

# GPs with a special interest: possible roles in diabetes care

Martin Hadley-Brown

## Introduction

The NHS Plan (DoH, 2000) formalised the position of GPs with special interests (GPSIs) and set targets for the numbers to be appointed. Diabetes was one specialty seen as appropriate for GPSI activity. However, few appointments have been made to date. In this article, the author looks at the possible roles for GPSIs in diabetes care, and explains how GPSIs might be appointed.

The central role of the GP within the NHS is traditionally that of a 'generalist' first contact doctor. He or she should be able to deal, at least to a preliminary extent, with any medical problem that a patient may present with. Herein lies one of the great attractions of UK general practice, namely its variety. However, while embracing that variety, there have always been GPs who have chosen to pursue a particular aspect of their work to a greater depth.

According to Professor David Haslam, Chairman of Council, Royal College of General Practitioners (RCGP):

*'The art of being a generalist is the key to any GP's work, and special interests are fundamentally there to complement, not replace, the core work of family doctors. But there is little doubt that enthusiasm for a special interest is truly beneficial to morale, recruitment and retention, and most importantly, to patient care.'* (DoH, 2003a)

For some these interests are clinical; for others they are educational or research based. Some GPs have worked in hospitals as clinical assistants, while others have become trainers and teachers, to give two frequent examples.

In recent years, GPs have also used their varied skills as organisers or policy makers within primary care trusts (PCTs). Now, both clinical and organisational expertise can be recognised within the

description of the GP with a special interest (GPSI).

The joint Department of Health/RCGP document *Implementing a scheme for GPSIs* (DoH, 2002) defines a GPSI as:

*'General practitioners with special interests supplement their important generalist role by delivering a high quality, improved access service to meet the needs of a single PCT or group of PCTs. They may deliver a clinical service beyond the normal scope of general practice, undertake advanced procedures, or develop services. They will work as partners in a managed service not under direct supervision, keeping within their competencies. They do not offer a full consultant service and will not replace consultants or interfere with access to consultants by local general practitioners.'*

## The NHS Plan

The NHS Plan, an ambitious aspiration to remodel the NHS to fit 21st century needs, was published by the Department of Health in 2000. It promises the delivery of improved clinical care while also providing a better experience for patients – more choice, faster access and greater convenience.

The NHS Modernisation Agency was formed to implement this plan. An offshoot of this agency, the National and Primary Care Trust Development Programme (NatPaCT) became heavily involved in formalising the recognition of the roles of practitioners with special

## ARTICLE POINTS

**1** Work as a GPSI may add a positive extra dimension to your work.

**2** Not all practitioners with special interests need be GPs.

**3** GPSIs are appointed and accredited by local PCTs. Terms and conditions of service are for individual negotiation.

**4** The ability to work constructively with colleagues from both primary and secondary care is essential to the success of any GPSI.

**5** Care must be taken to avoid professional isolation as a GPSI. Primary care specialist societies, such as the new Primary Care Diabetes Society, can be helpful.

## KEY WORDS

- GPSIs
- Diabetes care
- Primary care trust
- Accreditation
- The NHS Plan

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**Table 1. Comparison of consultant and GP workforce totals in 1993 and 2003\***

Workforce totals	1999	2003
Consultants	23 321	29 217
GPs	28 467	30 598

\*DoH figures comparing 31.9.99 and 31.12.03, published in DoH (2004)

### GP SPECIALTIES

- Care for older people
- Child health
- Epilepsy
- Headaches
- Coronary heart disease and echocardiography
- Dermatology
- Diabetes
- Sexual health
- Mental health
- Palliative care
- Respiratory disease
- Emergency care
- Ear, nose and throat
- Drug misuse

*Figure 1. Initial targets specialties for GPSI services.*

interests. GPs are not the only professionals to be recognised in this way – there are also programmes involving nurses, optometrists and other therapists.

Within the Department of Health paper *Practitioners with Special Interests* (DoH, 2003a) is stated the ambition to provide one million extra outpatient appointments in primary care rather than hospitals by 2006. Another ambition is a maximum waiting time for a first outpatient appointment of 3 months by 2005. To achieve this shift of service into the community, the NHS Plan promised 1000 GPSIs taking referrals from other GPs by 2004.

Interestingly, this is all to happen within a workforce where, between 1999 and the end of 2003, consultant numbers have risen by 25.3% but GP numbers by just 7.5% (DoH, 2004; *Table 1*).

### GPSI GENERALIST SKILLS

- Interpersonal communication
- Teamworking
- Leadership
- Teaching and training
- Planning and service development
- Participation in audit and clinical governance

*Figure 2. Generalist skills expected of a GP with Special Interest (GPSI).*

Within this framework, however, lies the opportunity for GPs with specific areas of clinical interest and experience to be commissioned by PCTs to use their expertise for the benefit of their local healthcare community.

