FOR – Community Diabetologists have little role in the management of patients with diabetes

Dr Niru Goenka
Consultant Physician in Diabetes & Endocrinology
Countess of Chester NHS Foundation Trust

Before starting…..

- Vast majority of diabetes can be managed outside hospital settings
- Diabetologists have a core role in planning and delivering services right across a locality (including outside hospital settings)
- I have developed and run a diabetes 'outreach' service
- Like and have professional respect for Community Diabetologist colleagues

The Motion

This house believes that Community Diabetologists have little role in the management of patients with diabetes

What makes a sub-specialty?

1. A clear definition of role and patient group served

2. Defined training requirements and a specific curriculum

3. Distinct ‘outcomes’ or ‘quality markers’ outside that expected in general care.

The case FOR the motion

- When applied to diabetes care the word ‘Community’ is not only impossible to define it is also
  - an unnecessary term, i.e. a tautology
  - harmful
- There are no defined training requirements and there is no specific approved curriculum
- No distinguishing ‘outcomes’ or ‘quality markers’ outside that expected in general diabetes care
- Costs are at least as much as more ‘traditional’ care

The case FOR the motion

- **When applied to diabetes care the word ‘Community’ is not only impossible to define it is also**
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    - **harmful**
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What defines a Community Diabetologist?

- Who holds contract of employment?
- How service is paid for?
- Responsibility for supporting/training primary care?
- Responsibility for leading/planning services across locality?
- Responsibilities to the acute take?
- Location where care is delivered?

What defines a community location?

- A place that is not hospital? But where does “community” begin?.....

What defines a community location?

- A place that is not hospital?   Also
    - Hospitals are seen as an integral part of local community
    - Closure or threat of closure can unseat a 'safe' MP
    - In many cases one of the largest employers in a locality
    - Often have good transport links such as bus routes etc…

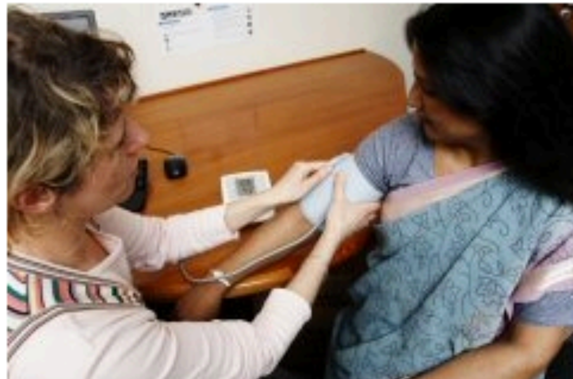
Why is this so difficult to define?

- What does the word “Diabetologist” actually mean?
- **I would argue that virtually every Diabetologist is a Community Diabetologist**
- The distinction is artificial and therefore the term is unnecessary

  (almost wrote an “unnecessary tautology”!)
- It is difficult to think of a branch of diabetes care in which one does not have responsibilities across boundaries

What do the Community Diabetes Consultants (CDC) say?

Welcome to Community Diabetes Consultants web site. Community Diabetes Consultants was formed in 2003. It is a network of consultants and others – from any discipline – that work or aspire to work in the community, providing specialised help for primary care and the person with diabetes, in locations that are local, using methods utilising the maximum benefit of multidisciplinary working, and modern educational and motivational techniques



CDC is part of the structure of Diabetes UK, gives advice to commissioners and Diabetes UK about specialised diabetes community problems. It has developed methods of best practice, position statements, in conjunction with Diabetes UK.

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What do CDC say?

"It is a network of consultants and others – from any discipline – that work or aspire to work in the community, providing specialised help for primary care and the person with diabetes, in locations that are local, using methods utilising the maximum benefit of multidisciplinary working, and modern educational and motivational techniques"

A threat to integration of care…..

