Developing new diabetes care models

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It seems a contradiction that as we are facing an unprecedented increase in the prevalence of diabetes, a number of well known diabetes centres are facing staff cuts. Many newly configured primary care trusts are facing large financial deficits and when required to address them by reducing expenditure look to reduce payments to hospital trusts along with all other providers. Simultaneously, hospital and community trusts are required to function increasingly as commercial organisations generating maximum income and in the manner of such organisations will look to reduce staff who cannot be immediately linked to the generation of revenue.

Future responsibility for ensuring that services are provided only within allocated funding is being passed to general practices under the guise of practice-based commissioning. It would seem unlikely that they will find the task easier than their predecessors. So how will diabetes services develop?

There has already been a sizeable shift in the provision of diabetes services from hospital departments to general practices over the past two decades, further encouraged and recognised within the Quality and Outcomes Framework of the 2004 GP contract. Provided that the resources, including time, interest and expertise exist within practices then much diabetes care may indeed best be provided within that setting. We are close to the patients and generally provide a familiar team who are fully involved in the management of varied co-existing medical problems.

However, all with experience of working with people with diabetes know of the pitfalls and complexities to be found within the realms of the condition and its complications. The full array of multidisciplinary skills are available within few, if any, practices; and while practices will differ in their willingness and ability to provide enhanced diabetes services there are few who would disagree that specialist care is appropriate in some scenarios.

While in some localities an intermediate tier of diabetes service may be ably provided by teams led by GPs with a special interest, there will remain those service users who can only be adequately served by specialist diabetologists and their teams, whether working within hospitals or in a community setting. Furthermore, what of the oft-repeated priority of 'patient choice'? People with diabetes rightly expect the best available services, delivered in a timely and accessible manner – the right people, in the right places at the right times. Traditionally, many hospital diabetes clinics have been overcrowded, remote and only accessible after wading through a long waiting list. Then to see staff with whom one is unfamiliar and who are likely to have moved on to new positions between visits has bred disenchantment. Granted, many departments have worked hard to address these shortcomings. Therein lies the best opportunities for 'integrated care', with primary and secondary care teams working together to facilitate the discharge of patients back to practices once the need for specialist care is over.

Clinicians, patients and financial managers may even agree that there are opportunities to reconfigure diabetes services so that they meet all the needs and aspirations of service users into the coming decade. The challenge is to achieve this without destroying the successes already achieved, and, all while also facilitating research towards a future without diabetes, or at least without its worst effects.

As an attempt to provide practical help for those involved in planning future diabetes services through practice-based commissioning, the Primary Care Diabetes Society led the development of a commissioning toolkit for diabetes. Produced together with the Department of Health, the Association of British Clinical Diabetologists, the National Diabetes Support Team and Diabetes UK, the toolkit advises on how to carry out a health-needs assessment for a local diabetes population and provides a generic specification for diabetes care. While recognising that differing areas may develop their own individual service models, use of the toolkit should help to ensure that planning is undertaken rationally and with due consideration of the consequences. It can be found at *www.diabetes.nhs.uk/downloads/commissioning_toolkit_diabetes.pdf* (accessed 20.12.06). ■

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