

Time for action



Integrated diabetes care is beginning to deliver in many locations. Do we now have a critical mass for national roll-out? It is time for healthcare professionals to act, say guest editors **Dr Rustam Rea** (right) and **Dr Garry Tan**, of the Oxford Centre for Diabetes, Endocrinology & Metabolism

Integrated care continues to make the headlines. Much has been written and said about it, with the danger that it ends up meaning all things to all people. However, for us 'integrated care' (or perhaps 'systems thinking') is an approach which involves breaking down barriers – those between family doctors and hospitals, between physical and mental health, between health and social care. Taking a 'whole systems' approach to the care of a local population can reap rich rewards in breaking down these seemingly intractable health and social care barriers. The term integrated care itself is a shorthand for these concepts, and will itself evolve; it will evolve into the (re-)organisation of the delivery of care for multiple health conditions, not just diabetes. Much of the work described in this edition of *Diabetes Update* is naturally rooted in diabetes, given the richness of data available, and because of the history of working across organisational boundaries.

However there continue to be both real and perceived obstacles to making whole systems change happen in practice. Some of these obstacles stem from an uncertainty, not just as to what integration is, but also what difference it can make to patients and clinicians.

What additional benefit will integrated care bring to my patients?

Many areas in the country will already have existing clinical networks, longstanding relationships between primary, community and secondary care and criteria for referring patients between different parts of the local health service. Providers, commissioners and service users alike will want to know what advantages there will be in return for the time and effort needed to implement a new integrated system of care.

One of the keys to integration is the **alignment of financial resources** with the responsibility for diabetes outcomes. This change can enable local diabetes communities to rapidly develop their own solutions to the needs of the local population. Some of these solutions might include addressing the variation in healthcare outcomes between different areas, introducing education programmes for specific groups of patients or perhaps increasing the level of dietetic support or of psychological services. All of these issues are very difficult to address effectively within

the traditional divisions that still exist between primary, secondary and community care in many places.

Many people find the process of navigating their diabetes care difficult and confusing. This can lead to non-attendance at clinics both in primary and secondary care and isolation from traditional diabetes care (eg, people living in care homes).

The integration of providers in a **single clinical governance structure**, which is given responsibility for the whole diabetes population, makes sure that these patients are thought about and provided with appropriate clinical care. Filling the gaps in the local diabetes service and removing duplication is of significant benefit to patients.

BIOGRAPHY

DR RUSTAM REA

Dr Rustam Rea is a Consultant in Diabetes at Oxford University Hospitals NHS Trust.

Together with Dr Garry Tan, and other clinicians in primary and secondary care, he developed a new model of integrated diabetes care in Derby. He was the Co-Chair of First Diabetes, an award-winning partnership organisation responsible for diabetes care in Derby. He is currently working with colleagues to develop integrated diabetes care across Oxfordshire. Dr Rea is one of the authors of the recently published guidance, *Best Practice for Commissioning Diabetes Services: An Integrated Care Framework*.

What is the benefit of integrated care to clinicians?

From a primary care perspective, integration means joint working and moving away from the traditional barriers between primary and secondary care. This involves removing the cumbersome referral process as it exists currently, and rejecting the idea that a referral is a 'bad' thing in a Payment by Results/cash for referral system. There is no doubt that it should provide better care, more quickly and more locally, improving access for patients. In order to achieve this, some form of **integrated IT system** must be put in place. In Derby, this involved installing SystmOne into the clinics and offices of the diabetes team in the hospital. As a result, all clinicians working in the integrated service had access to the contemporaneous clinical records of the patients and were able to enter the discussions and decisions made with the patients at the time of the consultation. No more asking, 'What medication are you taking?' or 'What did you discuss at the consultation in the hospital?', but, rather, each consultation was built on the previous one, no matter who saw the patient.

The turnaround time for referrals and advice changed dramatically. Instead of exchanging letters, with their inherent delay and often lack of crucial information, clinicians were able to 'task' each other and receive more comprehensive advice within hours.

This more effective interaction between GPs, practice nurses, community teams, hospital nurses and consultants starts to build a **'diabetes community'** of clinicians. Discussing patients

both face-to-face and via a common IT system leads to a shared knowledge of diabetes – its complications and treatment, and a sharing of the patient’s journey. Such ‘upskilling’ of clinicians can happen in many contexts, but when integration is working well, this sharing of knowledge and experience becomes the norm. This, in turn, can lead to local education programmes and diabetes updates being developed and delivered by all those involved in the integrated service.

What are the pitfalls to integration?

What happens when integration is not working well? There are lots of conflicting priorities and calls on clinicians’ time and energies. Inevitably, not everyone will be enthusiastic and engaged all the time. One of the key lessons from implementing integrated services is the need for **continuous clinical engagement**. This can take various forms, including regular updates of new and existing services, how to make referrals, which parts of the service are showing sustained improvement in patient outcomes and, most importantly, how to change parts of the service that are not working as well as originally intended.

Although some clinical engagement can be done electronically, in our experience face-to-face conversations, both formal and informal, are crucial to the success of any integration. These can allay concerns about ‘top down’ imposition of new structures or seemingly neglecting the good work that is already being done in many clinical services. The new style of leadership needed for this type of collaborative work has been discussed in a recent King’s Fund paper that highlights the importance of developing collective leadership.

Now what?

The diversity of the way care is currently organised throughout the country means that there is unlikely to be a ‘one-size-fits-all’ solution as to how organisations should break down

BIOGRAPHY

DR GARRY TAN

Dr Garry Tan has been a consultant physician in the Oxford Centre for Diabetes, Endocrinology & Metabolism (OCDEM) since 2011. He moved to OCDEM from a consultant post in Derby, where he was involved with the establishment of various integrated care organisations to deliver diabetes care. He strongly believes that the quality of care for people with diabetes can – and should – be improved by anyone working with people who have diabetes.

barriers and coordinate care. The issue will be to ensure that the key components are included in any such redesign (integrated information technology, clinical governance for the whole pathway, aligned financial and clinical incentives, patient empowerment and engagement and clear clinical leadership).

On page 24 of this issue of *Update*, Heather Bird describes the new Diabetes UK publication on integrated diabetes care. She highlights the five enablers that allow integration to flourish, building on the previous document from NHS Diabetes, Diabetes UK, the Association of British Clinical Diabetologists, The Primary Care Diabetes Society and many other organisations back in 2013. Each of these five enablers has been integral in providing a better service both for patients and clinicians as outlined above.

Any service contemplating integration of care will do well to examine each in turn and plan how to develop them further. Lindsay Oliver’s summary of the Year of Care Programme, on page 26, looks at integration both around the individual patient (Care Planning) as well as a more systems-wide approach (House of Care). Both are essential if patients are to be engaged in their care and new services are to be sustainable.

Finally, the comparison of integration in Sri Lanka and Sweden by Eleanor Kennedy, on page 16, reminds us that, even in highly developed social care societies, local clinicians need to take responsibility for the provision of integrated care for their local population.

Integration will never succeed with a top-down approach. Only by building local ‘diabetes communities’, responsible for the quality of care delivered to the local population, will talking about integration be translated into action. This is the challenge for all of us – turning the words into reality.

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