Intermediate care: Exploring the options

Gill Freeman

Introduction

Standard 4 of the National Service Framework (NSF) for 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 (e.g. those for coronary heart disease [DoH, 2000a] and older people [DoH, 2001b]) has had a huge impact on the workload of healthcare professionals in the primary care sector. This article discusses the development of intermediate care for people with diabetes, which would ensure that all adults will receive high quality care throughout their lifetime.

Historically, specialist health services have cared 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. In light of documents such as *The NHS Plan: A plan for investment, a plan for reform* (Department of Health [DoH], 2000b) and *Shifting the balance of power within the NHS* (DoH, 2001c) this is quite rightly changing.

There is much expert knowledge of diabetes within primary care that can be used in caring for people with the condition who, although needing more intensive input, are not yet – nor ever may be – ready for specialist services. This knowledge is being used in initiatives that can be grouped together under the title of 'developments in diabetes care' or '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 special interests' – 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:

- to provide expert triage of the person with diabetes
- to make available appropriate and up-to-date treatment for the person with diabetes
- the development of primary care skills
- the provision of education for primary care staff and the person with diabetes.

Reasons for service developments

There are several reasons behind the development of these intermediate services.

Waiting list times

Waiting lists of people who need to be seen by a specialist team are getting longer day by day. This is mainly due to the increase in the number of people with diabetes, and in some cases is also due to the lack of a sufficient number of healthcare professionals being employed (although some practices are now employing their own diabetes specialist nurses [DSNs]). In addressing

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1 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.

2 Intermediate care includes the employment of healthcare practitioners with an interest in diabetes.

3 The main aim of developing such a care programme is so that the needs of primary care practices and the populations they serve can be met.

4 Evaluation of intermediate care services is in its infancy but initial anecdotal evidence indicates many benefits.

KEY WORDS

- **Diabetes care**
- **Intermediate care**
- **Service development**
- **GP with a special interest**

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1 The main aims of establishing intermediate care in the author's locality were to develop a flexible service that, firstly, is responsive to a changing population and practice needs and, secondly, develops and supports the practices involved.

2 The first task was to analyse referrals to secondary care. This covered referrals to consultants and DSNs from primary care and other disciplines within the secondary sector.

3 The second task was to establish what was already happening in primary care. To do this, a questionnaire was distributed to all practices within the area.

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 refer inappropriately when the problem could be dealt with in primary care. Expert triage should reduce the number of such inappropriate referrals to the specialist service.

Insulin initiation

There are increasingly more people with type 2 diabetes being initiated to insulin, which is still traditionally seen as a role for the specialist service, although many practices now successfully initiate insulin treatment in primary care. This improves the quality of care for people with diabetes and also lowers the cost of care, as the number of referrals to secondary care and waiting list lengths are reduced.

Continued attendance at secondary care clinics may be because some practices prefer their diabetes population to be seen by someone with more specialist knowledge than they feel they possess. However, more specialist teams are discontinuing their annual review and old-style follow-up clinics.

One of the many options available for intermediate care could resolve this situation. For example, a GP with a special interest (GPwSI) working with a DSN, or a primary care clinic run by a consultant physician may be the answer. A GPwSI could support other GPs and also provide leadership to integrate services between primary and secondary care. Developing joint working practices is something that many localities (for example Peterborough) are working on. A further advantage of this is that it could avoid duplication of care.

The process of service developments

In the author's primary care trust (PCT), Innove Ltd (a healthcare consultancy company) has helped analyse diabetes care. The goal was to produce an 'options appraisal' to ascertain how best to use intermediate care. The main aims were to develop a flexible service that, firstly, is responsive to a changing population and practice needs and, secondly, develops and supports the practices involved. During the process, national guidance (DoH, 2001a) and the PCT's draft diabetes service guidelines have been referred to as necessary.

A sub-group of the local diabetes network, including representatives from primary and secondary care, was invited to participate. The first task for the sub-group was to analyse referrals to secondary care. This covered referrals to consultants and DSNs from primary care and other disciplines within the secondary sector. The amount and content of the referrals have been studied as well as re-referrals. The reason for this exercise was to ascertain whether the number of referrals could be reduced.

The second task for the sub-group was to establish what was already happening in primary care. To do this, a questionnaire was distributed to all practices within the area, the purpose of which was:

- to identify gaps in the service so that they can be addressed
- to raise awareness in the specialist services and the PCT of the skills that already exist in practices (this would help give the specialist team confidence in planning and implementing a discharge policy)
- to enable planning and development of the entire service involved in caring for those with diabetes.

The knowledge and experience of the diabetes facilitator employed by the PCT and the data generated as a result of the new General Medical Services (nGMS) contract were also drawn upon. This exercise identified gaps in the services provided and training needs within the practices.

Mapping and re-design

The next step was to set up a diabetes service mapping and re-design event. This allowed the development of high quality services in which the most appropriate professional would provide the correct clinical care; it also allowed the identification of methods to improve

patient care and efficiency. The process was described as 'trying to understand the patients' experience at various stages of their journey through the healthcare system'. The ideas generated at the end of this process provided a summary of the main options to consider for the extra resources available.

Options

It was important, when looking at the options, to consider whether the goals would be long- or short-term. After individual consultation with members of the team, five models were looked at in greater depth.

Model 1: GPwSI service

This model was a short-term solution – one session per week (supported by a DSN) – the benefits of which would be: expert triage, which is delivered in a central location, resulting in the reduction of referrals to secondary care; and its availability for all service users in the area. Concerns for this option included the following.

