The first national conference for intermediate care teams with a special focus on the role of GPSIs

This report is from a conference that took place on 5 July at the National Motorcycle Museum, Birmingham. The event was supported by an unrestricted educational grant from Novo Nordisk.

Introduction

The GPSI accreditation was devised to assist in the delivery of seamless care across the primary and secondary care settings. Aimed not just at GPs but also at other healthcare professionals involved in or affected by the planning or delivery of intermediate services, this was the first national conference to focus on issues relating to the role of GPSIs in diabetes. Organised by the Primary Care Diabetes Society in association with the journal *Diabetes & Primary Care*, it provided a forum for debate among all parties who may be affected by the growing number of GPSIs in diabetes care. This meeting aimed to address issues such as the exact definition of a GPSI, how many GPSIs exist, the implications of their role for other members of the healthcare team and how they operate within the world of practice-based commissioning.

GPSI accreditation: Learning by example

Peter Dickson, Medical Director of Bradford and Airedale tPCT, began the first presentation of the conference by describing the way in which his tPCT ensures that GPSIs operate within a coherent and quality-assured clinical pathway. By using an accreditation process that utilises both evidence-based paperwork and a face-to-face discussion with candidate GPSIs, Bradford and Airedale tPCT have identified the following main issues to be addressed:

- Education and training to be maximised.
- Consultant and/or peer support to be in place.
- Solitary working to be minimised where possible.
- Audit to be a necessary responsibility.

The GPSI accreditation process is driven by the NHS Plan, innovation and empowerment, market economics, practice-based commissioning and the modernisation of the NHS workforce.

Peter cited the secretarial support needed to carry out a thorough and valid accreditation process as an absolute requirement.

Bradford and Airedale tPCT has been at the forefront of diabetes service redesign and has provided models of clear definitions and explicit processes for GPSIs in the diabetes accreditation process.

The tPCT has a population of around 500000 individuals comprising a large ethnic minority; as such, it has a significant number of people with diabetes.

GPSIs in diabetes: Who, what, where and how?

As defined by the Department of Health and the Royal College of General Practitioners, GPSIs are not, and should not be, replacements for consultants, and should not interfere with access to consultants. 'However, it is very important that GPSIs have a holistic view and are not just patient conveyer belts to consultants,' said Brian Karet, GPSI in diabetes, Bradford.

Brian went on to define intermediate care as a service for patients that does not require the resources of a general hospital, but is beyond the scope of the traditional primary care team. 'It should deliver high-quality care by a multi-disciplinary team close to the patient.'

For example, with the shift of diabetes care away from secondary care, some primary care teams are concerned about their role in insulin maintenance. The intermediate care team is there to ensure that when an individual is discharged from specialist services, they will still receive high-quality care.

'Communication needs to take place both horizontally and vertically,' Brian said, 'That way, everyone knows who does what and what is expected of them.'

Implementing our health, our say

David Colin-Thomé, OBE, National Clinical Director for Primary Care, concluded the first session 'The role of GPSIs and their wider impact' by looking at the implications for local and national practice. He identified the GPSI as a key player in shifting the care model from reactionary to preventative with regards to chronic conditions.

He described GPSIs as one of the ways in which local care can be redesigned. 'Competition to have services commissioned from them will help shape up existing GP services,' he said. 'Even the best clinician may not make the best practice leader if they can't provide the right management.'

A new approach to planning diabetes services

Carrying out a needs assessment as described in the Diabetes Commissioning Toolkit identifies the growth in diabetes, and the local burden creates a profile that cannot be ignored by financial planners. However, Bernie Stribing, Network Manager for Diabetes and Renal services at Leicestershire and Rutland PCT, reported difficulties in bringing people on board with what, at times, can seem a huge task.

Engaging with all healthcare professionals and support staff in the care of people with diabetes can enable a comprehensive service to be created in a way that helps meet local needs.

Despite demographic differences, all centres participating in the early implementation of the toolkit are now able to work through the identified priorities for diabetes as part of their service planning.

