Reflections from Scotland on the NSF for Diabetes in England

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Introduction

January 2003 heralded the birth of the NSF for Diabetes Delivery Strategy (DoH, 2003). In Scotland, the Service Diabetes Framework was published in Spring, 2002 (SEHD, 2002). The first draft of the clinical standards was published in August, 2001 (SEHD, 2001). We have been working on the implementation process since then. This article reflects on the shared and different approaches of the frameworks, what we can learn from each other and our joint challenges for the future.

On first reading the NSF for Diabetes, I was struck more by its similarities with the Scottish Service Diabetes Framework than the differences. Both documents highlight the key building blocks to achieving a high quality of diabetes care, and use consultation processes as well as a broad based steering group to help formulate the documents. Perhaps then, we should not be surprised that both documents share the themes of quality care in diabetes that patients, healthcare professionals and Diabetes UK have been describing for some time.

What differ, however, are the implementation process and the structures in which care is delivered. If we need a tangible example of how devolution to the nations has impacted, then we need look no further than healthcare. The emerging structures and philosophies are shaping healthcare very differently between England and Scotland, in response to the cultural and geographical differences as the devolutionary process was intended to achieve. I suspect it is these differences which lead to any contrasts in care.

The contrasts

The greatest contrasts that I identify between the Scottish and English documents are the target setting and monitoring processes. Scotland has standards of care laid out within the Clinical Standards Board for Scotland (CSBS) Diabetes Standards, which were finalised in October, 2002, following pilot assessment visits (SEHD, 2001). The standards highlight the processes of care including:

- Education for professionals and patients.
- Multidisciplinary team working.
- Clinical review processes.
- Information technology.
- Audit.

The standards are then evaluated using a combination of self-assessment form completion and assessment visits by multidisciplinary teams (including people with diabetes) who have completed training in the process. The visits are currently being undertaken at health board level (there are currently 15 health boards in Scotland) and will be completed at the end of 2003, with a national report identifying trends and gaps. The CSBS has now been subsumed into NHS Quality Improvement Scotland. This organisation brought together all of the quality assessment groups within the Scottish Executive Health Department, both reducing overlap and working towards an organisation that has the ability to act on failing standards. This aspect was reinforced within the new white paper for health, *Partnership for Care* which was published in February 2003 (SEHD, 2003a):

> ***'NHS Quality Improvement Scotland will provide clear authoritative advice on effective clinical practice, set national standards and inspect and publish reports on performance...inspections will be entirely independent of government and of NHS Scotland'.***

SIGN 55 (Scottish Intercollegiate Guidelines Network, 2001) for diabetes clinical standards

ARTICLE POINTS

1 The NSF for Diabetes and the Scottish Diabetes Framework share common themes for quality care in diabetes.

2 The implementation and monitoring processes, target setting and the structures in which care is delivered differ between the two documents.

3 Managed clinical networks are the next evolutionary stage of the local diabetes service advisory groups as outlined in both documents.

4 The frameworks have identified retinopathy screening, empowerment and education as priorities.

5 Frameworks offer opportunities not solutions; ways of maximising the opportunities are outlined.

KEY WORDS

- **Quality care**
- **Care delivery**
- **National standards**
- **Local network**

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PAGE POINTS

1 Scotland has a system of national standards which are assessed at a national level; audit is still encouraged at a local level to inform the local quality cycles.

2 The need for leadership of local diabetes service advisory groups is underlined by the earlier experience of the LDSAGs; lack of leadership has often failed to deliver change in practice.

3 Clinical leadership has been highlighted as another key point by both frameworks, but they differ in their approach to patient involvement.

4 It seems likely that the patient champions will also require support and use of the wider network to inform their role and priorities.

5 A Scottish diabetes group has been set up with a number of implementation groups focused on the early prioritised building blocks.

also operate at a national level. The Scottish Survey (SEHD, 2003b) has moved from being a collective anonymised national database of people diagnosed with diabetes, and now includes some clinical data (e.g. number of people who have had an annual HbA_{1c}). This survey has already provided the impetus to improve the quality of the data which in turn will drive the equity of care.

Scotland therefore has a system of national standards which are assessed at a national level. Audit is still encouraged at a local level to stimulate quality improvement at a local level. However, national processes are the tools to driving standards upwards and their success has yet to be seen.

The NSF for Diabetes describes a very different philosophy:

> ***'...reviewing the local baseline assessment, establishing and promulgating local implementation arrangements with a trajectory to reach the standards.'***

This process allows responsiveness to local situations and challenges and ensures that standards are realistic, achievable and in line with the policy described in *Shifting the Balance of Power* (DoH, 2001). There will also be participation in local and national audits. The Department of Health has also invested in a project in user development which Diabetes UK will take forward.

