Intermediate diabetes care: Moving from models to reality

Brian Karet

Department of Health (DoH; 2006a) *Our health, our care, our say*. DoH, London

DoH (2006b) *Turning the Corner: Improving Diabetes Care*. DoH, London

Diabetes UK, Association of British Clinical Diabetologists (2005) *Joint Position Statement: Ensuring access to high quality care for people with diabetes*. Diabetes UK, London. Available at http://www.diabetologists.org.uk/ (accessed 13.06.2006)

Health and Social Care Information Centre (HSCIC, 2005a) *Quality and Outcomes Framework, 2004/05*. HSCIC, London. http://www.ic.nhs.uk/services/qof/data (accessed 13.06.2006)

Brian Karet is a GP at Leylands Medical Centre, Bradford, and a GPwSI in diabetes.

Over 1.7 million people in England have diabetes according to the 2004/2005 prevalence data for the Quality and Outcomes Framework (QOF; Health and Social Care Information Centre, 2005). This figure is predicted to rise to 2.5 million by 2010 (Department of Health [DoH], 2006b).

The natural history of diabetes is one of deteriorating control over time. Maintaining good diabetes control necessitates a high level of input and expertise to prevent the onset and progression of complications which are already thought to be costing the NHS 10% of its annual budget (DoH, 2006b).

We know that the QOF, which is delivered entirely in primary care, has gone a long way to improve surrogate markers of diabetes control, but in order to continue to achieve these and future targets, primary care will need to devote more resources to the care of people with diabetes. These resources comprise not just the cost of additional drugs and devices but the provision of skilled personnel both to engage with people with diabetes and to train and educate the medical staff in the community who provide day-to-day care.

Expertise in community care

This higher level of expertise has hitherto, in many parts of the country, been the sole responsibility of secondary care, but a string of Government publications (most recently DoH, 2006a) have suggested to commissioners that this traditional model is no longer sustainable. Practice-based commissioning is likely to be an additional driver for the provision of this expertise to be largely community based.

The key to this change in the delivery of what is now being termed 'intermediate care' – the provision of high levels of diabetes expertise in the community – is to ensure that this system is robust and can be demonstrated to be not just safe but effective too. Diabetes UK and the Association of British Clinical Diabetologists (2005) have voiced concerns about this change of direction and its impact not just on patient care, but also on the sustainability of secondary care diabetes units that for many years have coped with the impact of rising disease prevalence. It is of course ludicrous to suggest that care would be delivered in the community without the support and direct involvement of secondary care consultants. Diabetes care must continue to be delivered by a multidisciplinary team.

How this change in the delivery of diabetes care is done in each locality depends on a number of factors, which are covered well in two DoH publications: *Implementing a scheme for general practitioners with special interests* (available at http://www.dh.gov.uk/assetRoot/04/05/98/61/04059861.pdf [accessed 13.06.2006]); and *Guidelines for the appointment of general practitioners with special interests in the delivery of clinical services: diabetes* (available at http://www.dh.gov.uk/assetRoot/04/08/28/75/04082875.pdf [accessed 13.06.2006]). Local demography, prevalence and incidence rates, and existing and planned levels of training and enthusiasm among primary care staff will be key determinants of what a service will look like, as will the availability of other core professionals including diabetes specialist nurses, podiatrists and dietitians. Any new service should try to be truly patient focused and improve the quality and consistency of care across the locality.

Moving from models to reality

Many models of diabetes care have already evolved, including a very comprehensive network of diabetes satellite clinics in Bradford, where I work, but one of our most pressing issues is the capacity of any service to address the demand. One novel solution to this problem has been started in Coventry and is described in the accompanying article by Jim McMorran and colleagues. Jim is one of the GPs with a Special Interest working in the service, and, as he says, such models only work with the consistent support of both primary and secondary care. Proponents of high-quality, patient-centred care will welcome such developments and await evaluations with interest. ■