- In fact, the term ‘community’ when applied to diabetes consultants is actually harmful
- It implies a divide where none ought to exist
- It implies that some do not have any duty for leadership, planning services or supporting primary care across a locality.
- We should actively avoid using it

The case FOR the motion

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  - **an unnecessary term, i.e. a tautology**
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YDF/ABCD survey 2008

- Trainees gloomy about job prospects
- Only 16% intended to work in the community
- 85% had not training related to working in the community

The Young Diabetologists Forum (Diabetes UK)/ABCD trainee survey

P Kar, K Higgins, M Atkin, T Richardson*

ABSTRACT

The Young Diabetologists Forum (YDF) is a forum for diabetes trainees in the UK. With help from the Association of British Clinical Diabetologists (ABCD), the YDF set up an audit amongst diabetes trainees to understand their feelings about the changing structure of diabetes care, present training needs and future job situations.

A 24-question e-questionnaire was set up. All diabetes trainees were sent invitations to participate in this e-based audit, via e-mail.

There were 192 respondents (42% of current trainees). Of these, 63% were male, and 60% were UK graduates. Twenty-three percent intended to work, as a consultant, in a teaching hospital, 31% in a district general hospital; 65% would like to work full time as a consultant, 26% part time. Sixteen percent intended to work in the community full time while 54% would consider that option part time with the rest of sessions being in secondary care. However, 85% had not had any training relating to working in the community. In all, 54% did not want to be involved in acute medicine; 65% felt that they would still choose the same specialty given another choice while 16% would not. A total of 96% of trainees were worried over future job prospects; 63% felt negative – to some degree – about the 'changing world of diabetes'.

The audit highlights the significant worry amongst trainees about future job prospects. If plans are to base specialty care predominantly in the community, then this is not reflected, at present, in the training curriculum. For the sake of trainees present and future, a manifest role for a specialist diabetologist, in the primary or secondary care setting, needs to be clearly defined – to help stop the erosion of morale and instil confidence in trainees about their position as specialists in diabetes care.

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Practical Diabetes Int 2008; 25(8): 323–327

KEY WORDS

specialist registrar; training; future of diabetes

Introduction

In recent years, diabetes care has been influenced by a number of drivers, including Practice Based Commissioning (PBC), Payment By Results (PBR), the new General Medical Services contract, the National Service Framework for diabetes, and an exponential increase in the population with diabetes. This has ignited the debate about the role of specialists in secondary care and the restructuring of diabetes service provision both in primary and secondary care, which are ongoing.

These uncertainties have created concern amongst trainees in diabetes regarding future job prospects. A further area of concern has been understanding (a) the current 'domain' of diabetes specialty care and (b) the extent of involvement of diabetes consultants in acute general medicine.

The Young Diabetologists Forum, affiliated to Diabetes UK, has been a voice of increasing influence for specialist registrars (SpRs) in diabetes and endocrinology for the past seven years. The Forum has sought to represent and support the interests of junior doctors who are involved in many aspect of diabetes care or research.

In association with the ABCD (the Association for British Clinical Diabetologists), the Young Diabetologists Forum conducted a survey amongst diabetes trainees to determine their perception of diabetes care and diabetes career progression.

Methods

An e-questionnaire comprised 24 questions (Table 1). The website was username and password protected for confidentiality purposes and responses were anonymised. The survey was also advertised on the Specialist Registrar web page of the ABCD website.

Currently, there are 453 SpRs in diabetes and endocrinology (inclusive of National Training Numbers [NTNs], Locum Appointed Trainees [LATs], Flexible trainees and Fixed Term Training Appointments; Joint Royal Colleges of Physicians Training Board, JRCPTB, database, May 2006). The survey was commenced in May 2006 and an e-mail informing all diabetes trainees with the username and password attached was sent out using the JRCPTB (previously the JCHMT) database. The survey finished in March 2007. The results were collated and presented at the Diabetes UK Annual Professional Conference in Glasgow 2007.

Results

There were 192 respondents, which comprised 42% of current trainees.

Partha Kar, Specialist Registrar in Diabetes, Southampton General Hospital, UK (current post: Consultant Diabetologist, Queen Alexandra Hospital, Portsmouth, UK)
Katherine Higgins, Consultant in Acute Medicine, Leicester Royal Infirmary, Leicester, UK
Marc Atkin, Clinical Research Fellow, Queen Alexandra Hospital, Portsmouth, UK
Tristan Richardson, Consultant Diabetologist, Royal Bournemouth Hospital, Bournemouth, UK

***Correspondence to:** Dr Partha Kar, MD, MRCP, Consultant Diabetologist, Queen Alexandra Hospital, Cosham, Portsmouth PO6 3LY, UK; e-mail: drparthakar@googlemail.com

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What exactly does “training to work in the community” comprise?

