

The National Clinical Programme for Diabetes: Are we on track?

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On behalf of the ESPIRIT Research Team
Evidence to Support Prevention, Implementation,
and Translation

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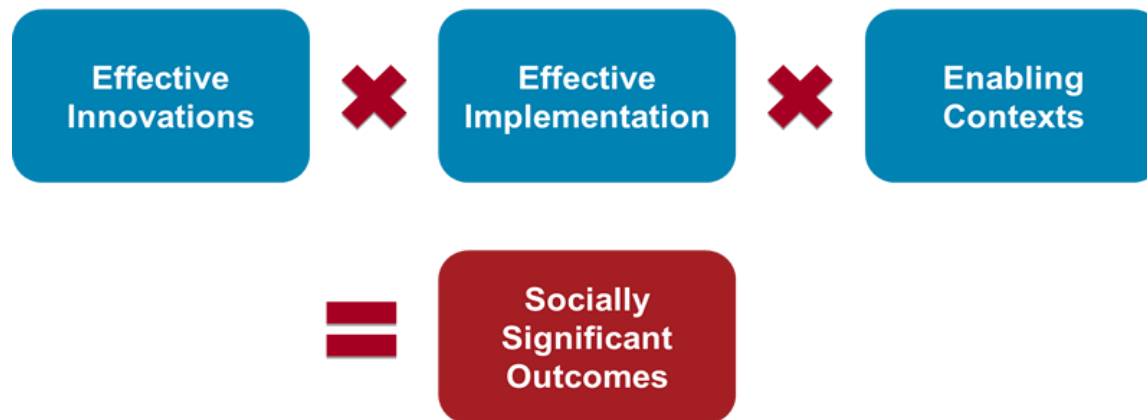
Aim

- To evaluate **the implementation** of the National Clinical Programme for Diabetes (NCPD)

What parts of the programme are working,
For whom,
In what circumstances,
And why?

Implementation

Formula For Success



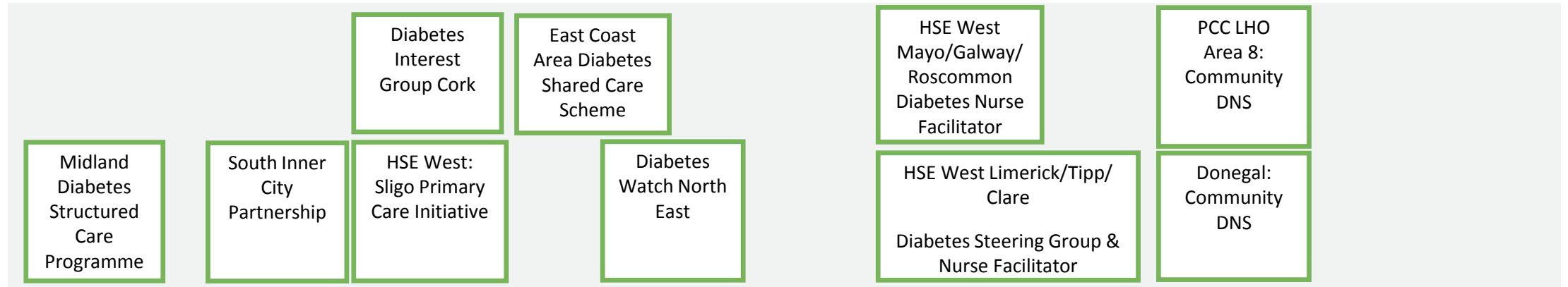
- “Tiny proportion of empirical studies acknowledged, let alone explicitly set out to study, the complexities of spreading and sustaining innovation in health service organizations.”
(Greenhalgh et al.2004; p 614)

Implementation outcomes

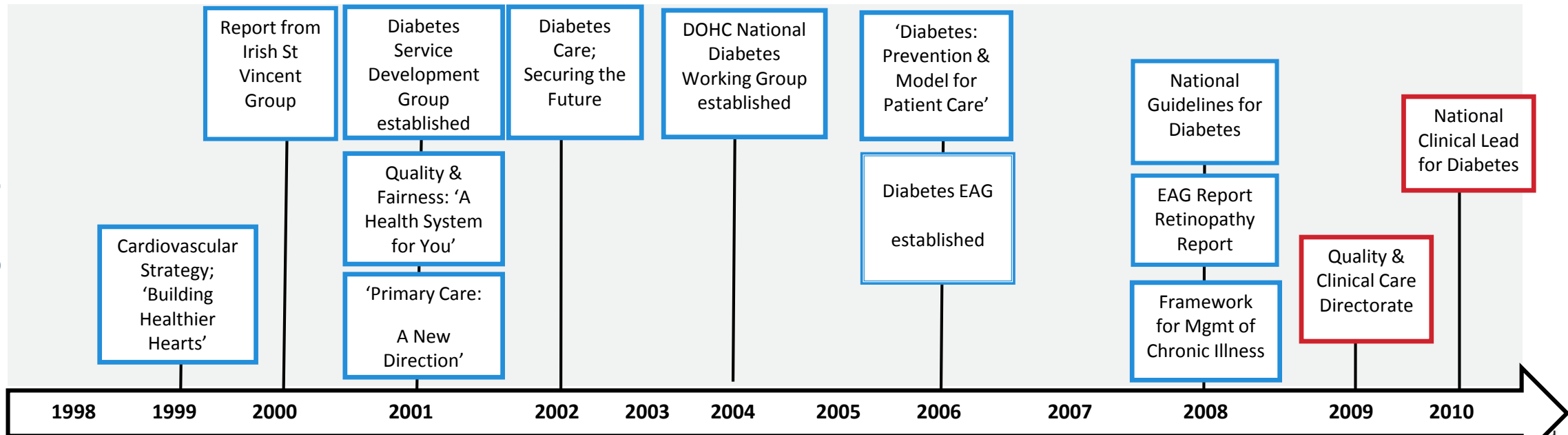
| Outcome | Definition |
|---|---|
| Acceptability (Credibility, relative advantage) | The perception among stakeholders that an intervention is agreeable |
| Adoption (uptake, utilisation) | The intention, initiation decision, or action to employ a new intervention |
| Appropriateness (Perceived compatibility, usefulness) | Perceived fit or relevance of the intervention in a particular setting |
| Feasibility (Utility, practicality, fit) | Extent to which an intervention can be carried out in a particular setting |
| Fidelity (delivered as intended) | Degree to which an intervention is being implemented as it was designed in a plan or policy |

Overview of Policy and Practice Developments 1998-2010

Local Level Initiatives



National Policy & Strategy groups



National Clinical Programme for Diabetes

- Set up **to improve and standardise patient care** by bringing together clinical disciplines to deliver greater benefits to patients and all users.
- The National Clinical Programmes will contribute to the **design and implementation** of a standardised and integrated patient journey.

