CURRENT DEVELOPMENTS IN DIABETES IN MORECAMBE BAY

Simon Wetherell, FRGCP

There are currently a number of initiatives under development to improve the service provided for people with diabetes in the Morecambe Bay area. At present, the implications of the fragmentation of primary care trusts are unknown, but Dr Simon Wetherell, general practitioner (GP) at Queen Square, Lancaster, describes the development of diabetic services, in particular the service for eye screening, as they have prospered under the care of the now defunct Morecambe Bay Primary Care Trust (MBPCT).

EYE SCREENING FOR DIABETIC RETINOPATHY: A PROPOSAL FOR A COMPREHENSIVE SERVICE

Diabetic retinopathy is the commonest cause of blindness in working-age people[1]. It is usually treatable if detected at an early stage[2]. The Diabetes National Service Framework (NSF)[3] required primary care trusts to implement an eye screening service for people with diabetes using digital photography, taking photographs of the retina through dilated pupils.

We currently have an optometrist-run eye screening service, which has provided an excellent service to those patients using it. Under the optometrist-based system people with diabetes have had their eyes examined on a yearly basis by specially trained and accredited opticians using slit lamps. However, the National Screening Committee[4] has laid down very specific rules about how eye screening for diabetic retinopathy should be performed. This must be done by digital photography, using certain camera types, backed up by particular software. Systems of administration, call and recall of patients, management of images and appropriate actions to be taken are tightly dictated by the new guidance.

The favoured solution to the geographical challenge of providing a service over the Bay area is the use of mobile cameras operated by two teams of specially-trained personnel travelling to 17 different sites around the Bay.

At the initial screen the digital images are sorted into normal and abnormal. All the abnormal ones and 10% of the normal ones are viewed by a staff grade ophthalmologist. Those images which the second screener decides need treatment will be seen by a consultant ophthalmologist, along with a further 10% (an extra safety feature we have decided to build into the protocol over and above National Screening Committee guidance). There is provision for severely abnormal images to be fast-tracked to the consultant. Those 8% of patients who are unsuitable for imaging with the technology (due to cataracts or failure of pupillary dilation) will be sent an appointment to see a staff grade ophthalmologist. From there, those patients with cataracts requiring treatment can be directly added to the operating list. GPs will be informed of all patients who default from screening.

Primary care professionals dealing with patients who have diabetes have a vital role in making this service run efficiently. Firstly, we need their help in completing our register of patients with diabetes – all practices have already been contacted about this. Secondly, with the new system we need the details of new patients as they are diagnosed – the primary care health professionals (usually the practice nurse) will need to consent the patients for this. Thirdly, the GPs will receive letters when patients fail to contact or attend for screening. Finally, GPs will receive the results of the eye screening, allowing them to attempt tighter control of the blood pressure and diabetes when early retinal changes are detected.

The only people with diabetes who are not recommended to have yearly retinopathy screens are those patients:

- under age 12
- with a terminal illness
- with physical or mental illness making screening and/or treatment impossible (although GPs can still consider whether an ophthalmic referral may be beneficial)
- with no perception of light in either eye
- who are under the care of an ophthalmologist for the management of diabetic retinopathy

In contrast to the previous system, all those patients seeing an ophthalmologist for eye conditions other than the management of diabetic retinopathy should be included in this new eye screening scheme. Obviously, patients may elect not to have screening performed. Hopefully the new service will be more accessible to housebound patients, as we are currently in negotiation with the Cumbria Ambulance Trust to provide transport to eye screening clinics for such people.

The new system is now phasing in steadily, with the optometrist-based system stopping at the end of September 2006. Patients are currently receiving letters about the changes. There will inevitably be teething troubles with the new system. It will only be successful if a high proportion of the people with diabetes use this new eye screening system. We hope to make it as easy to use as the old optometrist-based system, which has been well liked. Feedback from patients and health professionals will be appreciated and encouraged to help ensure the smooth operation of this new service.

Normal retina

Screener to ask

Exclusions from screening:
- <12 Years Old
- Terminal Illness
- No perception of light either eye
- Under care of ophthalmologist only for DM retinopathy
- Physical or mental disability preventing screen or treatment (consider referral to ophthalmologist)
- Patient declines screening

Pregnant women (not Barrow)

Pre-existing retinopathy

Renal disease

Later—GP information from QOF

GP

Different recall times

Exclude from screening
? Temporary
? Permanent

Patient does not decline to go on resister

GPs compare own use with register list

Letter to those patients not on register

Details of those not declining sent by GP to register

Patient details input onto register

Register staff to search for patients due for screen—offer newly diagnosed / newly found patients screen soon

Invitation to make appointment sent by post

GP is advised to discuss this with patient

Actively decline to go onto register

Letter to GP that details are on register

GP/ PN— consent to send patient details to register

Does not contact after 4/52 or DNA

Decline screen (includes patient having private check by optometrist)

