

Research papers

Specialist diabetes clinics in primary care: the views of GPs about the impact on quality of care

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ABSTRACT

Background New models of diabetes care are emerging within primary care, reflecting a wish to provide higher quality care, address increasing prevalence, shift services from secondary to primary care, and increase specialisation within primary care.

Aim To obtain general practitioners' (GPs') views about the impact of the new service on quality of care.

Design of study Self-completion questionnaire and semi-structured interviews.

Methods Questionnaires were sent to all GPs in Bradford outside the specialist diabetes clinic practices. Interviews were also undertaken with a subsample of responders and non-responders.

Results A 60% response rate was achieved; 83% of responders had made referrals to the clinics; 83% (including some non-referrers) believed the clinics were providing a valuable service. Benefits included good quality care, convenient access, sufficient time

with patients, and responsiveness to patients' needs. Thirty-five percent of referrers nonetheless mentioned concerns or weaknesses in the new arrangements: increasing waiting-times for first appointments, uneven geographical distribution, poor communication with GPs and concern over the quality of expertise.

Conclusion GPs generally gave a positive evaluation of the clinics. Issues to be addressed when considering the development of similar models of specialist care in community settings include: variability between clinics, the need for strategic planning, the role of specialist nurses, equity of access, the need for increased skills within all primary care teams, and integration with secondary care.

Keywords: diabetes, GPs with a special interest, interprofessional relationships, referrals, specialist clinics

Introduction

The increasing prevalence of diabetes continues unabated.¹ Its human and financial costs, particularly clinical complications, mean that prompt and effective care is essential.²⁻⁴ Yet primary and secondary care services are under pressure from ever increasing demand. While most specialist expertise is located

within secondary care, waiting lists are often long. Government policy for the past 15 years has focused on the development of primary care and, in particular, the acquisition of specialist skills by primary care practitioners, both general practitioners (GPs) and nurses.⁵⁻⁷ Early discussion by the Implementation Group for the *National Service Framework (NSF) for Diabetes* has similarly highlighted the centrality of community-led services.⁸

Box 1 Clinical activity of the specialist clinics

Within three years of the specialist clinics being established, 2067 patients were attending them (17% of patients on the diabetes register), 1746 attended the hospital (14%), and 8359 received care from their GP or mini-clinic (69%). Over 700 patients attending the clinics had been transferred to insulin therapy. Between April 1998 and September 2001, 42% of the 2415 referrals to the clinics were from GPs within the clinic practices themselves; 38% of patients in the three PCTs served by the clinics were registered with those practices.

In Bradford, 17 specialist diabetes clinics were set up in 1998 by GPs, in conjunction with the health authority, to address the waiting lists that had built up during a delay in recruiting a consultant diabetologist. Unlike other specialist models of diabetes services within primary care, which exist to serve patients from within the practice, the Bradford model was set up as a resource for all GPs in three primary care trusts (PCTs).⁹⁻¹¹ The clinics' main functions included the transfer of patients onto insulin and stabilisation of insulin-treated and non-insulin-treated patients (see Box 1): both functions represent a degree of intermediate care which lies outside the remit of normal primary care. Health Action Zone funding was obtained for the clinics. Selection of clinics was based on GPs' interest in diabetes and an adequate infrastructure. Clinical support is provided by the community diabetologist.

Despite the increasing growth of specialist clinics in primary care, there has been a noticeable absence of evaluations of their impact on quality of care. We undertook a questionnaire and interview study to obtain the views of other GPs.

Methods

An evaluation of the clinics, funded by Diabetes UK, was carried out between 1999 and 2001. Given that the Bradford model provides a service for all GPs within the city, it was important to find out the views of local GPs. A questionnaire was devised from key issues that had been raised from interviews with a range of health professionals working in both primary and secondary care, and from a sample of 55 patients with diabetes who were local service users. The design of the questionnaire was discussed both in a multidisciplinary research advisory group and a service users'

advisory group. The questionnaire was piloted with GPs working in specialist diabetes clinics that were not included in the subsequent survey. The questionnaire was sent to all 140 GPs outside the specialist clinic practices two-and-a-half years after their introduction. It included closed and open-ended questions and asked about referrals to and relationships with the clinics, their advantages and shortcomings.

