GPSI in diabetes: 10 principles for service success

Stephen Lawrence

Article points

1. Based on the experience of helping to develop community diabetes care in Medway, the author has identified ten generic principles required to secure the success of any GPSI service.
2. A GPSI in diabetes has not the depth, knowledge or experience of a consultant diabetologist, but their knowledge of the condition is very advanced and, if it is aptly applied, can facilitate a gradual reduction in the number of less complex referrals to the diabetes unit.
3. It is likely that in the evolving NHS, GPSIs will be an essential link between primary and secondary care.

Key words

- Clinical assistant
- GPSI in diabetes
- Integrated care
- Service development

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The NHS Plan (Department of Health, 2000) aimed to establish at least 1000 GPs with a special interest (GPSI) by 2004, and the author took on the role of GPSI in Diabetes in November 2004. He had worked for 3 years as a clinical assistant, a role that enabled him to secure the confidence of consultant colleagues. This article outlines 10 principles for GPSI-led service success based on the experience of developing community diabetes care in Medway, Kent.

Embedded in the NHS Plan (Department of Health [DH], 2000) – in which the goal of establishing at least 1000 GPs with a special interest (GPSI) by 2004 was announced – was the inception of a new breed of GP. At this time the GPSI was dubbed, somewhat inappropriately, the "consultant GP" by the media. In fact, the position of GP with a "special" interest, rather than "specialist" interest (a subtle but very important distinction), was not such a new concept since there had hitherto existed similar roles under the guise of clinical assistants and hospital practitioners.

During the pre-GPSI era, in addition to running a busy surgery, many GPs went on to develop an interest in a particular field of medicine. Such interests were often quite informal and pursued in partnership with a consultant colleague who provided variable levels of clinical supervision and education in the chosen field.

The reality for many clinical assistants, however, was that they were essentially deemed an extra and relatively cheap pair of hands. They would shadow their consultant colleagues, receive limited support, and have very little (if any) input into service development in their chosen field. But, while the role of clinical assistant has been rather denigrated by some charting the development of the GPSI, the author's opinion and experience is that the role has provided an invaluable springboard to the development of the GPSI, especially in securing the confidence of consultant colleagues.

As a clinical assistant in the field for 3 years prior to becoming a GPSI in diabetes in November 2004, the author has had the privilege to gain insight into the mechanics of a successful GPSI-led service. Based on the experience of helping to develop community diabetes care in Medway, the author has identified ten generic principles required to secure the success of any GPSI service.

1. Consultant "buy-in"

It is essential to secure the confidence of secondary care colleagues, without which any GPSI service would flounder at the first hurdle, becoming simply an irritating appendage of secondary care. Both the author and another clinical assistant colleague had worked closely

with the local diabetologists for some years prior to becoming GPSIs. This close working relationship galvanised the confidence of consultant colleagues in the Medway team's working patterns and abilities.

2. GPSI credentials and professional development

An interest in a chosen field is an essential and defining prerequisite to the role of GPSI. However, it would be inappropriate to employ someone on these grounds alone with no development of skills or knowledge, short of reading the odd article. Clearly the opportunity to work out a clinical assistant apprenticeship (as the author did in diabetes) no longer exists, but approaching a local consultant colleague with a view to sitting in on a few outpatient clinics is recommended.

Beyond clinical experience, one should show evidence of ongoing development with regard to attending national professional meetings such as those of the Primary Care Diabetes Society and Diabetes UK. After several decades of relative inertia with regard to the development of new pharmaceutical agents, diabetes research has seen prolific growth prompted largely by landmark studies such as the UKPDS (UK Prospective Diabetes Study; Holman et al, 2008), Steno-1 and -2 (Gaede et al, 2003; 2008), the DCCT (Diabetes Control and Complications Trial; DCCT Group, 1995), and 4T (Treating to Target in Type 2 Diabetes; Holman et al, 2007), not to mention ACCORD (Action to Control Cardiovascular Risk in Diabetes; ACCORD Study Group, 2008) and ADVANCE (Action in Diabetes and Vascular Disease: Preterax and Diamicron MR Controlled Evaluation; ADVANCE Collaborative Group et al, 2008).

The GPSI in diabetes should ensure familiarity with such landmark studies because they have been a key part of shaping current management of people with the condition. As for GPSIs in other areas, the GPSI in diabetes should, at the time of annual appraisal, be able to produce evidence of ongoing professional development in this area in addition to a plethora of information surrounding work as a GP. Formal accreditation of the GPSI role has been debated by the Royal College of General Practitioners (RCGP). It is the author's opinion that colleagues pursuing a GPSI role in diabetes should also ultimately be working towards a diploma or MSc in diabetes.

3. Service needs analysis

Service needs analysis should indicate a need for the post of a GPSI, resulting in mutual benefit to care of people with diabetes in primary and secondary care.

By November 2004, Medway Maritime Hospital, like many others, was struggling with a growing diabetes burden. This was fuelled by greater awareness and subsequent identification of the silent epidemic of type 2 diabetes. As is common to all specialties, a proportion of inappropriate referrals also exacerbated the situation. GPs admitted to the need for guidance in diabetes care and people with diabetes were waiting for very long periods for their outpatient appointments. The PCT was keen to meet its obligations and was driven by the National Service Framework for diabetes (DH, 2003a). A needs analysis clearly indicated the requirement for a solution. While other models of service delivery were considered, the GPSI approach was deemed to be the most appropriate and cost-effective.

