The Francis report, the "Four Horsemen of the Apocalypse", and the future of diabetes care in the NHS

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The publication of the Francis report (Mid Staffordshire NHS Foundation Trust Inquiry, 2010; 2013) reveals the failings at Mid Staffordshire. While the scope of the report is far broader reaching than just diabetes, this condition is indisputably a central piece in the NHS's role and the findings are clearly of much relevance to all in the diabetes community. Furthermore, some of the individual cases that triggered the major coverage in the lay press related specifically to the care of diabetes (e.g. Daily Mail, 2013).

The debate following the publication of the report has so far focused on *how* the crises happened but ignores what, in my opinion, is the more fundamental and important question of *why* (Hawkes, 2013a).

Many will blame the pressures of structural change and a target mentality (Wood, 2013). Labelling these as the genesis of what is wrong with patient care is over-simplistic and misses the significance of four seismic changes that I feel have fundamentally altered UK healthcare and which are discussed below. Together, they appear to offer a dramatic societal exemplar of the "law of unintended consequences" (Merton, 1936).

We do not, I believe, need systems of greater scrutiny; rather, we need a healthcare system where good, consistent and compassionate care is hard-wired into the system's culture (Lee, 2004).

The "Four Horsemen of the Apocalypse"

The portents to this crisis could be labelled the "Four Horseman of the Apocalypse", as I shall explain below.

Death

Project 2000 was an initiative designed to improve nursing standards in the UK (Gray and Smith, 1999). Nurse training was delivered as part of structured, classroom-based learning marking a conscious move from an apprenticeship to an academic certification model.

Qualified nurses, although more academically qualified, lacked the direct experience of clinical practice and required more support and supervision. In line with their technical competency, nurses shouldered administrative and regulatory duties, eroding the time available for direct patient care.

This marked the first step in what has been described as the "care gap".

Famine

The European Working Time Directive (European Union, 2003) dictated that no junior doctor should work for more than 48 hours per week and thus substantially reduced the capacity of the medical workforce and destroyed the traditional medical firm structure (Pickersgill, 2001).

The reduced reliance on junior doctors and a focus on their education rather than service delivery further widened the care gap.

War

Consultants

Changes in nursing and junior doctor working demanded a change in the model of consultant working and prompted a call for a consultant-delivered service model (Academy of Medical Royal Colleges, 2012). Consultant specialisation also impacted on general service delivery, creating a number of predicted problems (Detsky et al, 2012).

While specialists have increased competency in some areas, they have become de-skilled in others. This had led to an increase in consultant-to-consultant (C2C) referrals. In some areas, up to 60% of outpatients activity

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is generated by internal referrals, while the national average is 21% (Robinson, 2009). C2C decreases continuity of care and obscures the lines of professional responsibility, for individual patients.

The reduction in "generalists" places the pressure of acute medicine on a shrinking population of doctors. This has resulted in a national initiative to develop a speciality of "acute medicine" (Joint Royal Colleges of Physicians Training Board, 2009).

Taken together, this has further contributed to the care gap.

GPs

Arguably one of the most significant events in primary care in recent decades was the re-negotiation of the employment contract that allowed GPs to opt out of the provision of 24/7 care (Department of Health, 2004; 2006), emergency care is now provided by out-of-hours companies and contracted GPs (Colin-Thomé and Field, 2010).

These doctors have no relationship with the patients and poor sight of past medical or social histories. The decisions made on further care are therefore based on incomplete information, and the default position is referral to the acute setting.

The marked reduction in the number of GP partners and a move in many practices towards salaried GPs (Lester et al, 2009) may well be a metaphor for the move from vocation to occupation.

This has affected continuity of care and obscured the attribution of ongoing professional responsibility and accountability.

Plague

There has been a dramatic increase in the number of older patients admitted as emergencies (Featherstone, 2012).

Dementia complicates one in five acute hospital admissions and over 20% of inpatients have diabetes as a comorbidity. Older patients exhibit high levels of frailty, with complex long-standing comorbidities being the norm (Bowman et al, 2001; Featherstone, 2012). The acute medical setting is probably not the most appropriate environment for a majority of these older patients (Hawkes, 2013b).

This could be summed up as the wrong people in the wrong place being looked after by staff with the wrong skill-set and is the final pressure on the care gap.

Failure of care is now increasingly possible and, indeed, arguably inevitable (Royal College of Physicians, 2012).

Implications for diabetes care and diabetologists

Diabetologists have a wide general medical view. Diabetic services must serve all patients groups, recognising their specific requirements. However, elderly patients with diabetes are the fastest growing, and arguably the most vulnerable, population group.

Many people with diabetes have comorbidities – hypertension and cardiovascular disease are best recognised, but renal disease, dementia and cancer are becoming increasingly common.

As noted above, over 20% of inpatients have a diagnosis of diabetes. People with diabetes are twice as likely to be admitted, stay twice as long in hospital and have a 10% higher mortality than people without diabetes (NHS Diabetes, 2008; Association of British Clinical Diabetologists, 2012). A majority of these individuals will be frail and elderly with one or more comorbidities.

The management of older patients and people with diabetes admitted in an acute setting is, in my view, suboptimal and needs to be improved.

Despite the call for diabetologists to become involved in specialist diabetes care in the community, there is a rationale for diabetologists to be at the leading edge of the delivery of acute medical care in hospitals. Diabetologists need to consider what their role in the post-Francis, newly structured NHS will be.

The questions to be urgently debated include whether diabetologists should:

- Become acute medical doctors, bringing together their general medical expertise in an acute assessment role.

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- Become inpatient care specialists, looking after all patients with a diabetes comorbidity and developing further sub-speciality interests in dementia and stroke.
- Become community based, developing high-quality, easily accessible services that reduce the requirement for hospital admission.
- Design a role that delivers all aspects of diabetes care, within an individual's role or as part of a "total" or "integrated" diabetes service.
- Involve colleagues who are GPs with a Special Interest in diabetes in the acute assessment of older people with diabetes presenting complex cases.

Conclusion

Any development will need to consider the new world's demands for high-quality care and improved outcomes and experience, while ensuring 24/7 access to care (NHS Commissioning Board, 2012).

The development of 24/7 consultant-delivered services is surely among the most significant developments in the modern NHS. It may also be the most powerful driver for service redesign to better serve people with diabetes.

As such, it could be the ultimate test of our collective and personal conscience as we resolve to defeat the Four Horsemen and transform healthcare delivery. ■

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