(HSE, 2011. National Clinical Programmes: Mission and Objectives)

Multidimensional interventions

National Clinical Programme for Diabetes

Working
Group

Clinical
Leadership

DSIGs

Retinopathy
Screening

Podiatry

Integrated
Care

Mixed Methods

Complete

Programme-level stakeholder interviews

- Qualitative interviews
- Current & former members of Working Group
- 19 participants
- July 2014-Jan 2015

Ongoing

Documentary Analysis

- Press releases
- Meeting minutes
- Media coverage
- Policy documents
- Protocols & guidelines
- 2011-present

Ongoing

Activity data

- National Diabetes Nurse Specialist Survey (54% response rate)
- 2 Practice audits of registration & uptake of retinopathy screening & interviews with patients
- Activity data submitted to NCPD

Starting

Case Studies

- 4 cases=DSIG
- 1 per HSE region
- Semi-structured interviews
- Endocrinologists, GPs, Practice Nurses, Podiatrists, DNS/ICN, Ophthalmologists, patients.

Results

Context & Main Driver



- Variation
 - Resourcing, organisation, delivery, standard

'There was a recognition that diabetes care wasn't as well organised in Ireland as perhaps in other jurisdictions and there was a suspicion what very little data was available to prove or disprove this, that outcomes, good outcomes, weren't being achieved either. (#12)

Retinopathy

Retinopathy Screening Programme



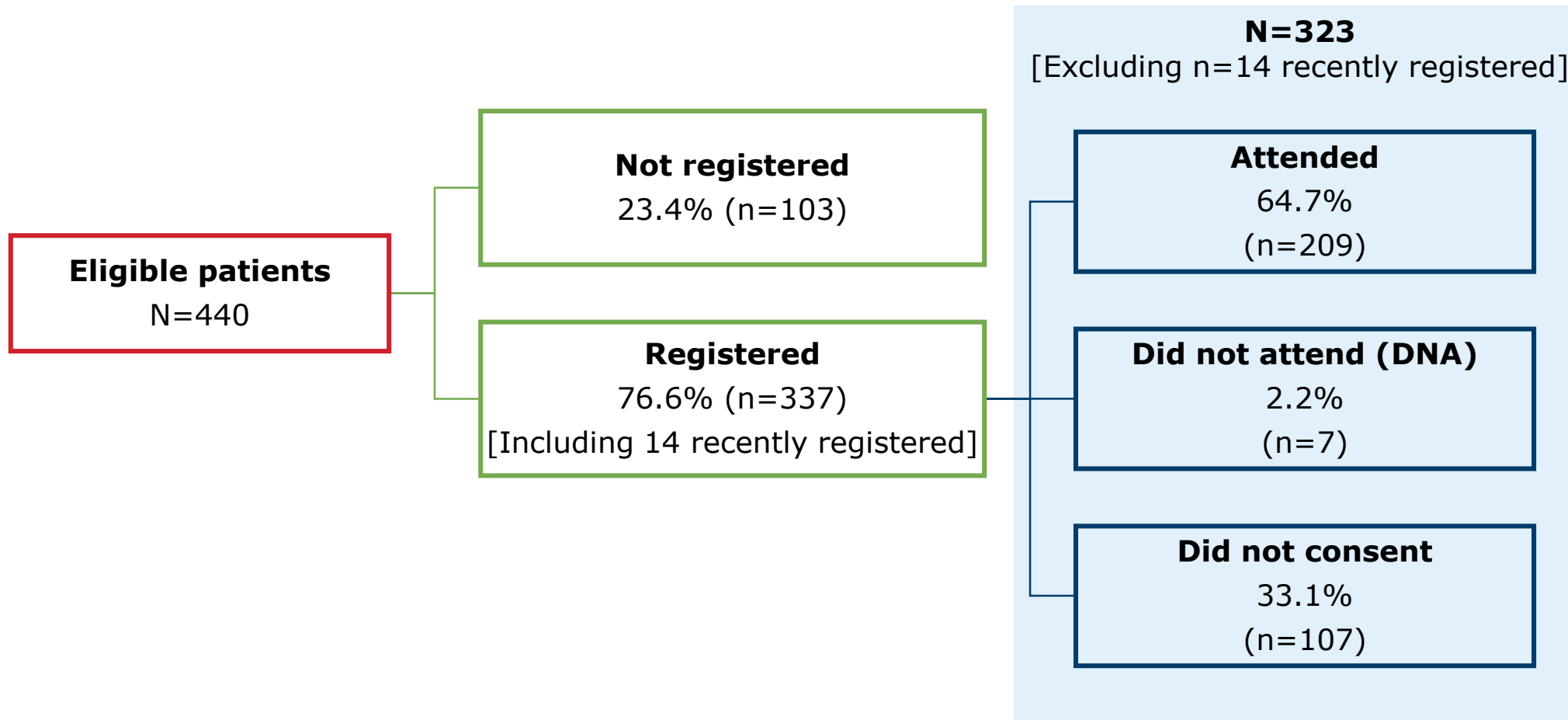
Outcomes

- ✓ Screening programme that is '*national, standardised, and non-discriminatory in terms of geography*' (#11)
- ✓ Patients being registered and screened
- ✓ HCP '*know exactly where you stand*' in terms of patients retinal status (#18)
- ✓ Saves endocrinologist time during review visit (#11)
- ⊖ Concerns about uptake
- ⊖ '*Trajectory of uptake is not as good as we had hoped for*' (#12)

Uptake: Large primary care centre (n= 10 GPs)