- Pathophysiology, management and complications of diabetes are the same regardless of location, contract status of provider or method of payment.

What exactly does “training to work in the community” comprise?

- View from CDC committee – community training would consist of
  - Leadership skills
  - Negotiation
  - Training primary care & ensuring training is embedded into local diabetes management framework
  - Service planning
  - Multidisciplinary team working

Community diabetes consultants: the case for additional training

Sir, On behalf of all diabetes consultants working in the community – whether employed through primary care or hospital trusts – we are writing in response to the letter in the March issue which suggested that additional training for community consultants was unnecessary.[1]

We agree that diabetes is the same condition whether it is managed in the hospital or community setting – or in specialist or primary care – but would like to point out a few of the challenges for consultants leading services for people who do not attend traditional ‘secondary care’, and where additional training is helpful to consultants who are considering working in this environment.

Strong leadership skills are needed to develop diabetes services in the rapidly changing environment of primary care (e.g. getting to grips with General Medical Services, Quality and Outcomes Framework and Practice Based Commissioning). ‘Our health, Our care, Our say’ encourages most diabetes management to be undertaken in local community settings or primary care. Clinics in the hospital setting are increasingly focusing on patients with highly complex or subspecialty diabetes needs. The community diabetologist has an important role in leading services for people who do not meet the criteria for such hospital clinics but who have more complex needs than those the GP can manage. The development of high quality services that have ‘economies of scale’ to cope with large numbers of patients (particularly in patient education, group consultations etc) will be essential. Community diabetologists are increasingly working alongside public health specialists, epidemiologists and statisticians on issues such as prevention and increasing the ascertainment of diabetes, whilst acquiring knowledge of techniques such as social marketing!

Clinically, community consultants are more likely to see patients who are not seen in a hospital clinic – e.g. those who are housebound, living in a nursing home, travellers, and psychiatric patients who all have particular diabetes needs. Community consultants need to develop new ways of working due to the fact that they also see patients who do not attend hospital clinics because the system there does not work for them.

Although many hospital-based diabetes care teams have always been involved with the education of GPs and practice nurses, the community consultant’s role includes not just delivering training but also ensuring it is embedded into the local diabetes management framework (e.g. Local Enhanced Services) which they have developed.

The consultant may be working in environments very different from those of hospital clinics (e.g. community centres, GP surgeries, mosques, even supermarkets!) with different computer systems and organisation of care. Multidisciplinary team working is as important as it is in secondary care, but there are different levels and disciplines in the community (e.g. local pharmacists, nursing home staff, district nurses, and case managers).

Community consultants are an important link between primary and specialist care. Experienced community diabetes consultants can see diabetes issues from both primary and specialist care perspectives and, with appropriate skills, can facilitate integrated care and partnership in the challenging NHS in which we are all working.

Dr Gillian Hawthorne, Dr Waqar Malik, Dr Felix Burden, Dr Chris Walton, Jill Hill (Community Diabetes Consultants committee)

CW is also an officer of Association of British Clinical Diabetologists (ABCD). The views expressed do not represent the views of ABCD.

Reference

1. Ahluwalia R, Goenka N. Community diabetes: a case of the Emperor's new clothes? *Pract Diabetes Int* 2009; **26:** 56.

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YDF community diabetes course – a high quality training opportunity, but is it mislabelled?

