Joint clinics: An effective integrated care model?

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The following article describes a joint partnership of a secondary care consultant working with a GP practice to offer specialist support for people with very poor glycaemic control in their local practice. This "localisation" of care has been on the agenda for a number of years, for the reasons discussed in the article: the patient can receive holistic continuity of care, easy access at their GP practice, and for NHS budget controllers, there is an assumption that providing services closer to home will be cheaper than hospital services (Department of Health, 2006).

The short description of the people seen in the clinic illustrates some of the complex needs of patients that primary care colleagues have to manage because, for one reason or another, the individual does not wish to attend the hospital diabetes service. However, often the root of their poor diabetes control is psychological or social and a medical solution is not appropriate. People usually do not have poor glycaemic control just because they need another tablet. While it is true that integrated care involves a much wider approach to meet the needs of these people, the traditional clinic model is also very limited. For example, the poor response to the clinics by the people with type 1 diabetes in the accompanying article probably shows that investment in a structured education programme like a DAFNE (Dose Adjustment For Normal Eating) course would be money better spent than seeing the person with diabetes in a one-to-one clinic.

The concept of integrated care is often talked about, but in reality may be difficult to achieve, particularly with separate budgets, tariffs, and limitations of IT systems that prevent sharing of data. I became a diabetes nurse consultant in 2003 in Eastern Birmingham. Soon after I started, the PCT, along with Solihull PCT and Heartlands Hospital, became one of three national beacon sites for implementing the principles of the well-known champion of integrated care in the USA, Kaiser Permanente (KP; Feachem et al, 2002). Those readers familiar with Eastern Birmingham will recognise one of the first challenges we faced was that the area does not feel like California, where KP is mainly based!

I was part of a small community diabetes team which, rather than replicate secondary care clinics in the community, focused on enhancing the skills of all the GP practices. This was achieved through developing a comprehensive menu of healthcare professional diabetes education programmes, including healthcare assistant study days, delivering the Warwick Certificate in Diabetes Care course locally, and insulin management and initiation courses. Good quality primary diabetes care was supported by diabetes guidelines and referral pathways jointly agreed with medicines management and primary and secondary care. Incentives and resources were included through local enhanced services. Community specialist clinics, group consultations and virtual clinics have also supported GPs and practice nurses to provide good "in-house" diabetes care but also to embed close working relationships between specialists and primary care across the local diabetes economy, and ensure that appropriate people are referred to secondary care.

This basic model is still in place now, despite various mergers and all the upheaval that entails, but separate budgets and payment schemes, and particularly the limited sharing of data, have made it difficult to replicate the integrated approach championed by KP. Integrated services are on the NHS agenda now, but with a new title: accountable care organisations. This again comes from the USA but with the strong primary care base we have in the UK, should be possible here. Instead of divisive tariffs for different providers, a network of providers serving a local area have a pooled budget and payment is related to delivering quality of care, good outcomes and achieving cost reduction goals – all top areas to manage the NHS in the current economic situation! Ideally, all working together for the health of a local population, and being accountable for the effectiveness of our work, should promote more effective joint working to improve quality and slow spending growth. Watch this space! ■