Editorial comment: Hospitalisation among patients with diabetes associated with a Diabetes Integrated Care Initiative: a mixed methods case study

Author: Partha Kar[A]

OVERVIEW

Editorial comment on 'Hospitalisation among patients with diabetes associated with a Diabetes Integrated Care Initiative: a mixed methods case study' by David Simmons, Dahai Yu, Christopher Bunn, Simon Cohn, Helmut Wenzel and Toby Prevost

Integration in diabetes care – in fact, in the care of any long term condition – seems to be the prevailing mantra nowadays. As things stand today, there are few who would disagree with the underlying principle of having a seamless service, cutting across traditional boundaries of primary and secondary care. Many models have tried to deliver this vision but in a climate of perverse incentives (such as the 'payment by results' tariff for each diabetes outpatient visit) it becomes tricky to successfully negotiate the divide while also trying to ensure engagement with the local trust that loses out financially due to the drop in traditional outpatient activity.

The recently published *Five year forward view*[1] inexorably drives this vision ahead. The integration of services for diabetes is simple; the end game for the users is the avoidance of repetition with multiple providers, ie the delivery of a seamless service, while for the providers, especially in primary care, it is the ability to access specialist opinion easily, learn from this specialist interaction and continue to improve care, locally to the patient.

Quite rightly, the aim of any initiative has to be to move away from the evangelistic claims of a few, and instead to assess the efficacy of the delivery of these new models by means of patient-based outcomes. The Cambridge group, in this article, raise the valid question of whether integration is actually what it is cracked up to be, as the evidence presented suggests no major change *per se*, and possibly a worsening of outcomes in some areas, thus raising the question whether the traditional model was/is any worse.

There are several important questions and considerations that should be taken into account when taking conclusions from this paper.

Author: [A]consultant endocrinologist, Portsmouth Hospitals NHS Trust, Portsmouth, UK

The first question has to be why change is needed; is it purely for financial reasons, ie to move away from the PbR tariff to allow more activity in the community, at less cost than a block contract, or is there something fundamentally wrong in patient outcomes compared with other areas that require a wholesale change in delivery of care? If unclear from the outset, healthcare professionals need to query why there is need for change if the existing outcomes are already good. As ever, the need for change should be dictated by the need to try and improve patient outcomes.

So if we turn to the data presented, it should be noted that the most robust research trial in diabetes (UKPDS) took 7–8 years to show positive outcome data, so it is probably unfair to expect a long-term care initiative to show any profound positive changes in a 3-year period, particularly when intervention is less intensive than any research trial.

This paper demonstrates no reduction in outpatient work, which is a consistent finding with other models of care and therefore not necessarily too surprising. There are two key issues that may drive this; first, when education levels are raised in primary care, increased awareness is generated and there is thus more referral into specialty clinics. A specific example of this in diabetes care are foot clinics and type 1 clinics, where attendance levels may increase due to awareness within the community that type 1 diabetes is fundamentally different from type 2, and that patients may benefit from specialist care, including foot care. Second, the rise in outpatient referrals appears to mirror the increase in diabetes prevalence locally, so when put in context, may not be so surprising either.

However, the surprise in this data is the worsening of acute admissions, as there is good evidence that this can be reduced in the first few years.[2]

A significant number of acute admissions are due to diabetic ketoacidosis, and the onus is on the specialist team or teams to develop a service that tackles this. The shifting of resources to allow greater care of type 2 patients in primary care with more concentrated services for type 1 patients has been shown to reduce acute admissions and improve outcomes.[3] Finally, an important assessment of the success or otherwise of a new service must be based on user satisfaction (or otherwise). This may help to give a more rounded picture of the outcomes achieved by the integration of care.

In summary, the questions raised by this manuscript are valid and we must be bold enough to challenge any initiative, as intrinsically as we must keep faith in evidence. The results presented are indeed disappointing but is also counterbalanced by positive outcomes demonstrated in previous integrated models.[2–4] It would be interesting to see the results at 5–7 years to assess whether the outcomes have improved and whether the investment made has been deemed worthwhile by the local patients. The sharing of experiences of what appears to work and what doesn't will be key to the future success of these initiatives. ■

References

1 NHS England. *Five year forward view.* Available online at www.england.nhs.uk/ourwork/futurenhs/ [Accessed 30 March 2015].

2 Kings Fund. *Portsmouth and South East Hampshire Diabetes Service.* Available online at www.kingsfund.org.uk/sites/files/kf/media/portsmouth-and-south-east-hampshire-diabetes-service-kingsfund-oct14.pdf [Accessed 30 March 2015].

3 Thynne A, Head J, Kar P. Safe Transition to Young adult Life (STYLe) through a restructured adolescent and young person diabetes transitional service. *Diabetes Care for Children & Young People* 2014;3:16–21.

4 Torjesen I. Emergency admissions for diabetes fall by almost 7% in integrated care pilot scheme. *BMJ* 2012;344:e3562.

Address for correspondence: Dr P Kar, 6 Cousins Grove, Southsea PO4 9RP, UK.
Email: drparthakar@gmail.com

PATIENT COMMENT

Future Hospital Journal 2015 Vol 2, No 2: 100–1

Patient comment: Hospitalisation among patients with diabetes associated with a Diabetes Integrated Care Initiative: a mixed methods case study

Author: John Oldham[A]

OVERVIEW

Patient comment on 'Hospitalisation among patients with diabetes associated with a Diabetes Integrated Care Initiative: a mixed methods case study' by David Simmons, Dahai Yu, Christopher Bunn, Simon Cohn, Helmut Wenzel and Toby Prevost

Ask patients with long term conditions what they find most frustrating about the UK healthcare system and they will invariably comment on the fragmentation of care, characterised by poor communications between agencies, and the absence of a coordinated and personalised care package. They often experience difficulty navigating the system, which can lead to suboptimal care and a feeling that clinical outcomes might have been better if services had been properly joined up. Patients with diabetes are usually sharing decisions about their care with clinicians and need support for self management across the whole healthcare spectrum. They rightly expect ease of access to primary care, specialist community-based services, diagnostic services and, when complications in their condition arise, to secondary care. Patients also prefer to receive their care in local settings close to home, if not in the home. Usually they take the view that the less time they spend in hospital the better.

The Diabetes Integrated Care Initiative (DICI) in East Cambridgeshire and Fenland set out to develop a new model of integrated care aimed at improving clinical outcomes and increasing patient access to specialist care. The conclusion that the DICI did not lead to improved care or less reliance on inpatient care is disappointing but clearly some patients viewed the enhanced community services as a step in the right direction. The extent to which patients were involved in the design of the DICI is not clear. Early involvement of patients in service design and in agreeing success criteria might lead to better outcomes. While patients want good community-based care, they also want speedy access to secondary care when they develop complications. Delays in referral from primary and community intermediate care to secondary care are a common complaint among patients and there may be a benefit in some situations to allowing a degree of self-referral to hospital specialists by those with complex long-term conditions. Also, patients see the sharing of information between different components of the service as being of vital importance and it is unfortunate that electronic data sharing was not allowed between general practice and other health services. Despite

Author: [A]patient representative, Patient and Carer Network, Royal College of Physicians, London, UK