DELIVERING INTEGRATED DIABETES CARE

Integrated care has much to offer people with diabetes. However, its delivery can be a challenge for healthcare professionals. **Heather Bird**, Senior Policy Officer at Diabetes UK, introduces a new document on integrated care from the charity, while National Director of the Year of Care Partnerships **Lindsay Oliver** explains her organisation's approach

Improving the Delivery of Diabetes Care through Integration explains what integrated care should look like and describes what various locations are doing to overcome barriers to make the system work better for people with diabetes. In England, the *Five Year Forward View* sees an 'increasing need to dissolve' barriers between different parts of the system[1]. This report shows practically how this can be done.

The document looks at five areas where significant progress has been made in improving the delivery of diabetes care through integration. These are Wolverhampton, Derby, North West London, Leicester and Portsmouth. Furthermore, five key integration enablers have been identified by the diabetes community as needing to be in place to facilitate the delivery of integrated care. Diabetes UK's new report explains the importance of each and looks at what the individual areas have done to implement these.

The five integration enablers

Integrated IT. Information sharing should be underpinned by an information system that provides

clinicians across primary, community and specialist care with a patient's clinical record regardless of setting. In Derby, GP practices and the hospital use SystmOne, allowing clinicians to see the patient's records regardless of whether the previous appointment was in primary or specialist care. This approach optimises care and makes the referral process more efficient.

Aligned Finances and Responsibility. Overcoming the rigid divide – both in terms of finance and responsibility – between primary and specialist care is central to facilitating integrated care. In Portsmouth, specialists have focused on super-specialist care and refer all other care back to primary and community services. This is possible because the diabetologists provide readily available support and regular training to GPs. Attendance at training and interaction with the diabetes specialist team is incentivised locally.

Care Planning. Care planning is a continuous process, in which clinicians and patients work together to agree goals, identify support needs, develop and implement action plans and monitor progress[2]. In Wolverhampton, the process is initiated through a questionnaire sent to patients prior to their annual review appointment, which includes a list of questions for them to consider and identify their priorities. This is discussed, and an action plan designed in collaboration with the clinician to inform their ongoing care.

> "Local commissioners and providers must work together…"

Clinical Engagement and Leadership. To maximise the chances of a model of diabetes care meeting the needs of people with diabetes and healthcare professionals, all the relevant people should be engaged in discussion at an early point. This has been a challenge in all areas, but perseverance paid off in North West London. The number of clinicians attending the meetings grew as people got to know one another and united behind the aim of the pilot.

Clinical Governance. Implementing a clear and effective clinical governance structure helps to align the ambitions of clinicians with those of commissioners and, most importantly, with people with diabetes. The Derby model has a single clinical governance structure. The service is jointly led by a GP and consultant, and supported by management staff seconded from secondary care.

How does this fit with national policy?

We know that the traditional model of NHS care, with a rigid divide between generalists and specialists, does not easily lend itself to the integration of the systems and processes involved. In all the areas we looked at, the initiation and drive for improvement required significant personal investment. This was often to implement change that flowed against, not with, the national policy direction for the NHS, for example on rigid competition and tendering regulations.

> "Care planning is a continuous process…"

However, we are hopeful that the publication of the *Five Year Forward View* signals a real change of direction. NHS England is calling for an end to the fragmentation of the system and the implementation of models – much like those described in our report – which overcome barriers and prevent people with long-term conditions getting lost in the system. Diabetes UK hopes that this central appetite for change will be the driver needed to make the delivery of integrated care happen at scale.

What needs to happen?

Local commissioners and providers must work together and learn from areas, such as those included in the report, to reconfigure services in their own area to deliver a whole system model of care, which provides both excellent ongoing management and rapid access to specialists when required. Commissioners and providers must align themselves and the system behind the goal of delivering better care for people with diabetes.

Further information and support

The full report, along with additional information and resources, is available on the Diabetes UK website at **www.diabetes.org.uk/integrated-diabetes-care**. This is part of a new set of resources from the charity, along with a consultancy service that can help local health economies with service improvement and redesign. There are more details of this at www.diabetes.org.uk/service-redesign-improvement-consultancy

Please get in touch

Diabetes UK wants to continue developing, and we know that there are other examples across the UK of areas improving the way they deliver diabetes care as a whole. We hope that sharing examples of what is being done can help areas meet the challenge of getting people with diabetes the right care, in the right place at the right time. So please do get in touch, via our website, and tell us about them at www.diabetes.org.uk/integrated-diabetes-care

References

1 NHS England (2013).

2 The King's Fund (2013). *Delivering Better Services for People with Long-term Conditions: Building the House of Care*

PHOTOS: THINKSTOCK

THE YEAR OF CARE PROGRAMME

Figure 1

The Year of Care programme was initially set up to look at how care for people with diabetes could be more person-centred. It offers individuals with diabetes both much more meaningful involvement in routine consultations, through a process of care planning and then support for self-management. It taps into both existing traditional services (specialist care and structured education) as well as community-based support (such as volunteering, walking groups and peer support).

The programme was based on the key components of the Wagner Chronic Care model and was initially piloted in three areas (Tower Hamlets, North of Tyne and Kirklees). The successful pilot demonstrated that care planning could be implemented in both routine general practice and in specialist care, but that a number of factors were important in determining the success of the programme. These are highlighted in the Year of Care House (Figure 1).

