Neel Basudev, the jointly sponsored RCGP: Diabetes UK academic fellow (2012-2014) reflects about integrated care in field of Diabetes. During the fellowship Neel evaluated the use of virtual clinics to support patients with Type 2 diabetes in the primary care setting. In the article below Neel talks about the challenges and ways of delivering care to this group of patients.

The terms integration and collaboration are often used when discussing service design and care pathways. Indeed, any new model of care that does not have integration at its core probably won’t get very far from the drawing board. The RCGP champions the case for care integration with patients at the centre of any such model and general practice pulling the strings of cross boundary working. Integrated care is certainly an attractive platform on which to base the management of long term conditions, which forms part of the core of general practice. But how do we know integrated care works and does it work for every long term condition? Moreover, even if it does work, how can we go about putting it in place in a clinical setting?

In the context of diabetes, whilst integrated working does happen more commonly in the NHS nowadays, there is still a division and isolation between primary and secondary care. In the current model, secondary care is multidisciplinary such that diabetes clinics often involve specialists, nurses, dieticians, and podiatrists amongst others. Primary care may also have some level of integration and collaboration as some practices work closely with their local diabetes specialist nurse or network. However, the link between primary and secondary care can sometimes appear to be variable or non-existent. Specialists and primary care physicians who work in an integrated manner in their respective settings may well treat patients independently and in isolation from each other. Thus there may still be duplication of care and confusion for the patient due to conflicting management plans, which makes care planning and self-management difficult to operate.

Joint practice based clinics can get around this problem by combining specialist and generalist skills under one roof. This can be done either with the patient present or as a virtual clinic whereby the patient is absent from this discussion. There are various models of integrated diabetes care already in place in the UK such as those in Tayside and Birmingham. The “Super Six” model from Portsmouth has attracted particular attention.

There are certain key challenges being faced in diabetes care and innovative systems must be designed to:

- Reduce variation in care
- Manage increasing treatment demand and complexity
- Enable more effective self-management
- Develop a workforce better equipped to deliver high quality care

To address these challenges, we have developed a diabetes virtual clinic (DViC) model that allows integration of care between health professionals from primary and secondary care (Figure 1).
Synthesis of the available literature in this field is complex as there are no standard definitions for many of the search terms and interventions are often numerous. Most of the studies suffer from flaws in their methodology and hence common findings from all the studies are difficult to gauge. It would appear that in several of the studies, there appears to be clinical inertia and some level of working between primary care and specialists does help, but this does not always translate into clinical benefit. There are definite and identifiable performance gaps in care that do need to be addressed and there could be associated cost savings via a reduction in unnecessary referrals and hospitalisation.

To test this model effectively, we have conducted a study using a multicenter audit of patient’s clinical records based on a two parallel arm randomised controlled clinical trial in a socially deprived area of London. The full results of this will be published shortly. Preliminary data suggests that gaps in care exist for patients but it is unclear if these are due to clinical inertia by the physician, patient resistance to treatment escalation, or perhaps a combination of both. For example, almost a third of patients overall remained on maximum oral medications by the end of the study but had failed to progress onto insulin.

The study of system level changes of this nature is complex in a “real world” primary care setting. This is in part due to the constant changes which general practice deals with such as changes to Quality Outcomes Framework (QOF) targets and local initiatives. Nevertheless, it is important to test new models of care such as this in as pragmatic and robust a way as possible in order to judge whether they can be generalised to wider populations and to assess the practicalities for their implementation.

For information about research opportunities from the RCGP please follow the hyperlink below

www.rcgp.org.uk/sfb

References
8 STANAWAY, S. 2010. Virtual clinics: An opportunity for integrated diabetes care Diabetes & Primary Care, 12, 245-250.