GENERAL PRACTITIONERS WITH A SPECIAL INTEREST IN DIABETES.

A discussion paper from the Association of British Clinical Diabetologists (ABCD)

Introduction

- The burden of diabetes is increasing remorselessly and existing diabetes services are experiencing progressive difficulty in dealing with the clinical workload whilst at the same time delivering an acceptable standard of care.

- This has prompted the exploration of new models of care amongst which is the development of the GP with a Special Interest (GPwSI). This is not a new concept. Although historically much UK diabetes care has been delivered by hospital based services there is a long tradition of general practitioner involvement in specialist diabetes care. Many hospital diabetic clinics utilise the services of skilled GP Clinical Assistants or Hospital Practitioners.

- The key role of general practice in delivering diabetes care in the UK was recognised many years ago and has led to the development of innovative integrated care schemes such as GP Diabetic Mini-Clinics (Wolverhampton, 1971) and Diabetes Shared-Care (Poole, 1976). Such schemes are now widespread in the UK.

- The enhanced role of the General Practitioner in diabetes care is in line with the government's desire to transfer some chronic disease management from secondary to primary care (see 'A National Framework for the Provision of Secondary Care within General Practice', NHSE, Leeds, HSG, 1996)

- In the NHS Plan (DOH, July 2000) the government announced its intention to create 1000 'specialist GP's' by 2004. In subsequent consultation papers diabetes has been identified as a suitable area for GP specialisation. (see 'Implementing a Scheme for General Practitioners with Special Interests.' DOH Website: www.doh.gov.uk, April 2002)

- ABCD strongly supports the enhanced role of the General Practitioner in diabetes care but believes that a proper training and accreditation programme is essential if we are to avoid the evolution of two different standards of care for our patients.

- ABCD believes that the GPwSI initiative will only succeed if there is a close and harmonious relationship between primary and secondary care. This will necessitate a clear understanding and agreement of respective roles and responsibilities.

Background

- Diabetes affects at least 2.5% of the population with as many more having undiagnosed Type 2 diabetes. The prevalence is increasing rapidly and this is expected to double the number of cases over the next decade.

- Diabetes is a major cause of acute and chronic morbidity and mortality. It reduces life expectancy in all age groups. Many of the complications of diabetes such as retinopathy, nephropathy and peripheral vascular disease are disabling and incur high health care and socio-economic costs.

- Recent evidence from large scale trials such as DCCT, UKPDS, HOPE and HPS shows that improved metabolic control will prevent or delay many of these complications.

- If detected early complications such as retinopathy can be treated effectively (by laser photocoagulation) and blindness prevented. Careful attention to foot care and footwear can prevent ulceration and amputation in patients with vulnerable feet.

- Diabetic control and quality of life can be greatly enhanced by effective patient education and encouragement of informed 'self-help'.

- Thus there is convincing evidence of significant clinical and quality of life benefits from the provision of high quality diabetes care.

- A recent Diabetes UK Survey of Diabetes Care in General Practice in the UK has revealed alarming deficiencies in resources and health care expertise (Williams DRR, et al, Diabetes UK Survey of Provision of Diabetes Services in the UK. London, 2002).

- A parallel survey of Secondary Care facilities carried out by ABCD has shown a similar but less dramatic variation in the quality of hospital-based specialist diabetes services (Winocour PH, et al, Diabetic Medicine, 2002: 19, 327-333).

- As a result of these and other considerations a number of innovative models of care are being examined to see if they might improve the quality of diabetes management especially in poorly performing areas. These include creating Community Diabetologists, extending the role of the Diabetes Nurse Specialist, enhancing the role of the Practice Nurse and the development of the General Practitioner with a Special Interest (GPwSI) in diabetes.

- Whilst supporting these initiatives ABCD believes that these new approaches to specialisation will only succeed if they are actively supported by local Consultant Diabetologists. This will require additional time/resource to enable them to do this effectively.

- For GPwSI's ABCD feels that it is vital that **training and performance standards** are defined at the outset before the new grade becomes widely established. It would be unacceptable if patients were to be offered a lesser standard of care as a result of an untried and untested 'innovation' in practice.

- This paper sets out ABCD's views on the minimum training requirement, competency and relevant continuing professional development (CPD) for GPwSI's.

GPwSI's in Diabetes - Key Questions to be Addressed

- What will be the precise role of the GPwSI?
- What training will the GPwSI require to become competent?
- What tests of competency will be necessary?
- Who will provide the training and assessment of competency?
- How will GPwSI's relate to local secondary care services?
- What will be the arrangements for appraisal and revalidation?

The Role of the GPwSI in Diabetes Care

With adequate training and competency the GPwSI could take over the care of a large proportion of patients with diabetes. However there are certain patient groups where it would still be more appropriate for care to be delivered mainly by a specialist service. These include

1) children and adolescents with diabetes.
2) pregnant patients with diabetes.
3) 'brittle' insulin treated patients.
4) patients requiring new/complex treatments eg CSII.
5) patients with severe complications e.g. retinopathy, nephropathy or foot problems requiring multi-speciality management and intensive control of risk factors.
6) patients who express a preference for secondary care.

