Challenges of redesigning diabetes care services

The Integrated Care supplement is edited by Stuart Bootle and Jill Hill, Nurse Consultant in Diabetes, Birmingham.

Diabetes and its complications are largely preventable through a structured, proactive and integrated approach to health and social care, working in partnership with individuals and defined populations actively engaged in health prevention and self-management.

The healthcare community is becoming ever more complex. Practice-based commissioning groups are evolving, many PCTs have split into provider and commissioning or contracting arms, GP consortia are bidding to provide services under practice-based commissioning, and alternative providers are emerging in competition with local traditional NHS service providers.

These national drivers have embedded the words 'service redesign' into the day-to-day language of local health economies. Commissioners need to act now and work closely with their providers to make 'service redesign' happen. They now have the power to help support new ways of working and to ensure that the right care is available at the right time and in the right place to meet all the needs of local people with diabetes.

In the past, most people with diabetes attended hospital outpatient clinics where they had to wait for several hours to see the doctor for just a few minutes. Now, the majority of people with diabetes get their routine care 'close to home', through their own general practice.

However, not every practice has the desire or skills they need to carry out such care. Data from the Quality and Outcomes Framework (available for 2006/2007 at http://www.qof.ic.nhs.uk [accessed 18.08.2008]) show that there is still considerable variation in what care people get, which is not necessarily related to deprivation or geography.

The role of specialist support

Although hospital-based clinics for diabetes still exist in most cities, very few are led by the consultant diabetologist in isolation. Much of the work of the specialist is now done by multidisciplinary teams, and for many years diabetes specialists have worked across the entire local diabetes community, organising district-wide programmes of care, supporting those primary care teams with less established diabetes skills as well as providing direct clinical expertise for individual patients with more complex problems.

Primary care teams need and want appropriate specialist support. Most people with diabetes need specialist input at some time in their lives; not only for the complications of diabetes, but also to help deal with the complexities that arise as part of routine ongoing care. But not everyone is getting it when they need it.

Getting expertise closer to patients involves much more than simply moving a traditional diabetes clinic to a new site. The challenge is to harness the skills and expertise of specialist diabetologists and multidisciplinary teams in new ways and effectively utilise the growing diabetes knowledge and skills base among GPs, practice nurses and other primary care team professionals. PCTs, practice-based commissioning groups and local practices need to work in partnership with their specialist services to overcome the challenges, make 'service redesign' a reality and improve the quality of care provided for people with diabetes.

In their article, Debbie Hicks and Kit McAuley examine the process of 'service redesign' in relation to diabetes care in Enfield, explore the challenges involved and consider the potential opportunities that exist to help make a difference for people with diabetes. ■

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