Patient Profile

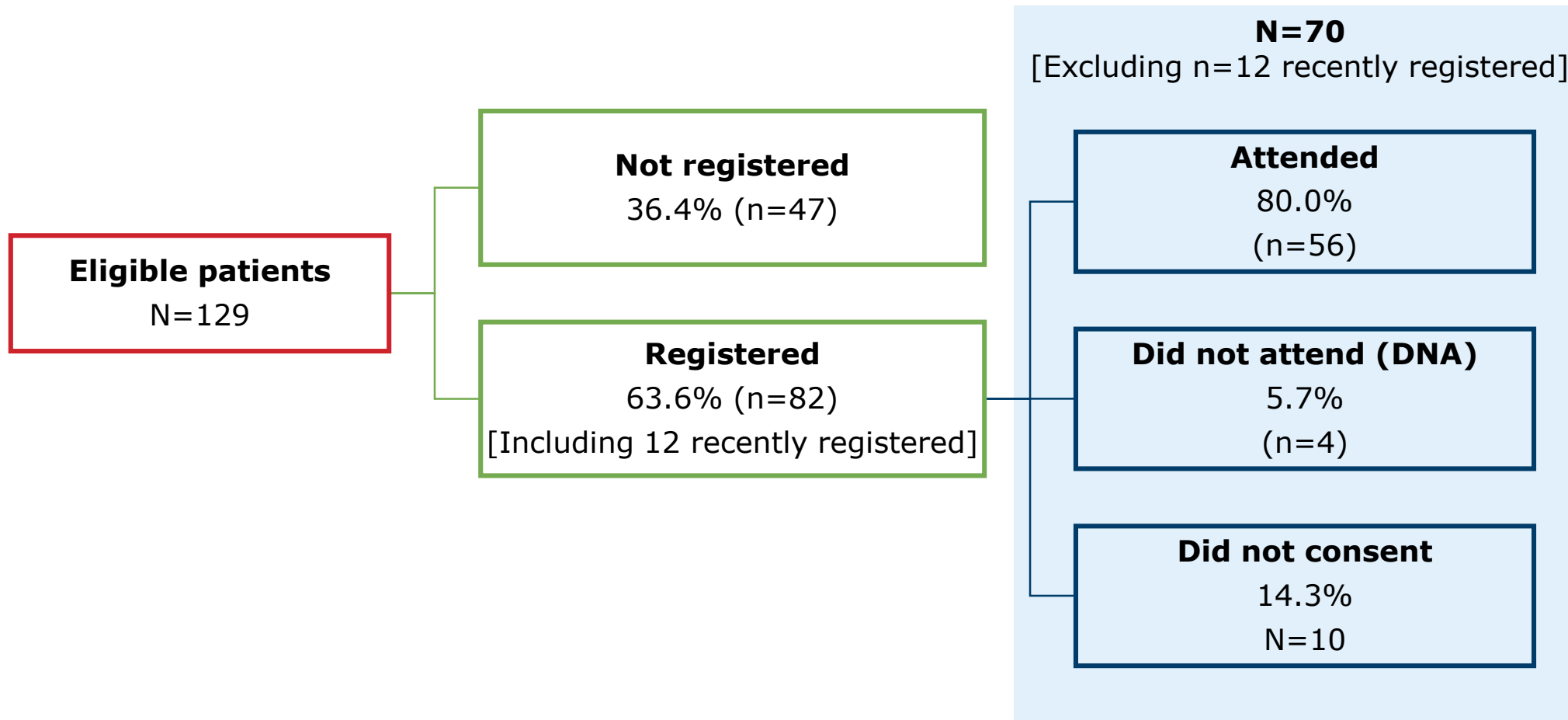
- 63.4 years (sd=14.2)
- 62% male
- 92% T2DM



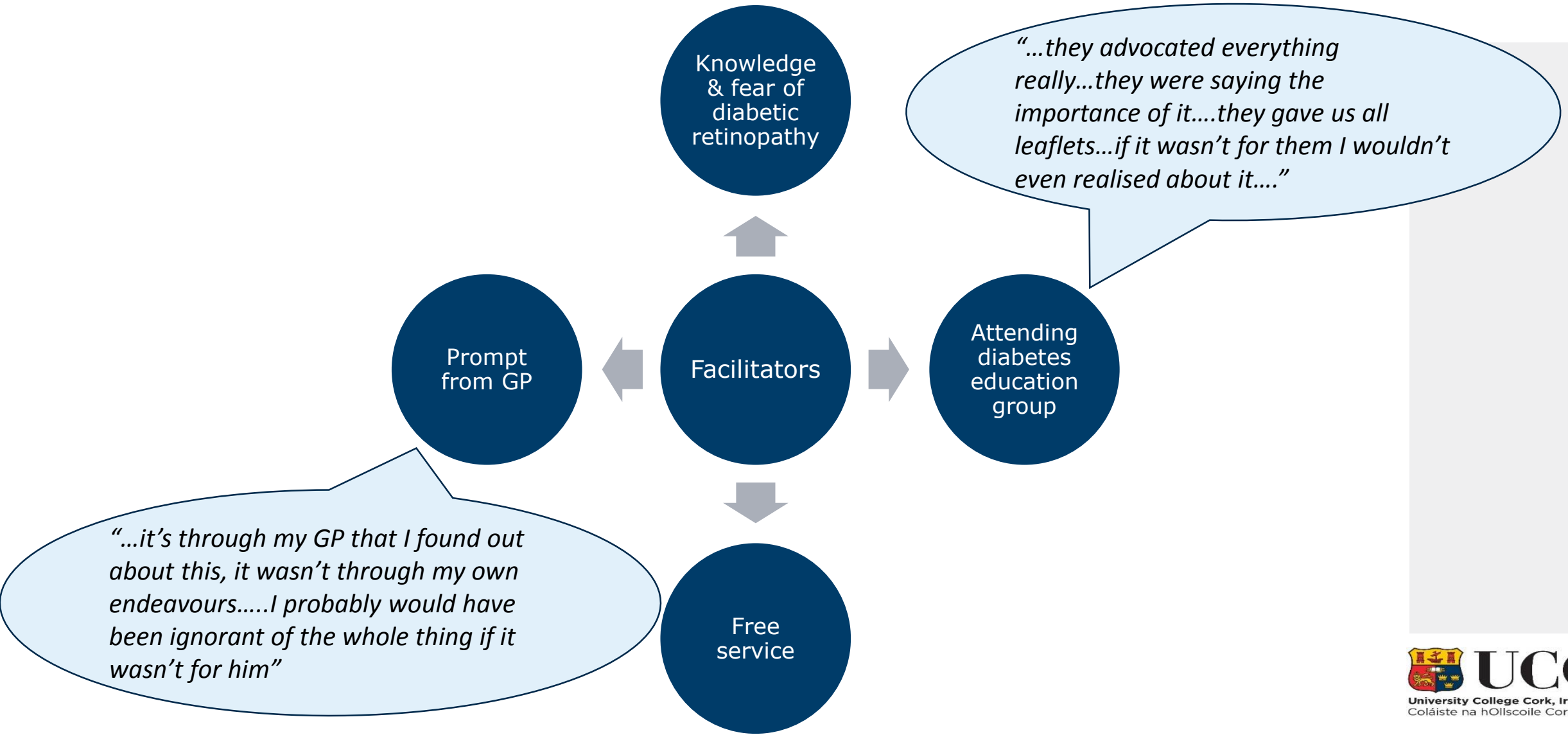
Uptake: Small rural practice (n= 2 GPs)

