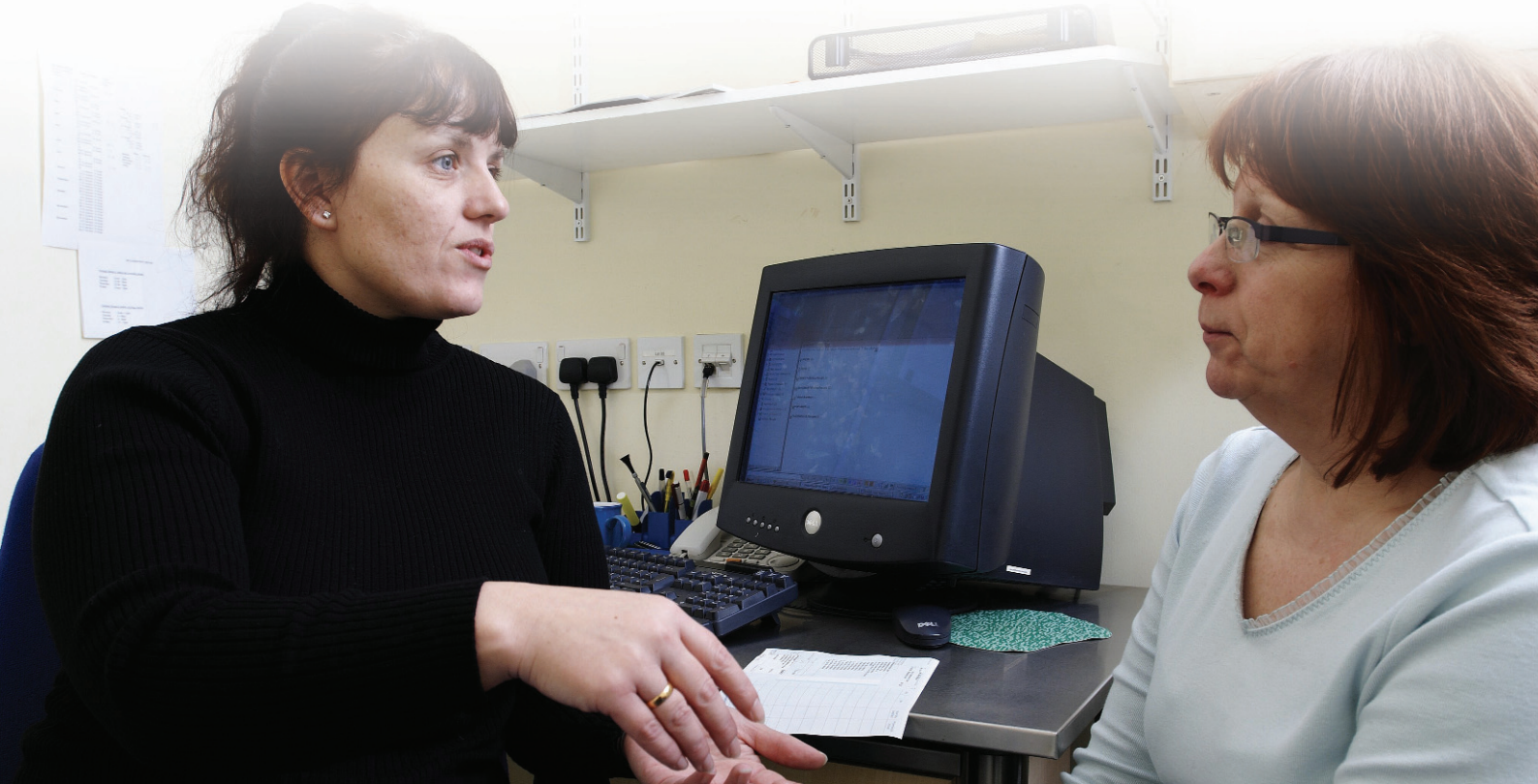
Diabetes in the NHS:

Commissioning and providing specialist services



This booklet was written and reviewed by approximately 75 consultants in Diabetes working in England. These individuals have been actively involved in the Specialist Service Liaison Group, in a survey, 'Diabetes and Diabetologists: A survey of the roles, responsibilities, working practices and job satisfaction of Consultant Diabetologists in England', or attended one of three Diabetes Development Programmes commissioned by the Specialist Services Liaison Group (SSLG) in partnership with the National Diabetes Support Team and the King's Fund.