Young Diabetologists' Forum Community Diabetes Course
Thu 27th – Fri 28th January 2011, Radisson Blu Birmingham

Day	Time	Session
THURSDAY 27th JANUARY 2011	13.30	Registration and Coffee
	14.00	**Introduction to the Community Diabetes Course:** *Felix Burden, Birmingham*
	14.15	**SpR presentations on local diabetes services,** *facilitated by Felix Burden*
	16.00	Tea and coffee
	16.30	**SpR presentations continue**
	18.00	**Chairman's Closing Comments/Housekeeping**
	18.30	Pre-dinner drinks, followed by dinner

Day	Time	Session			
FRIDAY 28th JANUARY 2011	08.30	Registration and Coffee			
	09.00	**Welcome** – *Felix Burden*			
	09.10	**Keynote speech: The Future of Diabetes –** *Rowan Hillson, London*			
	09.40	**Community diabetologist perspective -** *Gillian Hawthorne, Newcastle*			
	10.10	**Hospital perspective -** *Paru King, Derby*			
	10.40	Coffee			
	11.10	**Micro-commissioning: personal health budgets -** *Azra Iqbal, Birmingham*			
	11.40	**GP consortium perspective -** *Azhar Farooqi, Leicester*			
	12.10	**Private provider perspective –** *Steve Riley, Enhanced Healthcare Services Ltd*			
	12.40	Lunch			
	13.30	**Workshop 1** *Diabetes Screening for those between 40-75years* *Paru King*	**Workshop 2** *Working with a private provider* *Steve Riley*	**Workshop 3** *Design software – what is needed and how would you use this data?* *Felix Burden*	**Workshop 4** *GLP-1 start service* *Gillian Hawthorne*
	15.00	Tea & coffee			
	15.30	**The Diabetes Dragon Den - Presentation of business plans to the commissioners** *(whole faculty)*			
	16.40	Close of meeting			

There is no such thing as “community diabetes training”

- “Community diabetes training” is simply management training which is diabetes specific
- These core skills are relevant to all branches of diabetes
- Every trainee should be encouraged to develop these skills regardless of the setting they aspire to eventually work in
- Describing it as “community diabetes training” is unwise as this implies the opposite and may even actually deter some trainees

There is no such thing as "community diabetes training"

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Are there specific community diabetes outcomes or quality indicators?

- Not much in the literature until I found these……….

Quality outcomes for a diabetes service

PS Sharp, S Woodman, W Heron*

ABSTRACT

Current NHS policy is to move services for chronic disease out of the hospital sector into the community, with services managed by a variety of health care professionals. There are often no clinical outcome measures specified for such clinics, and we therefore describe results for one such service run by a consultant, a dietitian and a specialist nurse.

The clinic is hosted by an urban GP practice, and reviews patients with a view to problem solving, management planning and discharge.

During a representative period, between 1 April 2007 and 31 March 2008, 144 patients were seen in 285 visits with a new:follow-up ratio of 1:0.98. The non-attendance rate runs between 15 and 20%. In a 21-month period, 213 patients were referred with conditions requiring improvement in diabetes control. Baseline HbA_{1c} was 10.0(0.14)% (mean [SEM]), and had fallen to 8.8(0.12)% at the time of discharge ($p<0.01$). Fifty-three of these subjects were judged to need insulin. In this group, the HbA_{1c} fell from 10.64(0.3)% to 8.6(0.2)% ($p<0.01$). In the remaining 160 individuals who needed reinforcement of advice, tablet or insulin titration, the HbA_{1c} fell from 9.8(0.15)% to 8.8(0.14)% ($p<0.01$).

The data here provide quality markers for a community diabetes clinic. Further figures from other services are required to provide commissioners with realistic quality markers against which services could be compared. Copyright © 2009 John Wiley & Sons.

Practical Diabetes Int 2009; 26(3): 96–97

KEY WORDS

practice based commissioning; diabetes commissioning; diabetes quality outcomes; community diabetes

Introduction

An important strand currently influencing the shape of diabetes care as a specialty in England is practice based commissioning (PBC). As originally conceived, PBC allows primary care physicians to identify deficits in their local services, and to tender for a local service through the commissioning arm of the primary care trust. Diabetes services are commonly seen as an early testing ground in this process. Locality based diabetes services are springing up around the country in various forms, managed by various health care professionals, including general practitioners, consultants and pharmacists. It is apparent, however, that quality and outcome standards for these services have not been developed to judge their success or otherwise.

The Diabetes Commissioning Toolkit[1] published by the National Diabetes Support Team is a valuable document, but very high level. It outlines a broad view on how diabetes services can be developed from a national 'Level 2' to a more local 'Level 3'. It does not, however, get down to ground level and describe what might be expected from a community service.