Patient Profile

- 66.5 years (sd=14.3)
- 60% male
- 96% T2DM

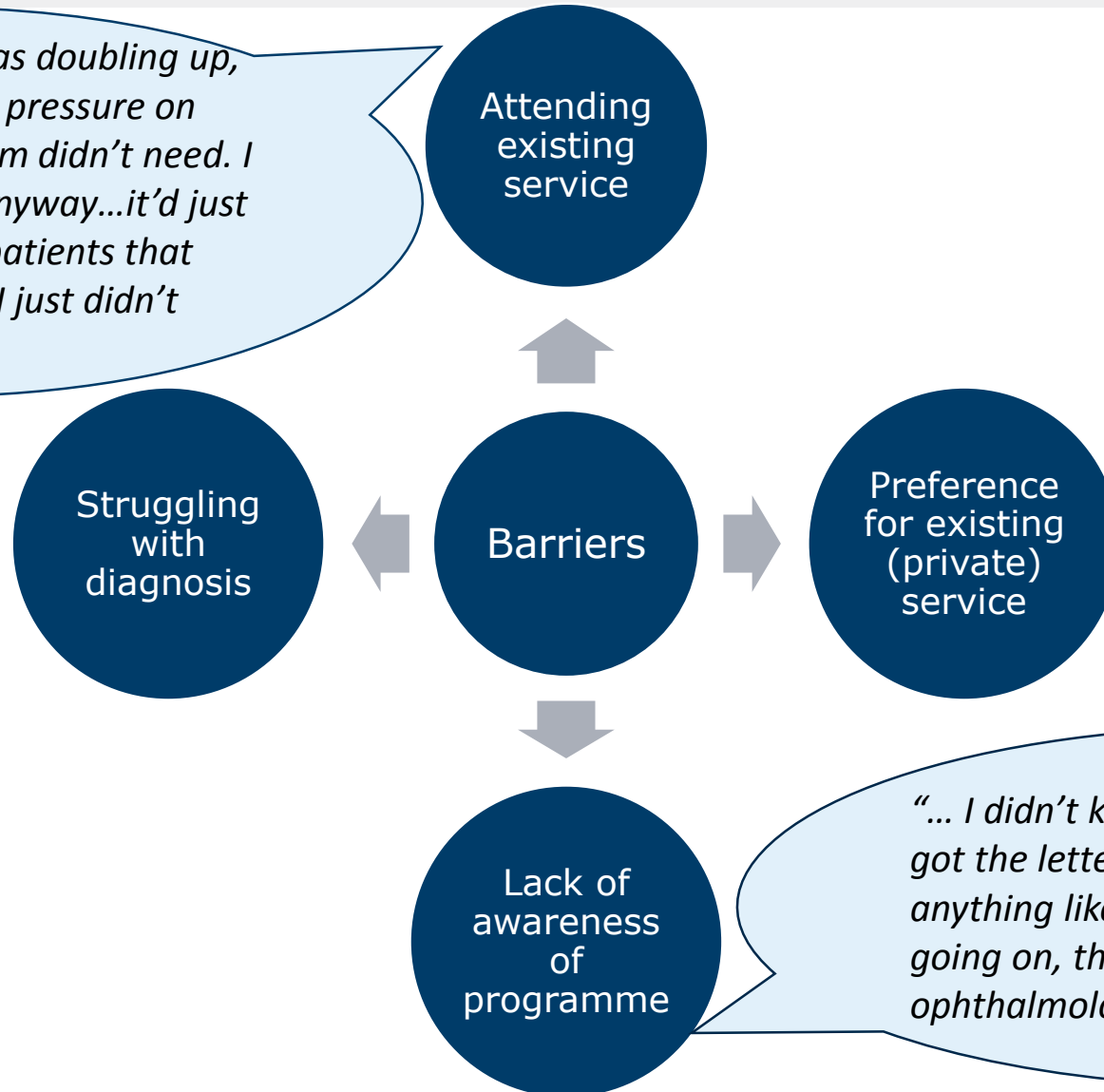


Facilitators of uptake



Barriers to uptake- patient perspective

"...suppose I just felt it was doubling up, and maybe putting more pressure on the system that the system didn't need. I was going once a year, anyway...it'd just be more queuing, more patients that maybe they didn't need. I just didn't answer...."



"... I didn't know anything about it and just got the letter...I didn't know there was anything like that kind of a programme going on, thought it was just left up to the ophthalmologists...."

Barriers to uptake- HCP perspective

Confusion for patients

- 'Some patients had appointments with the retinopathy screening programme, their local one and then they were getting letters from the national one. And there was a bit of confusion about which one.' (#10)


Time consuming registration process

- 'I was horrified to hear that the nurses were registering patients and it's taking them six minutes on average per patient. It's not a good use of their time...there needs to be a better process for registering patients.' (#7)

Connection and communication with clinicians on the ground


- 'So the fact it has started is wonderful...but some of the reasons [for the poor uptake] are the connection with the clinicians; the GPs, the endocrinologists, on the ground has not been as clear.' (#12)

Facilitator: Feedback loop



So much funding has gone into it and it is a fantastic programme and it would just be awful to think that people weren't getting to the screening just for the want of maybe getting them on the register and also making sure that they know about it and when they get their invitation they know that this something they should go to.

And engaging everybody along the way, like GP's, practice nurses, public health nurses, dieticians, everybody to keep patients reminded that they should go. (#18)



'Its just brilliant to have the opportunity to feed it back to the people who can make the changes'

National Footcare Model

Model of Care- 'Half successful'



On Track



Recruitment of
additional
podiatrists

- 'Bodies on the ground'- 16 posts secured Jan-June 2015
- 18,514 appointments (Jan- June 2015)

Data source: Activity data submitted to NCPD 2015

- Jan-June 2015
299 nurses educated about the model of care for the diabetic foot