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Foreword

Diabetes has come a long way since the publication of the National Service Framework (NSF). Self management is now recognised as the key to improved health outcomes, but people with diabetes also need the active support of organised, proactive and expert health, community and social services.

The importance of doing simple things well, the three Rs of registration, recall and review, has sometimes masked the recognition that diabetes is not only expensive and increasing in prevelance, but is a complex, poorly understood condition that needs considerable expertise to get the best results.

The rapid move to provide routine care closer to home has meant that specialist expertise has sometimes become disconnected and less available to people with diabetes. Everyone is losing out. The recent changes to the way the NHS is organised provide opportunities to address this. But the practical aspects, the 'how to do it', are often poorly understood.

This small booklet aims to address this issue by providing details of the improved pathways that can be designed for people with diabetes, the governance issues that can be addressed by PCTs and the money that can be saved by acute trusts and commissioners, if the expertise of consultant diabetologists and the teams they work with is used to the full.

I am delighted to be able to recommend this work to everyone who is interested or involved in improving the experiences and outcomes for people with diabetes.

Sue Roberts

Summary

1. Diabetes is a common, serious, expensive and poorly understood condition with devastating complications for individuals. Prevalence is rapidly increasing, making it a threat to the sustainability of health and social services.
2. Diabetes and its complications are largely preventable through a population actively engaged in health prevention and self-management working in partnership with health and social services which are systematic, proactive and integrated.
3. While the basic elements of registration, recall and review are in place for 90% of people with diabetes, and steadily improving, this is insufficient to improve outcomes, which remain poor for 50%.
4. Commissioners need to ensure that the right amount of expertise is available at the right time and in the right place to meet all the needs of local people with diabetes.
5. Specialist expertise is currently locked into secondary care and needs to be released to work closely with primary care.
6. All the levers are in place to allow this to happen now, but they are often poorly understood or implemented. This booklet describes how to unlock this expertise and outlines the advantages for PCTs, practice based commissioners, acute trusts and clinicians.

Using the skills and expertise of specialist teams

1. Acute Trusts
    a. can reinvest up to £1,500 for every admission with diabetes for improved patient care
    b. reduce the 20% increase in length of stay with associated savings
    c. reduce the 50% excess death rate in people with diabetes and Acute Coronary Syndromes
    d. improve the poor quality of patient experience for people with diabetes in hospital

2. Practice-based Commissioners and PCTs can
    e. Reduce the number of expensive admissions through improved pathways
    f. Improve quality and safety
    g. Contain escalating drug costs
    h. Develop and maintain a skilled workforce in primary care and community settings
    i. Develop a comprehensive strategy for prevention to support local long term financial stability

Action

To achieve these benefits and the linked improvement in quality and value for money.

1. **Commissioners*** need to ensure that diabetes networks, and the people with diabetes who are part of them, are a key part of their commissioning and planning mechanisms to secure fundamental service redesign based on local need across the whole diabetes community.

2. **Employers (currently usually acute trusts)** need to undertake a radical review of consultants' job plans to include a larger percentage of programmed activities devoted to planning and coordination, supervision and training, both within the hospital and across the many organisational boundaries.

3. **Acute Trusts** need to recognise that although diabetes is a long term condition, its management in hospital affects every part of the organisation, with implications for patient experience, governance, efficacy and outcomes.

4. **Specialist diabetes teams** need to review their working practices to ensure that their input, in content, style, and place, matches the needs of the local population as determined through a far sighted commissioning process.

5. **Consultants** need to review their working practices to ensure that the total commitment of a diabetes medical team to diabetes, endocrinology, general medicine and teaching of juniors doctors can be carried out effectively and to a high standard.

*Throughout this document 'commissioners' refers to anyone with local commissioning responsibility. This includes PCTs and practice based commissioners working together with common strategic aims.

Introduction

"I want to live my life with diabetes – not suffer with it"
A man with diabetes in the West Midlands
NSF launch event, 2003

Diabetes is an immensely complex, important and costly condition. Yet it is difficult to see, to live with and to understand. People with diabetes rarely have physical signs before they get complications. The complex chemical and metabolic state which is diabetes cannot be grasped, cut out or dealt with by gadgets or technology. Two-thirds of people with diabetes also have another 'silent' condition such as hypertension or early heart disease.

