Changing roles for diabetes healthcare professionals

Multi-professional working and development have emerged in the past 20 years as important primary care phenomena. This collaboration is integral to the way we help people with diabetes look after their condition, and grow together professionally (Humphris, 2007). In this edition of the journal we reflect on changing roles and responsibilities. On the patient journey that is diabetes, the person living with the condition will encounter a seemingly bewildering array of healthcare professionals (HCPs) across primary and secondary care settings.

Living with diabetes can open a door to an extended network of HCPs, which may include podiatrists, health educators, dietitians and retinal screeners. Those of us working in primary care realise that people with diabetes frequently find this confusing, and we need to help them understand how to identify, and use, the strengths of individual professional roles.

Secondary care

It is tempting to suggest that professionals working in secondary care have not had to confront the same contract and work-practice changes that primary care teams have. In a heart-felt polemic published in this edition of the journal (starting on page 126), a retired NHS consultant refutes this by reacting passionately to the Francis report on the Mid Staffordshire NHS Foundation Trust (Mid Staffordshire NHS Foundation Trust Inquiry, 2013). He blames many of the failings at this hospital on changes in systems implemented in the NHS in the past decade, which have led to suboptimal patient care. He urges his diabetes-focused secondary care colleagues to reconsider their roles in light of this report.

We do know that the number of all hospital consultants has expanded in the decade after the turn of the millennium, although this growth has now slowed (Federation of the Royal Colleges of Physicians of the UK, 2011). This coincides with a time when much of diabetes care has effectively been transferred to primary care. Equally, primary care teams have become accustomed to contacting hospital or community-based diabetes specialist nurses, many of whom can act as surrogate consultants, as they have considerable experience in implementing complex injectable regimens.

GPwSIs in diabetes

Ideally, GPs with a special interest (GPwSIs) in diabetes should be people who sit between the hospital and the general practice setting. Their role was envisaged as an intermediate grade and has given rise to the phenomenon of intermediate care (Department of Health, 2000). Commissioning of diabetes care in England, however, would appear to be upsetting this balance, with a call now coming for a re-evaluation of the GPwSI role (Schofield, 2013).

Primary care team dynamics

Roles and responsibilities have evolved quickly within the primary care team, which remains the most important unit for the person with diabetes in terms of accessing care and prescription-based regimens.

GPs are self-employed; they usually work in practice teams in the UK and plan care processes in this context. Although the number of GPs has not grown at the same rate as consultants, many have developed a real interest in diabetes, which has expanded on the back of the Quality and Outcomes Framework (QOF) over the past 10 years or so.

The role of the practice nurse remains central to a practice's diabetes care, with the number of these professionals and their individual responsibilities expanding quickly in the past 15 years (Humphris, 2007). A 2008 study found that practice nurses recognised their changing role on the back of the new General Medical Services (nGMS) contract and responded positively to it, although they had

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not always benefited financially. In addition, it has been recognised that, as with GPs, their workload has increased (McGregor et al, 2008). Practice nurses had to reluctantly accept the enhanced data recording needed on clinical systems to meet QOF requirements despite many feeling that this could be detrimental to the more holistic, patient-centred approach that they valued.

In this edition of the journal, the roles and responsibilities of healthcare assistants (HCAs) in diabetes care is critically examined (starting on page 120). In the piece, Jane Diggle raises justifiable concerns about HCAs being asked to expand their role into areas where they have no specialist competence or training, and she calls for an examination of this role and a careful appraisal of this group. As their employers, GPs should recognise the limitations of HCAs and be aware of professional boundaries and responsibilities, while encouraging HCAs to make the most of opportunities for training and upskilling.

Finally, GPs also have a duty to ensure that they, and their employees, code diabetes conditions accurately. In an adjoining comment piece (starting on page 116), Roger Gadsby and colleagues warn of the hazards associated with coding "diabetes resolved".

The pharmacist

Primary care team members will recognise that the community pharmacist has an increasing role in diabetes care with the growing "pill burden" experienced by people with diabetes. As chronic, multisystem illnesses become more common, the pharmacists' role in ensuring the safe and regulated dispensing of pharmaceuticals is vital.

In this edition of the journal, the role of the pharmacist is systematically appraised (starting on page 131). While recognising that the literature review had limitations in terms of its scope and evidence base, the reviewers found some evidence that pharmacists can help to reduce HbA_{1c} in some people with diabetes by aiding therapeutic concordance. They suggest that tight glycaemic control is extremely important early on in the course of the condition's management, and this review demonstrates the useful role that pharmacists can play in helping individuals successfully control their diabetes.

The person with diabetes

While the focus of this editorial is on the changing roles of HCPs, the fundamental building blocks of diabetes care are fashioned around patient-centred collaborative care. Patient empowerment can be defined as "helping patients discover and develop the inherent capacity to be responsible for one's own life" (Funnell and Anderson, 2004).

While working within the rigid constraints of the diabetes domain of QOF, and the "box ticking" mentality that it induces, HCPs should accept that people with diabetes should be the experts on their own lives and ultimately responsible for the choices they make. Overall management strategies should be explained to people living with diabetes, who are then facilitated to make their own changes in behaviour.

Forward together

The roles and boundaries of inter-professional diabetes care are changing and expanding. More professionals are joining teams, bringing new roles and responsibilities. All have important tasks and professional boundaries, but strengths and limitations should be recognised. The person with diabetes must be the focus of such teams and be empowered to understand the condition. Clear explanation of these inter-professional strategies should be provided to people living with diabetes, and they should be allowed to respond by seeking advice from the appropriate member of the team, and using this advice to make changes in behaviours of their own choosing. ■

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