Data source: Activity data submitted to NCPD 2015

Training &
education in
primary care

Risk stratified patient pathway

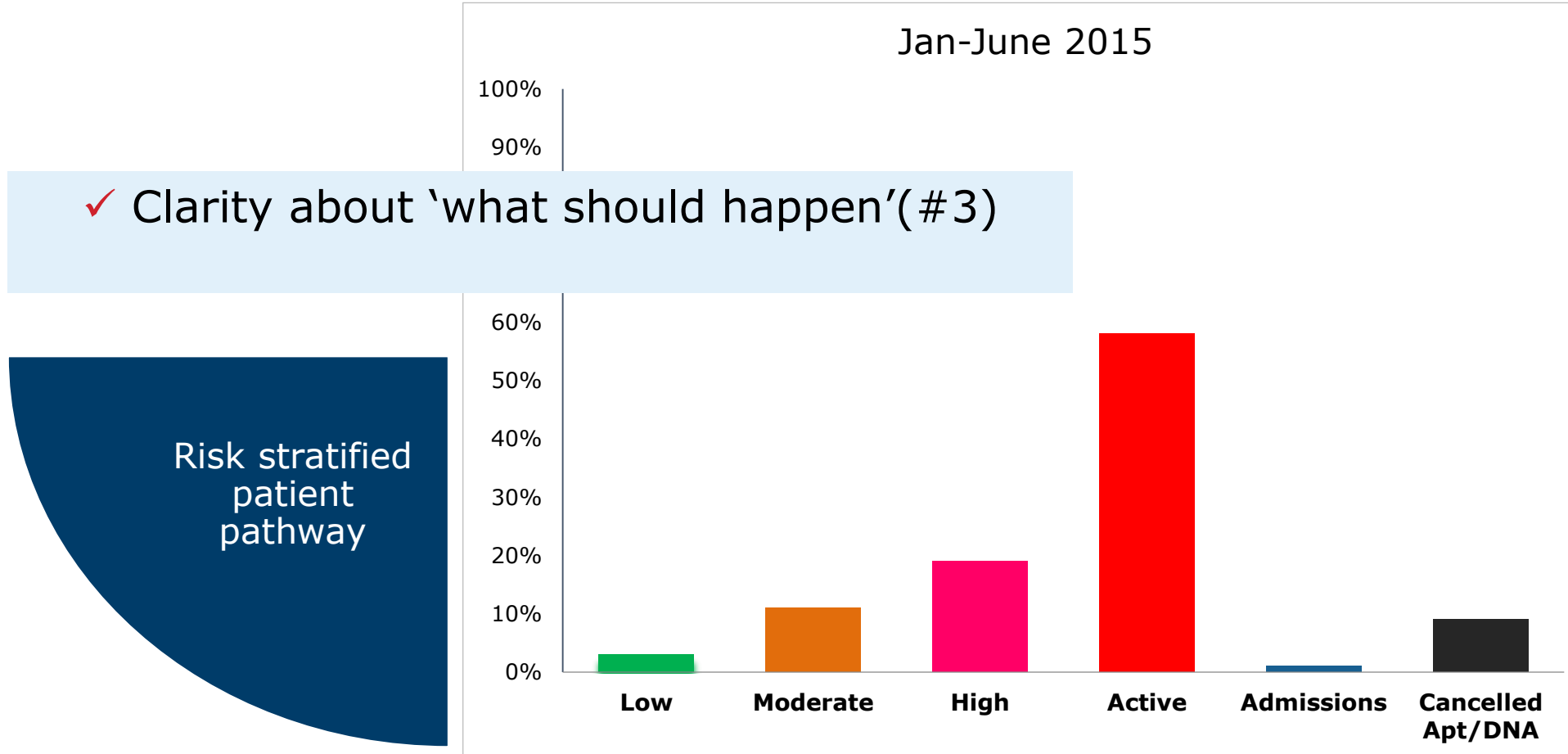


Figure. Patients seen by podiatrists according to risk
Data source: Activity data submitted to NCPD 2015

Facilitators: Geography & staffing

Its working really well here because of the **appropriate staff in place** and because they are **doing as the program recommends** and as they are employed to do, to **form links with the relevant stakeholders** in the area. So its working very well, as it is in other parts of the country...

Where staff are in place, then they can educate, they can upskill the relevant health professionals and just make sure that referral pathways are in place and **made known to everybody**.

But there are other areas where the **podiatry expertise could be miles and miles away** and it is really difficult to get patients to go. And you know, by and large its a journey they will have to do on a very regular basis and a lot of people its very hard to get them to do that. And there are some areas that just have **nobody to refer to**. (#18)

Barrier: Gaps in the pathway

- “We don’t have the support that is set in the national document”
 - Lack of buy-in from GPs and practice nurses
 - Not enough community podiatrists
 - Differential access to vascular service around the country
 - Acute services ‘swamped’ with active foot disease

Risk
stratified
patient
pathway

To get this programme up and running you really need a lot more people on the ground. We’re struggling at the ulcerated foot, the ‘active foot’ as it’s called in the model of care. We’re not even close to meeting what would be called for at the moderate or high-risk end. (#4)

Barrier: 'Trying to get everybody on the same hymn sheet'

- Different employers/funders
- Lack of clarity about service
- No governing role

Realignment
of existing
resources to
diabetes

Here it is all **private podiatry** we don't have an actually employed community podiatrist that we can say 'will you look after these patients'. Its all private. The HSE does pay these podiatrists but we don't really know what they do, we have **no governing arm** over them as such. (#19)

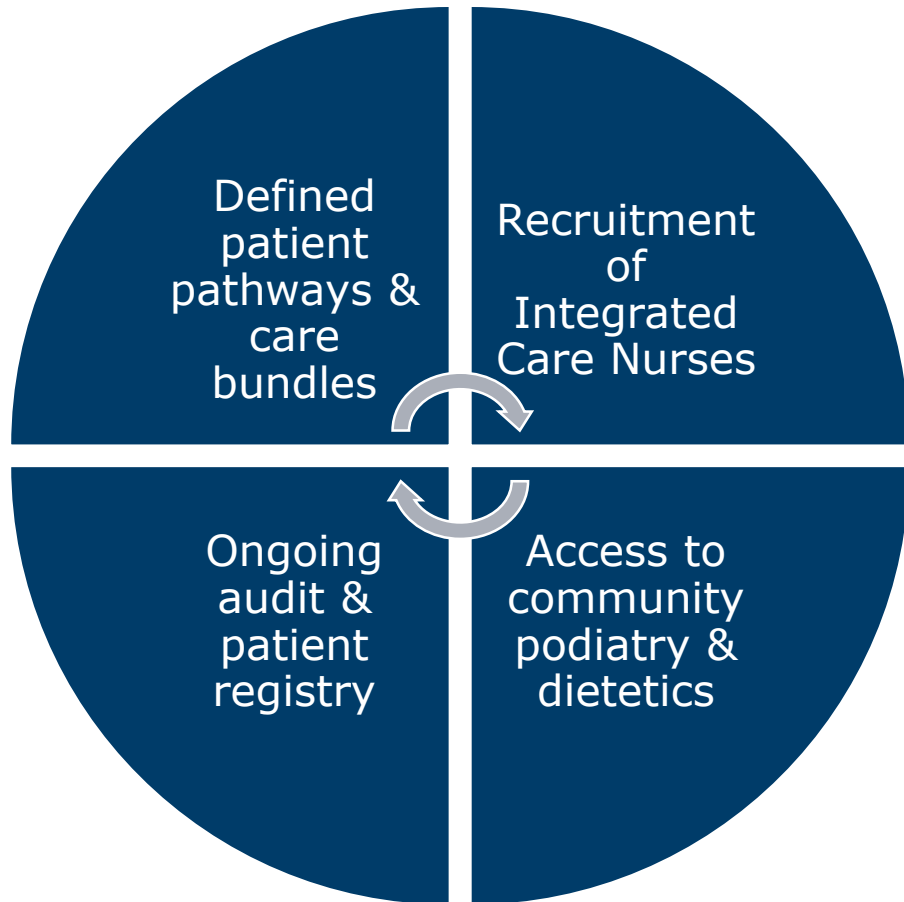
Integrated Care

'The foot-care strand, retinal screening, gestational diabetes, the ICT section, clearly research, structured group education, they all sort of dovetail into integrated care really.' (#18)

