Preparing for local developments in diabetes in general practice

Helen Bowker

ARTICLE POINTS

1 A baseline review was undertaken to ascertain which diabetes services were being provided within general practice, how they were organised and delivered, and the issues affecting provision.

2 The review provided a detailed picture of care within primary care, highlighting good practice, service gaps, strengths and weaknesses.

3 The data will provide a 'benchmark' for future service provision.

4 The baseline review has helped to secure funding and a commitment from the PCT to restructure the service, re-deploy resources more efficiently, and support professional development.

KEY WORDS
- Diabetes services
- General practice
- Service provision
- Baseline review

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Introduction

Preparing for local developments within diabetes has never been as important as now, with the predicted, increased prevalence of diabetes in the UK (Williams, 2001), the growing elderly population, and part two of the NSF for Diabetes on the horizon. The 'baseline review' described here was a lengthy, but timely, qualitative piece of work. It provided a detailed picture of care within general practice and captured the essence of local service provision, highlighting good practice, service gaps, strengths and weaknesses. This article describes how the baseline review was performed and how the findings will aid the development of an integrated and efficient service, providing equitable and quality care.

Throughout the reforms of the 1990s, the Labour Government indicated its commitment to improving quality and integrating services, making them more equitable. The key themes echoed in 'Driving change in the NHS' (Department of Health [DoH], 1997) were raising quality standards, increasing efficiency, new roles and responsibilities, and driving performance. In the present climate, politicians and patients expect health professionals to take responsibility for improving quality, based on local need, thereby ensuring that care provision is accessible, efficient and of a high standard (DoH, 1998).

As the cost of health care continues to rise, providers of diabetes care face a great challenge, particularly as there is no guarantee of additional resources. There is a need to assess and re-evaluate the current provision of diabetes care within general practice to determine whether existing and well-established resources require tailoring to meet needs in more efficient, equitable and cost-effective ways (Wright et al, 1998).

The White Paper (DoH, 1997) heralded a turning point for the NHS, replacing the internal market with integrated care, and promoting a modern and dependable system. The focus of care transferred to the quality of care, indicating that patients should be guaranteed quality; the quality of care is therefore the driving force behind decision-making processes.

Evidence for quality

The Audit Commission (2000) highlighted unacceptable variations in care, and the lack of programmes of education in diabetes available to health professionals. This is reflected in the amount of ambiguous and conflicting advice given to individuals with diabetes, which may alter the overall outcome of diabetes. The majority of people with type 2 diabetes are thought to receive all their care within general practice (O'Gara, 2000).

Locally, however, outpatient waiting times have continued to rise and the demand for specialist services is exceeding capacity. Care provision varied throughout the community, and generally fell short of national recommendations, despite compelling evidence from the Diabetes Complications and Control Trial Research Group (1993) and the United Kingdom Prospective Diabetes Study Group (1998).

Study aim

It was necessary to ascertain which diabetes services were being provided within general practice, how they were organised and delivered, and the issues affecting provision.

The baseline review will assist the planning of future service delivery, and identify methods for increasing capacity in general practice and for supporting healthcare professionals in the delivery of care. Overall, the data will provide a 'benchmark' for comparison and measurement in the future.

Questionnaire development

The North West Diabetes Programme began in 1995, following a conference between the chief executives and NHS chairs in the North West. They met to discuss whether the aims of the St Vincent report (1989) could be achieved through continuous service improvements. In 1997, the development of a peer review group, was recommended by the North West Regional Diabetes Development Group, to evaluate a district's progress in implementing their local programme of care. This peer review process is now known as the Diabetes Services Accreditation and is coordinated by the Centre for Health Care Development (CHCD).

Individual districts wishing to participate in the peer review process, in order to gain an objective opinion, approach CHCD and invite them to perform an assessment of the local organisation and delivery of diabetes care. The assessment framework used by CHCD considers nine key service areas. These can be viewed in any completed report document (www.diabetesappraisal.co.uk) and include: primary prevention, strategic planning, structured programme of care, annual review, special groups, specialist and tertiary services, patient self-management, professional education, and quality assurance.

