Keeping you up to date from the National Team

Common pathway implementation

More than 150 delegates touched down at Kingsholm, home of Gloucester Rugby Club, to share their experiences from the implementation of the new common pathway for diabetic eye screening.

The event, hosted by the NHS Diabetic Eye Screening Programme (NDESP) national team, was attended by representatives of 66 of England's 83 local programmes as well as regional QA team members and software suppliers.

During the morning, the software suppliers ran user group sessions to answer queries from local programmes relating to the pathway compliant software which is now up and running in all but two programmes – implementation in these programmes having been delayed due to a procurement exercise.

In the afternoon, Jo Harcombe, education, training and communications lead for the NHS Screening Programmes, facilitated a workshop for the local programme and QA staff. Delegates were divided into groups to share good practice, discuss what had gone well during the pathway implementation, what could have been gone better and what the future of diabetic eye screening should look like.

Feedback from the workshop will be collated, shared with colleagues and used to inform any future national projects.

NDESP national programme manager Lynne Lacey said: "The national implementation of the new common pathway has been a challenging and complex task and I would like to thank all national and local programme colleagues for their hard work and support over the past couple of years.

"It will take a little while for everyone to get used to the changes but the long-term benefits of the new pathway will be considerable."

"Everybody wants the best outcomes for people with eye disease. The new pathway will lead to better consistency and comparability between services, more reliable and accurate data and improved patient safety. The overall effect will be that we will drive up standards and improve outcomes for people with diabetes across the country."

National Diabetic Eye Screening Conference 2015

The second joint national diabetic eye screening conference will be held at the Royal Society of Medicine (RSM), London, on Friday 24 April.

The joint meeting between NDESP and the RSM's ophthalmology section will be of interest to all those involved in diabetic eye screening, including local programme managers and clinical leads, screeners, graders, GPs, diabetologists, paediatricians, ophthalmologists, public health professionals and commissioners.

The theme of the conference will be 'The Bigger Picture'. Topics will include inequalities in screening, the national diabetes audit and national screening updates. Speakers will include Dr Anne Mackie, Director of Programmes of the UK National Screening Committee.

For more details, to book your place or register your interest, visit *https://www.rsm.ac.uk/sections/sections-and-networks-*

New patient leaflets

NDESP has launched two new national patient leaflets and an information sheet for GPs and other primary care professionals.

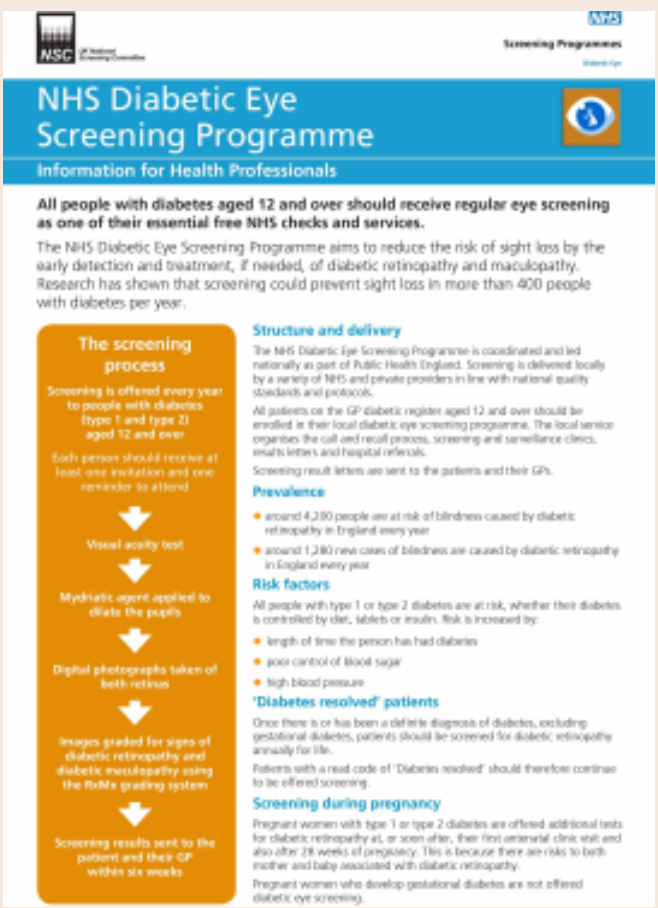
Local programmes can order supplies of the new leaflets free of charge in the same way as they already do for the national invitation leaflet.