In Southampton, we are developing a model of diabetes care which is sensitive to the fact that many primary care teams refer to the diabetes service only for general advice, but not for ongoing follow up. In this model, therefore, secondary care continues to take on the complex follow ups, particularly those requiring the input of multiple specialties. However, a new tier of care has been introduced which is designed to take on those referrals deemed to be for advice only, subsequently discharging the individual back to the primary care team. A typical new referral would be seen by the dietitian and diabetes specialist nurse to ensure that there were no problems with the basics of the subject's knowledge. The consultant would review medical aspects and diabetes treatment. A collective management plan would then be generated after discussion with the patient. The pilot for this aspect of the service has been running for the last two years and, clearly, all aspects of the development are subject to regular review. However, the present results are reported as an example of what might be achieved in terms of workload and outcomes by a fully supported consultant-led service operating a once-weekly clinic with no input from junior staff. The results provide an example of what might be expected from such a service as a standard against which other providers could be compared.

Methods

The diabetes clinic is hosted by an urban GP practice which provides administrative and secretarial staff. The service is provided through a consortium of GPs in a limited company, providing diabetes services for a population of approximately 100 000 people. Clinical staffing for the clinic consists of a consultant diabetologist, a diabetes specialist nurse and a dietitian, with no cover for leave or absence. The clinical session takes place weekly. Clinical activity was recorded and notes for those seen in the service between June 2006 and April 2008 were reviewed. Baseline HbA_{1c} results

Patrick S Sharp, MD, FRCP, Consultant
Sarah Woodman, RD, Dietitian
Wendy Heron, RGN, Diabetes Nurse Specialist
Southampton City Primary Care Trust, Southampton, UK

***Correspondence to:** Dr PS Sharp, Diabetes Resource Centre, Royal South Hants Hospital, Brinton's Terrace, Southampton SO14 0YG, UK; e-mail: patrick.sharp@suht.swest.nhs.uk

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Glycaemic outcomes following discharge from an intermediate care diabetes clinic

*PS Sharp**

ABSTRACT

In a previous report, we described an intermediate care diabetes service which achieved a new:follow up ratio of close to 1:1. This report examines the glycaemic outcomes over the following 18 months of those individuals who were discharged back to primary care.

Between June 2007 and May 2008, the service saw 166 new and 238 follow-up patients with 91 discharges back to the primary care team. The referral HbA_{1c} was 10.1%, and on discharge was 8.7%. Patients were discharged with a management plan. At 12 months post discharge the HbA_{1c} was 8.6% and at 18 months 8.8%.

These results are encouraging in the sense that robust management plans produce sustainable improvements in glycaemic control. However, it is clear that following discharge, further improvements in glycaemic control cannot be expected. It is therefore suggested that follow up should be continued until the individual glycaemic target is reached. Copyright © 2010 John Wiley & Sons.

Practical Diabetes Int 2010; 27(2): 53–54

KEY WORDS

intermediate care; new to follow up ratio; early discharge

Introduction

In the modern NHS, caught between the dual pressures of payment by results (PbR) and a reduction in funding, value for money will become increasingly important. In all services, a push towards a reduction in the new:follow-up ratio is already a symptom of this. In a previous report,[1] we described an intermediate care diabetes service which achieved a new:follow-up ratio of close to 1:1. However, rapid discharge should not in itself be used as a marker of quality. Of necessity, the individual is discharged before the glycaemic target is reached, the assumption being that further improvements will accrue with time. Whether this is truly the case is not presently known. We therefore followed up patients with respect to their glycaemic outcomes following discharge from the intermediate care clinic to assess the outcomes of rapid discharge.

Methods

The diabetes clinic is hosted by an urban GP practice which provides administrative and secretarial staff. Clinical staffing for the clinic consists of a consultant diabetologist, a diabetes specialist nurse and a dietitian. The clinical session takes place weekly, and takes the form of an intermediate service in that it is designed to provide a rapid access, problem-solving service for the primary care clinical team, advising on management plans with subsequent discharge back to primary care. Patients requiring longer-term follow up are discharged with a recommendation that they are referred to secondary care where staffing is such that those requiring long-term follow up can be catered for.