Perhaps these differences are mainly a reflection of geography but they do also appear to reflect some of the philosophical differences mentioned earlier. It will be interesting to observe the different approaches and whether locally driven initiatives result in improvements or risk worsening inequity of care provision. Will national assessments reduce existing inequity or merely highlight it without the required support and investment to effect change?

Networks

Both frameworks point to managed clinical networks (MCNs), the next evolutionary stage of the local diabetes service advisory groups (LDSAG) as an important driver within service areas. The need for leadership of these networks is underlined by the earlier experience of the LDSAGs; lack of leadership has often failed to deliver change in practice. In Tayside, Scotland, there is an example of how a network can deliver benefits to all involved. For more information visit: www.diabetes-healthnet.ac.uk.

Clinical leadership has been highlighted as another key point by both frameworks, but they differ in their approach to patient involvement. The NSF for Diabetes suggests having a patient champion (the views of local people with diabetes). However, in Scotland a different approach is taken. Diabetes UK in Scotland is taking forward a patient and carers involvement project funded by the Scottish Executive. The project has the aim of supporting and training lay members of LDSAGs and MCNs to fulfil their roles, ensuring a robust patient voice as a driver for patient centred areas. This programme will work with the LDSAGs, MCNs, voluntary groups of Diabetes UK and the wider community of people with diabetes to help them maximise their influence within the networks.

The training will include a core knowledge of diabetes, the healthcare system, advocacy, assertiveness and negotiating skills. In addition, the individuals involved will be linked with a wider network of interested people with diabetes and their carers to secure as wide a voice as possible. This is an exciting opportunity to utilise the creative potential of working with groups outside of the NHS in partnership. It seems likely that the patient champions will also require support and use of the wider network to inform their role and priorities. Diabetes UK is currently working towards ways of supporting users throughout the UK in their involvement in service planning and development.

Implementation approaches and challenges

As already established, the Scottish Diabetes Framework (2002) is facilitated and driven by national initiatives and monitoring. However, it is being implemented at a local level, responsive to local situations. A Scottish diabetes group has been set up with a number of implementation groups focused on the early prioritised building blocks. This process of breaking the framework into bite-sized chunks gives early direction and

guidance to teams charged with the delivery of the framework.

Both frameworks have identified retinopathy screening as a priority and the 2002 implementation report based on the Health Technology Board for Scotland (HTBS) recommendations was published in June (SEHD, 2003). This requires both central funding for call-recall software and management and local funding by boards to set up a quality screening method based on the report. The boards are currently costing this process with the aim of full implementation by 2006. England, Wales and Scotland are working together within the national screening committee to ensure consistency, particularly in evaluation.

The implementation group is also looking at the education of professionals and is working with the National Health Service Education in Scotland (NES), the multidisciplinary board whose responsibility is to develop and monitor quality NHS education. The first stage has been to develop multidisciplinary competencies based on CSBS standards for teams offering diabetes care. This will form the basis of a Scottish curriculum which could be offered by several Scottish universities in a standardised way with sensitivity to local needs. The approach should improve quality educational opportunities whilst recognising existing courses and in addition support team working and continuous professional development.

Empowerment, education and information

Both frameworks highlight the importance of empowerment, education and information in securing patient centred care. In recognition of this, one of the first initiatives to be supported by the Department of Health is the further piloting of DAFNE which has received a great deal of interest following positive reviews by the medical press (DAFNE Study Group, 2002). The patient focused sub-group of the Scottish Diabetes Group has recently been set up and is chaired by a lay person who has had diabetes since childhood. This group has identified patient education and empowerment as key areas to review and recommend that there is a standardised approach to empowerment in Scotland. It is hoped that we can learn from DAFNE as well as other initiatives, and consult widely with healthcare professionals and patients within Scotland. This offers the opportunity to learn to work differently with people with diabetes to enable them to manage their own care, independent of the healthcare teams.

Our shared challenges

Scotland's recent white paper *Partnership in Care* has finally heralded the end of NHS trusts, with the NHS boards remaining the commissioners of care. Similar to the recent restructuring in England, the concern remains that yet another restructuring will take the energy and focus from clniical improvements. Key messages are partnership and collaboration with devolved responsibility to local level, moving away from central command and control.

Although these are similar aims of *Shifting the Balance of Power* (DoH, 2001) the methods are quite different. It may be interesting to compare the approaches in the future. Resources are perhaps the biggest guarantee of the implementation of the frameworks. The GP contract, for example, has UK-wide implications as do the recruitment and retention issues affecting all four nations.

Frameworks: opportunities not solutions

How can you maximise the opportunity for the people you work with?

- Get involved with your local network ensuring that the members of the primary and secondary care teams are represented.
- Use your influence to argue for resources, education and involvement of patients to improve care.
- Be willing to review your own practice and learn new approaches.

Ghandi said 'You need to be the change you wish to see in the world'. So be bold, creative and willing to work with your local network, Diabetes UK offices and voluntary groups to deliver the care people with diabetes deserve. ■

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