Respect, engage, change – it’s time to end the white noise

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Abstract
The burning question at the moment is ‘What we can do to optimise delivery of diabetes care?’ Fundamental questions need be raised as to how far we respect each other’s professional positions, how far we actually engage with patients and what we can do to improve these vital relationships. We need to look at the power of social media, as to how it could help us engage with each other cutting across all boundaries, whether it be between professional ranks or patients. How can we genuinely put the patient in charge of services, be guided by them to achieve a higher quality diabetes service all across the country? In essence, the time has come for us to respect each other, and engage not just in words but in action – and have the boldness to change. In the words of Barack Obama: ‘Change will not come if we wait for some other person or if we wait for some other time. We are the ones we’ve been waiting for. We are the change that we seek.’ It is time to shake off the rhetoric and make excellence a norm, not an exception. It is time to stop the white noise, it is time to do. The time for siloed working must be over: patients with diabetes deserve much more than that. Copyright © 2014 John Wiley & Sons.

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The maze of providers
Sometimes you wonder how fragmented the NHS must look from a patient’s point of view. You have your hospital care delivered by your local acute trust, you have your ‘checks’ being done by primary care, you get requests for screening from another organisation; in the middle of all that, someone else is in charge of your podiatry care. So many health care professionals (HCPs) and bodies, all under the auspices of the NHS, yet so disparate as individuals, are hosted under different organisations, different trusts – all existent but fundamentally lacking in the concept of communication between each other, hamstrung by narrow parochial siloed working – all resulting in fragmented and fractured care. The irony? In all these silos the intention or desire to care is high but somehow the realisation that the sums of all those parts could make us stronger has yet to happen universally.

Mary MacKinnon was a leading light among nurses; passionate in her belief about HCPs working together, believing in the principle of a team all working to the common goal of trying to improve patient care – and there perhaps has never been a greater need or time for this to happen. There have been heated debates about the data associated with outcomes within the NHS but there is no denying the fact that they do not necessarily show the health care system in a bright light. The reasons have always been varied and multiple – ranging from discussions about the merits of a tariff-based system, the wide ranging yet avoidance of individualised care promoted by the Quality and Outcomes Framework, the lack of a global IT system – but above all, what seems to have resulted in an air of toxicity is one thing: lack of mutual respect.

Lack of respect
What is it exactly about the NHS now? There seems to be an entrenched desire to establish who works the hardest – and all seem to be falling over each other to establish who actually wins the golden prize. That also seems to engender a belief that, by default, others could do more – not just in diabetes, but elsewhere in the health system; you have leaders coming out of the woodwork to advise others how to do things ‘differently’. The question is: ‘Is that based on years of absorbing knowledge of those particular specialties or area of working – or is that looking at the problem from the prism of their own eyes?’ It all boils down to a lack of respect for what the other person...
End the debate – primary care is where it is at

Let’s get to the nub of it: diabetes care in this country is run by primary care – more specifically, the practice nurses. One can argue about the policies which have resulted in this, the appropriateness of it, but that would be wasting time and energy. As specialists, let us be ready to take a step back and see the vast expanse of the work that policy makers, leaders of the system, have gradually asked primary care to do:

• Screening.
• Diagnosis and education.
• Early intervention.
• Dealing with the person as a whole – knowing their psychosocial make-up and other comorbidities.
• Seeing the patient in their home environment.
• Intensification.
• Complication screening/counselling and management.
• Appropriate referral.
• Keeping patients out of hospital.

Add in the fact that diabetes is only a fraction of what primary care deals with and it is perhaps time for us as specialists to step up to the mark and help those colleagues a bit. No, it is not just about having more specialist resources: it is partly also about using our present resources differently.

So what can we do as specialists? For sure, there will always be a role for super-specialised bits of diabetes care – and it is not often you hear GPs asking to look after antenatal diabetes or, indeed, pump care. There have been attempts to define areas of specialism but, whatever the conclusion, that debate needs to end soon. The bigger role for the diabetes specialist, whether they are a consultant or a nurse specialist, has to be one of an educator, one of support, one of being there when needed for primary care. If diabetes care is principally delivered in primary care, we, the specialist community, must have a big responsibility to support the very burgeoning load of primary care. (Box 1.)

