A Primary Care Diabetes Society 2013 national survey of GPwSIs in diabetes

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PCDS
Primary Care Diabetes Society

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Article points

1. Survey results presented here provide the first comprehensive data-set on the demographics, clinical practice, education and accreditation of GPs with a special interest (GPwSIs) in diabetes.
2. Despite a decade of pleas for effective community-based diabetes care, this survey suggests that GPwSIs services, on the whole, are disorganised and dysfunctional, which in turn is doing a disservice to people with diabetes and the needs of the health service.

Key words

- GPs with a special interest
- Integrated care
- Questionnaire
- Service delivery
- Survey

Authors

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Despite the publication in 2008 of a comprehensive competency and accreditation guide relating to GPs with a special interest (GPwSIs) in diabetes, there remained a lack of data not only on the numbers of GPwSIs in diabetes working in England and Wales but also on what they do within their role and what level of expertise they have. Survey results presented here provide the first comprehensive data-set on the demographics, clinical practice, education and accreditation of GPwSIs in diabetes.

In England and Wales, the 2001 National Service Framework for Diabetes (Department of Health [DH], 2001) signalled a shift in the delivery of diabetes services from secondary care to primary care and this has been further promoted by the new General Medical Services contract, the associated Quality and Outcomes Framework (introduced in 2004), and the 2012 Health and Social Care bill, for which the key changes came into force in April 2013. The sum total of these changes is to bring the care of those with long-term conditions, and particularly diabetes firmly, within the domain of primary care and, in England, under the budgetary responsibility of the new Clinical Commissioning Groups (CCGs).

Funding changes have given GPs additional resources but they also now have the responsibility for delivering quality process components of diabetes care as well as outcomes that are clinically relevant and that matter to patients. Over this time the need for properly trained and accredited GPs with a special interest (GPwSIs) has emerged as a means of delivering improved access to services, previously for primary care trusts (PCTs) and now for CCGs (in England), both by providing clinical expertise in the community alongside other specialist professionals and by acting as a driver for integrated care.

Since 2006, when the Government signalled a clear move from secondary to primary care (DH, 2006), several publications from the DH (e.g. 2006; 2007) have heralded GPwSIs as being crucial to the delivery of effective and coordinated community-based diabetes services. As part of a huge GPwSI standardisation service, the Royal College of General Practitioners (RCGP), in conjunction with the DH and the Royal Pharmaceutical Society of Great Britain, set about producing 15 documents aimed at the then PCTs to set up and accredit a GPwSI service. It was clear in this documentation (RCGP et al, 2008) that GPwSIs could only be accredited as part of a planned local service and not as individuals, no matter how competent they were, and that this accreditation was not transferable from one area to another because of this. This was intended not only to provide a coherent framework within which GPwSIs could work but also to reassure patients that a GPwSI was a competent professional with enhanced skills, able to work autonomously but only as part of an integrated service.

Despite the publication of this comprehensive competency and accreditation guide for PCTs, there has remained a lack of data not only on the numbers of GPwSIs in diabetes working in England and Wales but also on what they do within their role and what level of expertise they have. Such information would be particularly

relevant for CCGs as they will have responsibility for commissioning of care, although not directly for accreditation of those providing the care (Schofield, 2013).

The survey presented here aimed to fill this information void.

Methods

The survey here was conducted using SurveyMonkey® (Survey Monkey, Palo Alto, CA, USA) between January and February 2013 using the Primary Care Diabetes Society (PCDS) database of GPs. The survey was emailed to 3010 opted-in GPs, which included those who had registered online or signed up at a PCDS event. Recipients who described themselves as a GPwSI were given 1 month to complete the survey and were sent a reminder by email after 2 weeks. None of the questions were made compulsory.

Subsequently, a supplementary questionnaire with a small number of follow-up questions was sent to responding GPs who supplied an email address as part of their completed survey.

Results

We had exactly 100 respondents to the survey, and a varying level of completion of the 35 questions asked, up to a maximum of 99%.

Location

There appears to be a reasonable geographical spread (*Figure 1*), with the notable exception of the East of England and North-East England, where no GPwSIs were recorded. Interestingly there were several GPwSIs in Scotland, where a structure for the provision of GPwSIs has not been in place. Most (62.5%) of respondents were male and the mean age was 47 years.