'Some Implementation on the Community Diabetes Nursing side of integrated care'

- 2013: 17 Integrated Care Nurses employed

'They were never intended to go in on their own, they were intended to go in as part of an integrated programme where GPs and practice nurses were providing the routine care and they go in as specialist help.' (#6)



Outcome: Uptake of ICN resources



'It depends on what area they're working in; what GPs are in their area' (#11)

- Current access to specialist input
- *'If its very rural and they are a long distance away from the hospital'*
- Practices with large patient numbers
- Existing initiatives: 'a program for nurses to join in with'

- 'In other areas where maybe people are in a position to choose, there might be opposition to it even, instead of just inertia' (#18)
- Lack of remuneration & resources for general practice

Outcome 2: Fidelity with intended model of care

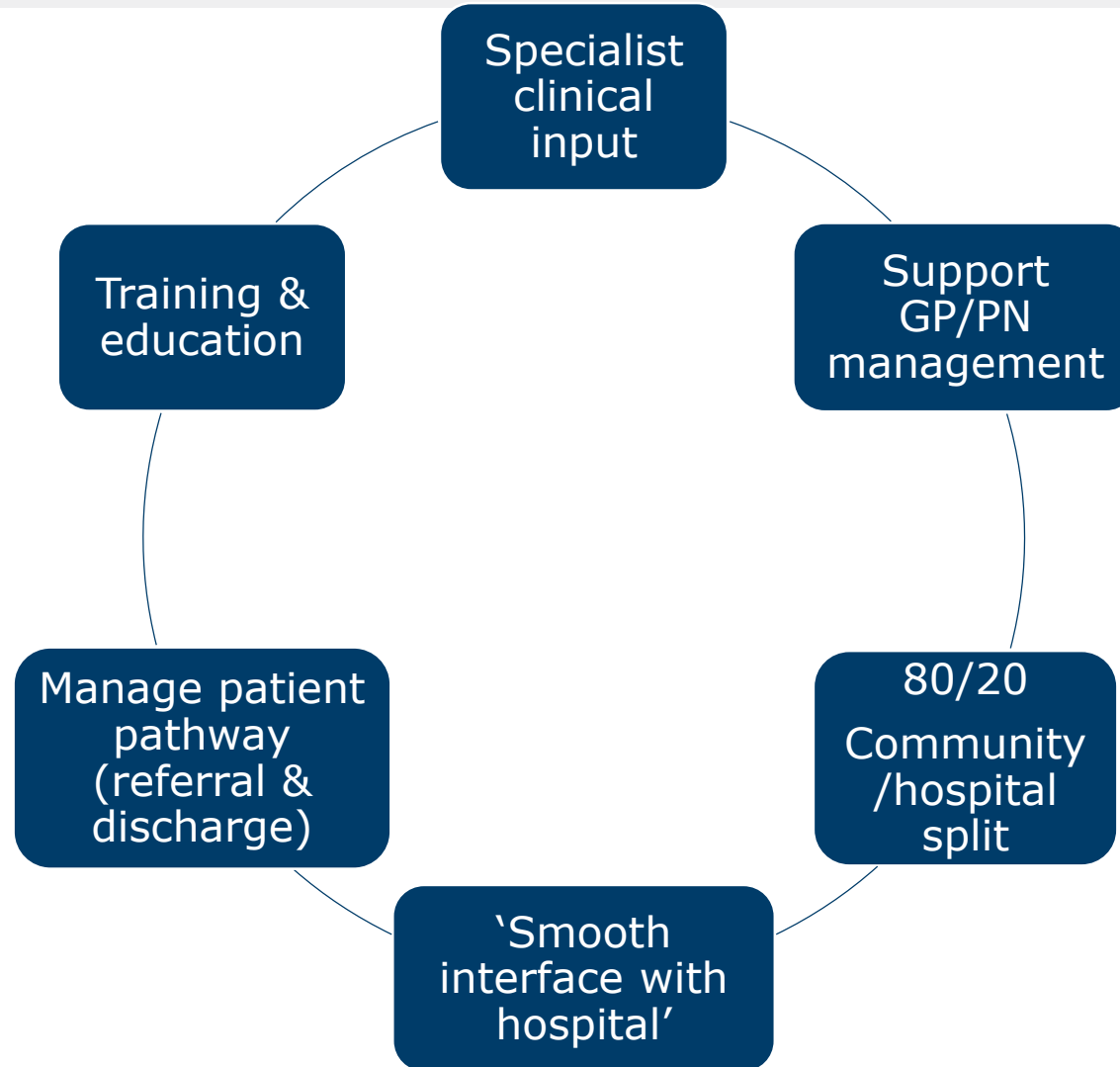
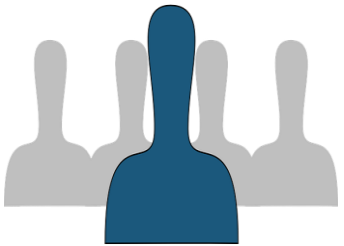


Figure. Intended role of ICN as part of the National Model of Integrated Care

'Pragmatic' approach to implementation



In some cases its a case of **how much they are allowed to do**, whether somebody will let you in the door or not, because they might not want to. If they let you in its positive and it will probably lead to something else but it **varies from area to area** in what way its being implemented.

Some nurses are very involved in **education** of healthcare professionals and maybe the public. Others are **straight into clinics** and there is just a huge amount of clinical work. (#18)

