Commissioning GPSI services: Achieving service provider status

Stephen Lawrence

Article points

1. An interest in the chosen field is an essential and defining prerequisite to the role of the GPSI.
2. Since its inception, the GPSI clinic has seen a progressive reduction in the number of referrals to both the community and hospital clinic.
3. The establishment of a practice-based service in diabetes works best if it has evolved from a pre-existing service.
4. Diabetes service development now lies in the hands of primary care.

Key words

- Practice-based provider
- Commissioning GPSI services
- Developing practice

Stephen Lawrence is an Intermediate Care Provider for Diabetes via GPSI-led community clinics for Medway PCT, Kent.

Over the past 18 months, the author has been involved in developing a provider role for intermediate diabetes care under the auspices of practice-based commissioning (PBC) and the project is now nearly complete. The new service redesigns an existing intermediate diabetes care clinic that has been running since its inception in November 2003. In this article, Stephen shares his experiences to provide information to those who have a desire to progress their diabetes interest to the status of service provider within PBC.

In 2000, the Department of Health (DoH) published their NHS Plan (DoH, 2000), part of which involved establishing at least 1000 GPSIs by 2004. Unbeknown to the pundits of the day, this new breed of GP, inappropriately dubbed ‘consultant GPs’ by the mass media, marked the beginning of a process that we now know as practice-based commissioning (PBC).

The GP with Special Interest, rather than Specialist Interest (a subtle though important distinction), has its origins in the era of clinical assistants when GPs would shadow their consultant colleagues, receive limited educational support and have little if any input into service development or redesign. While the role of the clinical assistant has been criticised by some who embrace the brave new world of the GPSI, my experience of being a Clinical Assistant in Diabetes proved invaluable in evolving into the role of GPSI; and the latter was instrumental in acquiring the experience and skills in order to embark on becoming a provider within PBC. While many of us are now entirely familiar with the principles of PBC, fewer may have fully grappled with the issue of the practice-based provider and all that this role entails. In order for a stable market economy to survive there must exist providers of services that can be commissioned.

I have been fortunate enough to receive an increasing amount of support from Medway PCT and the local consultant diabetologists in moving from the role of clinical assistant to that of current proposed practice-based provider. Indeed, it is essential in the process of setting up a community diabetes service to secure the confidence of secondary care colleagues in order to ensure that you do not simply become an irritating appendage of secondary care; and to optimise the development of the patient care pathway.

An interest in the chosen field is an essential and defining prerequisite to the role of GPSI. However, it would be inappropriate to employ someone on these grounds alone with no development of skills or knowledge, short of reading the odd article. The opportunity to work out a clinical assistant apprenticeship in diabetes, no longer appears to exist due to the positions being increasingly converted to GPSI posts, but one could approach local consultants with a view to sitting in on a number of outpatient clinics. Beyond clinical experience, one should show evidence of continuing professional development, for example a diploma or MSc in diabetes.

Setting up a GPSI clinic

A needs analysis should be performed, which should support the need for a community diabetes clinic resulting in mutual benefit to people with diabetes, and the delivery of primary and secondary care.

Local reasons for setting up a GPSI clinic

By November 2003, Medway Maritime Hospital, like many others, was struggling with an increasing diabetes burden – fuelled by increased diabetes awareness of both the person with diabetes and the healthcare professional. The number of GP referrals to the diabetes unit soared; which only served to exacerbate the situation and left people with diabetes waiting inordinately long periods for their outpatient appointments. The local GPs admitted the need for guidance on diabetes care and the PCT was keen to meet its obligations as driven by the NSF. While several models were considered as possible resolutions, the GPSI post was considered to be the most appropriate and cost-effective.

GPs were issued with clear guidelines for referring a person with diabetes appropriately; and all referrals to the diabetologists are triaged by the GPSI with one of the following outcomes.

- The individual is seen by the consultant or the GPSI in a hospital clinic.
- The individual is seen in the GPSI clinic.
- The individual is returned to their GP if the referral letter contains insufficient information to ensure maximal use of the outpatient appointment (*Box 1*).

The service was audited to establish the efficacy and efficiency of the GPSI model (see *Box 2*); and an audit of people with diabetes' experiences of the clinic yielded very favourable results. Data also indicated that glycaemic control improved quality of life in those referred to the GPSI clinic.

Local results

The GPSI diabetes service was established with a strong ethos towards, wherever possible, discharging assessed individuals back to their own GPs with a specific management plan aimed at empowering primary care colleagues with regard to the future management of similar cases. In the first 2 years of the scheme, more than 50% of individuals with diabetes who were referred were discharged back to their GP with a detailed management plan: lasting in many cases for more than a year.

