

Seamless care: The challenge between primary and secondary care systems

Jill Hill

Introduction

The management of someone with diabetes involves a number of different disciplines, in a variety of settings. People with diabetes move between different healthcare professionals, and seamless diabetes care should enable everybody involved in a patient's care to be informed of the complete picture of his or her diabetes management, and the events that impact upon it. Seamless care is essential to avoid the use of scarce resources to repeat care unnecessarily, and to avoid the omission of aspects of care. The achievement of seamless care, then, suggests a requirement for clear paths of communication, shared standardised pathways and treatments, and consistent, agreed targets. How confident can people with diabetes be that their care moves smoothly from one area to another? This article discusses some of the differences between primary and secondary diabetes care that challenge the concept of seamless diabetes care, at both the individual patient and national institution levels.

The management of diabetes care has changed dramatically from the traditional secondary care model of 50 years ago, where most people were seen in large crowded outpatient departments, to taking place in a variety of settings which involves the skills of an increasingly diverse multidisciplinary team. The impact of the diabetes epidemic has driven more diabetes management into primary care, with the recognition that most routine diabetes care should be managed at the primary level (Fitzsimons et al, 2002), but with patients with complex needs still being the focus of secondary care. However, models of care vary from one primary care trust (PCT) to another, and indeed, within individual PCTs. Moreover, many patients move from one setting to another and back again. For example, someone with type 2 diabetes may be referred to the local community diabetes centre to start insulin, and then returned to routine care with his or her GP and practice nurse once stabilised on the new treatment. A woman may be referred to secondary care when planning a pregnancy, and remain under the care of the hospital until her pregnancy is completed, before returning to primary

care. Even patients who remain long-term in secondary care for diabetes management (for example, those with renal failure or other complications) will receive some care from their GP and practice nurse.

The changing face of diabetes management in the NHS

The Audit Commission described the great variation in the quality of diabetes services across primary and secondary care in the late 1990s (Audit Commission, 2000). It recommended that the effective management of routine diabetes could be done in primary care, leaving secondary care to manage more complex patients. Models of care like Kaiser Permanente illustrate this (Feacham et al, 2002): patients are triaged into appropriate settings, with the majority of patients being managed in primary care with a great emphasis on patient self-management, and a smaller proportion of patients receiving more intensive management temporarily for a limited period of time in an intermediate care setting, until stabilised and returned to primary care. A small proportion of patients (probably about 10% of the total diabetes population) with complex

ARTICLE POINTS

1 Seamless diabetes care is essential to avoid unnecessary waste of precious resources or omission of care.

2 With the launch of the nGMS contract, it may seem there is inconsistency in targets to be achieved in primary and secondary care.

3 Diabetes care involves an increasing number of different healthcare professionals in different settings, with varying competencies and standards.

4 Seamless care requires all stakeholders to follow agreed standards and pathways, and requires a clear communication network that includes all contributors to care.

KEY WORDS

- Primary care
- Secondary care
- Targets
- Communication
- Choice
- Change

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1 The NHS Plan encourages refocusing of diabetes services to address patients' needs.

2 The seemingly endless changes in the NHS can also reduce the consistency and standardisation required for seamless care.

3 Practice Based Commissioning will encourage clusters of GP practices to work together to choose the most cost effective treatments for their patients.

4 The diabetes NSF aims to standardise care so that no matter where people receive their diabetes care, they should expect to receive an agreed level of service.

5 Diabetes teams in secondary care are well defined, with each member having a recognised role and focus.

needs are managed in a secondary care-like setting until stabilised or for long-term care if necessary.

The NHS Plan encourages refocusing of diabetes services to address patients' needs, and that may include local accessible care (NHS, 2000). The impact of the diabetes epidemic has encouraged more care at the primary care level as diabetes outpatient clinics became unmanageable. Changes in the funding of the NHS, with the shifting of resources into primary care from hospitals (Department of Health [DoH] 2001a), is a source of tension, as hospital teams still cope with increasing workloads. This may be because either more patients continue to be referred as GP practices cannot cope with the increasing numbers of people being diagnosed, or a stable hospital diabetes population increases in complexity, needing more time and support. The impact of the new General Medical Services (nGMS) contract may increase referrals as practices attempt to meet the targets set and accrue the necessary points associated with remuneration (British Medical Association, 2003).

The seemingly endless changes in the NHS can also reduce the consistency and standardisation required for seamless care. The introduction of Foundation Hospitals may see the provision of routine diabetes care moving back into secondary care again. The development of Local Enhanced Services (LESs) within PCTs, through the nGMS contract, may encourage the provision of certain diabetes services (such as insulin initiation) that traditionally have been provided by diabetes specialists in secondary care to now be provided by some but not all GP practices within a PCT.

