Should primary care clinical records be externally evaluated?

Samantha Rosindale, Helen Lockett, Robert Dyer, Robert Bromige, Adeltrude Darby

There is a wealth of published articles surrounding the topic of insulin initiation, advocating that it moves away from secondary care and is supported and developed within primary care settings (Kenny, 2005; Hill, 2007; Sanderson, 2007; Wilkins, 2007). The main driver behind this is The NHS Plan (Department of Health, 2000). It encouraged the refocusing of services to address patients' needs, which includes ensuring that care is local and accessible. It also developed new financial systems to fund the NHS, which incorporated shifting resources into primary care with schemes such as practice-based commissioning, payment by results and the new General Medical Services contract. This article describes a local audit of people with type 2 diabetes. It also considers the subsequent discussions between the primary and secondary care teams.

The government's White Papers *Shifting the Balance of Power, The Next Steps* (Department of Health [DH], 2002) and *Our Health, Our Care, Our Say: a New Direction for Community Services* (DH, 2006) have been implemented since the publication of the NHS Plan. These not only incorporate the plan but, for the first time, aim to benefit people with long-term conditions by creating a significant "shift" in the way care is delivered, away from care provided in specialist settings towards responsive community-based services. While these proposals are widely supported, there are practical challenges in delivering care closer to home. The debate regarding how the recommended shift of diabetes services could and should be organised has now gathered momentum (Greenwood et al, 2005; Kenny, 2005; Munro et al, 2005; Hill, 2007).

Insulin initiation has been an area of diabetes management that both secondary care teams and the authors' local PCT had recognised was being approached by general practices with varying levels of expertise. This was evidenced by the referrals that the secondary care diabetes team received from GP practices within the Torbay area to initiate insulin in people with diabetes. While some practices were initiating insulin and requesting advice on change of regimen, for example, others were referring for complete assessment of the patient to commence insulin therapy with follow-up support thereafter. This led to inefficiencies within the secondary care team and affected the payment by results system.

From a secondary care perspective,

Article points

1. The debate regarding how the recommended shift of diabetes services could and should be organised has now gathered momentum.
2. The PCT funded support for a secondary care diabetes specialist nurse (DSN) to discuss the outcomes of the audit with each individual practice that was involved.
3. This approach has been seen by all of those involved as an effective way of standardising diabetes management, developing an audit tool and providing an opportunity for quality assurance of both professional development and patient care.

Key words

- Clinical support from secondary care
- Clinical governance
- Audit
- Type 2 diabetes

Author details can be found at the end of this article.

Box 1. Aims of the current study

1. Discuss with the appropriate general practice staff the cases identified by Rosindale et al as "need to consider insulin therapy" or those who "need to intensify oral medication regimens".
2. Decide with the general practice staff whether this assessment, method and categorisation was appropriate for the individuals.
3. Decide on changes and agree clinical management plans for those patients.
4. Through discussion of these cases, assess competency and confidence of the health professionals involved and identify the learning, training and development needs of each individual healthcare professional and practice.
5. Increase confidence to initiate and maintain insulin therapy for those people with type 2 diabetes needing insulin.

implementing these new working practices has been beneficial in the reorganisation of our diabetes services. It has seen our workload change from the provision of traditional diabetes care (such as the annual review for people with type 1 diabetes, which is now being incorporated into routine general practice) to acting as a highly specialist service provider for specific areas of diabetes management, such as pregnancy and insulin pumps – i.e. caring for "complex" patients. It has also allowed for better use of specialist time, to develop patient education programmes, such as carbohydrate counting courses, and to offer more clinical support to primary care teams with informal meetings and telephone advice. This has resulted in closer working relationships and better communication between primary and secondary care.

Previously, a retrospective review of GP records from five practices, by Rosindale et al (2008), identified 376 people with type 2 diabetes and an HbA_{1c} >7.5%. Within that group, 88 (23%) required an intensification in their oral medication regimen and 74 (20%) needed consideration for insulin therapy. Our conclusion was that despite primary care teams attending accredited insulin initiation courses, there may be a "theory–practice gap" in the escalation of treatment for people with type 2 diabetes. It was felt that closer liaison between primary care and specialist diabetes teams was required to underpin this learning.

Using these data as a baseline, the PCT funded support for a secondary care diabetes specialist nurse (DSN) to discuss the outcomes of Rosindale et al (2008) with each individual practice that was involved. The outcomes of this initiative are discussed below. The aims of the study are outlined in *Box 1*.