Variation in type of patients attending service

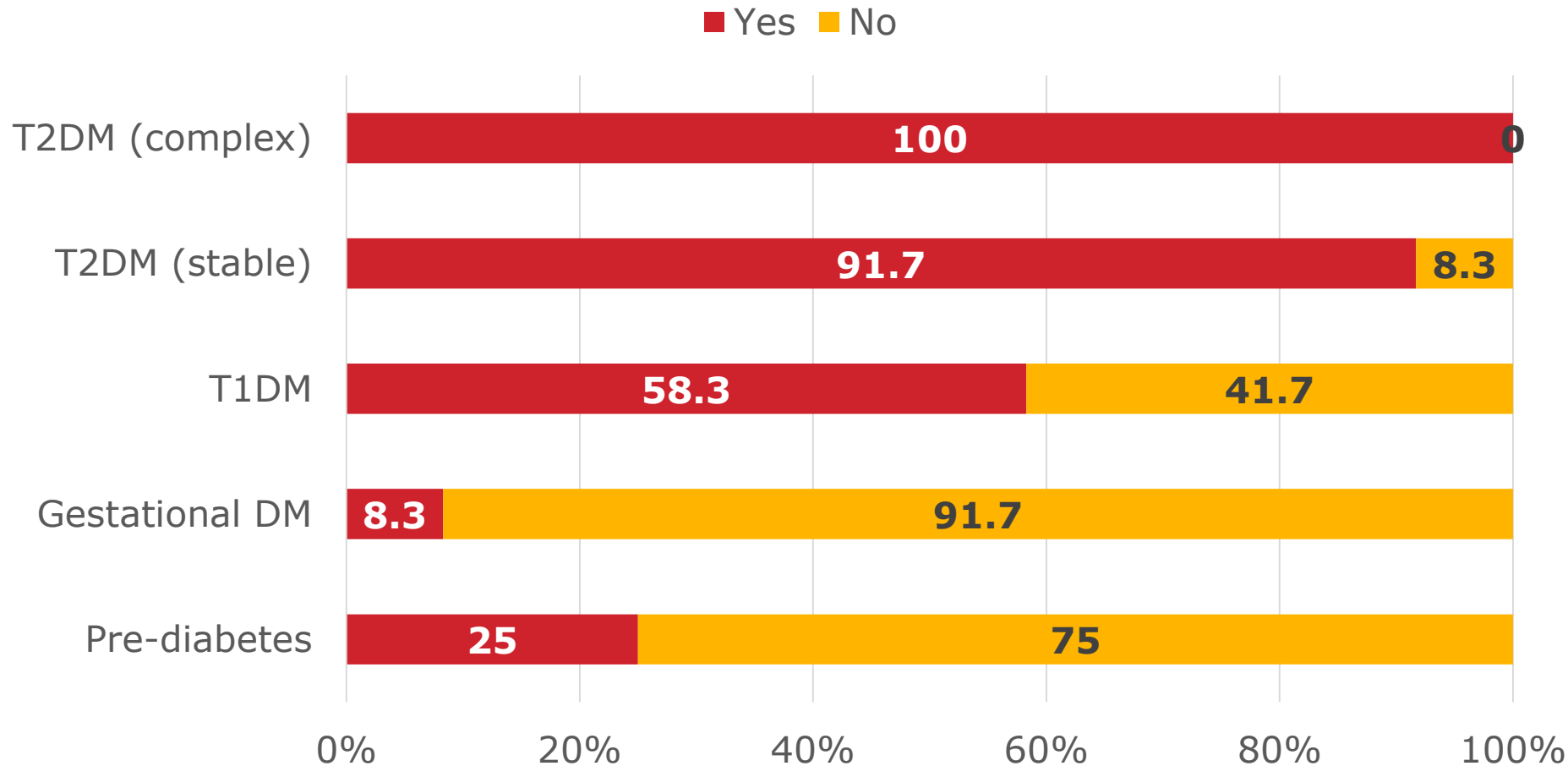
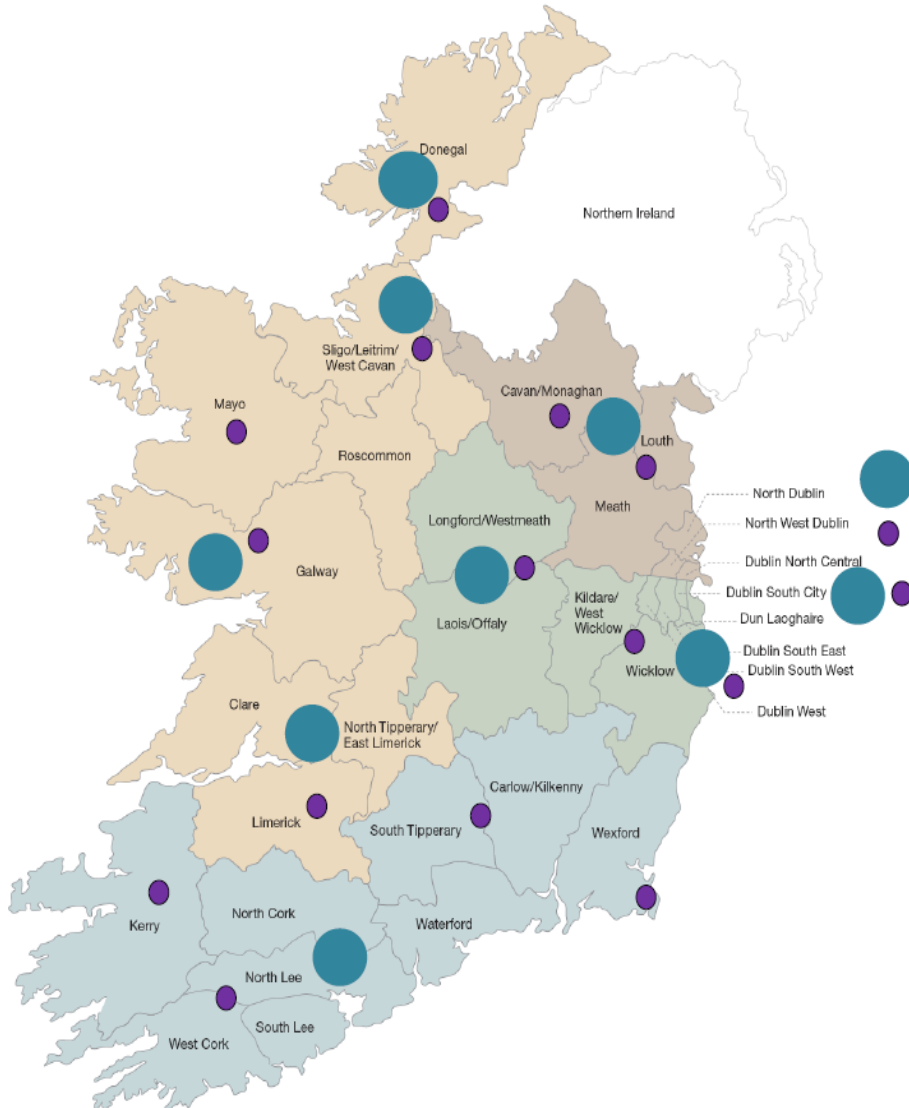


Figure. Type of patients attending ICN service (n=12)

Source data: National Survey of DNSs Nov.2015

Adapting to pre-existing models of care



These pockets of excellence around the country are all using **slightly different models**... They're not a thousand miles away but they're not the National Model of Care. And we haven't had the opportunity or the ability to standardise it because we weren't paying for it....