Semi-structured telephone and face-to-face interviews were subsequently carried out with eight GPs, including six non-respondents to the questionnaire, and with two practice nurses, nominated by GPs as responsible for diabetes care in their practices. Interviews lasted between 30 minutes and one hour. The interviews were designed to address possible non-response bias and to add greater depth to the data collected. The interviews were tape-recorded and partially transcribed. Themes were identified and relevant sections fully transcribed.

Results

Referrals

In total 84 questionnaires were returned following one reminder (a 60% response rate). Seventy respondents (83%) had made referrals to the clinics, the most common reason (83%) being to transfer patients with Type 2 diabetes onto insulin. Seventy-four percent of referrers had referred patients who had previously attended the hospital. Reasons for non-referral are shown in Box 2. Although an earlier phase of the study had identified a fear that patients might re-register with the specialist clinic practice, none of the present respondents specified this as a reason for not making referrals (in response to a

Box 2 Reasons for GPs not referring to the specialist clinics

- Patients' preference for hospital referral (17 out of 84 respondents)
- Unknown quality of care in specialist clinic (11)
- Lack of availability of transport (8)
- Insufficient information about the clinics (8)
- Inconvenient location of clinics for patients (6)
- Referral of patients with diabetes to another GP in their own practice (6)
- Being able to care for their diabetic patients themselves (6)

specific question in both the questionnaire and interviews).

Of those who referred to the clinics, 24% said it was 'always' important to give patients a choice between a clinic and hospital; 54% said this was 'sometimes' important. Proximity to a patient's home was the key factor in selecting a clinic (mentioned by 87% of referring GPs); 59% felt it was 'always' or 'sometimes' important to give patients a choice between different specialist clinics.

Once a patient's condition had stabilised, 29% of GPs 'always' wanted responsibility for care to be returned to them, and 69% 'sometimes' wanted it. Of those who always wanted clinical responsibility to be returned, only 40% reported that this in fact occurred, a further 10% had to ask for it, and 40% said it was only sometimes returned.

Benefits of the new service

The overwhelming majority of GPs who responded to the questionnaire (83%) felt the clinics were providing a valuable service (this included 68 referrers and two non-referrers). The most frequently cited benefits related to the quality of care and service, particularly convenience, speed of access, time for patients, and responsiveness to patients' needs.

'More able to provide the detailed service some diabetics need and to have the time and services for more complex needs. Obviously have greater expertise too.' (252)

'They have time to do in-depth assessment of patients' needs.' (330)

Familiarity with and confidence in staff were important, and respondents commented that the clinics were well organised, with helpful staff. One suggested that patients were more likely to heed the advice of a clinic doctor than of their own GP.

Access to a range of specialists in a community setting was highly valued, as was the availability of all services on the same site. Other comments included the usefulness of having a domiciliary service and the availability of interpreters. The diabetes specialist nurse (DSN) service was particularly valued.

'My only real reason for transferring care to them {the specialist clinic} is for the input of the specialist diabetic nurses to transfer patients to insulin. If I could access the nurses direct, I would not really need to use the {clinic} because, if the patient has diabetic complications, I feel they ought to be referred to the hospital.' (312)

'The domiciliary service provided by the satellite nurses is very useful. I've used that for nursing home patients, residential home patients, and patients in their own home who are elderly.' (GP2)

One interviewee commented that he had been used to putting patients onto insulin in a previous practice in

another area, but the lack of specialist nurse support made this inappropriate now:

