

Rocket science or common sense?



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The report entitled “Department of Health: The management of adult diabetes services in the NHS. Seventeenth Report of Session 2012–13” was published on 22 October 2012 (House of Commons, 2012).

The report confirms that good diabetes care, as in many other specialities within the NHS, is a “postcode lottery”.

Whilst the report contains lots of information that we all know about, including the rising prevalence of diabetes and the lack of structured care checks other than those covered within the Quality and Outcomes Framework (QOF), it also contains interesting nuggets which I have picked out to highlight for you.

Firstly, the report states:

“The Department explained that there will always be some variation in performance because some populations have more people at risk of diabetes than others but recognised that variation is mostly driven by differences in how primary care trusts deliver diabetes care and in clinical practice between healthcare professionals. The Department considers that the new arrangements for commissioning primary care will reduce variation and increase consistency in the delivery of diabetes care.”

This issue just reinforces the “postcode lottery” and I cannot see how the new clinical commissioning groups will make any difference.

They are fledgling organisations with a huge task in front of them – diabetes care is not at the top of their agenda when faced with other issues, such as cancer care and mental health problems.

Unfortunately, there is no recognised single model of diabetes care that can be adopted by these new organisations and,

therefore, consistency is difficult. Education and training are required to ensure that all the general practitioners and practice nurses are skilled and up-to-date to provide good basic diabetes care.

The report continues that:

“The Department explained that it had sought to incentivise improvements in diabetes care through the Quality and Outcomes Framework, the system through which GP practices are rewarded for undertaking specified clinical activities and achieving specific treatment standards. The Quality and Outcomes Framework was initially effective in improving the delivery of care and outcomes for people with diabetes in primary care, but these improvements have since plateaued.”

The National Diabetes Audit 2010–2011 (NHS Information Centre, 2012) showed that people with diabetes were being seen regularly and QOF points were claimed but outcomes had not improved. However, we also need educated, motivated patients to ensure high-quality care is effective.

In regard to diabetes education, the report states:

“Too many people with diabetes are developing avoidable complications because they are not being effectively supported to manage their condition and do not always receive care from appropriately trained professionals across primary and secondary care. For example, the National Audit Office found that just 5% of those diagnosed in the previous 12 months received structured education in 2009–10.”

I have heard anecdotally from other nurse colleagues across London that the amount of diabetes education available has reduced as

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the primary care trusts (PCTs) are not able to fund programmes, such as DESMOND or DAFNE. My own PCT only funds 12 education programmes for 120 people with diabetes per year out of a population of 17 000.

The report continues to state that:

“The Department acknowledged that its Payment by Results tariff system for secondary care, which pays healthcare providers for clinical activity and was designed to increase capacity in hospitals, is not appropriate for incentivising the care required to treat a complex long-term condition such as diabetes. Diabetes requires integrated multi-disciplinary care but the Payment by Results tariff has created boundaries between providers all of whom are responsible for delivering diabetes care. In these circumstances providers are competing for payments rather than attempting to create a seamless care pathway in the best interests of people with diabetes.”

Finally, the people who make the rules have had an epiphany and realised what most of us working in diabetes care have been saying about integrated care for years. However, until the budgets allow integration, the “silo effect” will continue.

Alarmingly, the report also includes the following statement:

“The Department has improved data on diabetes to support those commissioning, planning and monitoring services and some of the best performance management data the NHS now holds is on diabetes care. However, these data are not being used by the NHS to improve performance.”

Although the aforementioned statement is included in the report, there are no suggested solutions as yet. Why if we have good data to inform how care is developed in the future are we not accessing this?

I have to admit that on reading the report, I felt like banging my head against something hard or having a very large vodka and cranberry juice (my favourite tippie), as this is not rocket science, just common sense! Let’s see what happens next – I can’t wait! ■

House of Commons (2012) *Department of Health: The management of adult diabetes services in the NHS. Seventeenth Report of Session 2012–13*. The Stationery Office Limited, London. Available at: <http://bit.ly/SvGTIz> (accessed 13.11.12)

NHS Information Centre (2012) *National Diabetes Audit 2010-2011. Report 1: Care processes and treatment targets*. The NHS Information Centre for health and social care, Leeds. Available at: <http://bit.ly/SjqJBb> (accessed 13.11.12)