DIABETES : TOWARDS AN INTEGRATED SERVICE IN THE COMMUNITY

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INTRODUCTION:

Provision Of Health Service Care for people with diabetes, at a time of burgeoning numbers and increasing complexity of understanding of the condition, serves to reflect on the current challenges with the management of long-term medical conditions within the NHS. Present diabetes care is frequently fragmented across primary, community, secondary and tertiary interfaces largely lacking a coordinated seamless system of care, often leading to patient disadvantage and sub-optimal outcomes.

Recognising the number of current issues that have been so identified, the Association of British Clinical Diabetologists (ABCD) wishes to engage in discussions on new ways of working towards a better system of diabetes care more appropriate to the delivery of clinical service within the modern NHS. This paper outlines the nature of these current issues and assesses the evident needs required to address aspects identified to enable a forward vision of diabetes care and service delivery to be developed. ABCD argues the case for an integrated network of diabetes care based in the community, under the auspices of a dedicated Diabetes Health Board of Stakeholders, involving multidisciplinary healthcare professionals and patient representation. ABCD recognises the principle of plurality of provider within the NHS and the fundamental principle of practice based commissioning. However, ABCD believes such an integrated Model of Care could be particularly well placed to reduce barriers presently impeding optimal patient care and also to enable more efficient and

effective usage of increasing financial costs currently subsumed by diabetes from the NHS budget.

Although the specific details for implementation of an integrated Health Board locality service will need to be determined, ABCD wishes to contribute to and support this new model of service for diabetes, and recommends funding of pilot studies in selected sites.

CURRENT ISSUES:

1. **Significant problems** with the delivery of present diabetes services are experienced, including lack of efficient/effective working between primary/community/secondary/tertiary services. Interface barriers are frequently encountered, often with competitiveness rather than collaboration.
2. **Recent health service initiatives** such as payment by results (PBR) and practice based commissioning (PBC) have altered working relationships and referral patterns between primary and secondary care. The policy of shift to the community has increased workload on primary care and altered/distorted secondary care activities (in many instances perversely shifting consultant workload more to endocrinological cases rather than complex diabetes management). Examples of loss of specialist resources for diabetes have been reported, reducing capacity/availability of specialist services to respond, when opinion is requested, thereby potentially destabilising overall provision of care.

3. **Role of the Consultant Diabetologist:** Reconfiguration of hospital based services has led to a changing role of the Consultant Diabetologist, with altered consultant work patterns towards more involvement in acute medicine but when encompassing referral triage to primary diagnosis speciality, has altered case mix workload to more that of extended elderly care; not necessarily best use of specialist diabetologist skills. Outpatient work has already become more focused on more complex case management (sub-speciality clinics),

with much less routine caseload; but nonetheless present systems are deterring complex referrals for specialist assessment and many follow-up patients are being pushed for inappropriate discharge from specialist care.

4. **Model of Care:** The present Model of Care has become increasingly protocol based rather than patient orientated. The “one-size fits all” lacks discrimination for individual needs. QOF measures intermediate parameters and ensures that more patients have the opportunity to receive good care, but long-term outcome benefit at individual level has yet to be established. We may already have reached that plateau. The present Model of Care does not easily separate the increased needs of the patient at “higher risk”.

5. **Patient Choice:** It is arguable that patient choice has diminished with the current Model of Care having become more prescriptive than empowering. There is limited engagement in eliciting the patient perspective, such as obtaining the balance between quality of life now versus uncertain long-term health considerations.

6. **Education and Training:** Despite the shift and considerable increase in diabetes care in the community, there is generally a lack of structured education and training for healthcare professionals with no formal assessment/accreditation of competencies and the minimal skills required for delivering diabetes services.

7. **Recruitment:** Many of these considerations in respect of the changing role of the Consultant Diabetologist have affected recruitment to the speciality and in particular have affected the perception and motivation of young trainees into the speciality. ABCD wishes to provide positive encouragement for future specialists in diabetes and is extremely keen to develop a forward thinking Model of Care that will prove attractive and professionally satisfying for the next generation.

NEEDS:

1. **A new/better way of working** to address these currently encountered problems is needed; to ensure high quality care for all people with diabetes, with equal access to the best possible care on the basis of individual clinical need (Joint Position Statement 2007, Diabetes UK, ABCD, Primary Care Diabetes Society).

2. Ensuring that diabetes care is **patient centred** with informed choice and respect for individual patient wishes – "Getting the Balance Right".

3. Moving towards more **integrated working** for all healthcare professionals with emphasis on more collaboration and less competiveness – better communication, better dialogue and better knowledge exchange. Ensuring close working together of all involved in service provision – improved partnerships, shared responsibilities, common purpose objectives within designated allocated budget.

4. The principle of **multidisciplinary working** within specialist teams remains fundamental (shared services, knowledge transfer, common practice, innovation). Systems of clinical care pathways would ensure that patients are seen by the most appropriate person for their clinical need with specialists primarily focusing on complex clinical management, whilst also ensuring a minimum critical mass of routine experience is still undertaken to maintain clinical skills and specialist advisory credibility.