The fundamental abnormalities leading to diabetic complications remain poorly understood and cannot be treated. The complex interactions between obesity, physical activity and genetic makeup mean every individual is a unique healthcare challenge. Diabetes is an empirical speciality; treatment is based on accumulated clinical experience and expertise gained over many years of specialist training, and day to day work with individuals to obtain the best possible outcomes.

This brief publication aims to increase understanding, raise the profile of diabetes and demonstrate how commissioners can have a key role in enabling diabetologists and the specialist multidisciplinary teams they are part of, to work in ways that ensure both better quality services and better value for money.

Every year 20% of people with diabetes will be admitted to hospital, usually for some incidental condition or complication. They account for around 9% of hospital expenditure. But the diagnosis of diabetes will be omitted from in 1 in 5 discharge summaries.

The facts

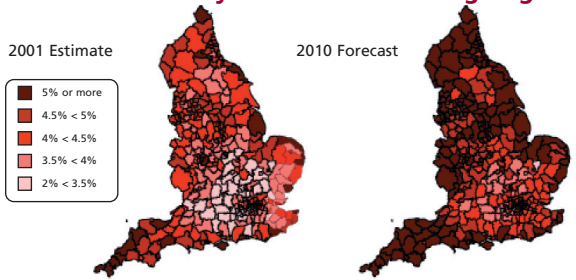
2.35 million people have diabetes in England.

- 100,000 people were newly diagnosed last year
  - 2,000 last week
  - one new diagnosis every 10 minutes
- 80% of people with diabetes die of heart disease
- Life expectancy is reduced by 15 years in people with Type 1 diabetes and 7 years in those with Type 2
- Diabetes is five times more common in ethnic minority groups and three times more common in areas of social deprivation
- 90% of people with diabetes have Type 2 diabetes.
- There are 25,000 people under the age of 25 with diabetes

Complications

Largest cause of blindness in people of working age
Most common cause of amputation
Most common cause of end stage kidney failure
Stroke increased 4 times
Heart disease increased 3 to 4 times
Depression increased 3 times
Erectile dysfunction increased 3 times

Increase in prevalence of diabetes over 10 years: 60% due to obesity and 40% due to ageing



Babies of women with diabetes are

- Five times as likely to be stillborn
- Three times as likely to die in the first months of life
- Twice as likely to have a major congenital abnormality

Costs

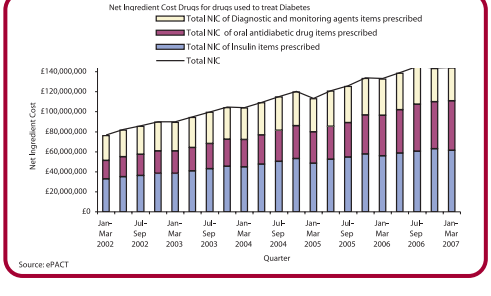
- 5% of all NHS expenditure
- 9% of hospital costs
- £3.5bn per year
- £9.6m a day
- The presence of diabetic complications increases NHS costs more than five-fold and social care four-fold

The issues

Improved patient related outcomes in all long term conditions are based on the 'better outcomes equation'.

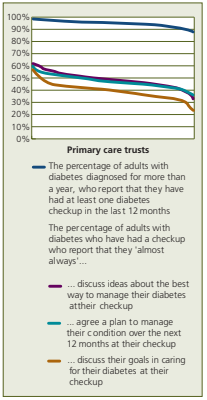
Organised proactive services  Engaged impowered patient = Better outcomes

The figure opposite shows this is currently very unbalanced. UK primary care leads the world in 'organised proactive care', and ninety per cent of people with diabetes are getting the most important health checks to help prevent complications. But fewer than fifty per cent of people with diabetes are truly involved in their own care, the other essential element of the equation. Forty per cent of people are still not achieving healthy blood glucose levels and for thirty per cent blood pressure and cholesterol remain too high. As many as half of all medicines may not be taken.



Like any long-term condition, diabetes must be managed by the individual on a daily basis. For some, merely knowing what might help and being supported to do that is sufficient. For others, it is critical for them to understand how and why they have diabetes and the details of what is going on in their bodies if they are to make healthy choices. Consultants in diabetes and specialist multidisciplinary teams have an important part to play in ensuring all these issues are addressed within every local diabetes service.

