The evolution of GPwSIs in diabetes: A need for organisation

The concept of a General Practitioner with Special Interest (GPwSI) was first floated in the NHS Plan of 2000 (Department of Health [DoH], 2000). By 2004 it was planned to have 1000 GPwSIs in post and accepting referrals as part of the overall target of achieving 1 million extra outpatient appointments in primary care by 2006 (DoH, 2000).

It was envisaged that GPwSIs should:

- supplement their generalist role by delivering a high-quality, improved access service to the needs of primary care organisations
- work as partners in a managed service
- keep within their competencies
- not replace consultants or interfere with access to consultants.

In a commentary in 2002, David Colin-Thome, the National Clinical Director of Primary Care, suggested such posts would be popular as part of a portfolio career on the basis that 16% of GPs had a clinical special interest in addition to their general practice work (Colin-Thome, 2002).

At about the same time, and in response to DoH overtures, the Association of British Consultant Diabetologists (ABCD) produced a discussion paper (ABCD, 2002) supporting the clinical concept of GPwSIs and citing both the rapidly increasing prevalence of diabetes and the clear evidence that improved metabolic control in diabetes delays, and in the case of retinopathy can prevent, complications arising.

All this early encouragement was tempered with caveats about training and acquisition of competence as well as accreditation, appraisal and re-validation. In many cases, GPwSIs in diabetes have migrated from secondary care posts and have gained experience over several years. The ABCD document suggests that a certificate of competency from a local consultant diabetologist might be a 'sufficient guarantee' of adequate training.

The now defunct NHS Modernisation Agency was responsible for implementing the GPwSI model and it produced a general document on GPwSIs in 2002 for PCTs (in conjunction with the Royal College of General Practitioners [RCGP]; DoH/RCGP, 2002) and a specific document on the appointment of GPwSIs in diabetes in 2003 (DoH, 2003). This was one of 15 such speciality-focused documents. Also in 2003, PCTs were issued with a specific step-by-step guide to setting up a GPwSI service (National Primary and Care Trust Development Programme [NatPaCT], 2003).

This useful document covers service design, clinical governance, risk assessment and audit and evaluation, and discusses models for accreditation. A sample contract for a GPwSI is shown on the NatPaCT website (www.natpact.nhs.uk/uploads/PDF - Supporting Documents.pdf [accessed 28.06.05]) and reference made to the fact a GPwSI can have a training and educational role, as well as taking part in stategic planning and review. This may play a significant part in how the post develops.

Moreover, the step-by-step guide advises PCTs to look at the development of the GPwSI service holistically based on a strategic service review. It encourages PCTs to look at options for service delivery and to make sure the service is designed around the patient pathway with patient involvement from the outset.

So, it seems as if PCTs are not short of advice as to how to implement this core part of the NHS Plan. However, so much about the detail is vague, which may suit PCTs, but I would suggest does not suit the doctors undertaking the job. The problems are summarised in *Table 1*.

Is there need for a diabetes GPwSI support organisation?

It seems to me that no other title-protected group of professionals, let alone doctors, could

Brian Karet

Do you have any comments on GPwSIs in diabetes? Please send them to

editorial@sbcommunicationsgroup.com

Brian Karet is a GP at Leylands Medical Centre, Bradford, and is a GPwSI in diabetes.

Table 1. The problems associated with setting up a GPwSI service.

- No central GPwSI accreditation model
- No agreed model contract
- No agreed remuneration scale
- No mentorship/ CPE (continuing professional education) model
- No agreed standards of audit/evaluation

justify the provision of a high-quality service to the public without some degree of standardisation. Such situations are common, however, and the current set-up with diabetes specialist nurses is an example in point, with no national training programme and no agreed role or job description for them.

Given the Government's light touch and the devolution of almost all aspects of GPwSI delivery to PCTs, local arrangements might suffice as long as there is agreement from all parties. But I would suggest such cosy local arrangements do not help the evolution of the service and do not give confidence to patients, commissioners or secondary care colleagues.

At a time when other aspects of diabetes care are being standardised (e.g. retinopathy screening, education), it seems illogical to have wildly varying working arrangements for GPwSIs. Already some PCTs are devolving accreditation arrangements to local postgraduate Deaneries, while others are using ad hoc local agreements often based on historical activity. Where I work in Bradford, we have 18 GPwSIs in diabetes alone, with significant variations in working arrangements. Many PCTs, however, where a service exists at all, have GPwSIs working in isolation, albeit with some level of secondary care support.

Given the future requirements of practice-based commissioning, this does not seem to be a sensible or safe option and the least the GPwSI should expect is some peer support without stifling the need to tailor service provision to local need. We need to discuss clinical and organisational aspects of care (which are often very different to those in secondary care) with colleagues, while at the same time keeping up-to-date through training, protected learning and audit.

The recent establishment of the Primary Care Diabetes Society (PCDS), which this journal represents, is to be greatly applauded as a voice and a forum for those who believe that high-quality diabetes services can be delivered in the primary care setting. However, not all doctors delivering diabetes services in primary care can, or even want to, become GPwSIs, but transparent pathways where GPwSIs exist must be developed to give credibility and authority to that aspect of the service .

The importance of discussion

It makes little sense to have a GPwSI support organisation divorced from the PCDS in either its house journal or its secretariat, and it is to be hoped that the PCDS can take the GPwSI cause forward. It should, however, try to be an independent voice and should be recognised as such. To achieve this, some model of assessment of competence and accreditation must be agreed upon regionally or nationally, although it is unlikely in the short term that this would be through a single postgraduate qualification. A support organisation should take part in discussions on these topics and act as a forum for debate.

Discussion among GPwSIs can be facilitated in a number of ways. An internet chat room is an increasingly popular method of exchanging views and raising topics for discussion. Face-to-face meetings and information dissemination are also both desirable roles.

Some PCTs may feel threatened by such an organisation impinging on their authority. They should not worry. The recent Audit Commission report on primary care commissioning (2004) notes very patchy service redesign by PCTs with only 17% of PCTs having GPwSIs in five or more areas and 36% of GPwSIs working in isolation. There are many areas where service redesign with GPwSIs has resulted in significant efficiencies, and support from local and national GPwSIs would facilitate this move.

This article is a sounding board for the idea of an independent, sustainable and recognised support organisation for GPwSIs. The NHS Plan's grand ideas have progressed – but how far? There is currently little idea of how many GPwSIs there are or what impact they are making. This is not a viable position, and, as professionals, I feel we have an obligation to our patients and ourselves to demonstrate we are worth the investment, in terms of both money and trust. ■

Association of British Clinical Diabetologists (ABCD; 2002) *General Practitioners with a Special Interest in Diabetes.* ABCD, London

Audit Commission (2004) *Quicker treatment closer to home.* Audit Commission, London

Colin-Thome D (2002) The NHS Plan: general practitioners with special interests. *British Journal of Cardiology* **9**: 359–60

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

DoH (2003) *Guidelines for the appointment of General Practitioners with Special Interests in the Delivery of Clinical Services: Diabetes.* DoH. London

DoH/Royal College of General Practitioners (RCGP; 2002) *Implementing a scheme for GPwSIs.* DoH/RCGP, London

National Primary and Care Trust Development Programme (NatPaCT; 2003) Practitioners with special interests. A Step by Step Guide to setting up a general practitioner with special interest (GPwSI) service. DoH, London