

# The new NHS and diabetes



Gill Freeman

The NHS reforms for England set out a 10-year programme to bring the NHS into the 21st Century. This aims to collect and analyse the needs (and wants) of a population and identify the service requirements to meet those needs. It asks for equal access to high quality, seamless and integrated care. The latter is not new to diabetes — integrated care has been a part of diabetes for many years, recommended by both health professionals and people with diabetes alike.

The development of Local Diabetes Services Advisory Groups (LDSAGs) has ensured that all people involved in diabetes care come together on a regular basis to improve care for people with diabetes locally. These groups are uniquely placed to oversee diabetes services and hold a wealth of information on integrated care and its implementation. As such, they will surely be turned to by commissioners in the new NHS, as a ready-made model, thus strengthening their position.

## Evidence for service development

The new NHS, based on health needs assessment, will require evidence to support the case for service development. This puts diabetes at the cutting edge with recent published evidence demonstrating that aggressive blood pressure and blood glucose control targets in diabetes improves outcomes with a reduction in morbidity and mortality (DCCT Group, 1993; UKPDS Group, 1998). This evidence will also support the plea for resources to meet the recommendations of the St Vincent Declaration. As well as recent trials, there is ample evidence to show that diabetes is a major cause of ill health to the population and cost to the NHS (Centre for Health Economics, 1992).

## Primary Care Groups and Health Improvement Programmes

Health authorities, along with primary care groups (PCGs), local authorities, trusts, voluntary groups and local communities, will plan strategies and develop Health

Improvement Programmes (HImPs). HImPs are 3-year health improvement programmes where the needs of the local population will be assessed and priorities decided upon — there will also be national HImPs. Diabetes has not been chosen as a national priority for health improvement; therefore, we must ensure that it is taken on as a local priority. PCGs will comprise teams of local GPs and community nurses, joining together to commission services for their local population, replacing fund-holding.

## Diabetes in the new structure

So, what can we do to ensure that diabetes is not overlooked? The answer must lie in communication in every sense of the word. The roles of all those contributing to diabetes care must be recognised and communicated to everyone involved.

Communication of demographic and clinical information must take place between health authorities and primary, secondary and community services to allow district diabetes registers to assess need, plan services and instigate research.

LDSAGs must make representation to the PCGs to inform them of their vital role in knowledge and organisation of diabetes care and the invaluable impact this would have on commissioning. PCGs must be made aware of and be encouraged to consult with LDSAGs about their strategies for diabetes.

On a more personal level, diabetes specialist nurses and facilitators should be encouraged to apply for membership to PCGs. This may be too late now, in which case active lobbying of nurses already appointed to the groups should take place, driving home the need for diabetes to be taken on as a local priority. In the same way, local GPs associated closely with diabetes care should be encouraged to take their place within the group to argue the case for diabetes.

Communication of knowledge through continuing education and information exchange for both professionals and people with diabetes and their families will

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enable good practice to be maintained and improved through primary, secondary and community services.

Perhaps the most important area of communication is with people with diabetes and their families/carers. It is imperative that the health care needs assessment of diabetes care revolves around the person with diabetes and their on-going needs (Williams, 1994).

### **Increased role to be played by people with diabetes**

There are not many conditions where individuals have control over the day-to-day programmes of care, but diabetes is one of them. The individual should therefore be seen as a valuable member of the care team, communicating with professionals and others involved in diabetes care so that their invaluable experiences may be passed on and learned from. The BDA, in its response to the White Paper, asks the Government to put greater emphasis on the role played by people with diabetes and their carers in commissioning diabetes care. Although the White Paper supports the view that the new NHS should be

accountable to patients and influenced by their views (BDA, 1998) the BDA believes that it needs to be more explicit in defining this role.

Although we are aware that all areas of the NHS, including diabetes, are under-resourced, I feel that injecting vast amounts of money into the service would be a futile exercise if communication between all those health care professionals involved in diabetes care was not considered a priority. ■

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