Making the most of primary care expertise

Gill Freeman

Specialist services in diabetes have continued to care for people who have no ongoing acute complications of diabetes, as well as those who truly require a specialist service. However, there is much expert knowledge of diabetes within primary care that can be used for people with diabetes who need more intensive input but do not require the specialist service. This knowledge is being used in initiatives that can be grouped together under the title of 'intermediate care'.

Intermediate care

There are a number of models in existence and, anecdotally, we hear that most are running successfully but few have been formally evaluated and audited as yet. In comparing these models, it soon becomes apparent that every locality has very different requirements, given the variations in population, culture and staffing levels. For example, some diabetes teams are working with more than one primary care trust and each requires different services. However, it is interesting to note that there are common areas of design, requirement and difficulties in many of the national models.

The first step for the majority of projects has been a needs assessment of diabetes care within the district to assess the levels of care, expertise and resources. This exposes the gaps that need to be filled. Without this it would be essentially impossible to proceed with the introduction of a new service. Following this, a clear referral pathway to the intermediate service is important for the service to run smoothly.

The structure of intermediate care teams appears to have a basic design consisting of General Practitioners with a Special Interest (GPwSIs), diabetes specialist nurses, dietitians, podiatrists and healthcare assistants, in a variety of formats. It seems unusual that when we have so much expertise and formal accreditation among the practice nurse population, there are relatively few taking a major role in the intermediate team.

However the team is configured, it is important that it has adequate resources, and this seems to have been a problem in several areas. Resource availability is one of the issues addressed by Helen Mitchell and Johanne Bird in their article offering practical advice on integrating care (see pages 149–51).

Existing teams have stressed the need for robust IT support for call and recall, and the need for the electronic patient record becomes even greater as teams cannot always access patient information because of incompatibility between primary and secondary care systems. This will have to be addressed to ensure patient safety and continuity of care. Other teams, including mine in Stockport, are hoping to use their IT systems to set up websites containing appropriate information for professionals and service users, although generally it appears that these will be local, not national.

Models of intermediate care require higher levels of professional expertise in diabetes to provide a safe environment in which to see the patients. Formal accreditation for GPwSIs remains under discussion, but many come from a background of clinical assistantship within secondary care or have completed a higher qualification in diabetes. In this situation, they have had the support of the diabetes consultant and it is important that this mentorship continues in order to share clinical expertise. This will also assist the GPwSI with providing regular updates to primary care colleagues.

As previously mentioned, evaluation of these services is in its infancy, but where it is in operation, several advantages have been anecdotally reported. These include a reduction in referrals to the secondary care team, freeing them to provide a truly specialist service and, following this, a reduction in waiting lists. This appears to have created difficulties in some areas in the current market-led NHS, where primary and secondary care can be seen as competitors.

Intermediate care appears to have shorter waiting lists than secondary care but this may change as other practices in the area familiarise themselves with the concept. Service users also report a higher level of satisfaction in not having to wait too long for an appointment and being seen closer to home.

Intermediate care has the potential to improve access to high-quality diabetes care and it is vitally important that areas of difficulty are resolved to ensure that, as ever, the advantage is to the service user. A potential difficulty arises from cultural barriers to effective diabetes service delivery. In her article, Grace Vanterpool describes these and details an initiative that aimed to overcome them in Slough (see pages 152–4). ■

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