As the CHCD framework allows exploration and discussion of a wide range of topic areas, an extensive semi-structured questionnaire was developed, based on this framework, to guide the baseline review process. *Table 1* highlights the main areas reviewed.

Table 1. Categories addressed in the baseline review of diabetes services

- Primary prevention
- Screening
- Structured programme of care
- Specialist services (DSN, dietitian, podiatrist, community nursing)
- The elderly and the housebound
- Patient and professional education
- Equipment
- Information and audit

Table 2. Healthcare professionals included in the baseline review

- Staff of 27 of the 28 local general practices
- All nine community nursing teams
- All members of the elderly care team
- All DSNs
- Two consultant diabetologists
- Dietitians and podiatrists from the hospital and community sectors

Subjects approached

As both clinical and administrative information were needed, the lead GP and practice nurse for diabetes and the practice manager within each practice were invited for interview. A senior member of each community nursing team and other nurses were invited to attend their interviews. To gain a true perspective of both the hospital and community services, representatives from both sectors were approached; *Table 2* lists those agreeing to take part.

Arranging interviews

Those who agreed to participate were visited, first to discuss the process and participation, and to emphasise why an hour of their time would be needed. This visit gave potential interviewees a chance to meet the people who would be performing the baseline review. It also provided an opportunity for questions to be answered, issues to be clarified and concerns allayed, as many individuals thought the process to be a policing exercise. A mutually convenient date and time were agreed and an explanatory letter was sent a few weeks before this date, explaining the process again and confirming the appointment.

A small questionnaire accompanied the letter, requesting details about the practice list size, prevalence of diabetes, contact details, IT systems, on-site equipment and educational needs. This information was sought at this point to allow more focus on detail during the baseline interview. Arranging interviews is not always a simple exercise – because of work commitments, some people within a practice or a team may need to be seen on separate occasions.

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1 The Centre for Health Care Development has been invited to assess the organisation and delivery of diabetes care in various districts throughout the northwest of England.

2 A semi-structured questionnaire was developed, based on the CHCD framework, to guide the baseline review process.

3 To gain a true perspective of both the hospital and community services, representatives from both sectors were approached.

4 Arranging interviews is not always a simple exercise – because of work commitments, some people within a practice or a team had to be interviewed separately.

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1 Interviews were very informal, enabling people to speak freely.

2 Qualitative data were examined and placed into common themes, and quantitative data were entered into a database.

3 Practice guidelines, patient information and professional educational materials were collected and have been kept for further review and utilisation.

4 There are currently few ongoing initiatives in primary prevention within the PCT.

5 Locally, collaborative working between public health and the diabetes services could promote the integration of diabetes into Health Improvement Plans.

Methodology

To reduce the risk of bias and disparity, and to ensure that all issues were covered to a similar depth, two interviewers performed each baseline interview. The same person led the process and the other scribed to maintain an accurate reflection of the respondent's answers.

Each baseline interview began with a short introduction and an opportunity for immediate questions to be addressed. Individuals were able to stop the process at any time or withdraw from the process. Those who took part were assured that confidentiality would be maintained, that individual responses would not be identifiable, and that practice information would not be shared with other practices.

Interviews were very informal, enabling people to speak freely. Although the questionnaire was used as a guide, individuals were allowed a certain degree of flexibility. The process took 4 months to complete and all participants were very cooperative, honest and supportive. Everyone saw this as a great opportunity to develop an equitable and fair service of high quality. No-one withdrew from the process.

Data collection

Data collection was very time-consuming, taking 2 months to complete. Qualitative data were examined and placed into common themes, and quantitative data were entered into a database. All of the information has proven to be of great value and, although there were different levels of care provision within each practice, individuals' motivation, enthusiasm and eagerness for improving local services was clear. There was evidence of good practice throughout and many areas of care provision can now be shared and introduced in other areas. Practice guidelines, patient information and professional educational materials were collected and have been kept for further review and utilisation. The amount of time that this process demands and the need to plan how the data are to be stored should not be underestimated.

Findings and recommendations

Because of the length of the final baseline report, the main issues have been summarised to provide an insight into future service developments.