Study subjects were those seen and discharged between June 2007 and May 2008 to allow a follow-up period of at least 12 months. Those who were discharged were followed via the central biochemistry results system, which records all biochemical results within the area, noting changes in HbA_{1c} and time after discharge to repeat of blood tests.

Results

During the selected time period, the service dealt with 166 new patients and 238 follow-up patients with 89 non-attendances. A total of 91 patients were discharged from the service in that time (excluding those who failed to attend to complete their assessment); their clinical characteristics are shown in Table 1. Of those discharged, 30 had started insulin, one had started exenatide, 32 had their insulin adjusted and 28 had their oral therapy adjusted.

The 91 patients discharged from the service were followed via the hospital biochemical results system. The average time to repeat of blood tests following discharge from the service was 7.4 months. The results of the HbA_{1c} follow up are shown in Figure 1. Patients referred to the service had an initial HbA_{1c} of 10.1% which fell to 8.7% by the time of discharge. At 12 months the HbA_{1c} remained at 8.6% and at 18 months was 8.8%.

Discussion

The observations presented here are very simple, but a few basic conclusions can be drawn. Firstly, the high HbA_{1c} and long duration of diabetes at referral suggest that patients are referred on for a second opinion at a late stage. This is fairly typical of clinical practice in the United Kingdom at the present time. Secondly, with appropriate adjustment to treatment, significant improvements in glycaemic control can be made in a short period of time. At first sight, the results are

Dr Patrick S Sharp, MD, FRCP, Consultant, Department of Diabetes, Southampton City Primary Care Trust, Diabetes Resource Centre, Royal South Hants Hospital, Southampton, UK

***Correspondence to:** Dr PS Sharp, Diabetes Resource Centre, Royal South Hants Hospital, Southampton SO14 0YD, UK; e-mail: patrick.sharp@suht.swest.nhs.uk

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Are there specific community diabetes outcomes or quality indicators?

ABSTRACT

Current NHS policy is to move services for chronic disease out of the hospital sector into the community, with services managed by a variety of health care professionals. There are often no clinical outcome measures specified for such clinics, and we therefore describe results for one such service run by a consultant, a dietitian and a specialist nurse.

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The data here provide quality markers for a community diabetes clinic. Further figures from other services are required to provide commissioners with realistic quality markers against which services could be compared. Copyright © 2009 John Wiley & Sons.

Practical Diabetes Int 2009; 26(3): 96–97

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Practical Diabetes Int 2010; 27(2): 53–54

Quality metrics are no different from that used in general specialist diabetes care

- The quoted quality outcomes are HbA1c improvement, N:F ratio, DNA rate and sustained HbA1c reduction
- These are no different to those used in general specialist diabetes care
- A reduction in HbA1c is not really surprising considering it is a diabetes clinic
- DNA rate are no better than that expected in general specialist diabetes hospital based care

The case FOR the motion

- When applied to diabetes care the word ‘Community’ is not only impossible to define it is also
  - an unnecessary term, i.e. a tautology
  - harmful
- There are no defined training requirements and there is no specific approved curriculum
- **No distinguishing ‘outcomes’ or ‘quality markers’ outside that expected in general diabetes care**
- Costs are at least as much as more ‘traditional’ care

The case FOR the motion

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- **Costs are at least as much as more ‘traditional’ care**

Costs of diabetes "community" clinic

2010-11 Outpatient Attendance Tariff

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Please note that commissioning PCTs should apply the Market Forces Factor when paying for activity within the scope of the mandatory tariff.

