



Colin Kenny is a GP in Dromore, County Down.

Integrating diabetes care: Is PBC the way forward?

The debate about implementing the UK's four national service frameworks for diabetes in the early part of this decade has been replaced by a discussion on where and how a quality diabetes service should be delivered in the changing cultures of the four health systems (DoH, 2001, 2003; Scottish Executive, 2002; CREST, 2003; Welsh Assembly Government, 2003).

The apparent whims of successive governments have forced primary care teams to live with and adapt to change. GPs and their teams have been flexible and coped well with reforms, including the first 'limited list' in 1985, the GP contract in 1990 and its revision in 1993, culminating in the 2003 nGMS contract which introduced the QOF. The QOF has ensured the delivery of a consistently high quality of diabetes care across all four nations (Kenny, 2007).

The other changing context is the NHS, which started as a centralised monolithic body, but has recently evolved into four national bodies; each apparently weakened, with power devolved to strategic health authorities (SHAs). While this devolution of power is most apparent in England, the Celtic nations have seen subtle changes to their health systems implemented by assembly governments.

Across the UK, primary-care organisations are increasingly responsible for making sure that the right services are in place for the people who live in the area they cover. They do this by making financial agreements with the local NHS services and sometimes with other service providers (commissioning); when done at the local level this is known as practice-based commissioning (PBC). England has agreed to try this with diabetes services; Wales has commissioning groups; in Northern Ireland the health minister has just agreed to try a limited form of commissioning; and Scotland is not currently planning to commission at all, but instead will vertically integrate its care across common care pathways, involving primary and secondary care.

It might be easier to describe the commissioning of diabetes services as an evolving position, where deliberate uncertainty and tension between primary and secondary care is being created and utilised by SHAs. There is much less certainty about PBC and little evidence of its effective implementation in England, in spite of a robust commissioning toolkit (DoH, 2006). In contrast, the QOF has been a considerable success with its payment-by-results, and has earned international recognition (Doran et al, 2006).

It is against this context of uncertainty that a joint position statement has been published (Diabetes UK et al, 2007). This document has now been updated to involve the views of primary care, represented by the PCDS, and nurses represented by the RCN. No-one could argue with a document which sets out its stall by asserting that 'all people with diabetes... should have equal access to the best possible diabetes care on the basis of individual clinical need'. It goes on to place the person with diabetes at the centre of care, with locality needs respected and the best possible services commissioned with effective communication between all service providers.

Much of this move to a primary-care based service has left secondary care providers of diabetes services feeling beleaguered. In 2007 a group of English secondary care providers produced the 'Model' campaign; lobbying for more resources and planning for high-quality, properly-resourced diabetes services – specifically asking for a targeted programme across a full range of medical specialisations (Gough, 2007). No one can argue against more resources for diabetes, yet underpinning commissioning of diabetes care is the more cost-effective use of existing resources. Much has focused on more appropriate use of the new patient tariff, currently paid to secondary care providers for new diabetes referrals to secondary care. This has the potential to make primary care teams reconsider these referrals, where they should be delivered, what services

are appropriate and how exactly they should be commissioned. This also has the potential to threaten secondary-care services.

The national service frameworks underlined the need for specialist diabetes services – especially in fields such as paediatrics and antenatal care and for those with complex complications. These are important and should be centralised and well-resourced. However, in many localities secondary care is providing the service they have always provided, without respecting the changes in the culture of primary care which has evolved with the nGMS contract. Commissioning has the potential to refocus all of this.

The powerful evidence base in diabetes care focuses on prescribing of medications: both for diabetes itself and its associated increased CV risk. This is common across primary and secondary care. GPs and their teams are experts in audit, quality improvement and ensuring adherence to medications since these have been demanded by the QOF. Many of the services provided in secondary care, while adding to the overall quality of the diabetes service, have a weaker evidence-base. PBC will focus carefully on the value of these services and use them strategically. It will be interesting to see if this form of commissioning of diabetes services in England provides the model for truly integrated diabetes care. ■

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