Following the launch of the NHS Plan, the NHS Modernisation Agency started work to develop guidelines and models for PCTs wishing to appoint GPSIs, and later other practitioners with special interests from other professions. Much of the GPSI work was undertaken and coordinated by Dr Clare Gerada, a GP with special interests in mental health and substance misuse, working under an arrangement between the RCGP and the Department of Health. The existence of a number of primary care specialist societies reflects fields with a track record of successful specialist GP work and these organisations were consulted during the drafting of GPSI guidelines.

*Figure 1* lists the clinical specialties that can be covered by GPSIs (DoH, 2002). For diabetes, the 'primary care specialist society' role was fulfilled by Primary Care Diabetes UK (PCDUK), which was an integral part of Diabetes UK until 2004. Following a recent reorganisation of Diabetes UK, PCDUK has disappeared as a distinct entity within it, and is to reform alongside, but independent of, Diabetes UK as the Primary Care Diabetes Society in 2004.

### Generic skills for GPSIs

Although specific guidelines have been developed, two groups of skills have been defined. These are generic skills applicable to a GPSI in any specialty, and

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**1** The GPSI role offers GPs with specific areas of clinical interest and experience the opportunity to be commissioned by PCTs to use their expertise for the benefit of their local healthcare community.

**2** The existence of a number of primary care specialist societies reflects fields with a track record of successful specialist GP work.

**3** Two groups of skills have been defined: generic skills applicable to a GPSI in any specialty, and specific skills relating to the clinical area to be covered.

### GPSI SPECIALIST SKILLS

- Diagnosis, assessment and continuing management of diabetes in primary care, including psychosocial aspects
- Continuing care of people with diabetes in ways that minimise the impact of the illness and optimise long-term health outcomes
- Prescribing relating to diabetes and related morbidities
- Coordination and use of local services
- Roles, structures and responsibilities of PCTs and methods of influencing them
- NSF for Diabetes, including national and local implementation strategies
- Other local and national policies and guidance relating to the care of people with diabetes

Plus:

- An ability to promote and support the education of people with diabetes to facilitate their self-management
- The ability to engage with service users and involve them in service planning and monitoring

Figure 3. Specialist skills expected of a GPSI in diabetes.

specific skills relating to the clinical area to be covered. Generalist skills are listed in *Figure 2* (DoH, 2003b)

For a GPSI in diabetes, the subject-specific skills listed in *Figure 3* are suggested.

#### How do I become accredited as a GPSI in diabetes?

There is no centralised GPSI accreditation, as stated in DoH guidance (DoH, 2003a; *Figure 4*).

The guidance document for GPSIs in diabetes draws heavily on a paper produced by the Association of British Clinical Diabetologists (ABCD), the consultant special interest group. The ability of this group to produce a considered document on this subject in a short time is an object lesson to those who doubt the need for primary care specialist societies, as PCDUK was being disbanded by Diabetes UK during the time of these consultations. Hence the GPSI document on diabetes perhaps bears more of a secondary care influence than might otherwise have been the case. That said, constructive and amiable discussions did take place between senior members of ABCD and primary care diabetes specialists, and these continue.

The document suggests the acquisition

of experience working under the direct supervision of a consultant physician with special interest in diabetes to a total of perhaps 40–50 sessions, at least for a practitioner without previous specific experience of diabetes care. In addition, a personal development portfolio showing evidence of advanced clinical skills and education acquired in a multidisciplinary environment is recommended. Attendance at appropriate courses, perhaps supported by the acquisition of a diploma qualification, is also helpful.

The RCGP recommends the maintenance of a personal development portfolio countersigned by an appropriate educational mentor or supervisor. Such a person is to be decided by the employing PCT, but local consultant diabetologists would be appropriate. An annual minimum of 15 h of continuing professional development activity in the specialist area, together with appraisal in both generalist and specialist work, is suggested, as is membership of an appropriate professional network e.g. a primary care diabetes society and Diabetes UK.

#### Appointment of a GPSI by a PCT

PCTs will differ in their reasons for seeking to appoint a GPSI. In some, the

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**3** The RCGP recommends the maintenance of a personal development portfolio countersigned by an appropriate educational mentor or supervisor.

**4** An annual minimum of 15h of continuing professional development activity in the specialist area, together with appraisal in both generalist and specialist work, is suggested, as is membership of an appropriate professional network.

## PAGE POINTS

**1** In some PCTs the aim may be to provide an intermediate level of clinical services that are more specialised than those offered by local practices but stop short of the need for consultant attention.

**2** In other PCTs the GPSI might be tasked with planning and supervising the provision of community diabetes services, with little or even no actual clinical activity.

**3** Before appointing a GPSI there should be a strategic assessment of service needs, provision and priorities.

**4** GPSIs are only one of a number of options available to PCTs, and other practitioners or service models may be more appropriate in a given situation.

## ACCREDITATION AND ASSURING THE QUALITY OF SERVICES

Practitioners with a special interest have extensive training and experience in their specialty as well as their formal professional qualifications as GPs, nurses or other professionals. This is a prerequisite of the service, and the PCT, with support from the local acute sector, is ultimately responsible for ensuring that practitioners have the appropriate skills and knowledge to deliver services to the highest standards.