		CONSULTANT-LED				NON CONSULTANT-LED			
Treatment Function	Treatment Function Name	WF01B First Attendance - Single Professional	WF02B First Attendance - Multi Professional	WF01A FollowUp Attendance - Single Professional	WF02A Follow Up Attendance - Multi Professional	WF01B First Attendance - Single Professional	WF02B First Attendance - Multi Professional	WF01A FollowUp Attendance - Single Professional	WF02A Follow Up Attendance - Multi Professional
100	General Surgery	204	225	95	100				
101	Urology	194	194	96	100				
103	Breast Surgery	150	185	76	84				
104	Colorectal Surgery	139	139	81	81				
105	Hepatobiliary & Pancreatic Surgery	167	335	105	105				
106	Upper Gastrointestinal Surgery	129	137	94	94				
107	Vascular Surgery	264	264	120	124				
110	Trauma & Orthopaedics	148	167	83	83				
120	Ear, Nose And Throat	121	155	63	78				
130	Ophthalmology	124	141	67	67				
140	Oral Surgery	129	129	74	74				
143	Orthodontics	198	198	84	121				
144	Maxillo-Facial Surgery	129	161	73	146				
160	Plastic Surgery	133	194	71	123				
171	Paediatric Surgery	204	225	100	100				
190	Anaesthetics	160	231	84	95				
191	Pain Management	160	231	84	95				
211	Paediatric Urology	194	194	96	100				
214	Paediatric Trauma And Orthopaedics	148	235	92	101				
215	Paediatric Ear Nose And Throat	121	155	73	78				
216	Paediatric Ophthalmology	124	141	86	86				
217	Paediatric Maxillo-Facial Surgery	161	161	81	146				
219	Paediatric Plastic Surgery	159	194	107	123				
251	Paediatric Gastroenterology	268	268	121	121				
252	Paediatric Endocrinology	257	257	109	109				
253	Paediatric Clinical Haematology	437	437	348	348				
258	Paediatric Respiratory Medicine	254	257	112	130				
300	General Medicine	222	222	104	108				
301	Gastroenterology	268	268	87	101				
302	Endocrinology	222	222	104	108				
303	Clinical Haematology	309	309	114	114				
306	Hepatology	352	352	159	159				
307	Diabetic Medicine	239	360	92	138				
320	Cardiology	215	215	103	108				
321	Paediatric Cardiology	215	215	133	133				

Costs of diabetes “community” clinic

- Outpatient PBR 2010-11 tariff is £239 (new patient) and £92 (follow up)
- Little recently published on costs per case of diabetes “community” clinics, but some abstracts, presentations and data in grey literature puts cost per case as between £80-140 per appointment.
- However staff costs are similar (consultant, DSN, admin etc…) – so why should diabetes “community” clinics be cheaper?
- They are not…….

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- However staff costs are similar (consultant, DSN, admin etc…) – so why should diabetes “community” clinics be cheaper?
- They are not……. the difference is purely down to the way the service is paid for – not the cost of the actual service

Smoke and mirrors

- In most cases cost of training, administration, facilities, investigations and travel expenses were excluded from community costs

"I was initially given a room in a GP Health Centre and told to get on with it. On asking awkward questions, such as who is going to type the letters, what about reception staff, nursing staff, setting up the clinic on the computer systems, network to a clinical database and access to investigations. Behind my back I knew they were all saying that as a Consultant, I was a bit precious, but I dug my heels in"

Meet the committee

Working for a Primary Care Trust

Patrick Sharp

Some four or five years ago, the wind of change started to blow through diabetes services in the UK. Working in an area with a business minded PCT, I felt the changes early. Suddenly, decisions on the direction of the service were being taken by shadowy figures whom I never met, and who certainly never asked my opinion. The Secondary care service was relegated to a referral service which was only reluctantly used. The reasons for this are now well rehearsed, and I won't go over old ground. My own response was "If you can't beat 'em, join 'em". I took a post which was half secondary care, and half within the PCT as 'Director of Diabetes'. Astute move, or howling mistake?

Like all the best questions, there is no quick answer. Having moved to a new post in a new area, I had to get used to starting again. We are all trying to climb our own particular mountain, and it is true in the NHS that if you take a Consultant post in a new area, you slide to the bottom and have to start climbing again. I therefore have to try to separate the starting again pains from true change in culture of working in a PCT.