The new patient leaflets are aimed at people who have positive screening results. ***They are:***

• Your guide to diabetic retinopathy – for R1 (background retinopathy) screening results

• Closer monitoring and treatment for diabetic retinopathy – for all screening results that result in referrals to a digital surveillance clinic or hospital eye service

The A4 information sheet is aimed at raising awareness of the screening programme among GPs and explaining the role of primary care in supporting and advising people with diabetes.



All the new resources were developed thanks to extensive input from public and professional stakeholder groups that included focus group meetings and online surveys.

The 2015/16 service specification for diabetic eye screening states that diabetic eye screening providers must use NDESP's national leaflets, so all local programmes must adopt the new leaflets by 1 April 2015. Any remaining stock of the former national leaflets, Diabetic retinopathy – the facts and Preparing for laser treatment for diabetic retinopathy and maculopathy should be recycled after that date.

Focus on Integrated Diabetes Care

Diabetes UK has recently published a policy document explaining what integrated diabetes care should look like, with examples of good practice from around England. There is much here that will be of interest to the retinal screening community, according to **Dr Susan Aldridge**, Editor of Diabetes Update, the charity's magazine for healthcare professionals. Here she presents a summary of Improving the Delivery of Adult Diabetes Care through Integration

Integrated care has been defined by the King's Fund and Nuffield Trust as 'an approach that seeks to improve the quality of care for individual patients, service users and carers by ensuring that services are well coordinated around their needs'. People with diabetes, and those with other long-term conditions, have much to gain from the integrated approach. The traditional diabetes service model does not really meet patients' needs, for it is too rigidly divided between primary and secondary care and is not really geared toward responding adequately to the ongoing, day-by-day challenges that diabetes brings. This is why there has been an increasing drive, in national policy, towards 'joining up' services and placing the patient – rather than the system – at the centre of care. Indeed, the NHS Mandate (2014-2015) specifically asks the NHS to 'improve the provision of care to ensure that it is coordinated around the needs, convenience and choice of patient, rather than the interests of organisations that provide care'.

There is both national and international evidence that the integrated approach does have the potential both for improving the quality of care and making cost savings,.

What does integrated diabetes care look like?

Patients with diabetes need to move easily between services according to their individual needs. This requires vertical integration of primary, community and specialist care, as well as integration of the processes, methods and tools needed. For those setting this up for the first time, or developing their integrated approach, it will be useful to have a 'model of care' to refer to. This is a concept that broadly describes how services are configured and, put simply, will set out who does what, where and how.

Diabetes UK helped develop the 'House of Care' framework, through its support for pilots of collaborative care planning. This is where people plan their care by agreeing with their healthcare professional what they want to achieve and how they are going to be supported to do it. The House of Care is a framework or metaphor for an integrated system with the patient at the centre. It needs stakeholders in local diabetes services to agree their model of integrated care and approach to delivery. This local model will be commissioned to deliver all the elements of the diabetes care pathway (including retinal screening, of course). Provision of these involves a multidisciplinary team working between generalists and specialists. Integrated diabetes care should also now refer to the recently published service specification, which outlines that provision of high-quality care for people with diabetes.

The key enablers of diabetes integrated care are:

- Integrated IT.
- Aligned finances and responsibility.
- Care planning.
- Clinical engagement and leadership.
- Robust clinical governance.
- The House of Care describes how these elements should be implemented within the integrated patient-centred approach to diabetes care.