Percentages of people having checkups and planning their care



Diabetes drugs are the fastest increasing group of drugs in the NHS. Items prescribed increased by 7.4% between 2005 and 2006 but costs rose by 14% because of the introduction of new drugs and new formulations. Specialists have a vital role to play in ensuring that these new preparations are used most appropriately to improve care.

Getting the right care and expertise

'The 2 things that patients with diabetes want are: much improved access to information and education and the knowledge that specialist expertise is easily available, not necessarily in the same room or clinic but that the GP knows when and how to access it quickly and easily'

Patient in commissioning meeting in North West England

Forty years ago most people with diabetes attended hospital outpatient clinics where they had to wait for several hours to see the doctor for just a few minutes. Now, in many places 85% or more get their routine care close to home (UK average 78%).

Not everyone in general practice has all the skills they need to carry out routine care. The Quality and Outcomes Framework (QOF) shows that there is still considerable variation in what care people get, which is not related to deprivation or geography. Primary care teams need and want specialist support. But not everyone is getting it.

In 2005/06, the specialist team in Bedford saw 1,611 patients in nurse review clinics and made almost 3,300 phone calls, one third initiated by other professionals or patients, the remainder as planned or proactive call outs. They made 256 home visits.

Commissioners need to ensure that when services are redesigned, specialist expertise follows the patient.

Although hospital clinics for diabetes still exist in most cities, very few consist of just the consultant. Much of the work of the specialist is now done by multidisciplinary teams, with the consultant providing high quality care 'via others'. This may involve supervision of staff individually or in multidisciplinary clinics in traditional and new settings. This booklet describes how commissioners can use local tariffs to promote such 'best practice' specialist care.

Working in new ways

Getting expertise closer to patients involves much more than simply moving a traditional diabetes clinic to a new site. The challenge is to harness the skills and expertise of specialist diabetologists in new ways. One advantage of carrying out more routine care in the community is that specialist time can be freed up for people with complex needs or advanced complications, often working in joint clinics with other speciality colleagues.

However, in rural areas bringing speciality care physically closer to home can be liberating for patients. A consultant established and led a multidisciplinary clinic in North Cheshire for people with the most complex kidney complications who often also have other pathologies such as anaemia and heart failure. They now have holistic care closer to home when previously they had to travel to Liverpool to access uncoordinated care from numerous consultants with duplicated appointments.

Technology can support these new ways of working. Some specialists run 'virtual clinics', either using the phone, texts or emails at pre planned times – or increasingly agree to offer an email answering service throughout the week.

Most people need specialist input at some time in their lives not only for the complications of diabetes, but also to help deal with the complexities that arise as part of routine ongoing care and when help with looking after people with problems 'out of protocol' can be the most challenging and useful. PCTs are looking for specialist services to support those primary care teams with less established skills, when starting patients on insulin, or for help with the most complex problems. There are many different ways to do this.

A patient with poorly controlled diabetes who did not want to increase their current twice-daily insulin injections was established on a regimen of two unusual insulin combinations that greatly improved blood glucose control. This was only possible with the specialist knowledge of the consultant who knew the duration of action of each of the constituent insulins.

An elderly lady with diabetes was becoming increasingly confused and a consultant diabetologist was able to identify chronic hypoglycaemia (low blood glucose) despite her HbA1c being just outside target. Removal of sulfonylurea resolved her confusion.

The model chosen for problem solving support will reflect local circumstances.

A consultant in diabetes has started to carry out clinical sessions within a general practice in a socially deprived area of Southampton where the QOF shows exceptionally poor control of blood glucose. Patients are referred from practices in the East and South of the city and about 8% of the local population are now seen. They are usually those with the most complex problems, who, despite this, have not accessed the hospital based service for various reasons. The patient is given a treatment plan and referred back to the GP. Patients are seen within four weeks. The 'new to follow up' ratio of 3:2 is achieved through the diabetologist's ability to give incisive and clear treatment plans in one or two sessions.

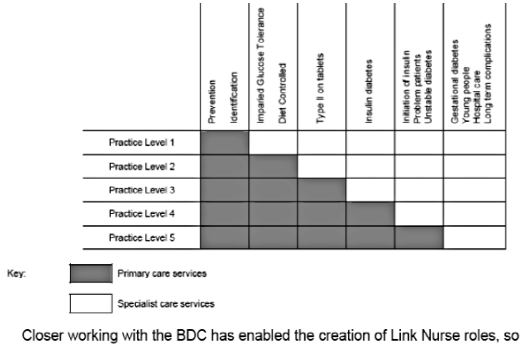
Approaches that enable local access to specialist consultants also mean unusual or very individual problems to be dealt with locally and quickly.