We must walk away from the finger pointing and criticism, and instead try to offer solutions not restricted by tariffs and contract negotiations. The role of a specialist has to be multiple, not just that of a ‘specialist’ – it has to be one also of an educator, a leader of the system, a person ready to take accountability, and a role model to inspire the next generation. Being an educator does not simply involve delivering didactic lectures: it involves many other forums such as virtual clinics, telephone access, email contact – and, above all, being there when needed. As a specialist, now is the time to adapt, to change, to embrace the new world – and, most importantly, we can only do so when we appreciate and realise the huge burden primary care carries. The role of a specialist is now multiple, whether as a consultant or as a specialist nurse – and we must try to adapt each of those roles in our job plans, embrace each role and remember the impact each role can have. Our work is not limited to the present: an eye needs to be kept to the future.

Beyond the world of a specialist, I would also exhort others to explore areas into which they can develop. To primary care, the appeal is to open the doors to specialists; patients have little time or energy for the parochial bickering or jostling for position – they need us to work together. If specialists are ready to assume the mantle of being educators, then primary care needs to open the door – not to have their data monitored but to have the opportunity to use the specialist’s skills to improve care for the multitude of people who have not been referred or could perhaps improve with specialist input; a fact hampered by the tariff system by which the NHS works.

What about the rest? 

Trainees need to see the present flux as a great opportunity to make a difference to the system. The question that needs to be asked is whether their training encompasses the roles that a specialist endeavours to have: there is a need to understand patients’ requirements, listen to their thoughts and their views – it’s not always about seeing a ‘specialist’ but about access and appropriate training. One keeps hearing about lack of role models, the lack of inspirational figures, the paucity of individuals from ‘the present generation’. I would disagree – the diabetes world is blessed with such individuals, flush with youth, burning with passion and a fierce desire to improve patient care (Box 2). They are spread all over the country, and they are all happy to help and advise: just find the time to ask.

To patients, the request is to have patience and give us time. Please do point out to us what needs to improve, where we can do things better, but also do appreciate that engaging with patients so far has only involved lip service. The present generation is trying to engage and learn, but this is while simultaneously battling with the financial challenges and, of course, the political landscape that brings constant change within the NHS. There are now some fantastic examples of patient leaders within the diabetes community – and, side by side with Diabetes UK, there indeed seems to be a belief and the desire to improve patient care by listening to what is needed. However, time is required and, if granted that, diabetes care can only flourish.

State of the art lecture
The 2014 Mary MacKinnon lecture

Box 1. Roles of a specialist

- Specialist
- Educator
- Leadership
- Accountability
- Role model

Box 2. The ones to follow: some fine examples of the current generation of diabetes specialists

- Karen Adamson
- Marc Atkin
- Peter Carey
- Kelly Cheer
- Pratik Choudhary
- Stephen Creely
- Russell Drummond
- Simon Eaton
- Patrick English
- Kate Fayers
- Benjamin Field
- Rajiv Gandhi
- Roselle Herring
- Frank Joseph
- Sarita Naik
- Rahul Nair
- Yashica Nathan
- Katharine Owen
- Dipesh Patel
- Mayank Patel
- Paul Peter
- Rajeev Raghavan
- Rustam Rea
- Simon Saunders
- Dinesh Selvarajah
- Garry Tan
- Emma Wilmot
- Naveed Younis
As regards industry, cautious optimism is perhaps the buzzword for the future. There is no denying the contribution made by the pharmaceutical industry to R&D, but it must be tempered with the need to be transparent. There are huge opportunities where HCPs and industry can work together for the improvement of patient care but most of that, quite rightly, has to be grounded in trust and faith. As a health care community, we hope that the new era will usher in a culture of openness which would help HCPs to engage without having the simplistic description of seeing industry as either black or white.