Practice Based Commissioning will encourage clusters of GP practices to work together to choose the most cost effective treatments for their patients, which may break traditional ways of working. The potential impact of the new Pharmacists' Contract in delivering LESs in diabetes care such as diabetes screening and patient education is

another example of potential variation in service delivery. These initiatives offer choice for both patients and the GP practices caring for them, ideally enabling the most appropriate provision of care for each individual. However, choice can challenge the provision of seamless care unless all stakeholders are informed of the pathway of care that the patient has agreed to follow to manage his or her condition. Choice, without good communication networks and agreed objectives and targets, can cause chaos!

Different agendas

The diabetes NSF aims to standardise care so that no matter where people receive their diabetes care, they should expect to receive an agreed level of service. The 12 standards have a broad vision covering all aspects from prevention of diabetes and its early diagnosis, to the management of complications (DoH, 2001b). One of the criticisms when it arrived was the lack of easily identifiable resources and clear targets. The standards may promote a division of labour for diabetes care, with Standard 1 (concerning prevention) very much a public health issue, Standard 2 (concerning early diagnosis) and Standard 4 (concerning routine care) the remit of primary care, and other standards very clearly being the remit of secondary care (e.g. Standard 8, the management of in-patients, and Standard 9, the management of diabetes in pregnancy).

Unlike diabetes management in secondary care, with the launch of the nGMS contract in April 2004, GP practices have very clear targets to achieve, with practice income related to the achievement of those targets (*Table 1*). Ninety-nine points out of a possible 1050 are focused on diabetes. LESs can reward and resource extra services (e.g. the one-off payment for initiating insulin in patients with type 2 diabetes in the practice, rather than referring to secondary care).

Delivery of diabetes care

Diabetes teams in secondary care are well defined, with each member having a

Table 1. A summary of the points available for diabetes management in the nGMS contract.

Quality and Outcome indicator	Points available	Maximum threshold (%)
The practice can produce a register of all patients with diabetes mellitus	6	
Percentage of patients with diabetes whose notes record BMI in the previous 15 months	3	90
Percentage of patients with diabetes in whom there is a record of smoking status in the previous 15 months, except those who have never smoked where smoking status should be recorded once	3	90
Percentage of patients with diabetes who smoke and whose notes contain a record that smoking cessation has been offered in the last 15 months	5	90
Percentage of patients with diabetes who have a record of HbA _{1c} or equivalent in the previous 15 months	3	90
Percentage of patients with diabetes in whom the last HbA _{1c} is 7.4 or less (or equivalent test/reference range depending on local laboratory) in the last 15 months	16	50
Percentage of patients with diabetes in whom the last HbA _{1c} is 10 or less (or equivalent test/reference range depending on local laboratory) in the last 15 months	11	85
Percentage of patients with diabetes who have a record of retinal screening in the previous 15 months	5	90
Percentage of patients with diabetes with a record of presence or absence of peripheral pulses in the previous 15 months	3	90
Percentage of patients with diabetes with a record of neuropathy testing in the previous 15 months	3	90
Percentage of patients with diabetes who have a record of blood pressure (BP) in the last 15 months	3	90
Percentage of patients with diabetes in whom the last BP is 145/85 mmHg or less	17	55
Percentage of patients with diabetes who have a record of microalbuminuria testing in the previous 15 months	3	90
Percentage of patients with diabetes who have a record of serum creatinine testing in the previous 15 months	3	90
Percentage of patients with diabetes with proteinuria or microalbuminuria who are treated with ACE inhibitors (or A2 antagonists)	3	70
Percentage of patients with diabetes who have a record of total cholesterol in the previous 15 months	3	90
Percentage of patients with diabetes whose last measured cholesterol within the previous 15 months is 5 or less	6	60
Percentage of patients with diabetes who have had influenza immunisation in the preceding 1 Sept to 31 March	3	85

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1 In primary care there is a wide variation in the level of competency and accreditation in healthcare professionals delivering diabetes care.

2 There is a variety of services between primary and secondary care. Some local diabetes centres may be working with three or more PCTs, all with different models of care.

3 The practice nurse is a key person in the successful delivery of diabetes care in practices.

4 The extent of the multidisciplinary diabetes team is widening in primary care.

5 Even within a GP practice, different patients may have access to a different standard of care.

recognised role and focus, supported with a relevant accredited qualification (for example, diabetes specialist nurses would have the ENB 928 or equivalent). Established competencies and a known level of knowledge are assumed, even if the numbers of staff making up the team varies across regions (Association of British Consultant Diabetologists, 1999).

However, in primary care, there is a wide variation in the level of competency and accreditation in healthcare professionals delivering diabetes care, from no recent diabetes training to attendance at recognised courses like the Certificate in Diabetes Care from Warwick University Diabetes Care, to Masters level. This is reflected in the variety of diabetes care services available in primary care, from some practices referring everything to secondary care, to other practices where a GP and practice nurse may even initiate insulin (Farooqi et al, 2004). Smaller hospital diabetes teams may know their local GP practices very well and be aware of the levels of service provided, and therefore triage patients according to the competence of individual practices. Larger secondary care diabetes centres may not have this local knowledge, which makes it more difficult to know which patients to discharge back to primary care.