Increasing everybody's skills

Providing direct clinical care in the community not only enhances access to information for individual patients but also gradually increases the skill base and confidence of whole primary care teams.

In Bury, a 'tier 2' service operating out of two community clinics enables the consultant to work alongside the community diabetes team to keep everyone up to date.

In Bolton, the PCT and the specialist service worked closely together to make this possible in a systematic way.



Closer working with the BDC has enabled the creation of Link Nurse roles, so that a specialist nurse from BDC is responsible for named general practices and can:

Each practice jointly assessed their own skills and consequent need for specialist diabetes support. This led to five different levels of practical support (with payment linked to three of these). Nurse facilitators worked with each practice according to the agreement, demonstrating good practice, training the team and providing support. Every practice also has a named consultant from the specialist team who meets with them two or three times a year to discuss issues, see patients and review progress. Over four years, all the practices doing basic care progressed and all are now linked to the upper three levels.

Many specialist services take on a formal approach to ensuring that everyone working in the diabetes community now has the right skills.

Working as part of a local diabetes community, a diabetologist ensured that at least one member of each GP practice has a diabetes diploma, which involved mentoring and workshops to support learning. Education is available for everyone, including the practice receptionists.

Specialist support for the whole community

For many years, diabetes specialists have worked across the whole local diabetes community, organising district wide programmes of care as well as providing direct clinical expertise for individual patients.

The healthcare community is becoming ever more complex. PCTs have split into provider and commissioning arms, GP consortia are bidding to provide services under practice based commissioning, Independent Sector Treatment Centres (ISTCs) are taking on day care surgery including clients with diabetes. Southampton City PCT employs a consultant Diabetologist who runs sessions to oversee and advise on all aspects of this complex landscape. The consultant chairs committees for the PCT and acute trust and advises the GP providers. Input is given to ISTC for protocols.

A Consultant Diabetologist led the first district wide eye-screening programme based on optometrists in Poole. Recently she has overseen the transition to digital retinal photography in response to the NSF. Based on her lengthy clinical experience of diabetes eye disease she was able to bring together the many stakeholders and ophthalmologists, optometrist groups and patients.

In Bedford, the diabetes specialist team has redesigned pathways and support for care homes, preventing admissions and making savings the PCT can reinvest.

Increasingly the PCT requires independent specialist advice to ensure that local providers are delivering the services the local community needs and which meet national standards.

In the Southwest, a local consortium of GPs in the area wish to set up a locality based diabetes service. One of the practices in the locality will host the service, and buy in specialist time to run it. The consultant in diabetes has been asked to draw up a service specification, including audit standards for this service. As the service has progressed, the GP consortium has formed a limited company, and seek to increase their numbers attending the clinic in expectation of increased funding through Payment by Results (PbR). The commissioning arm of the PCT has asked the consultant in diabetes to review this service in the context of the PCTs diabetes model of care, and potential contracting arrangements.

Medicines management, governance and innovation

There are also issues of governance and safety for the PCT to consider and where expert advice is essential. Many of these involve medicines management.

Managing new and expensive drugs

The dipeptidyl peptidase IV inhibitors are a new class of drug for diabetes. Despite limited clinical trials, results are promising. The Consultant in Diabetes has been invited to attend the District Pharmaceutical Committee to make a presentation. The literature has been reviewed, and results placed in clinical context of existing therapies. The committee agrees to allow limited use of this new agent on the understanding that the Consultant produces guidelines on its use and oversees all new initiations of the treatment for the first 6 months. Thereafter the Consultant will be asked to review results and report back to the committee.

Specialists also have an important role in introducing new ideas and getting research quickly into practice. There are many innovative examples, such as the pens used by those who inject insulin, insulin pumps and the development of accredited patient education. Guidance, supervision and education around new classes of drugs are helpful to everyone locally. Inhaled insulin would be a recent example. Once established these often become incorporated into protocols and delivered by others with new training.