5. **Acute medical services** will need specific essential provision, providing specialist support for hospital inpatients (approximately 15% of those in hospital beds) to maximise quality of care and minimise length of stay. Such could be a "stand alone" slimmed down service separate from the community specialist team but alternatively (? preferred) seconded sessions to the Acute Trust could be made from the Community Diabetes Health Board. Community specialist teams would work towards reducing acute admissions and facilitating earlier discharge from hospital.

6. **A coordination of total locality diabetes services** needs to be determined with an appropriate infrastructure, probably incorporating a community diabetes service with a "central" contact point to allow appropriate direction of different problems, to enable liaison with other related services eg ambulance, retinal screening, which could well be on a basis of a "**hub and spoke" network** within the community.

7. **A host organisation** (? Primary Care Trust, ?? Acute Trust) would need to take responsibility for human resource (HR) considerations. The host organisation would need to be receptive and committed to an integrated, locality based, provider service with provision of both generalist and specialist services outside the hospital environment and within a dedicated service budget. A high standard of professional support will need provision for all healthcare professionals, including with special reference to study leave/education, clinical excellence awards, pensions etc.

THE WAY FORWARD:

Arising from these current issues and identified needs, ABCD puts forward for discussion the following proposals towards a new integrated way of delivering diabetes services, primarily based in the community:

1. **A community-based integration of primary and secondary care services** for diabetes (and almost certainly the tandem sub speciality of endocrinology as well) should be established, with stakeholder representation of healthcare professionals, commissioners and providers, and patients participating through **an integrated health board locality service.**

2. Specialist diabetes healthcare professionals, including the majority currently based in secondary care teams, should come under a **single contractual employer** (probably the PCT, although other options are not excluded), with job plans primarily addressing

community service needs for both diabetes and endocrinology. Such job plans would require flexibility to ensure differing specialist requirements are met. The option for **sessional secondment** to acute trusts would support integrated care across the interface of community/emergency care. Specialists could support public health commissioners in commissioning for health and well being, and providing clinical governance for providers. The **host management organisation** (? PCT) will need to extend their employer responsibilities to the newly incorporated personnel, ensuring an understanding of their requirements (medical directorship, governance, training needs etc).

3. The provision of an integrated health board locality service would require an **allocated given budget** (the detail to be determined ? per capita of population; ? based on local medical demographics). Funding should be allocated to **patient-care systems** rather than to individual treatments, and all providers (including pharmacists) would contribute to the integrated locality service. To ensure the principle of practice based commissioning is met, the budget allocation would be based on that identified as required for provision of diabetes services, with **options of a practice based commissioning consortium either**:

    a. **Commissioning Services from the integrated health board**, including that of training and governance for its own healthcare professionals. Sessional salaried work with payment to the host organisation (? PCT).

    b. Or alternatively accept specialists as part of the integrated health provider organisation as suggested within the NHS Alliance Report whereby **specialists and generalists function as commissioners and providers of their service and support service redesign by clinical teams.**

Other specific advantages include:

- The business model will have **governance** based on quality frameworks, patient choice and patient satisfaction.

- The model would allow a **common governance structure** for GPs and Consultants and align the common interests and priorities of generalists and specialists addressing population needs whilst maintaining a control over the finite healthcare resources available for diabetes.

- The structure of such a health provider could encompass a "**not for profit organisation"** principle (eg a social enterprise), with specialist staff maintaining their contract/pension rights with the host organisation (ie as NHS staff who have already been seconded into social enterprise initiative), with a **system of incentives for service redesign,** in turn leading to a successful organisation and savings available for reinvestment in clinical service.

- Such a "not for profit organisation" would be further incentified by deriving **management support from the host organisation** avoiding overhead management support that would come with a "for profit" alternative company.

4. **The PCT (or other host organisation)** could also have a diabetes provider service role with the principle of maintaining the specialist multidisciplinary team working in the community. This could be developed through combining **central provision and coordination of services ("hub") possibly encompassing a poly clinic, whilst providing primary care support ("spoke") for routine diabetes care in general practices.** Such a model of delivery may be required for more rural services or to provide alternative choice. The "hub" centre would undertake responsibility for: **structured education and training** for patients as well as healthcare professionals, supporting patient involvement (see below), promoting health and wellness and ensuring involvement in **innovation and research activities** (in liaison with the NHS Diabetes Research Network).

5. **Patient involvement:** It is recognised that patients should be more actively involved in determining diabetes care appropriate to their needs, either by equal participation within

the integrated health board, or by individual agreement with their HCP concerning their personal overall care. With sufficient access to information/expert advice, patients should be able to set their own treatment priorities with differing **packages of care** according to individual circumstances. With such patient involvement the future option of **individual patient budgets** becomes a possibility.

6. **Pilot studies:** The incorporation of diabetes care within an integrated service organisation with a dedicated budget is attractive for many reasons. Initial pilot studies in selected sites are recommended.

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