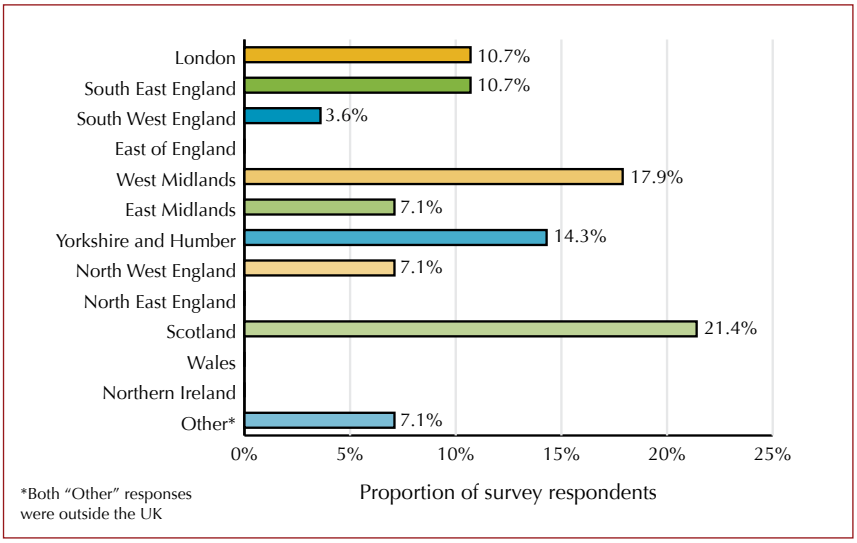

Figure 1. A summary of survey responses to the question: "In which part of the UK do you provide GPwSI services?" (n=28; sent as follow-up question to responders, not all of whom supplied contact details).

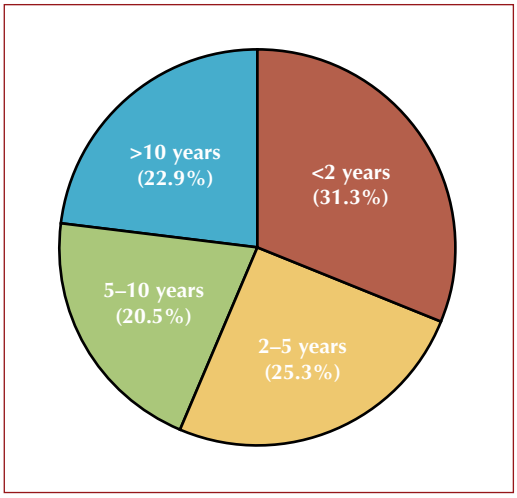

Figure 2. A summary of survey responses to the question: "How long have you worked as a GPwSI?" (n=83).

Employment

Thirty-nine per cent of respondents said they had a contract with a PCT, CCG or Health Board and only about 25% had been accredited as a GPwSI. When asked about how long they had been a GPwSI, answers varied from "just started" to "30 years". The duration distribution is shown as a pie chart in *Figure 2*.

Education and accreditation

Master's degrees had been obtained by only 9% of responders, with 50% listing a diabetes diploma as their highest postgraduate qualification and 20% having no formal qualifications. Interestingly 7% of responders listed MRCP as their highest postgraduate qualification. Only one-third of respondents had been through a formal accreditation process related to their work as a GPwSI at any point.

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"Respondents reported obtaining educational input from a variety of sources; a large majority read a specialist diabetes journal and more than half also attended diabetes conferences."

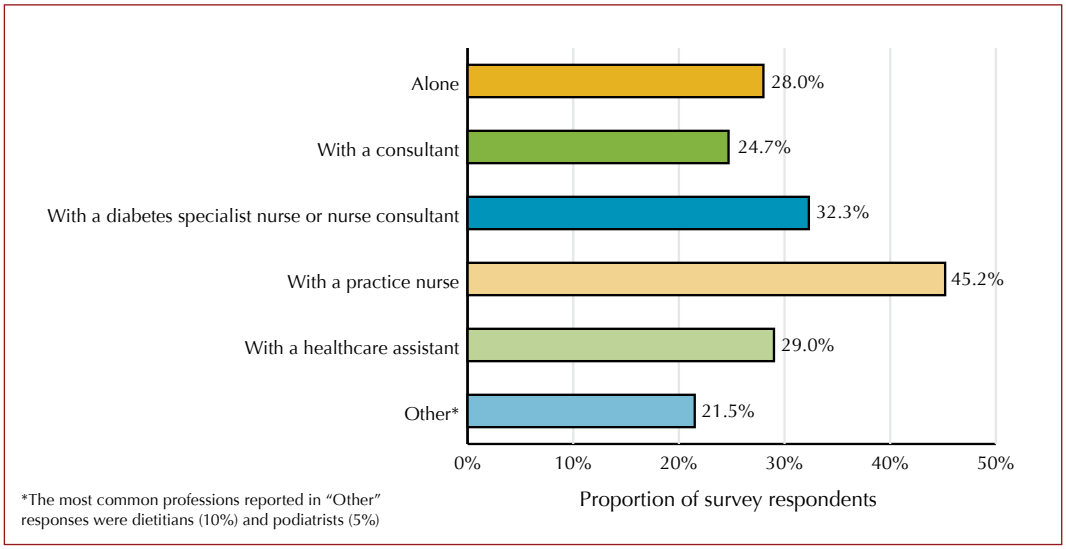

Figure 3. A summary of survey responses to the question: "When you work as a GPwSI, in what ways do you work?" (n=93; multiple responses allowed).

majority read a specialist diabetes journal, of which *Diabetes & Primary Care* was by far the most read, followed by *Practical Diabetes* and *Diabetic Medicine* (the latter indicating probable professional membership of Diabetes UK). More than half also attended diabetes conferences, of which the annual PCDS national conference and the *Diabetes UK Professional Conference* were the most frequently cited. Nearly two-thirds attended events sponsored by pharmaceutical companies.