Once an adequate level of competency has been achieved it is probable that GPwSI's will receive direct referrals from colleagues in primary care. However, it is very important that for the present the above criteria are applied to these referrals. In time these categories may change depending on the level of GP specialisation and demographic changes e.g. the increasing prevalence of type 2 diabetes in children and young adults.
The care of many patients could be 'shared' between the primary and secondary sectors but this will require efficient co-ordination and effective communication. Many patients already move between primary and secondary care and it is important that this process should be 'seamless'.

Training and Competency

- Initially it is likely that most General Practitioners intending to become GPwSI's will have previous experience of working in hospital diabetes clinics. With these individuals evidence of at least **12 months of continuous involvement** (minimum one session per week) **in a consultant supervised diabetic clinic** plus **confirmation of competency by the local consultant** might be considered a sufficient guarantee of adequate training. In the event of a dispute about competency an external assessment by an experienced diabetes consultant may be necessary.

- For G.P's without this background experience who wish to become GPwSI's then a requirement **to work in a consultant supervised diabetic clinic for 12 months** (minimum one session per week) is in our view essential. There could be special dispensation for General Practitioners who have considerable previous experience of working in a hospital based diabetes service although this may have to be time limited (e.g. within the previous 5 years?).

- Competency could be assessed by an exit' test which might take the form of a **Diabetes Knowledge MCQ leading to the award of a Diploma**. However, it would be complicated and expensive to set this up and it will probably not be achievable without substantial additional central finding. This is an issue which could be addressed jointly by ABCD, Primary Care Diabetes (PCD) and the Royal Colleges of General Practitioners and Physicians.

- Training is available through **courses such as the 'Warwick' course** and it is likely that other similar courses will be developed. Clearly the quality of these courses needs

to be properly assessed and some form of standardisation introduced before they can be used as some sort of measure of competency. **Supplementary training** should be available **in local specialist diabetes departments** by agreement. Training must cover all relevant areas including up-to-date knowledge of therapies, control targets and the detection and management of complications. It should take into account local variations in practice. Communication skills are especially important but these are generally well developed in primary care.

- The relationship of GPwSI's to local secondary care services is crucial. There will need to be **clear guidelines and definitions of respective responsibilities**, **care pathways** and **referral policies**. This will require close co-operation between primary and secondary care.

- There would be much merit in a continuing **involvement of the GPwSI in a local specialist diabetic clinic**. This could take the form of working with the consultant for one session a week. This would not only have educational benefits but would provide an important communication link between primary and secondary care.

- There should be clearly defined arrangements for the **regular appraisal and assessment of competency** of GPwSI's. This should involve a requirement for evidence of **adequate and appropriate CME** to enable them to keep up to date with developments in clinical care and therapy. Local specialist diabetes teams should be involved in with this.

- GPwSI's should be active **members of relevant professional organisations** e.g. Primary Care Diabetes, Diabetes UK.

- **Governance issues including quality, effectiveness and risk** will be the responsibility of PCT's who will need to confirm individual GPwSI competency

- Other important issues which will relate to both primary and secondary care are district **diabetes registers, audit and clinical governance**. Again local diabetes consultants will be able to support these activities given sufficient resources.

General Points

- The development of General Practitioners with a special interest in diabetes is an exciting opportunity to improve the standard of primary care of diabetes and also relieve the pressure on local specialist care services. This should allow for an improvement in the care of patients in both sectors.

- GPwSI's must be adequately rewarded to reflect their specialist expertise and they must be provided with adequate resources to function effectively. This will include appropriate facilities, adequate support from practice nurses trained and experienced in diabetes care and access to support services such as retinal photography, dietetics and specialist podiatry.

- The GP with a Special Interest will not be a consultant specialising in diabetes. The consultant diabetologist undergoes a rigorous five year specialist training programme culminating in the award of a CCST. Most consultants are also trained specialists in general medicine which is very appropriate for the management of complicated patients

with multi-system problems. Consultants have access to acute medical beds which enables them to provide specialist care for patients with acute diabetes complications such as ketoacidosis. They also work closely with other specialities such as vascular surgery and orthopaedics when managing patients with lower limb problems.

- Diabetes, because of its chronicity, complexity and necessity for patient education and motivation is a more holistic subject than most other medical specialities. There is increasing emphasis on patient empowerment and it is very important to ensure that there is active patient participation and support for any new model of care such as the development of GPwSI's. The issue of informed patient choice must be recognised. If the patient prefers a primary or secondary care environment this preference should be acknowledged and met wherever possible.

- The successful introduction of GPwSI's will require substantial support from secondary care. Time and resources for this must be built into consultant job plans.

- The infrastructure required to support the secondary care diabetes service must be maintained. There is substantial evidence that improvement in primary care of diabetes usually leads to an increase in specialist referrals. This should be monitored and additional resources provided to secondary care to address any such increase in workload.

(RHG on behalf of the ABCD Committee, 17 September 2002)