Working towards seamless care

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

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Stuart Bootle is a GP in Derbyshire and a Healthcare Business Consultant, Healthcare Continuum

Type 2 diabetes is a chronic, progressive and complex condition associated with significant morbidity and mortality. The increased cardio-metabolic risk associated with diabetes exposes people to both acute and chronic complications due to microvascular and/or macrovascular angiopathy (Holman et al, 2008). The complications themselves, their consequences and their treatments have a profound impact on people with diabetes, their families and the NHS.

There is now good evidence to show that a structured approach to the management of hyperglycaemia and other cardio-metabolic risk factors can make a significant difference to long-term outcomes for people with type 2 diabetes. Indeed, the recent UK Prospective Diabetes Study data (Holman et al, 2008) demonstrated that previous intensive glucose control resulted in a continued reduction in microvascular risk and emergent risk reductions for myocardial infarction and death from any cause.

The progressive nature of the condition means that healthcare professionals need to work in partnership with people with diabetes, tailoring and adjusting treatment over time. Early diagnosis and intervention is increasingly recognised as a priority. Many clinicians now follow the joint American Diabetes Association/European Association for the Study of Diabetes consensus guidelines (Nathan et al, 2008) and consider starting metformin, unless contraindicated, as well as supporting people to make the appropriate lifestyle changes, at the point of diagnosis. This is where the challenge begins: what do you do next?

There are more and more treatment options available for the management of hyperglycaemia. This increasing choice raises more questions than answers. What do we use after metformin? What about triple oral therapy? When do we consider insulin? Where do dipeptidyl peptidase-4 inhibitors and glucagon-like peptide-1 agonists fit? The recently published NICE guideline for the management of type 2 diabetes (NCCCC, 2008) provides limited advice on where the newer agents fit. This lack of clarity has the potential to leave many people with type 2 diabetes exposed to the vascular damage associated with sub-optimal management of hyperglycaemia.

Over the next few years we will see more new classes of drugs entering the market. We have recently seen treatments withdrawn because of safety concerns. This means that clinicians now need to keep up-to-date with this dynamic therapeutic environment and make complex decisions in relation to efficacy, benefits and safety on an individual basis.

The need for seamless care is now greater than ever. However, 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.

With these issues in mind, the following article explores the need for specialist diabetes teams to support primary care in recognising the need for intensification of therapies for people with type 2 diabetes who have suboptimal glycaemic control. Samantha Rosindale and her team have demonstrated that bringing specialist and primary care teams together to discuss a retrospective review of patient case notes, can:

- Document clinical governance issues in practice.
- Reveal unmet need in terms of the management of hyperglycaemia.
- Identify the learning, training and development needs of practice professionals.
- Improve working relationships between primary and secondary care.
- Have a positive impact on patient care. ■