Since its inception, the GPSI clinic has seen a progressive reduction in the number of referrals to both the community and hospital diabetes clinics. The majority of referrals arriving for triage are entirely appropriate and represent more complicated cases. While the significantly reduced outpatient numbers are welcomed by the consultants, it is felt that the more complex cases coming through to outpatients require deeper cerebration.

We now have the relative luxury of being able to offer most people, where required, a 30-minute consultation. As we (primary care practitioners) have become more confident at managing people with diabetes there has been a concomitant reduction in the total number of referrals; resulting in a shift in the role as a practice-based provider to target struggling practices to help improve their care. There still remains a significant rate of referral of somewhat more complex cases who may be more appropriately managed in the GPSI diabetes clinic than in secondary care; which conveniently sets the stage for the evolution to practice-based provision.

Becoming a practice-based provider

In the process of establishing a practice-based provider status the following ideas were adopted.

- *A private diabetes clinic was set up.* This was

Box 1. Information required to allow the person with diabetes to attend the outpatient appointment.

The referral letter should contain the following information.
- Clear statement of presenting complaint
- Date of diagnosis of diabetes
- Co-morbidities
- Current medication
- Weight
- Blood pressure
- BMI
- HbA_{1c}
- eGFR

Box 2. Results of the audit of the GPSI service (03.06.2005).

Out of 230 people with diabetes seen in the GPSI clinic:
- 122 were discharged back to their GP with a management plan.
- 69 were returned to their GP due to insufficient information in the referral letter (see *Box 1*) or not meeting referral criteria.
- 11 were listed for a 6-month review at the GPSI clinic.
- 55 were listed for a 12-month review at the GPSI clinic.
- 37 were referred to the diabetes specialist nurse team for insulin initiation.
- 108 were referred for retinal screening.
- 117 were referred to a joint education session.
- 93 were referred to podiatry.
- 12 did not attend.

Page points

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2. Diabetes service development now lies in the hands of primary care and presents us with another opportunity to be instrumental in optimising the care of the person with diabetes.

done via Specialist Provider Medical Services since this offers greater convenience than Alternative Provider Medical Services as individuals with diabetes do not need to be registered with the provider in order to receive care. We have a one-stop ethos, aiming to provide as many services under one roof as possible.

- *Space for the clinic was identified.* Two rooms were reserved for the clinic. One of the rooms houses a retinal screening camera; this arrangement will endorse the Community Diabetes Clinic where people can elect to attend for retinal screening rather than attending the hospital. The second room houses other equipment; including a HbA_{1c} and microalbuminuria assessment machines to allow for immediate testing and results as required.
- *Get help with funding and business.* Help was secured from the pharmaceutical industry; which consisted of invaluable input from a highly qualified business consultant over a number of weeks. The result was a detailed Business Case setting out information regarding the patient pathway, running costs and a risk assessment.
- *Gain the support of colleagues.* Ongoing consultant support is essential to the success of a community clinic, and one should be prepared to reassure secondary colleagues that while there may be some shift in the complexity and numbers of individuals coming through to their department, working together can reduce the impact of the change. This happens by clarifying the patient pathway so that appropriate individuals are swiftly discharged back to primary care.
- *Identify the burden of diabetes affecting the respective PBC clusters and approach the relevant clinical leads.*
- *Recruit a diabetes specialist nurse.*
- *Identify a project manager who will administer the service.*
- *Advise other colleagues that the service exists.* Close contact with the Choose-and-Book manager was essential with a view to having the community diabetes clinic included in the list of referral options.
- *Make it easy to share information.* We are in the process of securing a licence for the use of Diabeta3 (Health Information Systems UK, London) at the surgery which will enable us to input and view data in the same system as used by secondary care, ensuring that referring practices receive information in the same format.
- *Don't leave out the people with diabetes.* We have designed an aide-memoire for people with diabetes in the form of a diary; in which the individual can record their blood glucose measurements; it also contains a jargon-buster, reference ranges for the metabolic parameters and common periodic checks together with lifestyle advice.
- *The service should be designed with a future audit in mind.* Audit facilities have been prepared since it is far easier to institute such measures at the start of a service.

These principles form the bare bones of developing a provider status for diabetes services. Others will need to adapt the model to suit their particular circumstances.

Final points

The author believes that the establishment of a practice-based service in diabetes works best if it has evolved from a pre-existing service that the GPSI is involved with. Clearly, this method is not exclusive of other approaches and the application of any one model will be governed by the prevailing local dynamics.

In conclusion, like many other services diabetes service development now lies in the hands of primary care and presents us with an opportunity to be instrumental in optimising the care of the person with diabetes. This baton should be grasped with enthusiasm otherwise we may by default hand the opportunity to our ultimate competitors in the form of private companies. ■

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