Results

Out of the 162 cases discussed with general practice staff, 110 (67.9%) were agreed to have been appropriately categorised in the initial retrospective review (Rosindale et al, 2008). Rosindale et al (2008) felt that insulin initiation needed to be discussed with 74 people with diabetes. Following review of these cases with the primary care team, 43 (58%) were suitable for insulin initiation. The primary care teams agreed that 67 people with diabetes (76% of the 88 cases identified by Rosindale et al [2008]) needed their oral medication increasing to reach a target HbA_{1c} of less than 7.5%. Many of these people also needed further advice on diet, exercise and lifestyle modifications. Clinical management plans were agreed in principle until they could be discussed with the respective patient.

The main reasons where agreement on categorisation was not reached for the remaining 32.1% (n=52), included patient character, coping abilities (which it was acknowledged was difficult to collate from electronic records), age, and non-attendance despite repeated invitations.

Identified learning needs

The GPs and practice nurses involved in this study felt that the majority of their learning needs centred around insulin, oral medications and dietary issues.

- Their confidence needed improving in titrating oral medication sooner after diagnosis and that, although the majority of the people with diabetes were self-monitoring their blood glucose, the results did not always affect dose titration of the oral agent, with healthcare professionals preferring to wait for an HbA_{1c} result.
- Some identified the need for improved dietary knowledge so that appropriate advice can be offered on an individual basis. They would like this to be supported by a specialist dietitian.
- The interpretation of patients' self-monitoring records following insulin initiation and advice regarding when to make appropriate insulin adjustments, including amounts for dose titration, was identified as a need.
- Some were unsure about when and how to change an insulin regimen, including uncertainty over the correct selection of insulin when the person with diabetes' glycaemic control has not improved or the initial choice of insulin does not suit them.

Clinical governance

Within-practice variation

Clinical governance issues were identified during case discussion. These included within-practice variation on the approach to the management of type 2 diabetes. Some of the practices involved had GP partners who approached diabetes management in different ways. The result was conflicting advice given to people with diabetes and practice nurses, making clinical support difficult for the latter.

Appointments

Normal appointment times (10–20 minutes) were deemed to be inadequate to holistically address the needs of the person with diabetes. Insufficient time resulted in deficient assessment, little discussion (particularly regarding management choices), and difficulty in initiating and reviewing change. There is a conflict between quality and quantity of appointments. From the healthcare professionals' perspective, the appointments felt rushed, resulting in numerous return appointments to ensure that all education and clinical needs were being addressed.

Documentation

It was also identified that there was a need to improve documentation for each consultation, so that it is clear and unambiguous. At times, documentation did not appear to be patient-focused, instead being a "tick-box" exercise for annual review requirements. There was limited documentation about individual discussions, balancing clinical priorities with the individual needs of the person with diabetes, and how objectives of care were changed to incorporate these needs. It is clear that GPs and practice nurses know their patients well and carry a wealth of information about their attitudes, social circumstances and abilities to cope. They are patient focused but this is difficult to document and was not always evidenced in care records.

Discussion

The results suggest that reviewing case notes has the potential to improve care and aid treatment to target. Despite voluntary inclusion, review and feedback was initially feared by the primary care clinicians, as their clinical practice was questioned by members of the specialist team. However, with initial reassurance that confidentiality would be paramount and that the aim was to help, not judge, much of this fear was allayed. The benefit of this process was soon realised and further intervention welcomed (and even requested). As a consequence of this study, working relationships between primary and secondary care have improved subjectively in the authors' locality, giving rise to better understanding of each other's roles, working environment constraints, pressures and financial systems.

The study does raise concerns that within primary care there is a lack of recognition for the need to intensify therapies for people with type 2 diabetes who have suboptimal glycaemic control. This is emphasised by the fact that on initial contact with the individual practices, all said that they did not have any individuals that needed insulin initiation. Surprisingly, there is not only a reluctance to commence insulin but also to titrate oral hypoglycaemic medications.

Rosindale et al (2008) stated that "whilst formal course attendance in itself is extremely worthwhile for learning new skills and underpinning theories; competency and confidence are gained from experience, knowledge and practise with individual patients in every day clinical practice". The GPs and practice nurses involved agreed with this statement.