How to get started with integrated diabetes care?

The above five key enablers of integrated care need to be introduced, if not already present, to facilitate the development of integrated care in a locality.

Integrated care

Optimal information sharing means clinicians having access to a patient's records regardless of clinical setting (ie, across primary, community and specialist care). Ideally, then all providers across the care pathway should use the same information system. This will mean that 'at risk' patients (those who are overdue their retinal screen, for instance) are automatically identified. Using data in this way facilitates treatment or checks to be carried out promptly and in the right setting, reducing the risk of an emergency admission.

Aligned finances and responsibility

A financially efficient integrated pathway means assigning responsibility for 'who does what', with all healthcare professionals involved delivering care to national standards. Diabetes UK has found unacceptable variation in quality of care and lack of consistency in delivery. Addressing these issues has been a focus of redesigns where integrated care has been introduced.

Redesigning the finance system that underpins delivery may be challenging but can be done. In the traditional model of care, provision of funding merely exacerbates the rigid divide between primary and specialist care. For instance, the tariff system to pay for specialist care may incentivise one part of the system to 'hang on' to patients who might more appropriately be treated elsewhere. However finances are redesigned, providers should accept the need to focus on the needs of the whole health economy, rather than those of their own part of it.

Care planning

Care planning is a continuous process, where patients and clinicians work together to agree on goals, identify support need, develop and implement action plans and monitor progress. Care planning is at the heart of the House of Care framework and should replace traditional routine care. The development of effective care planning requires the presence of all the other components of integrated care.

The benefits of care planning have been effectively demonstrated in Tower Hamlets, where a House of Care pilot has taken place. In 2005, the indices for diabetes care here were among the worst 10% of primary care trusts. By March 2012, after running the pilot, Tower Hamlets had the best indices in England. Moreover, patient satisfaction with their care improved dramatically. Positive answers to the question 'I have had about the right amount of involvement in my care' rose from 52% in 2006 to 82% in 2009.

It should be noted that care planning is not the same as developing a care plan. The care plan, for a newly diagnosed patient, stops short of the ongoing collaborative partnership between them and the healthcare professional that is the hallmark of true care planning.

The person with diabetes must be actively engaged in the process and given time to think through their own priorities. In Wolverhampton, for instance, they do this by sending the patient a questionnaire before their annual review, providing an opportunity to do just this. The answers then form the basis for discussion and action planning at the appointment.

Clinical engagement and leadership

All relevant stakeholders need to be engaged in discussion early on when integrated diabetes care is being developed. The setting up of the North West London Integrated Care Plan (ICP) illustrates both the challenges and central importance of this. The initial development meeting was attended by the Chief Executive of Imperial Hospitals NHS Trust, diabetologists, diabetes lead, commissioners, representatives of Central London Community Healthcare Trust, GP leads, psychiatrists, Diabetes UK and Age UK. Senior figures gave the ICP their backing in terms of financial and managerial support, which enabled other stakeholders to focus on getting the plan up and running. However, it did prove difficult at first to get clinicians from all providers fully involved and supportive of the pilot ICP. There were concerns about the challenges the integrated approach posed to their position and current way of working. These concerns were gradually alleviated through the appointment of an external chair to lead the pilot, bringing people together so they could get to know one another and start to unite behind the common goal of improving care for their people with diabetes. Finally it is, of course, vital to involve people with diabetes. Initially, in North West London, patients were represented by Diabetes UK. Later, it was decided they should be directly involved in order to help determine priorities. They were therefore included in all the groups and an additional patient and user committee was established to discuss the progress of the pilot as a whole.