Contracts with PCTs for delivery of care

While many areas have expressed an interest in intermediate care, where appropriate, it still helps to keep certain individuals in primary or secondary care. This was the conclusion of David Millar-Jones, GPSI in diabetes and Associate Specialist in diabetes, Pontypool, Wales, when discussing how contracts with PCTs for delivery of care will work from the GPSI's perspective.

The support and confidence in David's intermediate care team, from primary and secondary care and patients, took over 6 months to establish, mainly due to obstacles from GPs of the opinion that the team was 'stealing' their work. In the past, some GPs referred all cases of type 1 and 2 diabetes to secondary care. Now, by producing general guidelines on the treatment pathway for diabetes (with some variation due to local practice), the intermediate care team is called in when metformin, a sulphonyurea and insulin sensitisers inadequately control blood glucose levels.

From the perspective of Andrew Kenworthy, Chief Executive of Kensington and Chelsea PCT, the emphasis remained firmly on accepting that the current delivery of diabetes services was not appropriate. Commissioning should focus on people with diabetes, not the organisations from whom services are procured. He said: 'We need local diabetes champions to challenge primary and secondary care, co-ordinate with Diabetes UK and drive change across all organisations. We need to take a stand!'

Good mentorship and how it should work in practice

Training for the GPSI and the intermediate care team needs to be evidence based to establish the confidence of people with diabetes and colleagues, while also establishing the competence of the team members. 'This training will help to create a GPSI capable of delivering care in a multifaceted role,' said William Nigel Taylor, Lead GP for diabetes and GPSI in diabetes, Sefton PCT.

The consultant mentor is the key to the delivery of this training and also for ongoing re-accreditation. Mentorship is important in establishing the team and maintaining high standards of patient-centred care operating at many levels. Ongoing GPSI training requires a personal development plan folder and an audit of work. The audit process also assists team development. Multidisciplinary team meetings and virtual clinics further support the training process and the team.

Ken Shaw, Consultant Physician and Endocrinologist, Portsmouth, reported that to date, the specialist diabetologist has been expected to provide local leadership for clinical services, innovation, education and research, but this responsibility is now shared with the GPSI in diabetes.

The joint guidelines from the Royal College of General Practitioners and DoH in September 2003 provided recommendations for ensuring specialist competencies. This involves working with education, mentoring support and clinical network facilities, good communication, regular joint working and – where appropriate – supervision from the diabetes specialist and supporting their clinical and management roles.

Close collaboration and communication, be it mentorship or otherwise, is essential to enable the best provision of clinical care for people with diabetes. The benefits of joint working are recognised and indeed appreciated by specialist diabetologists as they adapt to the major changes in their own roles.

Perceptions of the changes to diabetes care

In the opinion of David Kerr, Consultant Physican, Bournemouth, specialist services have to change and these changes are possible. 'Where the care occurs doesn't matter one bit,' he said. 'What matters are results.'

Data from audits are crucial to be able to prove that any specialist service is providing exceptionally good care. Additionally, specialists should dovetail with other specialities, spend more time educating and training peers than seeing patients, and must be involved in clinical research.

Omar Ali, Formulary Development Pharmacist, Surrey and Sussex Healthcare NHS Trust, discussed shared care prescribing with integrated care pathways and the difficulties in managing long-term conditions. For example, prescribing budgets are finite and non-flexible: prescribers cannot overspend by 10% and justify this with data showing that this loss will be recouped in 10 years by long-term health benefits.

In contrast to a model of diabetes care led by GPSIs, Debbie Hicks outlined the Enfield PCT model: a novel, nurse-led approach that has improved access to care and provided financial savings.

Conference discussion and summary

Led by the conference Chair, Martin Hadley-Brown, GP, Thetford, the speakers discussed the question of whether or not the role of the GPSI was already threatened. David Kerr answered that is was not, so long as the care GPSIs offered was, in terms of clinical outcomes, better than what was there before.

While Enfield PCT does not have any GPSIs in diabetes, Debbie Hicks ascertained that this was not a threat to GPSIs as there had never been any in the first place. Additionally, Martin Hadley-Brown reminded the audience that there are some areas where the creation of GPSI posts does not fit with the model created by the diabetes commissioning toolkit.