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Editor

Diabetes care in 2005: What's it all about?

The catch phrase for 2005 is likely to be 'joined-up working'. What does it actually mean? If one works through the often impenetrable jargon, the message seems to be that everyone involved in diabetes care (including the patients) should be working towards common goals, which are in the interest of patients rather than the institutions providing the care. The approach is based on the concept of managed diabetes/clinical networks and it is noteworthy that key roles are supposed to include (hopefully in no particular order) a network manager, clinical champion and a person(s) with diabetes (Diabetes UK, 2004). Part of joined-up working will be developing the role of non-doctors to allow them to prescribe medicines as part of patient group directions/directives (National Prescribing Centre, 2004). This may be extended to other areas, including the ordering of X-rays and biochemical investigations.

In a sense, the move is towards multidisciplinary individuals in addition to multidisciplinary teams. Overall, much of what is being discussed makes intuitive sense although there will have to be clarity about responsibilities related to adverse events, particularly from a medico-legal perspective and definitions of where areas of expertise begin and end in order to avoid the charge that this is simply an attempt to provide doctors on the cheap. Unsurprisingly (to the editor at least), a good example of the genre of joined-up working has already been developed in Scotland with the DARTS/MEMO project from Tayside (Morris et al, 1997).

Nevertheless, some question marks remain. Cynics may argue that this is simply another attempt at reorganisation (after the failures of internal markets, fund-holding, etc) and it is the slippery slope to rationing diabetes services in order to support the more lucrative fee-for-service aspects of health care (Coomes R, 2004). Certainly, the costs of this approach are unclear – while there may indeed be no additional cash available, one suspects that current resources may be recycled to support the additional number of non-clinicians needed to 'manage' the new system. The success of the changes in healthcare delivery will be measured by surrogate outcomes (e.g. achieved HbA_{1c} values) and audit of processes (e.g. uptake of retinal screening programmes) rather than harder end-points – such as mortality rates, blind registrations, etc – partly as a consequence of the time involved. As ever, robust pilot data in the form of randomised clinical trials of the proposed changes are lacking. Early local experience has raised concerns that the end result can be a stifling bureaucracy, rationing and a failure to try new ideas, therapies and approaches because of concerns about costs to the service irrespective of benefits to patients.

Put in context, whatever had gone on before did not work properly as evidenced by the carnage associated with diabetes, the variability of diabetes services across the country and the exponential growth in the sheer number of people with the condition. The new proposal might work but surely we need, at the outset, to define the outcomes of importance. Diabetes remains what it has always been, a thoroughly miserable condition, a pain in the neck and a condition low down on the totem poll of diseases that attract funds from the government of the day. Best bet is to never get the condition in the first place. That is the *Diabetes Digest's* suggestion for the first outcome that matters when assessing whether or not diabetes care in 2005 is working.

Happy New Year to all our readers.

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National Prescribing Centre (2004) *Patient Group Directions: A practical guide and framework of competencies for all professionals using patient group directions*. National Prescribing Centre, Liverpool. Available at www.npc.co.uk/publications/pgd/pgd.pdf (accessed 09.02.05)