Primary prevention

There were few ongoing initiatives within the PCT; however, a few practices had held day events within the surgery to raise awareness of diabetes among their local population. The work of Tuomilehto et al (2001) is significant within the field of preventing the development of type 2 diabetes in those at risk and could support local initiatives. The findings of this group indicate that changes in lifestyle and increased exercise could reduce the risk of developing type 2 diabetes by up to 58%.

Locally, collaborative working between public health and the diabetes services could promote the integration of diabetes into Health Improvement Plans, to keep people healthy and raise awareness throughout the PCT, as supported within *The NHS Plan* (DoH, 2000) and *Testing Times* (Audit Commission, 2000). This will be a positive move towards addressing Standard 1 in the NSF for Diabetes (DoH, 2001).

Screening

Local findings are probably similar to those in other areas of the UK, with variations in the groups considered to be 'at risk' and the method of screening.

Urinalysis is generally performed on new patients and those who are symptomatic. Most practices obtain a fasting venous glucose in individuals with coronary heart disease; however, there are a few practices where little consideration is given to other at-risk categories, as suggested by Diabetes UK (2001) in their position statement.

Local guidelines on diagnosis and management of diabetes within general practice were not considered easy to understand. In response, some practices had developed their own, evidence-based guidelines and others were out of date, often leading to inappropriate referrals to hospital services. Glucose tolerance tests (GTTs) are generally performed within the hospital, as not all practices have access to phlebotomy services at appropriate times.

In an attempt to identify the 'missing million', the position statement by Diabetes UK (2001) has been distributed throughout

general practice while the PCT awaits national screening guidance. Locally, the issues around screening, diagnosis and management of diabetes are being integrated into programmes of professional education and clinical support. With regard to improving access to GTTs, a protocol is being developed, to support and guide those practices with an interest in providing an in-house service.

Structured programme of care

Throughout general practice, equity of access varied greatly, as did the quality of care provided. Professionals acknowledged the need for education, training and in-house clinical support, and were very positive about improving care to patients. On the whole, members of the multidisciplinary team expressed concern, as they felt that their role and responsibility in care provision, particularly in 'shared care', was unclear. In some practices, this led to fragmented and poorly coordinated care, which was worsened by the lack of clarity in local management guidelines, often exposing patients to duplicated care, little care or no care at all.

A significant number of practices refer all people to hospital services for specialist input, placing huge demands on these services. In the practices adopting the shared-care system, it became apparent that certain elements of care were not being performed. Provision of care to the housebound is far from adequate and this group of people frequently miss out on eye, foot and renal screening.

By contrast, a minority of practices are providing an excellent in-house, evidence-based local service and only refer to the hospital when complications arise. Their experiences could be shared and the development of a 'buddy' system is planned, linking practice staff together to create a positive support mechanism and learning from experience. Interestingly, nearly all practices were interested in developing their in-house service, but stipulated that they would want active management plans for each patient seen within the hospital.

The main issues to be considered are as follows:

- For the PCT to develop a strategy for diabetes utilising integrated care pathways, defining the category of care to be delivered within general practice, i.e. all patients with uncomplicated type 2 diabetes, and to define clearly the roles and responsibilities, so that patients will know what care to expect, when to expect it, and from whom to expect it.
- Clarification of responsibilities in the provision of 'shared care' is being agreed and this will be supported within education programmes and clinical support. The PCT has been approached to review chronic disease management payment within the structure of care provision, to consider linking performance with NSF targets.
- The development of an integrated system of care that will function at the interface between care sectors is being planned, to improve access to specialist care locally.
- Provision of care to the housebound is currently being addressed by the housebound subgroup of the local implementation team for diabetes, which is currently reviewing who should have overall accountability for care.
- The 'TiDES' team (see Box below) is planning to perform a baseline review of all nursing and residential homes within the local PCT area.

Access to specialist services

- ***DSNs:*** A significant number of individuals diagnosed with type 2 diabetes are referred to the DSN service for education, dietetic advice, assessment of glycaemic control and commencement of insulin. This 'fast-

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4 A minority of practices, however, provide an excellent in-house, evidence-based local service and only refer to the hospital when complications arise.