The involvement of a specialist registrar and a DSN from the secondary specialist team sought to bring a fresh dimension and started to encourage a collaborative approach to the management of type 2 diabetes in general practice. The opportunity to meet each individual surgery with discussion, feedback and advice on management of their patient population sought to reinforce this approach. Most stated that this support was a positive experience, highly appropriate and very much appreciated. It enhanced their clinical practice and met many of their own learning needs underpinning the knowledge gained from

Page points

1. The results suggest that reviewing case notes has the potential to improve care and aid treatment to target.
2. The study does raise concerns that within primary care there is a lack of recognition for the need to intensify therapies for people with type 2 diabetes who have suboptimal glycaemic control.
3. Most of the healthcare professionals involved stated that this support was a positive experience, highly appropriate and very much appreciated.

Page points

1. This study demonstrates the need for increased specialist dietetic support within the community to bridge the gap between primary and secondary care.
2. A dietitian would have been invaluable during the feedback to the surgeries helping to address many of the knowledge deficiencies identified by the primary care staff.
3. This approach has been seen by all of those involved as an effective way of standardising diabetes management, developing an audit tool and providing an opportunity for quality assurance of both professional development and patient care.
4. While competency and confidence for primary care are being improved with this service development, there will always be people who remain reluctant to commence insulin.

course attendance and gave rise to growing confidence.

This study demonstrates the need for increased specialist dietetic support within the community to bridge the gap between primary and secondary care. A dietitian would have been invaluable during the feedback to the surgeries helping to address many of the knowledge deficiencies identified by the primary care staff. Unfortunately, this is often not possible due to limited time within dietetic services.

Limitations

The authors recognise that these results are limited as only a small group of GP practices within one geographical area are represented. However, similar simple initiatives could be replicated in the readers' local area to enhance the development of working relations between primary and secondary care.

A further limitation is that the practices involved were self-motivated and enthusiastic about diabetes as evidenced by volunteering to take part in this study. In addition, four out of the five practices already initiate insulin and had completed an accredited insulin initiation course. Less-well informed practices may have different learning needs but we believe that the review of patients by the specialist care team followed by discussion with the practice would identify the needs of each practice and result in more open communication between primary and secondary care, whatever the practice's initial motivation.

Service development

This approach has been seen by all of those involved as an effective way of standardising diabetes management, developing an audit tool and providing an opportunity for quality assurance of both professional development and patient care.

From these results Torbay Care Trust has decided to fund a specialist nurse and dietitian to work with other practices in the area and has developed a simplified pathway for insulin initiation to underpin the development of a Locally Enhanced Service for insulin initiation. Implementation will be based on the method used in both this article and the previous publication by Rosindale et al (2008). The main aims will be:

- To reduce variation in clinical care for people with diabetes in Torbay.
- To increase the number of general practices in Torbay able to assess the need for insulin therapy in people with type 2 diabetes.
- To increase the number of general practices in Torbay able to initiate insulin.

Conclusion

While competency and confidence for primary care are being improved with this service development, there will always be people who remain reluctant to commence insulin. We would suggest that they should be referred to secondary care to ensure that all possible options have been discussed before the patient makes a final informed choice not to proceed to insulin. ■

Author details

Samantha Rosindale is an Advanced Diabetes Specialist Nurse, Helen Lockett is a Specialist Registrar and Robert Dyer is a Consultant Physician at Torbay Hospital, Devon. Robert Bromige is a GP and Adeltrude Darby a Practice Nurse at Compass House Medical Practice, Brixham, Devon.

Department of Health (DH; 2000) *The NHS a plan for investment, a plan for reform*. DH, London

DH (2002) *Shifting the Balance of Power: The Next Steps*. DH, London

DH (2006). *Our health, our care, our say: a new direction for community services*. DH, London

Greenwood R, Shaw K, Winocour P (2005) Diabetes and the quality and outcome framework: integrated care is best model for diabetes. *BMJ* **331**: 1340

Hill J (2007) Starting insulin in type 2 diabetes: From secondary care to primary care. *Journal of Diabetes Nursing* **11**: 342–5

Kenny C (2005) Diabetes and the quality and outcomes framework. *BMJ* **331**: 1097–8

Munro N, McIntosh C, Feher M (2005) Shifting diabetes care: rhetoric and reality. *Practical Diabetes International* **22**: 153–4

Rosindale S, Lockett H, Bromige R et al (2008) Suboptimal glycaemic control in primary care; is the need for intensification of therapy recognised? *Practical Diabetes International* **25**: 269–72

Sanderson C (2007) Insulin initiation: A primary care perspective. *Journal of Diabetes Nursing* **11**: 344–7

Wilkins J (2007) Insulin initiation: A secondary care perspective. *Journal of Diabetes Nursing* **11**: 348–50