Working to incentivise wellness in diabetes care

It is good to read in Rowan Hillson's editorial that "most adverse effects of diabetes can be prevented or reduced by modern, evidence-based, systematic, integrated care". She acknowledges the difficulties in achieving that goal within a changing system. Where we are going wrong, according to the Policy Exchange, an independent think tank, is in continuing to treat illness instead of incentivising wellness (Featherstone and Whitham, 2010).

The statistics are worrying: hospital admissions for people with type 2 diabetes have increased by 65% in the past decade (Featherstone and Whitham, 2010); the National Diabetes Audit 2008–2009 (NHS Information Centre, 2010) found around half of people with type 2 diabetes, and only one third of people with type 1 diabetes, received all the care processes recommended for them. Care planning appears to be more written about than achieved (NHS Information Centre, 2010), there is much wastage around prescribing and taking of medication (Donnan et al, 2002), and education, for healthcare professionals and people with diabetes alike, is suffering badly from changes to funding. Yet numbers of people with diabetes continue to increase year on year and obesity rates show no sign of slowing down. How is the brave new world of commissioning and consortia going to tackle these concerns?

The grapevine tells me that some highly experienced diabetes specialist nurses have been demoted or made redundant in the reorganisation of care. I never thought I would see the day when nurses would lose their jobs. As Dr Hillson points out, we know what to do – we need to identify the resources to enable it to happen, and we need to work differently. Twenty years ago I wondered why reasonably well people were tolerating sitting around in outpatient departments for hours to see a specialist for, maybe, 10 minutes. I wonder today about the efficiency of some diabetes clinics where a hard-pressed practice nurse has 15 minutes to gather QOF points, impart education and enthuse people with a long-term condition to look after themselves. Few I have spoken to have an active part in deciding how diabetes management fits into the new organisation. As a Scot, I suspect healthcare professionals in Scotland, which is not suffering the same upheaval, are looking down and wondering how it will all work out.

So, of course, Dr Hillson is right. Education *needs* to be commissioned. Local priorities *should* be set. It *is* important to get diabetes on the agenda. Service improvements *must* be implemented. We really *must* engage people in their own care. We haven't the time, nor the resources, to do it for them. We must ensure diabetes care is available to all. Variances in care (have you noticed how these used to be termed inequalities?) need to be addressed.

But we must not dwell on doom and gloom, otherwise nothing will get done. Change can allow those with fresh eyes to see things that could be done better. We must seize the opportunity to improve the lives of people with diabetes, and therefore our working practices. Perhaps it is a good time to consider the recommendations of the incentivising wellness document (Featherstone and Whitam, 2010), increase the uptake of the National Diabetes Audit to allow accurate surveillance, assess cost-effective models of care for long-term conditions, overhaul QOF to concentrate on improving outcome measures (truly incentivising wellness), pilot new joint business models that focus on long-term condition management and reduce the need for hospitalisation steadily over 5 years. Oh, and I would add, involve nurses in the process!

It can be done! The Cambridge example shows the huge benefits a willingness to work together and plan for the future can bring. ■

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