No details sent to register

Newly diagnosed patients with DM in primary care

Newly diagnosed patients with DM in secondary care

Advise to discuss with GP/PN and confirm in writing (? Temporary or permanent)

Active Management
- Phone/ Letter
- NOT to use p
would want f
- Register staff

Letter sent from register to patient confirming terms of opt out—copy to GP

Inform GP

Two DNAs or two non contacts

Primary Care

Register staff

Eye Screeners

Ophthalmology Dept

Slit Lamp Clinic

Diabetic maculopathy with circinate exudates

Not needing further attention yet

Information to GP and register including length of inactivation

Not significantly abnormal

10% picked by software— Audit

Information to register and GP— including recall time

10% picked by soft-ware— Audit

2nd grade— initially staff grade— later screener (will need arbitration grade for dis-agreements then)

Normal

Screen performed by camera (screening staff)

Image good

1st grade by screener

Possibly abnormal

Significant abnor-mality

Pictures to consult-ant ophthalmologist

Significant abnormality seen

Urgent referral

Register staff to make con-sultant ophthalmologist ap-pointment for patient

Ungradeable image

Unexplained loss of visual activity ≥ 2 lines on chart

New appointment offered

Patient seen in OPD

/ Fax/ E-Mail
phone at same time as
ree for incoming calls

List of patients from screeners to register staff

Not needing further treatment now—but will always need screen by slit lamp (e.g. small pupils)

Treatment
? Laser

Out-Patient staff to make follow up appointments

Cataract etc

Book onto operating list directly

Follow up by ophthalmologist

Patients booked directly into slit lamp clinic

Staff grade ophthalmologist sees patient in slit lamp clinic

Inform GP and register

Review after treatment

Audit information

BLOOD GLUCOSE MONITORING

The MBPCT spent over £700,000 per year on blood glucose monitoring strips. We have an objective to cut this cost, while at the same time improving the information gained from self-testing. In order to achieve this, we are currently looking at tendering companies to give a discount on the testing strips in return for being the preferred provider. The firm winning the contract will also need to provide training in blood glucose monitoring for both patients and health professionals, and there will also be training for health professionals on broader diabetes issues. Quality control will also be much easier to achieve.

This will not mean that patients will have to use the preferred system – there will still be free choice. However, many patients are happy to use any recommended meter and all the equipment that is currently being considered at tender is endorsed by us. General practices and pharmacies will be encouraged to participate, and we hope that by having a uniform type of meter and education system blood glucose monitoring will be more appropriately and accurately performed. There is no question of limiting patients to a certain amount of test strips – they should use what is clinically appropriate for their case.

DIABETES EDUCATOR

Another requirement of the Diabetes NSF[3] was that patients should receive education about diabetes. The MBPCT has agreed to fund a diabetes educator post, and this is currently going through the process of being advertised. The first priority is to set up an education programme for those people newly diagnosed with type 2 diabetes. This has been shown to be effective in improving diabetic control[5]. The education programme to be used is the 'X-pert patient' education system, designed specifically for type 2 diabetes. There are hopes that in the future staff could also be trained up to deliver type 1 diabetes training, such as the DAFNE (dose adjustment for normal eating) course.

Prior to December 2005 we had almost three years with diabetes facilitators organising health professional education. They ran three Warwick training courses, which in total educated about 50 health professionals, as well as organising various insulin initiation teaching events. Since the MBPCT was unable to find the funds to continue to employ the diabetes facilitators, health professional education in diabetes has been neglected. I feel it is vital to reverse this situation, as training 20 more health professionals in primary care to the level of the Warwick course may have far more impact than employing one or two more people to work full-time in diabetes. I hope that the diabetes educator will help with ongoing health professional education.

ENHANCED SERVICE FOR DIABETES

Negotiations with the old PCT on the issue of provision of an enhanced service have stalled on two occasions for financial reasons. Part of the funding from the enhanced service was to pay for extra diabetes nursing time to support practices having difficulty delivering routine ongoing care for their patients with diabetes. The remainder of the funding was to be used to enable practices to deliver diabetes care above and beyond what is expected in the Quality and Outcomes Framework[6], for example glucose tolerance tests in-house, yearly fasting glucoses on patients with impaired glucose tolerance to provide early diagnosis, as well as insulin manipulations, care of more complex patients and improved care for those who are housebound. Some practices are already providing all these services without payment, although insulin initiation is currently funded. I remain hopeful that in the future we will be in a position to re-launch the entire enhanced service.

CONCLUSION

The funding of diabetes developments remains difficult. However, the new retinal eye screening service is just commencing, and all those health professionals who deal with patients who have diabetes need to be aware about this. Please encourage patients to use it and feed back any difficulties. The diabetes educator and the glucose monitoring changes will hopefully have significant positive effects on diabetes delivery in primary care. I have no idea what impact the new PCT configurations will have on these developments – and no one else appears to have any better idea either. I remain hopeful that new funding arrangements with the new PCTs will allow us develop diabetes care along the lines of the twice-blocked enhanced service.

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