Accreditation is a local decision for PCTs, and routes to accreditation differ from practitioner to practitioner. Some have diplomas or similar formal qualifications, while others offer the PCT more experience-based evidence of their competencies. It is for the PCT, drawing on the expertise of secondary care clinicians and managers, to set the competencies needed to deliver the service and to ensure that each practitioner meets these before accrediting them as a practitioner with a special interest.

*Figure 4. Accreditation and assuring the quality of services (DoH, 2003a).*

aim may be to provide an intermediate level of clinical services that are more specialised than those offered by local practices but stop short of the need for consultant attention (ABCD, 2002; Figure 5).

In other PCTs the GPSI might be given the task of planning and supervising the provision of community diabetes services, with little or even no actual clinical activity. In any event, it is hard to conceive the idea of a GPSI working in isolation – diabetes care is a collaborative enterprise.

Whatever the local model, a properly considered analysis of the job and service specification is essential. The job plan should be in place before the GPSI appointment is finalised, although in practice this has not always been the case.

PCTs have access to another very useful DoH paper, the *Step-by-Step Guide to Setting up a GPwSI Service* (NATPACT/01/CE or via [www.gpws.org](http://www.gpws.org)). This starts with the premise that experience has shown that a successfully implemented GPSI service will be a joint PCT and acute trust initiative. The document goes on to make five key points:

1. Before appointing a GPSI there should be a strategic assessment of service needs, provision and priorities.
2. GPSIs are only one of a number of options available to PCTs, and other

practitioners or service models may be more appropriate in a given situation.

3. Patient groups should be involved in the development and planning of new services.
4. The support of all parties affected by a service should be gained, from service users to GPs who may be making referrals, other professionals (e.g. DSNs, dietitians, podiatrists) and local consultants.
5. The clinical role of GPSIs is not the only one that may be called upon. Their role as trainer, coach and educator to other professionals, or as a service developer or planner, may be equally important.

The guide then develops these points, giving PCTs a useful template, and discussing in detail issues ranging from service provision, appointments, records and training to employment status and indemnity.

Unfortunately, despite the availability of well-worked guidelines such as these, there remain far too many tales of GPSI appointments made without effective prior planning. Thus there are GPSIs unclear of their roles, lacking professional support, and who may be dangerously vulnerable should things go wrong.

However, if care is taken with the creation of a GPSI (diabetes) post, there is undoubtedly the potential to

**WHICH PATIENTS SHOULD THE GPSI SEE?**

No set model – ‘the type of patients and referral process will depend on specific local factors including current service provision across the PCT and the competence of the GPwSI’

**WHO SHOULD STILL BE SEEN BY SPECIALISTS?**

Children and adolescents with diabetes

Pregnant women with diabetes

Patients with unstable type I diabetes or those susceptible to repeated severe hypoglycaemia, hyperglycaemia or diabetic ketoacidosis

Patients with complications, e.g. retinopathy, nephropathy or foot problems requiring specialist management of those complications or associated risks

Those requiring specialist psychological support

Those with rare or unusual types of diabetes

Those who choose specialist diabetes care, or whose GPs choose to refer them for such care

Figure 5. Guidelines for the appointment of a GPSI in diabetes (DoH 2003b).

offer an improved community diabetes service and an attractive job. It should be possible to work towards NHS Plan targets of accessible, appropriate high quality services, while adding to the attractiveness of general practice as a career path.

**Pay and conditions of service**

There are no nationally negotiated or recommended terms or conditions of service for GPSIs. Approximate figures mentioned on Department of Health websites are in the region of £200 per session, but actual appointments have been made both at higher and lower figures. Pay is not the only aspect of the job requiring negotiation – others include:

- Professional indemnity
- Resources for continuing professional development
- Accountability, governance and appraisal
- Scope of the service: who is seen, where and when?
- Relationships with secondary care
- Availability of supporting staff: DSNs, podiatrists, dietitians, and clerical staff.
- Administrative arrangements and support: appointments, letters, audit.

**Conclusions**

The GPSI role is a recognition and extension of the work that many GPs have been doing for years. It is an opportunity for career development for GPs who wish it, and for service development by PCTs for patients. Local flexibility is a strength, but also contains potential pitfalls. Some excellent work has been done producing guidelines regarding GPSI appointments. Too often, however, such appointments are being made with inadequate preparation. The success of a GPSI service is likely to be proportional to the care with which it is developed. ■

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**PAGE POINTS**

**1** There are no nationally negotiated or recommended terms or conditions of service for GPSIs.

**2** Other areas of the job that require negotiation include: professional indemnity, resources for continuing professional development, accountability, governance and appraisal, and the scope of the service.

**3** The GPSI role is an opportunity for career development for GPs who wish it, and for service development by PCTs for patients.

**4** The success of a GPSI service is likely to be proportional to the care with which it is developed.