When participants were asked about the types of educational events they would be interested in attending, traditional speaker-based events were preferred to webinars by a ratio of more than two-to-one. The content generally preferred was case-based discussion and learning about new technologies, although about one-third expressed an interest in telemedicine and IT.

Practice

The majority of respondents undertook one session of GPwSI work a week, while some carried out up to 4 sessions a week and 15% did one session a month or less. Most (75%) were partners in a GP practice, the vast majority of which were multi-partner practices (at least three GPs); only 7.5% worked in a single-handed or two-doctor practice. Only 15% of respondents were salaried GPs. Most (61%) worked in training practices and they were working a mean of 6.5 GP sessions a week.

When asked where the GPwSI sessions were delivered, most respondents (56%) stated that they worked in their own practice using their own practice IT system, with 21% working in a hospital and only 15% working in a community clinic. Only 12% used an IT system shared by primary and secondary care.

Less than one-third reported working with other GPwSIs in the same area and approximately two-fifths did not know how many other GPwSIs worked in their area. The majority worked alongside at least one other professional, the most common being a practice nurse, followed by a diabetes specialist nurse, a healthcare assistant and a consultant diabetologist; 25% were working alone (*Figure 3*).

Support

Over 70% of respondents provided support for colleagues, and this was mainly in person or by phone and to a much lesser degree by email or e-consultation. They also provided education to colleagues mainly by giving talks or contributing to locally produced educational material.

Similarly, most obtained consultant support directly or by phone or email but 25% said they had no direct support at all.

Over 80% of respondents had access to diabetes specialist nurses, diabetes education services and a rapid-access foot service. Continuous glucose monitoring, however, was only available to 25% of respondents.

Workload

Over 90% of respondents ran general diabetes or insulin clinics, with much smaller numbers doing specialist lipid clinics and specialist hypertension clinics (<10% for both). Interestingly, about one-third were involved in diabetes service planning. When asked about personal inclinations, most expressed an interest in clinical work (diabetes, lipids or hypertension), but almost half also expressed an interest in education (50%), service planning (40%) and psychology(25%).

With regard to referral patterns, over four in every five estimated that they referred on less than 10% of people with diabetes to secondary care, but nearly one in ten referred on more than 20% (a pie chart of the results is presented in *Figure 4*).

Service user engagement

When asked about patient input in service delivery, most respondents said that patients had "a lot" of or "some" input into the service, but one-fifth reported that patients had no input at all.

Comments from participants

Participants were asked to comment on their experience of being a GPwSI and to provide suggestions regarding the service offered, and several clear themes emerged from the responses.

Several commented on the new health priorities, observing that GPwSIs could play a pivotal role in keeping people out of hospital and that:

> "GPwSIs need support in the new NHS to avoid putting unnecessary pressure on secondary care"

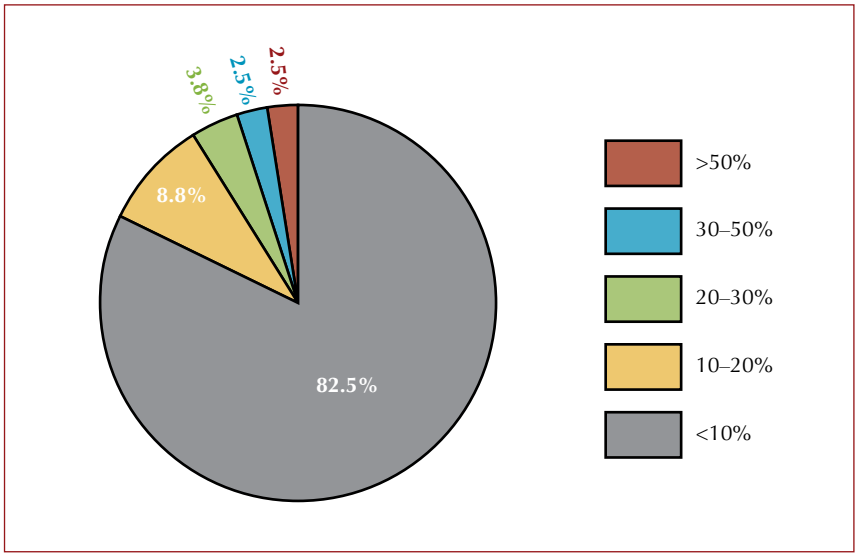

Figure 4. A summary of survey responses to the question: "What percentage of the patients that you see are referred on to secondary care?" (n=80).