- Staff development would be limited to the GP and DSN.
- Small numbers of patients would be seen.
- Practices which had expressed an interest in providing additional services would be disappointed.
- Referring to other GPs may be unpopular with some practices.

Model 2: Focused enhanced services

This model was a medium-term solution with locally enhanced services being provided by practices for their own patients and those from other practices. A benefit of this would be a greater spread of high quality care, but a concern would be that it would be more difficult to accredit and monitor than a GPwSI scheme.

Model 3: Generally enhanced services

This model was a long-term solution to raise skill levels in all practices that wish to do so. The main benefit of this would be widely spread high quality care and a concern would, again, be that it would be difficult to accredit and monitor.

Model 4: Enhanced podiatry and dietetic input

This model was a medium-term solution which employs healthcare assistants in podiatry and dietetics for less complex service users. This would benefit a large number of patients but would not reduce secondary care referrals in the short-term.

Model 5: DSN role reconfiguration

This model was a medium-term solution which would reconfigure current working practices within the DSN team and introduce skill mix. A high percentage of practices expressed a desire for DSN support in the questionnaire and it would include a structured education programme for patients as recommended by the National Institute for Health and Clinical Excellence (NICE, 2003), including podiatry and dietetics. However, this would produce only small reductions in referrals to secondary care in the short-term.

Other models of service delivery

Meanwhile, other intermediate service models available across the country were studied. There appears to be a great variety in the services available nationally. In areas where recruitment of specific services is difficult, such as dietetics, healthcare assistants have been trained to deliver the relevant advice. Other initiatives include provision of an annual review for the housebound patient, and a community pharmacist with a special interest in diabetes who reviews patient medication at annual review.

The lead in these services is most often a GPwSI, although there are some areas with a community consultant in diabetes or a lead DSN who dedicates a certain amount of time to the initiative. Nocon and Leese (2004) feel that GPwSIs act as an 'interface' between primary and secondary care, particularly in the 'knowledge gap' between GPs and consultants. Hadley-Brown (2004)

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1 There appears to be a great variety in the services available nationally. For example, in areas where recruitment of specific services is difficult, such as dietetics, healthcare assistants have been trained to deliver the relevant advice.

2 To those practices already deemed to be providing a good service, intermediate care would provide such advantages as staff education, advice on complex cases and structured telephone support for those on insulin.

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1 It must be remembered that a single model for intermediate care will not be possible, given the variations in population, location and staffing levels.

2 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.

3 We must not lose sight of the fact that the most important contributors to its success are the service users. It is hoped that the options will be presented for discussion at a patient and public involvement meeting in the very near future.

believes that GPwSIs will provide an intermediate clinical service that 'stops short of the need for consultant attention'. For others, GPwSIs will act as a strategic planner for diabetes services within their districts or as an educational resource. Whoever leads the service should have an accredited qualification in diabetes or relevant specialist experience (Hadley-Brown, 2004).

To those practices already deemed to be providing a good service, intermediate care would provide:

- staff education
- advice on complex cases
- pre-conceptual care
- glucose tolerance tests
- lifestyle advice for those with impaired glucose tolerance
- structured telephone support for those on insulin
- training for staff in delivering one-on-one and group patient education.

For those practices which felt they needed further help, the new model provided:

- education for newly diagnosed patients
- provision of an annual review
- insulin initiation
- staff education
- work on service users with impaired renal function (pre-referral).

Monitoring and evaluation

An important consideration in all of these intermediate services is ensuring that their value and impact can be measured, thereby resulting in ongoing changes and improvements.

Evaluation of these services is in its infancy, but where it has been performed, several advantages have been seen (unpublished observations). Anecdotally, these include a reduction in referrals to the specialist service and an increase in the discharge of patients from secondary care, resulting in the reduction of waiting times. The evaluations also indicate that the waiting times for the intermediate service is shorter compared with those for secondary care, although this may change as other practices in the area familiarise themselves with the concept. However, Munro et al (2005) say:

> ***'Previous attempts to shift diabetes care from secondary to primary care have shown mixed results in short-term studies... it may take at least a decade before outcomes – good or bad – become measurable.'***

Discussion

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 other areas, in a flexible way with a long-term aim of further enhancing the quality of patient care available in practices.

Our project now awaits its final chapter: which model will be considered the most appropriate?

The decision is going to be an extremely difficult one and amid all the work that has been put into the organisational aspect of current changes, we must not lose sight of the fact that the most important contributors to its success are the service users. It is hoped that the options will be presented for discussion at a patient and public involvement meeting in the very near future. ■

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

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

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

DoH (2001b) *National Service Framework for Older People*. DoH, London

DoH (2001c) *Shifting the balance of power within the NHS*. DoH, London

Hadley-Brown M (2004) GPs with a special interest: possible roles in diabetes care. *Diabetes & Primary Care* **6**(2): 93–7

Munro N, McIntosh C, Feher MD (2005) Shifting diabetes care: rhetoric and reality. *Practical Diabetes International* **22**(5): 153–4

National Institute for Clinical Excellence (NICE; 2003) *Guidance on the use of patient-education models for diabetes. Technology Appraisal 60*. NICE, London

Nocon A, Leese B (2004) The role of UK general practitioners with special clinical interests: implications for policy and service delivery. *British Journal of General Practice* **54**(498): 50–6