'It was suggested to me that it was really something for the remit of the {specialist} clinics and, in terms of back-up, once they're on insulin again, we don't have trained nurses who can go and check how they're doing with their insulin.' (GP6)

Improvements in services and care were often couched in comparative terms with hospital care, for instance in relation to continuity and communication:

'Patients can see a diabetes specialist without having to travel to the hospital and see a different junior doctor each time.' (135)

'Much better communication including phone discussions. Easier to understand clinic letters.' (304)

One mentioned the educational role of the clinics:

'I have learned from them by reading how they have dealt with individuals.' (158)

Disadvantages and shortcomings of the new service

Twenty-three (35%) of those who had made referrals to the clinics mentioned one or more shortcomings. Whereas proximity to patients' homes and fast response times were cited as benefits of the clinics, some GPs were unhappy with these aspects of the service:

'Not close enough to patients. They will not travel to {X} from {Y}.' (108)

'Long wait to be seen, especially at the more popular locations.' (127A)

Communication was also criticised, with a variety of perspectives being expressed:

'In the past I have found the letters from the clinic inadequate (not giving full details of results).' (135)

'Lack of consistent communication system i.e. letters from diabetic GP specialists are narrative rather than structured.' (301)

'If insulin is not started, I would like to be informed why not, and patient returned to my care – doesn't always happen.' (137)

Concerns were raised about duplication of work within the specialist clinic and in the referring GP's practice, and a lack of clarity about the management of associated problems. An apparent lack of integration with secondary care was mentioned. According to one of the interviewees:

'The integration is not at all clear – the overlap – between the hospital, mini diabetic clinics and the {specialist} clinics. It's not that clear who goes where,

who's seen where, and there's so much variation across the city. Some GPs are referring all their patients to the {specialist} clinics, and others like ourselves, we are running our own monthly diabetic clinic, which we've done for several years, so obviously there's a workload implication.' (GP2)

The quality of care gave some cause for concern:

'Cholesterol not checked, especially HDL ratio and triglycerides.' (123A)

'Concerns about quality/overall care for patients with complications and multiple co-existing morbidity.' (118)

High rates of non-attendance and problems in follow up were also mentioned:

'Occasionally appointments {are} not sent to patients who then become "lost" in the system – picked up in practice by accident when seen for other problems.' (145)

Respondents were concerned that the clinics would be unable to meet demand for their services:

'Not able to take on the large number of patients who could benefit. There are just too many diabetics in Bradford and it is going to get a lot worse.' (108)

'I personally think that there needs to be another {specialist clinic} in this area because there are just so many patients. If we referred all of our insulin-dependent diabetics, they wouldn't be able to cope. We actually look after a lot of them ourselves. We've actually got about 50 insulin-dependent patients in our surgery. Most of them are actually coming here, even though we're not a {specialist} clinic.' (GP2)

Doubts were expressed about the particular expertise attributed to the clinics:

'I am not convinced all provide management quality that our practice could provide if time, staff resources and space allowed.' (320)

'Some GPs know about diabetes more than the doctors providing these services in {specialist} clinics.' (153)

Three respondents specifically mentioned wanting to provide such clinics themselves, as a means of improving services for their own patients.

Discussion

The questionnaire survey achieved a high response rate, and the findings were supplemented by interviews with non-responders. Weaknesses of the methodology included the lack of information about the length of GPs' practice experience, the presence of a GP diabetic lead, or a practice nurse being responsible for referrals to the specialist clinics. The focus of the study was on the views of GPs. No assessment could

be made of the effectiveness of this model of diabetes care; however, the results provide valuable insights into other aspects of quality of care.

Our findings provide a clear and detailed account of GPs' largely positive evaluations of a specialist clinic service for patients who do not necessarily need hospital care and which has advantages over the hospital service, particularly shorter waiting times and convenient community locations. Sufficient time for consultations and good quality care were also highlighted.