Improving safety

A decision was taken at a clinic visit to change a person with diabetes from twice daily insulin to a more complex four times daily regimen. The GP was asked to prescribe the insulin, following which the Diabetes Specialist Nurse would teach them how to manage the new regimen. In the interim, the patient ran out of insulin, collected the new prescription from the GP and started this treatment without appropriate advice. This resulted in major hypoglycaemia, following which the patient initiated a complaint. The consultant in diabetes was asked to coordinate the investigation into the incident, respond to the patient, and amend local protocols to ensure no repetition of the event.

What commissioners need to do - making the best the norm

Commissioners can act now to improve the quality of their local diabetes provision, by adapting some of the ideas and examples that are flourishing elsewhere to the needs of their local population.

Commissioners have the power to help support new ways of working and new relationships and ensure that if the site of patient care changes specialist expertise remains available.

Currently the Payment by Results (PbR)[1] system of payment for care does not fully reflect all the work that is done or the work that is needed to support people with long term conditions.

Commissioners can support specialists working in new ways by using local tariffs. They can choose to pay less for traditional multidisciplinary services and more for new innovative services. In this way specialist care can be supported including complex care, joint clinics, multidisciplinary working, community care, general practice visits, training and education and contacts by email and phone, provided this is what is required by the local model of care.

Commissioners can use these powers to ensure that the right amount of expertise is available at the right time and in the right place to meet all the needs of the local people with diabetes.

A suite of resources, including a diabetes commissioning toolkit and PbR fact sheet, is available to support commissioners.

Local flexibilities in PbR have been agreed[2]. This means that the vast majority of care delivered to people with diabetes does not need to attract the national tariff. PbR regulations state that flexibilities are subject to advance agreement by both providers and commissioners.

In patient care for people with diabetes

Diabetes should be recognised as a major issue for Acute Trusts.

Length of stay is increased by 20% where diabetes complicates another problem (about 2/3 of admissions)

Patient experience in hospital is poor;

- 30% of patients report staff are unaware of their condition
- 10% get no help with their diabetes in hospital
- 11% do not receive the right food

Outcomes are poor;

- 40% of people on coronary units have blood glucose problems; only 30% of them have treatment plans.
- A minority get the insulin they need.
- The death rate is increased by 50% in those who do not get insulin.

Chief executives and finance directors need to know that

1. Identifying and treating diabetes amongst inpatients can sometimes increase the payment your hospital receives under Payment by Results.
2. Many Healthcare Resource Groups (HRGs) come in pairs, one HRG for a procedure or diagnosis with complications and co morbidities and another HRG for cases without these complicating factors. HRGs with complications are obviously paid at a higher rate.

Around 10% of hospital beds are occupied by people with diabetes.

3. The identification of diabetes can sometimes mean that a patient is reclassified into the HRG with complications, triggering the higher payment**.
4. This means that trusts can potentially increase their income if people with diabetes are **identified** and **treated efficiently**.
5. Serious governance issues can be avoided and outcomes can be improved.

This can be achieved by new ways of working **with** specialist diabetes teams and **within** diabetes teams.

** Further details on this complex topic is being prepared as a technical factsheet.

The 2007/08 tariff and diabetes

The following table gives potential financial gains available in certain circumstances

Condition (HRG – all non-elective)	Additional £ per case for the Trust**
Hip or lower limb fracture (H36/37)*	1,894
Other neck of femur fracture (H88/89)	1,569
Stroke (A22/A23)*	1,516
Acute myocardial infarction (E11/12)	1,697
Bronchopneumonia (D42/43)	1,282
UTI (L09/10)*	1,596

** for these conditions, being over 69 automatically means the patient receives the with complications/comorbidites tariff*

*** (before Market Forces Factor is applied) if diabetes is a complicating factor in treatment*

Of the top 25 HRGs, 5 are directly related to diabetes

'When in hospital for eight days, it was not until the third or fourth day I was given my insulin injection before food…Listen to those who need insulin injection(s). They know what insulin they need and when.'

A person with diabetes

A recent audit by King's College London found that 10% of people in hospital across all conditions had diabetes, and around 50% of these were on insulin (compared with 20% of the local diabetes population). Length of stay was increased by 2.7 days.

A large body of literature identifies insulin management as the key issue to tackle. Diabetes generates anxiety amongst non-diabetes trained staff and is poorly managed or sometimes ignored. Diabetes specialist teams can provide protocols, train ward staff and visit people with diabetes on wards to improve staff confidence and patient care.

