has been further promoted by the GMS contract and its associated QOF, introduced in 2004, which provides GPs with significant additional resources for delivering quality process components of diabetes care. At the same time, GPSIs have emerged as part of the NHS plan (DH, 2000) as a means of delivering improved access to services for primary care organisations (PCOs).

Primary care diabetes services

The UKPDS (UK Prospective Diabetes Study; Holman et al, 2008) has now removed any doubt that improved glycaemic control leads to better outcomes. Steno-2, a small trial but based in primary care, has shown that multifactorial interventions – of the sort that well-organised GPs do all the time – improve cardiovascular outcomes over almost 14 years of follow-up (Gaede et al, 2008). It is interesting that 57% of the intervention group in this trial received statins, 60% aspirin, and 90% an angiotensin-converting enzyme inhibitor – figures that would be regarded as no more than average for diabetes care under the QOF. In addition, previous studies of diabetes care in general practice have shown that well-organised, register-based systems in primary care can deliver care as good as, or better than, that delivered in secondary care (Griffin, 1998).

PCTs have not been slow to appreciate the benefits of diabetes care delivered by primary care and practice-based commissioning and the uneconomic tariffs imposed on secondary care have accelerated this move. PCTs have appreciated that the service will not evolve beyond the process-driven aspects of the QOF – valuable as they are – without a higher level of expertise in the community, led by GPSIs increasingly with support from community-based diabetologists. Indeed, the document *Guidance and Competences for the Provision of Services using Practitioners with Special Interests: Diabetes* (Royal College of General Practitioners [RCGP] et al, 2008) makes it clear that accredited and competent practitioners should not work in isolation but as part of a supported multidisciplinary team.

Optimal diabetes care

Type 2 diabetes is a condition of dramatically increasing prevalence especially among ethnic communities. Its control over time needs increasing levels of interventions targeted at different risk factors, not least of which is the use of insulin alongside the ever-expanding armamentarium of oral and injectable antidiabetes agents. Good care for those with diabetes needs robust systems for call and recall and mechanisms for identifying people receiving suboptimal care. In addition, the early identification and treatment of complications needs not just high levels of organisation within primary care but also the clarification of pathways to other specialties.

Working together

The new coalition Government's White Paper – which can be viewed in detail and in summary at www.bma.org.uk/healthcare_policy/index.jsp – stresses the importance of reducing inequalities and promoting partnership working between health and social care and high-quality integrated care delivered close to the patient (DH, 2010). Quality is defined not just in the traditional terms of effectiveness and safety

but, importantly, in terms of the broader experience of the individual and their carers. GP consortia are charged with commissioning most community-based services and elective hospital care on the basis not only of clinical outcomes but also of patient-reported outcome measures.

Pulling together the components of a service that promotes supported self-care while maintaining quality is not the traditional domain of secondary care, however the RCGP guidance makes it very clear that leadership and service development are skills a GPSI ought to possess in addition to accredited clinical and educational competencies. This is especially true when providing care for people with several long-term conditions, and it is well recognised that people with diabetes often have cardiovascular, mobility and mental health problems – all of which have health and social care components.

The role of a GPSI in diabetes

GPSIs should have a pivotal role, not only in advising on and providing aspects of more complex clinical care but also in organising and planning services, including education for healthcare professionals and people with diabetes, as well as community-based prevention and screening initiatives.

The new White Paper is probably the single biggest revolution in the way healthcare is delivered in England and Wales since 1948. Working on the ground, delivering frontline care on a daily basis gives GPSIs a unique insight into the barriers and opportunities to improve systems and services. This vision has often been frustrated by the risk averse and sometimes downright obstructive attitude taken by PCTs when initiatives to improve care have been proposed. Provided that GP consortia do not get engrossed in navel gazing and petty protectionism, this a wonderful opportunity for GPSIs to significantly influence and manage the way that services are designed, monitored and evaluated.

Alongside all this, and probably more importantly for the sustainability of the model, GPSIs have a duty to support themselves. Training and the acquisition of core competencies must be standardised and GPSIs need to promote a respected accreditation and revalidation system that must include a significant component of measuring the impact and outcomes of the integrated model of diabetes care. GPSIs also need implicit support of government, PCOs and consultants and need to have a coherent voice representing them.

The dynamic and influential Primary Care Diabetes Society hosts a GPSI subsection and a forum is available on the PCDS website (www.pcdsociety.org) to get and share views from existing and aspiring GPSIs in diabetes and for you to express your views on this or indeed any topic surrounding diabetes care.

Conclusion

How GPSIs survive and prosper will be best judged not only by numbers but also by how these reforms, as a whole, deliver improved outcomes for people with diabetes with greater efficiency and increased equity. Let's work together with people with diabetes and nursing, dietetic, podiatry, psychology and consultant colleagues to use the new opportunities to the maximum. ■

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