> "Care planning has made me look at patients differently. I focus less on the disease and take a more holistic perspective"
>
> **Practice Nurse**

Care planning

Care planning recognises that both the healthcare professional and the person with a long-term condition bring different expertise and experience to a consultation. Although healthcare professionals have knowledge and expertise about the clinical care of a particular condition, it's really only the person with the condition who knows how it impacts on their life. In many cases, care planning replaces the annual surveillance reviews, which are sometimes just a 'tick-box activity', with a collaborative consultation between the individual with the long-term condition and the healthcare professional. There is a real opportunity for people to share information with their healthcare team and openly discuss their issues and concerns, as well as get help with accessing the services and support that they require to self-manage their condition. The key care processes that enable this change are:

- An initial appointment with a trained healthcare assistant to complete the disease surveillance and to promote the opportunity offered by the care planning appointment.
- An opportunity for preparation – sending out test results with a short explanation and agenda setting prompts in accessible language ahead of the annual care planning review.
- A patient-centred consultation delivered by the healthcare professional who is committed to partnership working, which explores and discusses agendas and helps individuals develop their own goals and actions.
- Mechanisms to develop support services in the community, which are based on the real needs of people with diabetes as identified during the care planning review.

This has been achieved by putting in place a systematic process of patient preparation. There is also training for

healthcare professionals in collaborative care planning and commissioning, linked to the services that individuals identify via care planning. These include traditional health and social services and community-based non-traditional services that support both self-management and psychological wellbeing. The core concept is to develop services that work together around the needs of the patient and acknowledge the individual's central role in managing their own health (Figure 2).

The Year of Care – care planning and the House

The Year of Care Programme found that effective care planning consultations rely on four elements working together in the local healthcare system: an engaged, empowered patient working with healthcare professionals committed to a partnership approach, supported by appropriate/robust organisational systems and underpinned by responsive whole system commissioning. These are brought together in the Year of Care House, which illustrates the importance and interdependence of each element – if one is weak, or missing, the quality of the programme and the impact it might have is lessened.

Key achievements

The programme has demonstrated that care planning can become the norm, with 76 per cent of people with Type 2 diabetes on practice registers having had at least one care planning consultation. In particular, in the disadvantaged community of Tower Hamlets, a number of improvements have been seen in a relatively short period of time:

- Patient reported involvement in care has risen from 52 per cent to 82 per cent.
- Blood pressure, cholesterol and HbA1c Dashboard records indicate both significant and ongoing improvements, eg, blood pressure of less than 145/85mm Hg has risen from 70 to 90 per cent, cholesterol of less than 5mmol/l from 65 to 83 per cent, HbA1c of less than 7.5 per cent has risen from 37 to 55 per cent – with year-on-year improvement.
- In the March 2013 National Diabetes Audit (NDA) 72.4 per cent of people registered with Type 2 diabetes (excluding only those diagnosed in the last six months) had had all nine NDA items measured in the previous 15 months. Attendance at retinal screening rose from 65 to 82 per cent.

> "Each time I get a greater understanding of my condition and understand more about how I can go about maintaining and improving it"
>
> **Person with diabetes**

In addition both people with diabetes and healthcare practitioners have reported an improved experience of care.

Beyond the pilot programme

Year of Care Partnerships now works with other organisations to support the implementation of care planning and the House of Care (www.yearofcare.co.uk). In varied settings, the principles of care and support planning can be applied to all long-term conditions, so long as all the critical success factors highlighted in the House are applied. In particular, the increasing rise in multi-morbidity raises the question of coordinated care planning reviews, which focus on the individual as a whole and move away from separate disease reviews. National Voices have described the generic elements of Care and Support planning in their online guide (go to: www.nationalvoices.org.uk/what-care-and-support-planning).

The Year of Care House is now often referred to as the House of Care and is used as a framework to deliver person-centred care by NHS England in their Long-term Conditions guidance and policy documents.

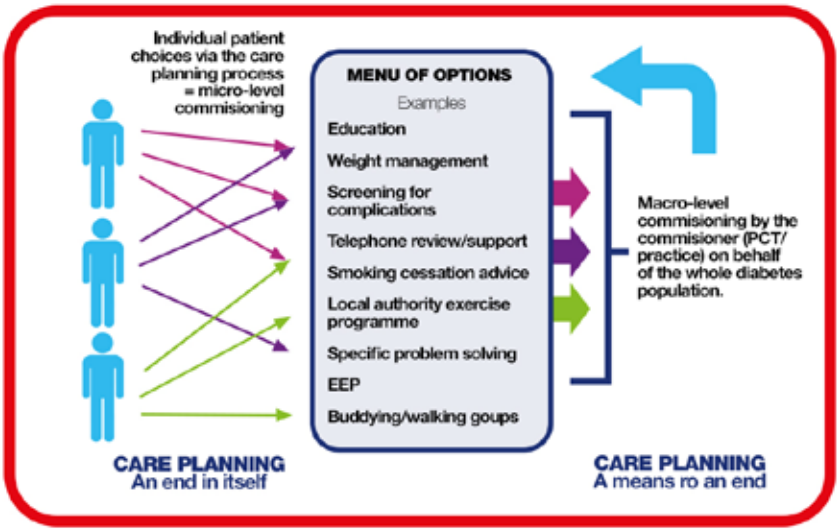

Figure 2

PHOTOS: THINKSTOCK GRAPHICS: YEAR OF CARE PARTNERSHIPS