Developing new models of diabetes care: sharing success from local innovation

Ken Shaw

The provision of diabetes care depends on a positive culture of change, requiring recognition, adjustment and effective management. Such words written in our editorial leader a decade ago[1] are as relevant today as they were then. Change is a continuous, inevitable part of daily life, and the clinical practice of diabetes is no exception. Technological, therapeutic and educational advances, and the sheer escalating numbers of people living with diabetes, place constant demands on the way in which diabetes care is provided. As we previously quoted: 'an enduring organization is one which is able of itself to adapt continuously not only to the needs of today, but also to the needs of tomorrow.'[2] It is, however, interesting to reflect on the drivers for change, which are a close inter-relationship of clinical need and political direction of the day. As both the complexity of diabetes care and its associated costs have increased, so has diabetes risen up the government agenda. At the same time, the NHS itself has been subject to constant change, requiring regular review of how clinical care is delivered and necessitating new ways of working. Although there are still many uncertainties concerning the immediate political way forward within the NHS, major changes are likely to lie ahead, with significant implications to the ways in which care is provided for people with diabetes.

Working in partnership

Integration of care has rightly been an increasingly crucial concept in recent years, recognising the need for efficient coordination of services and close collaboration between individual health care professionals. Anticipating the potential impact of future NHS reforms on local diabetes services, a joint position statement from a number of UK organisations[3] stressed the importance for all those involved in diabetes care to work in partnership, providing 'the right care, in the right place, at the right time'. Ensuring access to high quality care for all people with diabetes requires that local diabetes networks, providers, commissioners and people with diabetes all work together so that communities are not disadvantaged by service reorganisation. However, integration itself has different interpretations. Much that has been written has related to integration of services or to partnerships between health care professionals, but for many true integration should be around the individual with diabetes and the personal experience encountered.[4]

The strategic policy of shifting the majority of diabetes care into the community and primary care setting has been necessary in terms of managing the burgeoning numbers of people with diabetes, and it has been very successful in improving overall outcomes as determined by current quality standards. Initial tensions between the sectors of primary care and secondary care, historically the domain of specialists, should now be consigned to the past, provided perverse financial incentives and professional rivalries are avoided. The opportunities and challenges of integrating specialist services within the modern NHS have been recognised both by those working in general practice[5] and by specialists alike,[6] the principles of which are encapsulated in the joint Royal Colleges' paper 'Teams without Walls':[7] 'providing an integrated model of care where professionals from primary and secondary care work together in teams, across traditional health boundaries, to manage patients using care pathways designed by local clinicians'.

New ways of working

As we have observed similarly with today's diabetes centres,[8] employing the analogy of Darwinian finches on the Galapagos Islands, local services have evolved to meet local circumstances. Guidance on the core components of a good diabetes service model, embracing integration and working partnerships, is clearly available from a plethora of documents, but it is evident that presently many different models are being developed across the UK. These individual innovations very much depend on local champions responding to local needs, but clearly from these various initiatives many good ideas and positive outcomes are being achieved that could be replicated elsewhere. Local diversity will be inevitable, but successes should be shared.

In this issue of *Practical Diabetes* we publish some illustrative examples of these evolving models of care, each of which has developed relatively unique features of service delivery, but each responding to the universal need for improving diabetes care for everyone within the changing climate of today's NHS.

Rustam Rea and his colleagues from Derby describe a novel 'Joint Venture' organisation as a partnership between acute and primary care, set up as a legal entity ('company limited by shares'), responsible for delivery of comprehensive care to the local diabetes community with a single integrated budget.

Charles Wroe reports on a presentation given by Steven Laitner on an integrated pathway hub delivered by a prime contractor which has been proposed for the East of England. The prime contractor is a single provider with the total, population-based budget and accountable for quality and cost of the entire patient pathway across primary, community and acute care.

In contrast, Partha Kar and colleagues in Portsmouth – having identified six areas (the 'Super Six') that need to continue within the acute domain, and having established those aspects of diabetes care with which the general practitioner is comfortable – propose a third sector whereby consultant staff withdraw in part from

their hospital employment contract and are then reimbursed by the primary care trust or commissioning body on a sessional basis to provide specialist work of more complex nature, which falls outside the determined domains of acute and primary care.

Dinesh Nagi in Wakefield has undertaken a widespread consultation of general practices within his locality, establishing their wishes in terms of specialist input, producing a 'shared vision' of integrated service, particularly addressing health inequalities in diabetes that have been identified.

These are but a few of the many innovative models of care that are developing at the moment, and there will be others who have set up their services somewhat differently. By sharing experiences with others, individual localities will avoid the evolutionary risks of isolation and good examples of successful clinical practice can be adopted elsewhere to the overall benefit of the diabetes population. It is interesting to reflect that there was a time when the hospital physician with an interest in diabetes was solely responsible for all matters pertaining to diabetes.[9] How times have changed! Diabetes is a complex disorder and its management is equally so. However, with all of these thoughtful, innovative and to some extent bold initiatives, the future of diabetes care looks certainly most interesting, yet also appropriate for the current direction of travel within the NHS.

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Declaration of interests

There are no conflicts of interest declared.

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