Money, money, money … Welcome to the bottom line

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Possibly more than other nursing colleagues we (diabetes specialist nurses and nurse consultants in diabetes) have long been aware of the need to prove our worth to both our patients and our employers. So the current emphasis on value for money is not new to our world.

However, what *is* possibly new is the overwhelming emphasis on successful financial management at whatever cost (or so it appears), as well as the reality of hospital closures and service reductions. There are many methods currently in use which seek to control and manage financial flows and expenditure, one of which is payment by results (PbR).

PbR is a way to reward hospitals for providing high-quality services at better than average costs. It is said to be key to patient choice (by, for example, Sigsworth, 2006) but in reality the 'cost' of this system on primary care trusts and local commissioners may reduce patients' access to specialist secondary care services. Conversely, acute trusts may seek to encourage outpatient appointments and, in particular, new appointments which attract a greater fee. All procedures will probably have a fixed fee and time limit, so again it is in the acute trusts' financial interest to reduce patients' length of stay, as increased throughput will increase bed usage and, therefore, increase funding. (Believe me, patients do appear on the bottom line somewhere, trust me!)

So where do diabetes services feature in all this? Consider practice-based commissioning: Farooqi (2006) recommends active management of both commissioning risks and fragmentation of services. Now is the time to really talk to your commissioners, GPs and service users in terms of what they believe to be good within current resources. I also recommend talking to secondary care managers who you may be employed by but who may not necessarily appreciate what you do with respect to care of the person with diabetes or your corporate contribution. Failure of such discussions could lead to cherry-picking by independent service providers leading to 'incalculable damage to coherent long-term care for people with diabetes' (Farooqi, 2006). Many of us have worked long and hard with primary and secondary care colleagues to join up services and improve patient outcomes and that clearly is at risk.

The concepts and drivers in the two articles within this supplement are products of this financial debate, and as one is based in an acute trust and the other in a primary care trust, reflect issues in both areas of diabetes management and services.

In the first article, Julie May focuses on leading service redesign within an acute trust, whose purpose was to avoid automatic admission the night before minor surgery due to diabetes. Her work on protocols to manage diabetes peri-operatively, and collaboration with all staff involved is enlightening, and has principles which could be applied elsewhere regarding length of stay and inpatient care.

The second article, by Debbie Hicks and Kit McAuley, describes the 'repatriation' of patients seen in secondary care into primary care. They also discuss the need for reducing the number of referrals to secondary care in the first place and the cost savings and other benefits achieved.

Underpinning both articles is financial review and improved management, and most importantly, although perhaps featuring less in the current climate, patient benefit. Both provide ideas and solutions and perhaps I could add one of my own – put on your Abba Gold CD and dream of a rich man's world, it always works for me! ■

Sigsworth J (2006) Rewarding Efficiency. *Nursing Management* **13**(3): 10–3

Farooqi A (2006) Practice based commissioning: what does it mean for diabetes services? *Practical Diabetes International* **23**(5): 197–8