Several people commented on the need for better integrated care and improved communication with both community-based and secondary care professionals. The need for standardised training and an accreditation procedure was also emphasised by respondents, and the dilemma of how appraisal and revalidation would work locally in practice was alluded to. The need for an agreed educational package tailored to GPwSIs beyond diploma level was suggested by some, as exemplified by the following comment:

> "We could do with a national agreed curriculum and advice on how to provide accreditation for GPwSIs."

Among the responses, the undertaking by GPwSIs of clinical specialist work such as Ramadan preparation and assisting with driving licence-related issues was mentioned, as was the equally important non-clinical role of service innovation, education and coordinating integrated care. A few respondents also commented on their feelings of professional isolation and lack of support.

Discussion

Although GPwSIs were first mentioned in the NHS Plan in 2000 (DH, 2000) and GPwSIs in

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diabetes have been around for at least 10 years, this is the first time there has been an attempt to publish a national profile of who they are and what they do.

Key limitations of this survey are that the responding sample was a self-selected (i.e. non-random) subset of all GPs, which means that generalisability of the results may not be perfect, and that the responders were self-defined as GPwSIs, rather than being defined according to set criteria. The impact of this limitation is exemplified by there being respondents from Scotland, where there are no formal GPwSI arrangements in place.

These limitations notwithstanding, the survey strongly suggests that the laudable ideals presented in the introduction to this article have largely broken down, both geographically and organisationally, with only 39% of respondents having a contract as part of a locality service and just 25% being formally accredited. In addition, less than 20% have achieved a Master's degree or equivalent, which was proposed as an acceptable level of educational attainment by the RCGP et al (2008). Although clearly fulfilling an important local role, both clinically and educationally, few of the respondents were working in a formal integrated care system and professional isolation was commonplace.

Given the current NHS reorganisation, reaccreditation was not high on the list of priorities for the evaporating PCTs and does not appear to be within the legal remit of new CCGs as this is essentially a provider function. Models of provision, such as "First Diabetes", in Derby (Rea et al, 2012), have an integrated financial model and support competency-based professional education across a wide spectrum of GPs, but they do not have the resources to train and accredit GPwSIs. NHS England, via its area teams, has a responsibility for setting standards within primary care; however, it is far from clear how the widely promoted models of integrated care (NHS Diabetes, 2012) can emerge and be supported and monitored for quality, service delivery and innovation.

Diabetes is an increasingly common and complex condition and is affected not just by other comorbidities but also by their treatment (Wami et al, 2013). Diabetes management is particularly suited to the holistic approach of primary care but, although numerous lifestyle and compliance issues are generic, many of the treatment challenges are complex, especially those concerning insulin, and this can result in suboptimal care (Peyrot et al, 2005)

Effective integrated diabetes care needs well-trained and motivated GPs with advanced clinical and organisational skills. Despite a decade of pleas for effective community-based diabetes care, this survey suggests that GPwSIs services, on the whole, are disorganised and dysfunctional, which in turn is doing a disservice to people with diabetes and the needs of the health service. ■

Department of Health (2000) *The NHS Plan: a plan for investment, a plan for reform*. DH, London

Department of Health (2001) *National Service Framework for Diabetes: Standards*. DH, London

Department of Health (2006) *Our health, our care, our say: a new direction for community services*. DH, London

Department of Health (2007) *Implementing care closer to home: Convenient quality care for patients. Part 3: The accreditation of GPs and Pharmacists with Special Interests*. DH, London

NHS Diabetes (2012) *Best practice for commissioning diabetes services: An integrated care framework*. NHS Diabetes, Leicester

Peyrot M, Rubin RR, Lauritzen T (2005) Psychosocial problems and barriers to improved diabetes management: results of the Cross-National Diabetes Attitudes, Wishes and Needs (DAWN) Study. *Diabet Med* **22**: 1379–85

Rea RD, Gregory S, Browne M et al (2012) Integrated diabetes care in Derby: new NHS organisations for new challenges. *Practical Diabetes* **28**: 312–3

Royal College of General Practitioners, Royal Pharmaceutical Society of Great Britain, Department of Health, NHS Primary Care Commissioning (2008) *Guidance and competencies for the provision of services using Practitioners with Special Interest (PwSIs): Diabetes*. DH, London

Schofield J (2013) What next for accreditation of GPs with a special interest? *BMJ Careers* 21 March

Wami WM, Buntinx F, Bartholomeeusen S et al (2013) Influence of chronic comorbidity and medication on the efficacy of treatment in patients with diabetes in general practice. *Br J Gen Pract* **63**: e267–73