Community Diabetes Consultants
A collaborative network leading the way

PCDS
Primary Care Diabetes Society

ABCD
Association of British Clinical Diabetologists

Diabetes UK

Royal College of Nursing
Diabetes Nursing Forum

Joint Position Statement

Integrated care in the reforming NHS – ensuring access to high quality care for all people with diabetes

Diabetes UK, the Association of British Clinical Diabetologists (ABCD), the Primary Care Diabetes Society (PCDS), Community Diabetes Consultants (CDC) and the RCN Diabetes Nursing Forum believe that all people with diabetes, including children and young persons, should have equal access to the best possible diabetes care on the basis of individual clinical need.

Current reforms in the NHS are having a significant impact on local services for people with diabetes. Although reconfiguration has the potential to improve the quality of services, problems can arise if changes are undertaken too hastily, without proper consultation or in a divisive manner. Cooperation is crucial, and there is a need to guard against service providers competing against one another. An integrated approach to planning and delivering care across all diabetes services is likely to produce the best results for people with diabetes.

Integrated care

People living with diabetes face many daily challenges managing their condition. The range of issues is different for every individual but includes diet and exercise, treatment-taking, psychological stress and illness and disability. The support of many different professionals is required, alongside informal carers, in meeting this complexity of need. Many professionals in primary, community, specialist and social care services have a role to play in providing this support and ensuring equal access to services.[1-6]

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Integrated diabetes care aims to ensure that the individual's experience of interacting with this range of professionals is both seamless and continuous and focuses primarily on the individual's needs. This approach is supported by UK health policy prioritising the development of a healthcare system designed around the individual, rather than round the needs of the system. Greater emphasis is being placed on the provision of services for people with long term conditions, such as diabetes, to support self care that are accessed closer to home.[7-12] Robust mechanisms must be put in place to reach national standards and ensure that all those providing care are working together to integrate care. Diabetes networks[*] and equivalent in all nations provide the means to lead the planning, provision, monitoring and quality improvement of diabetes care across local communities. These fora able appropriate involvement with clinical staff, managers and people with diabetes themselves (adults and younger persons) to advise and inform.

Working in partnership

Integrated care requires that all the people involved in a person's diabetes care work together in partnership: generalist and specialist clinicians, allied healthcare professionals, social care and support staff and the person living with diabetes and his/her family. Each person should be fully aware of their own and others' roles and responsibilities. Health professionals should also know what has happened during interactions between the person with diabetes and other members of the healthcare team. Shared records and information technology systems are a prerequisite for achieving these goals.

Effective commissioning of integrated care is vital if organisations are to work in partnership across the whole system of care, delivering services that are tailored to the needs of individuals.[12] Integrated care offers commissioners a route to improving clinical outcomes and the patient experience, reducing inequalities and ensuring that all adults and children with diabetes have access to high quality and safe care [7]- the right care, in the right place, at the right time.

Local models of care

Local models of integrated care ought to encompass all the components of the diabetes service including primary prevention, diagnosis, education, management, secondary prevention, surveillance

[*] Local Diabetes Services Advisory Groups in Wales

and control of complications. Such models should be developed and agreed locally but informed by national standards and principles.[1-4]

Local diabetes networks* need to be engaged actively in commissioning (planning), agreeing and delivering local models of care. The needs of the local diabetes population should be assessed and services specified to meet all the components required to deliver an integrated services across primary, community, specialist and social care boundaries. [13]

The form of an integrated diabetes service will vary from one area to another depending on local circumstances, population needs, staff competences, demographics and the facilities available. An integrated service is most easily achieved when as many of the components of diabetes care as possible are provided on a single, accessible site.[1]

Changes to the provision of diabetes care

Inequalities in the health outcomes of people with diabetes persist so the need to improve diabetes services remains.[14,15,16] Moving more ongoing care out of hospitals into the community can be positive, as long as people with diabetes continue to have access to the skills and facilities they need. Many people with diabetes have very positive experiences and good clinical outcomes from care delivered by general practice teams or intermediate specialist diabetes services. Challenges remain for local areas to improve services that support self-care and reduce variations in outcomes as reported in the Healthcare Commission Service Review and National Diabetes Audit.[17,18]

The emphasis of reform must be on improving the quality of and access to diabetes care. Collaborative working drawing on the skills and expertise of generalist and specialist care teams is essential and change must not be about exacerbating competition between different service providers. Evidence is emerging that the redesign of diabetes services is being implemented in some areas through cutting specialist diabetes services.[19,20] A partnership approach is vital when changes to services are proposed. Any change to a local service should be developed and implemented through collaboration with specialist services, general practice teams, people with diabetes and their carers, based on competency and wellbeing.

Where changes to continuing care and follow-up arrangements are being proposed by local commissioners, the following principles should be addressed to ensure consistency of approach and to reassure people with diabetes that their standard of care will not be compromised:

- The new model of care, detailing local care pathways and roles and responsibilities, must be clearly defined. Local agreement of the model should involve the diabetes network* including people with diabetes and their carers.

- Paediatric diabetes services and children and young persons with diabetes, and their families, must be engaged in the needs assessment and service specification process, working with commissioners to ensure appropriate care delivery and support.
- It is recommended that the Diabetes Commissioning Toolkit is used in England to assess the needs of the local diabetes population, including children, and to specify all parts of the diabetes service.[13]
- Locally, people with diabetes should be fully informed of the implications of any proposed changes and reassured about their ongoing access to a competent and skilled workforce in the new care environment.
- Any proposed changes to the ongoing care of individuals with diabetes should be based on individual assessment. Discussion with people with diabetes and their carers about the impact of service changes should be undertaken in a sensitive and timely manner, with particular consideration given to the importance that people attach to continuity of care.[21]
- Where necessary, arrangements should be in place to commission appropriate follow-up care from ‘out of area’ services to meet the individual needs of the person with diabetes.
- The choice of the person with diabetes should be respected.
- Communication between all members of the integrated diabetes care team is essential[22] to assure the provision of appropriate shared care.
- Individual care plans provide a focus for discussing and agreeing changes to care with each person with diabetes, including the details of where ongoing care will be provided. Each individual should have the opportunity to agree who their lead health care professional will be.[23] Block letters informing people that their follow-up care is to be moved are not acceptable.
- The impact of change on people with diabetes must be closely monitored.

It is essential that all people with diabetes, no matter where they live, have access to the standards of care defined within the UK national frameworks. [1-5] Local diabetes networks*, providers, commissioners and people with diabetes need to work together to ensure that communities are not disadvantaged by service re-organisation.

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