I had some strong first impressions, and at risk of offending my PCT colleagues who might read this, I would highlight two of them. Firstly, PCT managers have no idea how to organise clinical services. This will change, but for the present, there seems to be a distinct lack of understanding on how services are run. I was initially given a room in a GP Health Centre, and told to get on with it. On asking awkward questions, such as who is going to type the letters, what about reception staff, nursing staff, setting up the clinic on the computer systems, network to a clinical database and access to investigations, I was met by blank stares. Behind my back, I knew they were all saying that as a Consultant, I was a bit precious, but I dug my heels in. I can only explain away this lack of clinical insight on the basis that PCT managers have never had to organise services directly: the GPs organise services, and PCT managers poke them with a stick from a safe distance. So, secondly, PCT managers are in charge, and clinical staff work for them (not with them). On starting with the PCT, I was allocated a manager whose job it was to 'manage' me, and not, as far as I could tell to help. To rub salt into the wound, one can occasionally be peppered with grapeshot from GPs who assume you have taken on the mantle of a PCT manager, although for the most part, one can shelter behind clinical camaraderie.

In the 3 years I have been in post, this is all changing. Initial disquiet at changes in the diabetes service is only part of an ongoing process. PCTs themselves have been through difficult changes. Most have been reorganised with consequent loss of staff and reassignment of roles. Many have not yet found their feet, and it is still difficult to find the person responsible for any particular aspect largely because they haven't sorted it out themselves. The biggest change has been the separation of the provider and commissioning functions of PCTs. Initially this was a very self conscious change, with commissioners refusing to speak to anybody in case they were 'influenced' in their decisions. I think this is now settling, but the separation of roles remains a real one, and although there is some coming together, I wonder how long it will last. Locally, provision of the less complex aspects of the diabetes service has gone out to tender, the bidding parties being 2 GP locality groups …. and the PCT provider arm. One wonders how friendly the PCT provider and commissioning arms will be if they do not award the contract to their PCT 'colleagues', as looks likely.

Was a change to a PCT post a good move or not? I can't tell you yet as it is still a changing landscape. What I would say, however, is that I do not feel disengaged from the processes. Talking to many of my secondary care colleagues, I often hear expressed a feeling of being sidelined. I certainly feel the opposite, being rather in the direct firing line in a sometimes acrimonious struggle. I generally enjoy the experience, but at the end of the day, I will either crash and burn, or come out a better person. One regret I have from which others may learn (and indeed I may hope to rectify myself), and that is that I have drifted off with the Provider arm, and am no longer part of the commissioning process. This may be rectified by joining one of the commissioning committees, and I might stand a better chance than most in achieving this as being an 'insider'. That is not to say that Consultants in the hospital sector might not be able to join the commissioning service, and I have heard of some striking successes in that regard from colleagues around the country.

At the end of the day, what we all want is engagement in the whole process of delivering a diabetes service. Joining a PCT is only one way of achieving this, but there are more ways than one of skinning a cat. However, I feel that PCT provider arms need not just clinical staff, but individuals experienced in setting up clinical services. Whether they acknowledge it or not, the commissioners also need clinical help. More Consultant staff in PCTs will not be a bad thing.

Smoke and mirrors

- In most cases cost of training, administration, facilities, investigations and travel expenses were excluded from community costs
- In addition, most data shows that on average 1-4/10 cases are referred on to hospital based teams (thereby incurring double payment)
- Studies done in 1990's looking at consultant outreach clinics during fundholding initiatives showed that these were always more expensive overall than hospital clinics.
- The main reason why community diabetologists exist is because commissioners don't like paying by tariff. Is this a reasonable basis for a subspeciality?

The Motion

This house believes that Community Diabetologists have little role in the management of patients with diabetes

The case FOR the motion

- When applied to diabetes care the word ‘Community’ is not only impossible to define it is also
    - an unnecessary term, i.e. a tautology
    - harmful
- There are no defined training requirements and there is no specific approved curriculum
- No distinguishing ‘outcomes’ or ‘quality markers’ outside that expected in general diabetes care
- Costs are at least as much as more ‘traditional’ care

An obligatory quote:- The path to wisdom.....

- By three methods we may learn wisdom:

    First, by reflection, which is noblest;

    Second, by imitation, which is easiest;

    and third by experience, which is the bitterest

?Dev Singh

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Confucious

Vote FOR the motion if……

- You believe diabetes care should be seamless, integrated and delivered without creating artificial barriers
- You feel that all of us need to work with collaboratively and engage with primary care rather than leaving it to a select few
- You think that the core skills of leadership, negotiation, service planning and multidisciplinary team working are important for all trainees whichever setting they choose to work in

THANK YOU