# Investing in diabetes services: Money well spent?

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Where most people receive their diabetes care has gradually shifted from secondary to primary care. However, the variable abilities between GP practices can mean that some people with diabetes of similar complexity receive all their care in their local practice (for example, some are competent in insulin initiation, but some are not) while some are with community diabetes teams, and others in secondary care.

The drive to move services away from costly hospital care into primary care has been a theme for some time, motivated from models elsewhere such as Kaiser Permanente (Feachem et al, 2002) but is increasingly being driven by the general economic situation in the UK and the need to keep costs down, coupled with an ageing population with expanding health needs from long-term conditions like diabetes. Shifting services, and maintaining quality *and* keeping costs down can be difficult and is not achieved by just moving specialist services into primary care (University of Birmingham Health Services Management Centre and NHS Institute for Innovation and Improvement, 2006).

Proposed changes to the NHS encourage the use of other willing and competent providers, including the private sector, to support GPs in supporting the health needs of people with diabetes (Department of Health [DH], 2010a). There is also a greater recognition that the patient is a crucial player in their care and can take on more self-management with education and support (DH, 2001). This is not a new concept but is becoming more formalised through structured education programmes and care planning in diabetes. Commissioners have the task of ensuring best value for money (through, for example, eliminating duplication, appropriate skills mix, and new ways of working like the use of virtual clinics to maximise skilled but relatively costly healthcare professionals).

The following article discusses the approach taken in Cambridgeshire to re-design and invest in diabetes services. It is clear that working with commissioners was important to agree what the needs of the population were, what would be the most cost-effective way of meeting these, and to calculate the costs (and savings) of the proposed changes.

Rather than just adding more diabetes specialist nurses and diabetologists to the team, the introduction of two diabetes care technicians means less complex routine aspects of care can be undertaken at less cost, while relatively expensive diabetes specialist nurses and diabetologists can focus on people with complex needs. The use of specialist healthcare professionals in virtual clinics can mean greater numbers of patients can be reviewed, while at the same time empowering and educating primary care colleagues and strengthening networks and working relationships. Agreement about what competencies are required (which will guide decisions about the level of staff who need to be employed) to deliver the service has to be considered to ensure staff are "fit for purpose". The recently revised diabetes nursing competency framework is a useful tool for this and is being considered as a model by other disciplines involved in diabetes management (TREND UK, 2011).

There is an increasing emphasis on outcomes and proving "worth" (DH, 2010b). The use of clinical outcomes, amount of activity, and costs (saved versus those invested) demonstrates value for money. Recent guidance from QIPP (Quality, Innovation, Productivity and Prevention) has identified certain medications as a potential source of saving money for the NHS. Pertinent to diabetes is the use of insulin analogues and blood glucose monitoring strips (National Prescribing Centre, 2011). Clinical experience can advise on appropriate use of medications to achieve good outcomes and quality while also making cost savings. The Cambridgeshire team have demonstrated that investing in an integrated specialist team can make savings in costs yet deliver in clinical outcomes: music to the ears of commissioners! ■