They're probably having to **adopt [or] adapt [to] the locally-existing model of care** as opposed to the National Model of Care (#12)



National survey of Diabetes Nurse Specialists



Facilitators

Good multidisciplinary team

Consultant support

Administrative support

GP engagement

Barriers

Relationship with primary care

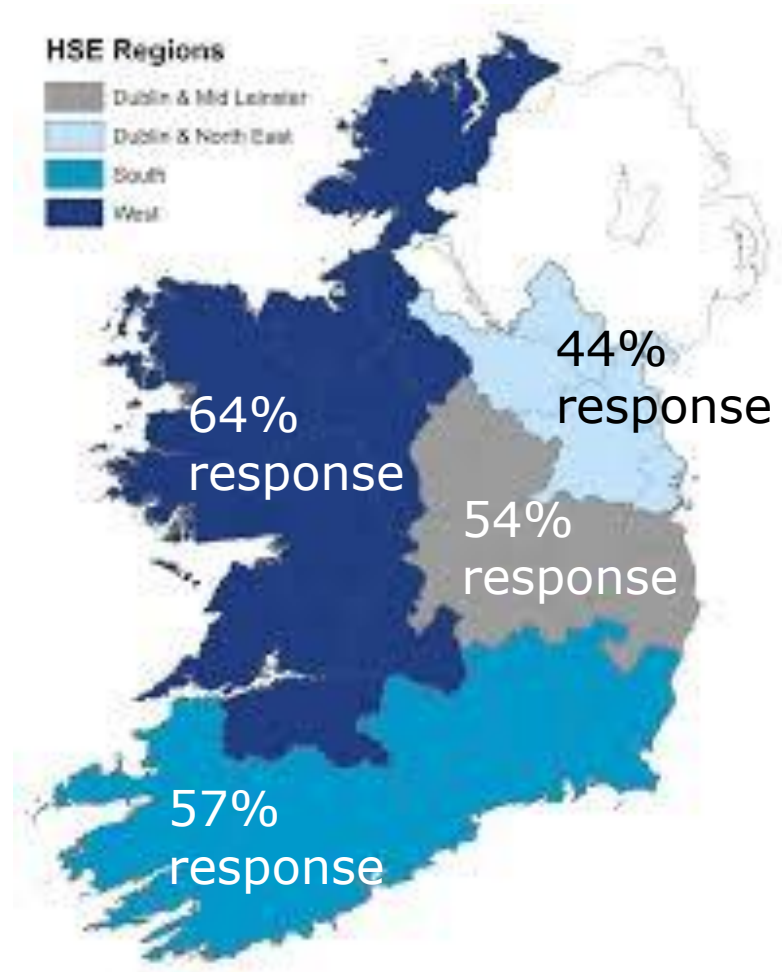
Role

- Not recognised or supported
- Too varied
- Lack of guidance

Resources

- Limited resources (e.g. space)
- Poor ICT in some areas
- Training needs
- Time constraints
- Patient numbers

National DNS Survey



- **If you have received this survey,** please take the time to complete it.

- **If you haven't heard about this survey please email:**

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A survey form titled "If, regarding diabetes, what are your specific roles in patient care? (tick all that apply)". The form lists various roles and has checkboxes for "Type 1 diabetes", "Type 2 diabetes", and "Other patient groups". The roles listed are: Patient management, Prescribing, Diet adjustment only, Insulin/CLP1 education, Checking injection sites, Glucose monitoring, Hypo Management, and Medical review. The form is partially filled out, with checkboxes marked for "Type 1 diabetes" and "Type 2 diabetes".

Diabetes Services Implementation Groups (DSIGs)

“DSIGs were meant to be implementation groups locally”
“Cause trouble, give out, ask for money”

‘Map and audit and look at where they were at locally.’ (#8)

Identify local needs

Decide how to implement locally & problem solve

Recommend, where appropriate, **reconfiguration and realignment** of current services to ensure efficient and appropriate use of all resources.
(Doc Analysis: Official terms of reference)

‘A forum’ to communicate local issues & disseminate strategy

Drive implementation

Programmes were established to improve and standardise patient care by **bringing together clinical disciplines and enabling them to share** innovative solutions. (Doc Analysis: RCPI website)

‘A bunch of local practitioners both GPs, practice nurses, consultants and managers in the locality who sat down together and tried to sort out the **practical problems** of providing a decent diabetic service [in that area] (#12)

Strengths: Dedicated proactive individuals

Identify local
needs &
maximise
existing
resources

We decide **local challenges and shortages** and short-comings and how best to address them. Then we **go and look for resources** and funding and staff and whatever we see...Looking at what you're doing and seeing are people well-utilised or could they be better resourced elsewhere. (#13)

'A forum' to
communicate
local issues &
disseminate
strategy

It was very worthwhile, very positive, even if you don't get any additional resources or additional moneys. Sharing experiences and learning from best practice in other areas is really useful. (#4)

Limitations: Authority

I suppose one of our challenges in the DSIG is that we **don't really have that power** to some extent or executive authority. And in some ways the DSIG has maybe evolved more into **just communicating strategy** and feeding back to the National Working Group. (#11)

The DSIG **ought to have some responsibility** for [allocation of resources], but it's somebody else who made the decision, who has no accountability whatsoever. So that sort of stuff **frustrates** you. You wish you had more control. (#17)

'I **don't have any power to do anything**. [It] can be frustrating, because they do ring and I listen to the problems that they are having and...I bring it forward to the national level and they say that is a **local area problem**, they need to pick that up with their manager. But their manager is not interested in it. (#19)

Decide how to
implement
locally &
problem solve

Drive
implementation

Limitation: local issues vs. regional structure

Following management geography

- It didn't work as well as it worked in some areas simply because they were an **organic group** that grew from the bottom of wanting to do it. Some of these other ones were put together because that was the **management geography** of the situation or the area but people didn't want to get together so it didn't work. (#12)

Size & scope

- 'It'd be onerous to ask busy consultants to implement things across a whole quarter of the country, across **hospitals that they have no direct involvement in.**' (#1)
- 'You also needed someone local to bring it back too from the DSIG's; there were only four of them so you just needed it **more locally implemented than that.**' (#3)

Conclusions

1. Differences in implementation largely due to differences in context
 - resources, management engagement
2. Resourcing and planning full continuum of care
3. Generating buy-in and engaging stakeholders in implementation (Damschroder *et al* 2009 Implem. Science, 4:50)
 - Attitude to intervention important-source confers credibility (Berwick 2003 JAMA,289:15)
 - Education, training, coaching
 - Local champions
4. Policy-practice feedback loop
 - PDSA improvement cycle
 - DSIGs
 - Improve patient care by bringing together clinical disciplines and enabling them to share innovative solutions.

Is the programme on track?

- Aim of NCPD is to standardise & improve care
- **Ongoing** monitoring of implementation & intervention outcomes

'...a suspicion, with little data were available to prove or disprove'

- Opportunities to embed this within the service



**WE NEED
YOUR**

**insight into how the programme
is progressing...**

Acknowledgements

- Participants and those who have contributed data
- National Clinical Lead, Programme Management & Working Group
- Health Research Board Research Leader Award

On behalf of the ESPIRIT Research Team

ESPRIT: Evidence to Support Prevention Implementation and Translation

<https://www.ucc.ie/en/esprit/>