Intermediate care: Bridging the gap

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Standard 4 of the National Service Framework (NSF) for diabetes (*Clinical care of adults with diabetes*; Department of Health [DoH], 2001a) states that 'all adults will receive high quality care throughout their lifetime.' This recommendation comes at a time when both community and specialist services are struggling to cope with the increasing number of people with diabetes. It is important to remember that the NSF for diabetes is not the only framework to be published: the shift of care to the primary sector in several of the other NSFs (such as those for coronary heart disease [DoH, 2000] and older people [DoH, 2001b]) has had a huge impact on the workload of primary care health professionals.

Background and aims

Historically, specialist services in diabetes have continued to care for people without ongoing acute complications of diabetes, either solely or on a shared-care basis, as well as those who truly require a specialist service. This is quite rightly changing.

There is much expert knowledge on diabetes within primary care that can be used to care for people with diabetes who, despite needing more intensive input, are not yet ready – and may never be ready – for the specialist service. This knowledge is being used in initiatives that can be grouped together under the title of 'developments in diabetes care' or 'developments in intermediate care'. Intermediate care services are those that are designed to bridge the gap between primary and secondary care, in order to relieve the pressure on specialist services and support diabetes care in general practice. This type of care can include the employment of 'practitioners with a special interest'. This group includes not only GPs but also other professionals such as nurses, physiotherapists optometrists, podiatrists, dietitians, community pharmacists and healthcare assistants working within primary care.

The aims of these intermediate service developments are:

- expert triage of people with diabetes
- appropriate and up-to-date treatment of people with diabetes
- development of primary care skills
- education of both primary care staff and people with diabetes.

Reasons for service developments

There are several reasons for these intermediate service developments.

Waiting list times

Waiting lists of people to be seen by a specialist team are increasing day by day. This is due to the increase in the number of people with diabetes. In some cases, this is without any additional healthcare professionals being employed, although some practices are now employing their own diabetes specialist nurses (DSNs). In addressing the waiting list times it is necessary to reduce referrals to secondary care. Although many practices deal with early complications of diabetes, there are still some that are deemed to refer inappropriately when the problem could be dealt with in primary care. Expert triage within primary care will reduce the number of referrals to the specialist service.

Insulin initiation

There is an increasing number of people with type 2 diabetes going on to insulin, and although this is traditionally seen as a role for the specialist service, many practices now initiate insulin treatment. This will improve the quality of care for people with diabetes and lower the cost of care, if referrals to secondary care are reduced.

Preference for specialist knowledge

Continued attendance at secondary care clinics may be because some practices would prefer their diabetes population to be seen by someone with more specialist knowledge than they feel they have. However, some specialist teams have discontinued their annual review and old-style follow-up clinics and are now holding true 'specialist' clinics for those people with diabetes who have more complex problems.

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Intermediate care services

Anecdotally, people with diabetes prefer to be seen in primary care, although some would still prefer to be seen by the specialist team, as they perceive this to be the 'gold standard'. Many specialist centres are also on direct public transport routes, actually making access easier. It would seem sensible therefore to locate intermediate care centres as conveniently as possible for the population that they serve.

So what do intermediate care services look like? There appears to be a variety of services across the country. Our district has looked at these more closely and identified the skill mix, which includes GPs with a Special Interest (GPwSIs), DSNs, podiatrists, dietitians, pharmacists, healthcare assistants and administration staff. In areas where recruitment of specific services is difficult, such as dietetics, healthcare assistants have been trained to deliver dietary and podiatry advice.

Other innovations include healthcare assistants performing annual review checks (including those of housebound people and care home residents) and pharmacists conducting medication reviews as part of an annual check.

One of the options available for intermediate care would be to have a GPwSI working with a DSN or a primary care clinic run by a consultant physician. A GPwSI would provide leadership to integrate services between primary and secondary care and provide support for other GPs (Diabetes UK, 2003). Developing joint working practices is something being looked into by many areas. It would also avoid duplication of care.

The lead in these services is most often a GPwSI, although there are some areas with a lead DSN or a community consultant in diabetes who dedicates a certain amount of time to this initiative. Whoever leads the service should have an accredited qualification in diabetes or specialist experience.

There are at least two other options available:

- 'focused enhanced services', where a small number of practices provide locally enhanced services for their own service users and those from other practices
- 'generally enhanced services', where diabetes skills are enhanced in all practices who wish to do so.

Some practices are already providing an excellent, comprehensive diabetes service. Further help required by practices is likely to include resources (mainly staffing), support from the specialist team, education for professionals and group education for people with diabetes. It is hoped that the savings made from reducing referral and waiting list times in secondary care will fund the extra resources required for development of diabetes services in primary care. Greater Manchester Strategic Health Authority set up a 'Tier 2' initiative 3 or 4 years ago to do just this.

Before developing an intermediate service, most areas have asked their practices for a baseline assessment of their diabetes care, which in itself is a very useful exercise. The purpose of this is threefold:

- to identify gaps in the service so that these can be addressed
- to raise awareness in the specialist services and the primary care trust of the skills that are already in place in their practices (this helps give the specialist team confidence in planning and implementing discharge policy)
- to enable planning and development of the entire service.

An important factor in all of these services is ensuring that they can be monitored so that their value and impact can be measured, resulting in ongoing changes and improvements.

Conclusion

It must be remembered that a single model for intermediate care will not be possible, given the variations in population, location and staffing levels. These services have been developed in a flexible way with a long-term aim of further enhancing the quality of patient care available in practices. ■

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Department of Health (DoH; 2000) *National Service Framework for Coronary Heart Disease – Modern Standards and Service Models.* DoH, London

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

DoH (2001b) *National service framework for older people.* DoH, London

Diabetes UK (2003) Position statement: General practitioners with a special interest in diabetes (GPwSIs). Diabetes UK, London