Initiating change – who to involve

Local diabetes network, to include:

- People with diabetes and groups representing them
- Healthcare professionals from the full range of relevant specialties from primary, specialist and community care
- Clinical commissioning group clinical lead
- Area team representative

Additionally

- Senior manager, including hospital Chief Executive
- Trust finance managers
- Trust IT lead
- Medicines management
- Existing network (eg strategic clinical network) representatives

Clinical governance

Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. Clear and effective clinical governance helps align the aims of clinicians, commissioners and people with diabetes.

In Derby, establishing a structure of clinical governance for its integrated care initiative was central. The Derby integrated care model has a single clinical governance structure. The service is led jointly by a GP and consultant, supported by management staff. The multidisciplinary team from primary and secondary care meet monthly to review safety, refine pathway and ensure quality of service delivery. The group is accountable to the board of the joint venture organisations (JVOs) which are not-for-profit organisations, with 50% of shares held by the acute trust and 50% by primary care by a group of GPs. The JVOs hold clinical leads to account for finances and delivery of the service. Patient participation groups meet in alternate month to contribute to service development.

Local integrated care initiatives

Wolverhampton

Wolverhampton has been delivering an integrated model of diabetes care for many years now. Specialist care is delivered in partnership with primary care to meet the clinical needs of the patient. The model of care is based on self-care through education, patient centredness and empowerment.

In Wolverhampton, all service providers across primary, community and specialist care have agreed to work within a model of care which emphasises an increasing proportion of service delivery in primary care. Specialist care is delivered in partnership with primary care, in the community or hospital as appropriate.

Derby

Derby introduced a new model of delivering diabetes care in 2009 – commissioned by the then Primary Care Trust. The basis of the new model was the creation of a new NHS organisation – a not-for-profit joint venture with shares held by the hospital and a group of GP practices. This allowed clinicians to work together to introduce the enablers of integration that mean clinical pathways can be developed around the user, and care seamlessly escalated to and from the specialist team as needed.

Leicester, Leicestershire and Rutland

Funding was provided by the CCGs in 2012/13 to transform the delivery of diabetes care across Leicester, Leicestershire and Rutland CCG areas. Who has responsibility for the provision of care across the service has been clearly defined. Core services are provided by all GP practices and an enhanced payment and ongoing training made available to support the delivery of more complex care in primary care. This is supported by the introduction of specialist community based team, which include consultant sessions, as well as improved access to patient and professional education.

Portsmouth

In 2010, the diabetes clinical lead at Portsmouth Hospital, a GP with special interest in diabetes, and commissioning managers developed a proposal for change. The model of care defines who does what within the system and is widely known as the 'super six'. The 'super six' are the areas of diabetes care that it was agreed must be managed by consultant specialists. The model of care is based on an increased role for primary care in the delivery of diabetes care. This is supported by the introduction of specialist community based teams, with consultant input, and improved access to professional education and support.

North West London

In 2011, NHS London provided £5.7m for a pilot project to improve the delivery of diabetes care and care for older people in North West London. The Integrated Care Pilot did not introduce any new services, but focused on better coordinating good practice to enable clinicians to work efficiently across provider boundaries. Investment was made in IT, leadership of the pilot, coordination of multidisciplinary groups and project management.

Take-home message

Delivering joined up, coordinated care for people with long-term conditions is the national policy challenge posed to all commissioner and providers. To deliver this for diabetes, commissioners and providers must take responsibility for reconfiguring services to deliver a whole system model of care, which provides excellent ongoing management and rapid access to specialist services when required. The clinical pathway must include all the components of good diabetes care and be configured according to local need. To operate effectively, it should be underpinned by the structural integration enablers of shared information systems; aligned finances and responsibility; care planning; clinical engagement and leadership and robust clinical governance.

The focus in any drive for change must be for providers and commissioners to align the system and themselves behind the goal of delivering better care for people with diabetes.

[i] To download Improving the Delivery of Adult Diabetes Care through Integration go to:
http://www.diabetes.org.uk/Professionals/Service-improvement/Integrated-diabetes-care/