GPs identified a number of concerns about the quality of care provided by clinics but their experiences varied. Whereas many schemes for GPs with special clinical interests (GPwSIs) involve just one or two clinicians within a PCT, in this instance the service was provided by a large number of GPs and other health professionals. The service was widely dispersed with little co-ordination: quality assurance, with full and open audit, is then particularly difficult. The situation was further complicated by the nature of the clinical skills required. While other GPwSI schemes involve a distinct range of procedures that fall outside the remit of generic primary care, chronic disease management focuses more on the extension of existing skills. There was only a limited amount of additional training when the programme was established. However, the availability of a community diabetologist to provide clinical support did offer a means of introducing more uniform standards, and more education and training sessions were subsequently provided, with contributions from the hospital consultants. The introduction of revalidation, designed to ensure high standards in general practice, has added weight to this process.¹² Some GPs have nonetheless argued for training to be voluntary, referring to their own professional expertise and right to autonomy in deciding what form of additional training is most appropriate for them.

Policy guidance also emphasises the need for new schemes for GPwSIs to have the support of, and involvement from, secondary and other services.⁷ In this instance, the clinics were set up as an alternative to hospital outpatient services for some patients. Their development arose at a time of difficulties in adequately staffing the hospital service but the new consultants, once appointed, felt isolated from a service that had arisen independently from secondary care; given the number of specialist clinics, and the responsibility for clinical overview falling to the community diabetologist, they knew little about the operation of, or approaches adopted in, many of the clinics. Although that situation has gradually improved and greater integration with secondary care is being achieved, the responsibilities of the hospital and specialist clinics continue to overlap. Closer collaboration in the early stages might have enabled a

more integrated approach. This would have helped in the development of high standards of care, smooth pathways between care sectors, and the confidence of consultants and other GPs.

Variability in the quality of communication, and in retaining or returning the responsibility for clinical care to GPs, arises from a reliance on individual clinics designing their own operational systems. Given the dissatisfaction expressed by many GPs, a standardised approach which takes account of best practice and the needs of referring GPs will help to ensure not just good communication but also more consistent patient care. As one of our respondents pointed out, good communication has an important educational element as well. Again, appropriate systems need to be put in place at the outset.

Some GPs singled out the importance of the DSNs and noted that these are only accessible through the specialist clinics. The extent to which the specialist clinic function can or should be split, so that individual team members can respond more flexibly to requests for support, needs to be considered when planning local services as a whole.

Some of the clinics were beginning to develop long waiting times. This was linked to high levels of demand, particularly in areas with large South Asian populations and a higher than average prevalence of diabetes. Some GPs referred to patients not being discharged back to their care – which might have reduced the pressure on the clinics themselves. In other areas, clinics were in close proximity to one another and operating under-capacity. Better strategic planning would have helped to ensure that the location of clinics was matched to need, while greater centralised oversight of referrals could have secured a better distribution of workload. As it was, some clinics were encountering the secondary care problems they were intended to overcome, notably long waiting times. The lack of equity that resulted from geographical location and differential waiting times was compounded by a lack of information about the clinics on the part of some GPs, and some reluctance to refer. As a result, not all eligible patients within the area had equal access to a service that was generally perceived as being of high quality.

While the clinics provide a specialist, intermediate level of service, most patients' care is from their own GPs and practice nurses. The development of a specialist service should not weaken the skills of other GPs or their opportunities for development. The specialist clinics could play an important role in enhancing skills if their remit were to be extended and they became local centres of advice and expertise. There is otherwise a danger that they will be seen as, and will indeed become, isolated islands of specialist expertise providing high quality care to the minority of patients who are referred to them.

The specialist clinics with GPwSIs do appear to represent an important shift from secondary to primary care and a means of addressing the higher prevalence of diabetes and increasing demand for healthcare services. They provide a service that is convenient for patients and popular with professionals. As the NSF calls for the development of new approaches to the delivery of diabetes care, this model provides an innovative approach that others might usefully consider.

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