Finally, to commissioners of services: there is a need to commission type 1 separately from type 2 diabetes. As any diabetes specialist will tell you, they are two different pathologies with different needs and different treatments targets. Why, then, commission it as one whole package called 'diabetes'? Many a type 1 patient’s care has suffered due to their care being meshed in with the world of type 2 diabetes, and we must be appreciative enough to separate the two pathologies and commission them separately.

There has to be a need to eschew partisan politics. It is not about whether a community service is better than the hospital service – as put so succinctly by the late Dr Niru Goenka: we must appreciate that the hospital is part of the community, not separate. A community diabetes team should not exist in isolation: the hospital is only a part of the patient’s journey – and services should be commissioned bearing that in mind, not reinforcing silos.

Of course, we must not lose sight of the fact that there are some excellent examples of diabetes care around the country, whether it be in centres such as Leicester, Sheffield, Bromley or Derby. Why, then, do we spend so much time trying to reinvent the wheel: why not learn and emulate good examples from within the NHS? The Portsmouth Hypoglycaemia Hotline is a perfect example whereby we have learnt and emulated a pre-existing model in place in Hull due to the kind help of Dr Chris Walton and Dr Belinda Allen.

This leads me on to the ‘new tool’ available to us HCPs: social media. Once looked upon as simply a plaything of the young, the scope of this has now expanded in a quite impressive manner. The main purpose is the opportunity it gives us as HCPs to embrace engaging with patients and, above all, acting as a forum for us to listen and perhaps learn.

Be it Twitter, Facebook or blogs, there is a world where patients with diabetes are expressing their views on the health service, and their views as to what could improve; but there is perhaps also a gradual realisation on both sides as to the challenges we all face. As an HCP, there are many such individuals to follow, many such blogs to read and groups with which to engage.

The concept of a team
Beyond everything we need to do, everything we need to change, there is no denying the strength and importance of a cohesive team. Mary MacKinnon was always a passionate believer in this and with good enough reason too. Diabetes care is not about whether the doctors or the nurses are the best, not about whether the specialists or primary care are the best, but instead, finally, about the realisation and appreciation that the whole team has individual components and individual skills which they bring to the table.

The ‘team’ consists as much as the practice nurse, as much as the consultant, and as much as the podiatrist. At the end of the day, we are all employed by the NHS – although our core employing trust may be different, we are all actually in one team and we must learn to appreciate that, respect other’s skills, engage with each other as a fellow professional and, finally, appreciate the need to perhaps make that little change or adjustment needed in our thinking to deliver diabetes care in a cohesive way.

In the words of Steve Jobs: ‘We don’t get a chance to do that many things, and every one should be really excellent. Because this is our life. Life is brief, and then you die, you know? And we’ve all chosen to do this with our lives. So it better be damn good. It better be worth it.’ No fewer true words have been spoken if one puts that in the context of diabetes care. This country is blessed with individuals who are passionate about what they do. We need to somehow harness that, somehow get past the siloed thinking and develop the concept of a team, cutting across artificial boundaries of convenience such as primary or secondary care.

Once upon a time, locally the team consisted only of specialist nurses with whom I worked along with my consultant colleagues. With time, knowledge and listening, that team gradually consisted also of the podiatrists and community nurses based in our community providers. People have always asked about the efficacy of the model of care to which we work locally – and beyond all the outcome measures, which are obviously key, one fundamental thing has been developing and hopefully earning respect across all the traditional divides. Today, the ‘team’ for diabetes care is slowly developing to involve all the 80 GP surgeries across the region, the GPs concerned and the practice nurses therein. There is still much to do but the essence of mutual respect and appreciation of each other’s workload, skill mix and pressure is certainly there.

Respect, engage and change
One always hopes that each individual comes to health care with a dream: a dream to improve things, try to help others, perhaps make it a bit better. The world of diabetes now is a complicated one – with the complexities of constant change along with financial difficulties and siloed working. In between all that, it is a constant battle to keep the dream alive. However, try we must, above all keeping true to the belief and ideology of Mary MacKinnon. There has never been a more important time to pool our strengths and work as a team – and that can only come from the desire to respect, engage and change.

Our dreams don’t die when we falter: they die when we give up.

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