Diabetes specialists need to be involved in planning care pathways throughout the hospital if quality is to be improved and costs contained. Specialist teams are developing new ways of working which can really make a difference.

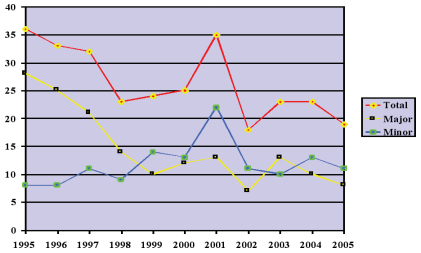
A study in the South West compared the management of diabetic ketoacidosis by specialist and non-specialist physicians. Those managed by non-specialists had considerably longer lengths of stay in hospital due to unnecessarily extended time on intravenous insulin, inappropriate insulin regimens and problems associated with converting back to subcutaneous insulin. By contrast, the specialist team was able to discharge the average uncomplicated patient within three days.

In Norfolk and Norwich, the team of diabetologists have reorganised their time and work between them so each has a link with a group of wards and can do regular problem solving ward rounds.

The involvement of a specialist multidisciplinary team with close links with the community can ensure improved outcomes and financial savings for people with expensive complications of diabetes, such as infected or gangrenous feet, as this natural experiment in Ipswich demonstrates.

In Ipswich, a Specialist Diabetes Podiatrist and Diabetes Nurse Specialist (DNS) initiated twice weekly ward round for all inpatients with diabetic foot problems, and education for medical and nursing staff. Major amputation rates fell consecutively for the next 3 years. When the team was withdrawn in 2000, major amputation rates started to increase again. Using the data they had collected, the team was able to show that savings on bed days were 4-5 times greater than staff costs. The DNS post was reinstated and amputation rates fell once again.

Amputations rates per 100,000 general population, 1995-2005



The rise in 'minor' (toe) amputations is best practice to prevent limb loss.

In Poole, the Consultant Diabetologist spends part of his time as an Acute Physician, helping to run the Emergency Admissions Unit with colleagues from other specialities. A local audit of laboratory glucose measurement showed that 22% of admissions had documented diabetes, newly diagnosed diabetes or impaired glucose tolerance. The presence of diabetes expertise from the moment of admission has helped to improve the management of diabetic patients, and direct involvement in policy making has resulted in improved care for other patients throughout the hospital.

Multi-tasking

- Diabetes
- Endocrinology
- General and acute medicine

Diabetes consultants are unique among specialists in having three completely separate strands to their training and expertise. Each demands very different working practices.

Diabetes consultants are seen as the 'general physicians' of the acute hospital as colleagues in other disciplines become more specialised. They are ideally suited to this work because a broad understanding of general medicine is essential for looking after diabetes patients and their clinical judgement is much in demand. This aspect of their work requires them to be readily available, or to respond to urgent situations.

Endocrinology includes both common thyroid problems, which like diabetes can be looked after well in primary care provided specific expertise is close at hand, and disorders of the pituitary, adrenal and other glands. These require sophisticated clinical skills and expensive and high tech diagnostic and surgical equipment only found in acute hospitals. Clinics can be scheduled and work predicted.

The diabetes component involves dealing with highly complex patients in many different settings, often via others. Currently no one is getting the best deal as consultants juggle the immediate demands of life threatening illnesses requiring their instant attention, with the need to be working in new ways, at new sites, and supporting teams and surgeries in planned reviews and meetings. This underscores the need for a fundamental review of job plans for consultants in diabetes to optimise their effectiveness.

Consultants are starting to develop new ways of organising the work amongst themselves, supported by their employers. In Bolton, the specialist diabetes team decided to move their contracts to the PCT to reinforce their support for primary care. They continue to provide acute medical, in patient specialist and endocrinology services to the trust, but each component is now clearly defined and set out in a workable contract. Working relationships remain as good as ever.

A group of three diabetologists decided to explore the idea of working as a team, sharing the work and balancing their various interests among them. The resulting arrangement included one half time in teaching and research, one exclusively in diabetes, one with more acute medicine and only two involved in endocrinology. Each individual job plan was very different and included sessions for working in the community. They expect that roles and job plans will change as service needs and career pathways develop.