4. Consultant and GPSI contribution

The general principle of chronic conditions being amenable to GPSI role development holds true. However, to secure a successful joined-up service, both consultant and GPSI should be willing to contribute to further service development. Many meetings were required to address the potentially frustrating issues arising due to the peculiarities of general practice, of which the consultant was unaware. The PCT was keen to establish a seamless service across secondary and primary care, while being in the invidious position of maximising care with limited funds.

5. Unambiguous referral criteria

GPs were issued with clear guidelines for appropriate referrals. All referral to the

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1. Over 50% of people with diabetes seen in the diabetes GPSI clinic were discharged back to their GP with a detailed management plan lasting, in many cases, for more than a year.
2. There should be adequate provision made for administrative support since this forms the bedrock of infrastructure to the service.
3. Without effective succession planning, the service is vulnerable to the whims of illness, annual leave or team members simply moving on.
4. A GPSI in diabetes has not the depth, knowledge or experience of a consultant diabetologist, but their knowledge of the condition is very advanced and, if it is aptly applied, can facilitate a gradual reduction in the number of less complex referrals to the diabetes unit.

diabetologists are triaged by the GPSI and may be:

- Seen by the consultant.
- Seen in the GPSI clinic.
- Returned back to the GP with a referral proforma if the referral letter does not contain sufficient information to ensure maximal productive use of the outpatient appointment.

6. Discharge policy

The service should aim to discharge assessed individuals back to their own GP. There should be a management plan aimed at upskilling and empowering primary care colleagues for future referrals. Over 50% of people with diabetes seen in the diabetes GPSI clinic were discharged back to their GP with a detailed management plan lasting, in many cases, for more than a year.

7. Administrative support

There should be adequate provision made for administrative support since this forms the bedrock of infrastructure to the service. In Medway, the author was fortunate to have excellent administrative support.

8. Audit

It is essential to establish the efficacy of any GPSI service model. An audit of patient experience yielded very favourable results. Analysis of quality-of-life data also indicated improved glycaemic control in people referred to the clinic, although the changes coincided with the inception of the new General Medical Services contract in 2004, which also impacted positively on diabetes care (DH, 2003b).

9. Funding

There is an increasing trend towards community-based service care delivery closer to home – the point-of-care approach. Such a trend has, in some areas, created a tension between primary and secondary care colleagues, raising concerns around the potential destabilising effect as funding follows the individual. While there will inevitably be a need for increased investment in primary care to meet the rising demand, this should represent a fair redistribution of resources since, in spite of the efforts of primary care services, we are more likely to succeed in significantly delaying the onset of complications of diabetes rather than preventing them altogether. Thus the need for highly specialised, high-quality secondary care in diabetes will remain as an ageing population with diabetes develops the comorbidites with which we are familiar.

10. Experience

Succession planning is a natural aspect of an evolving service comprising not only the GPSI but also the healthcare assistant and diabetes specialist nurses. Without effective succession planning, the service is vulnerable to the whims of illness, annual leave or team members simply moving on.

The GPSI is not a consultant substitute – they are autonomous professionals in their own area of expertise. A GPSI in diabetes has not the depth, knowledge or experience of a consultant diabetologist but their knowledge of the condition is very advanced and, if it is aptly applied, can facilitate a gradual reduction in the number of less complex referrals to the diabetes unit. The majority of referrals arriving for triage gradually came to represent individuals with complex needs. While the significantly reduced outpatient numbers were welcomed by the consultants, they feel the resulting cases coming through to the outpatient clinic are more complicated, requiring deeper consideration.

In Medway, the author's team reached the relative luxury of being able to offer most people with diabetes a full 30-minute consultation. As the numbers being referred to the GPSI clinic gradually declined, the author's role shifted into targeting struggling individual practices to provide assistance to improve their diabetes care delivery through case study and roundtable discussions. In addition, a need to provide another service to well-performing practices was identified, in order to preserve the high standard of care.

The UK is among the lead in developed economies with regard to well-developed and high-standard primary care. There is good evidence indicating that primary care is the most effective system for people with diabetes and the health service. Unfortunately, there is quite a gulf in the UK between primary and secondary care and communication is poor in both directions. GPSIs would have enough knowledge to be a contact between primary and secondary care and have a mentor in secondary care, or work in a consultant's team, but they will not be full specialists. They should keep their generalist skills.

What plans are there for the development of GPSI accreditation?

Initially, RCGP and DH worked together so that PCTs made sure that GPSIs had a suitable qualification and also accepted work experience. It is very likely that as GPSIs increase in number, the process of accreditation will acquire greater rigor and consistency. Indeed, this is an aim for RCGP and other stakeholders.

The RCGP document for practitioners with a special interest in diabetes (RCGP et al, 2008) provides essential reading regarding competencies for the provision of services by practitioners with a special interest. It provides more detailed information to guide accreditors and practitioners towards the type of evidence and competencies that may be expected to be seen and tested during the nationally mandated accreditation process set out. Of particular importance in the emerging world of GP commissioning is the following comment derived from the RCGP guidance for GPSIs: "commissioners should note that the training and personal development of practitioners with a special clinical interest need to be ongoing and will require support from specialist practitioners and/or access to relevant peer support".

Conclusion

It is likely that GPSIs will increase in importance over the coming years, especially in the climate of an increasing government trend towards devolving greater responsibility and accountability to family doctors. It is likely that in the evolving NHS, GPSIs will comprise an essential link between primary and secondary care. They will be ideally placed to contribute significantly to person-centred service development by combining their knowledge of secondary care, PCT management and primary care. ■

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