Models of care

There is a variety of services between primary and secondary care. Some local diabetes centres may be working with three or more PCTs, all with different models of care. Some PCTs have developed LESs for routine diabetes care to be managed in primary care, or other incentivised schemes. There are usually different levels within this, so some GPs will provide very little basic care but another GP in the same PCT may be able to provide almost all but the most complex care, including insulin initiation. Some GPs may provide a 'specialist diabetes service' for other GPs, in their role as GPs with Special Interest in diabetes (GPwSIs).

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practices. Some inner city areas may find it difficult to recruit and retain nurses, and so the service provided in a particular practice may fluctuate over time, depending on whether an interested nurse is in post.

The extended diabetes team

The extent of the multidisciplinary diabetes team is widening in primary care. Recognised deliverers of care like GPs and practice and district nurses are being joined by optometrists in local retinopathy screening programmes, and from April 2005, the new Pharmacists' Contract will encourage an increased role in routine diabetes care. This could include medicines management, education, screening, and monitoring. While the extension of the diabetes workforce is necessary to share the increasing workload of routine diabetes management, communication and seamless care could be threatened. Patients attending secondary care units usually see all the people involved in their care in the one place, often at the same appointment. In primary care, the members of their diabetes team are often in different venues, run separate clinics, and may have poor communication between them, often via a paper system.

Even within a GP practice, different patients may have access to a different standard of care. This is a particular issue for people who do not speak English (*Figure 1*). For example, in the PCT in which the author works, group education for people with newly diagnosed type 2 diabetes is available in Urdu but no other Asian languages. Therefore, patients who speak Urdu in a particular practice may be able to access this service but other patients in the same practice may not if they speak another Asian language.

Information technology

One of the essential requirements for providing seamless care between different disciplines is an efficient, effective national communication system. When preparing for the launch of the nGMS contract in April 2004, it was in the interest of GP practices to have efficient computer



Figure 1. Even within a GP practice, different patients may have access to a different standard of care. This is a particular issue for people who do not speak English.

systems to collect the necessary data for calculation of points achieved (and therefore income). Access to hospital letters, clinical chemistry results, and consultations within the practice are easily accessible in the GP practice. Similar systems may be available in diabetes centres. However, accessing primary care systems directly from secondary care and vice versa is usually impossible. Other members of the diabetes team may be excluded completely from both primary and secondary care records (for example, the community podiatrist) and rely on letters to convey information. This lack of compatible shared information technology systems can result in delays in treatment and time wasted trying to telephone for information, or lead to repetition of tests, for example.

The development of the National

Programme for Information Technology (NPfIT), particularly the Electronic Patient Record (EPR), should improve communication between all agents involved in a patient's diabetes care, so each healthcare professional will be able to access information provided by each contributor along the patient's pathway of care.

Different targets

GP practices now have very specific targets to achieve for the Quality and Outcomes Framework for the nGMS contract. The achievement of points is associated with income for the practice, so practice staff have the incentive to improve diabetes control in their diabetes population. For example, a maximum of 16 points are available to the practice if 50% or more of patients have an HbA_{1c} of <7.5% within the last 15 months, but the

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practice will also gain 11 points if 85% or more patients achieve an HbA_{1c} of <10.0% (Table 1). The blood pressure target is <145/85 mmHg for 55% or more of the population, and cholesterol is <5 mmol/l for 60% or greater. Although the nGMS targets are a guideline towards the ideal, and are likely to become tighter over time, they have become the benchmark for adequate diabetes care in many practices, and achieving results beyond the targets does not result in added income, so there may be little incentive to spend time on improving diabetes control beyond that required for the maximum points for diabetes (99/1050).

Patients receiving diabetes care in secondary care may be encouraged to aim for much lower targets. HbA_{1c} of <7.0%, blood pressure <130/80 mmHg and cholesterol of <4 mmol/l would be the targets for many people with diabetes. Even nationally targets vary, with the National Institute for Clinical Excellence (NICE) recommending between 6.5 and 7.5% (NICE, 2002) and the NSF <7.0%.

Conclusion

Diabetes service providers need to adapt to cope with an increasing workload due to more people being diagnosed with diabetes, and the impact of the nGMS contract. More diabetes is being managed in primary care with the involvement of an increasingly more diverse team of healthcare professionals, leaving secondary care to manage those with more complex needs. However, patients move from one system to another, and coupled with the choice of services available, seamless care between systems can become difficult.

PCTs have the responsibility for the implementation of the diabetes NSF across primary and secondary care. The development of Local Implementation Teams (LIT) and similar groups aims to ensure all diabetes stakeholders are involved so a consensus of diabetes services is agreed. This should mean priorities are agreed, resources are allocated fairly, networks are formalised, and shared guidelines and patient pathways to include all involved in

diabetes care are developed. The setting up of shared posts between primary and secondary care may be helpful. Empowered patients ensuring they get appropriate care no matter where they receive that care would be ideal. Shared information technology, eventually through the EPR, is essential. Finally, and perhaps most importantly, strong leadership to ensure it all happens is critical! ■

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