Training that is fit for purpose

Diabetes is likely to consume an even larger proportion of NHS resources unless the opportunities to prevent it and manage it are acted upon. The Wanless[3] report concluded that unless people with diabetes are engaged in all aspects of this preventative programme, good outcomes and financial stability will not be achieved. It is essential that there is a highly trained expert and specialist workforce to ensure that everyone working within the diabetes heath and social care community is equipped to support this.

Currently there are concerns. Recruits are not coming into the speciality in the number that is needed. Trainees are not being exposed to the new working practice of the future. Straw polls of specialist registrars in diabetes consistently show that only one or two individuals out of groups of 50 or more have visited primary care professionally since leaving medical school. Where this has been achieved, it has usually been at the direct instigation of the individual themselves.

The group that wrote this report observed that training in new skills is as important for current consultants as for the future.

They have succeeding in introducing a new set of national competencies for specialist training. These include the skills, knowledge and attitudes to work across organisational boundaries, and to understand the opportunities and levers that the NHS provides to improve care.

Seventy two consultants have now benefited from a King's Fund development and leadership programme to help them to work more effectively in the current world, and thus to become better teachers and role models.

'The old model of training by 'osmosis' is obsolete, and consultants and other members of the multidisciplinary team need to be given time to ensure adequate training of future specialists.'

A good example is the care of diabetic pregnant women in Poole. These women attend a dedicated multidisciplinary clinic with Specialist Registrars (SpRs) who have been trained in this sub-specialty over a six month-period. This training includes observing the Consultant and Diabetes Specialist Nurses within the clinic until they feel able to see patients alone, with the support of the multidisciplinary team on hand at all times.

'We are training SpRs for a job they will no longer be doing as Consultants. We must get them out into the community where they can listen to what primary care staff want from a diabetes service. This is usually an answer to the question they were referred for. What they normally get is perpetual hospital follow up for the patient with no answers. We need to train SpRs to write treatment plans for patients with a view to discharging them back to the primary care team and to teach them about how to find their way around the healthcare landscape – not just acute care. Locally, we will be rotating SpRs into the community clinics, and hold management sessions to inform SpRs of the changes going on.'

A diabetologist

In Northamptonshire the consultant Diabetologist does not just look after individual diabetic patients, but also has an important leadership role in the whole local diabetes service. They have drawn on the King's Fund Development Programme locally and arranged a two-day residential course for SpRs. This deals with such issues as the organisation and re-organisation of the NHS, organising a diabetes service and how to strengthen leadership skills. These skills are vital for future Consultant Diabetologists and others may wish to consider embedding these firmly within future
training schemes.

Role of Networks

Diabetes Networks, described in the NSF, are in a unique position to work across natural diabetes communities, bridging primary, specialist, community and social care. They bring together a range of people from different disciplines with a mix of expertise. They have three roles. (described opposite).

PCTs and GP commissioners can use networks not just to coordinate services but to support their local heath needs assessment and help redesign services with the patient at the centre.

Diabetes networks can bring large numbers of people with diabetes into the process and achieve direction and action that can support commissioning of major change.

Role of networks

- Planning together – to support commissioning
- Working together – to coordinate provision
- Using information to support both

The next steps

It is now clear what needs to be done to improve diabetes services, reduce variation and improve patient orientated outcomes. The NHS reforms enable this to be done now. The tools to support this are available.

Commissioners need to

- Ensure that diabetes services are a priority in their commissioning plans.
- Work with networks to develop and procure models of care which reflect local heath needs assessment, best standards of clinical governance, emphasis prevention and specify improved outcomes.
- Work with networks to ensure that a service that crosses organisational boundaries can function effectively.
- Ensure models include specialist expertise in the right place.
- Use the flexibilities within PbR to develop local tariffs for outpatients so that acute providers have the financial resources to support their clinicians in new ways of working.

Acute Trusts need to

- Understand that although diabetes is a long-term condition, its management has implications for every part of the organisation.
- Identify people with diabetes in hospital and, using appropriate tariffs, generate income to improve in-patient care.
- Include diabetic specialists in all clinical units to improve pathways and reduce length of stay.
- Ensure that consultant job plans make provision for the unique nature of their tasks, responsibilities and working practices
    - o Within the acute hospital
    - o Across the whole diabetes community

Consultant diabetologists need to

- Establish new ways of working with colleagues to enable the best use to be made of their varied skills and interest.
- Reorganise rotas and clinics to provide opportunities for trainees in diabetes to experience the rewards of working with patients and for patients in new settings with new challenges.

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