The 'TiDES' team

In June 2000, four clinicians representing South Manchester Primary Care Trust (SMPCT) and South Manchester University Hospitals NHS Trust (SMUHNT) were invited to participate in a national clinical governance development programme in Leicester (Dr Rachel Rowe, Consultant Diabetologist; David Needham, GP; Mary Findlay, DSN; and Linda Goulden, Practice Nurse). As a result, the views of patients and healthcare professionals on the diabetes services were sought (Diabetes Services Review, 2000). This created a very good response, and 17 areas were identified for service development to address growing demands. However, service provision within each general practice remained unclear and, as a result, a small, multidisciplinary, self-managed team was established, comprising the four clinicians, entitled the 'TiDES' (Teamwork in Diabetes Excellence in South Manchester) team. The team was employed to fulfil the action plan of the Diabetes Services Review (2000; http://nww.manchester.nwest.nhs.uk): to obtain a detailed review of service provision within general practice, to identify methods of increasing capacity with primary care, and to increase healthcare professionals' knowledge and clinical expertise in the delivery of diabetes care. Overall, the remit is to integreate services and reduce the divide between the hospital and community sectors. The TiDES team work alongside the existing diabetes team.

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1 Inequity of access to both podiatry and dietetics was evident.

2 Many people were considered as missing foot care, where it was not being provided locally.

3 Most of the community nurses and elderly care team felt that their service was greatly under-used in the management and care of people with diabetes.

4 Many community nurses felt that their roles and responsibilities were unclear and ad hoc.

5 Plans are in progress to standardise the information given to patients, and this material will be produced in various languages.

track' route is used by general practice, as the community services have very lengthy waiting times. However, many of the same individuals are simultaneously being referred the hospital for a consultant outpatient appointment, thereby creating very lengthy waiting times. Many patients are often stabilised by the DSN service several weeks/months before the consultant appointment, which begs the question: is the referral necessary in the first place?

Allocating DSNs to groups of practices will increase local access to specialist care within general practice and will provide clinical support within practice and promote multidisciplinary working, through more effective channels of communication. This will reduce outpatient waiting times, people will be seen sooner locally, and, through the provision of clinical support professionals ,will be able to develop professionally. Overall our patients will benefit.

- ***Dietetics:*** Shortages in dietetic time are acknowledged throughout the UK, and often lead to long waits for appointments. Patients failing to obtain an appointment often seek advice and information from other sources. This is often ambiguous, conflicting and out of date, affecting the outcome of their diabetes in the long term. Locally, there are huge variations in knowledge, advice and information provided, as well as in the standard of educational materials for patients.

The development of group education sessions for individuals diagnosed with type 2 diabetes will improve access to specialist information and support within a month of diagnosis. These sessions will be run fortnightly (as a 6-month pilot) at various locations, dates and times, and will be provided by a multidisciplinary team. It is hoped that this will provide patients with accurate information, at a time when they are more receptive to making positive lifestyle changes (Everett and Kerr, 1998).

- ***Podiatry:*** Inequity of access to podiatry was also evident. A few practices have an in-house service, which includes screening and treatment, but others do not have this and patients have to be referred on. Many people were considered as missing care, where it was not being provided locally. Increasing clinical support and in-house training for practice nurses and GPs within foot screening would provide support in practice, increase knowledge, and strengthen confidence in applying new skills, into clinical practice.
- ***Community nursing:*** Most of the community nurses (CNs) and elderly care team felt that their service was greatly under-used in the management and care of people with diabetes. Currently, local CNs provide a service to the housebound with acute problems, which generally consists of performing an HbA_{1c}, blood sugar profile, blood pressure measurement or injecting insulin for those with poor eyesight. They felt that their role and responsibilities in the care of people with diabetes were largely unclear and ad hoc.

The role and responsibilities of this group of nurses are currently being reviewed locally. This offers them a great opportunity to be proactive and become involved in the direction of their role development. The CNs want to provide a greater package of care to the housebound, to expand and develop their skills to enable them to commence people on insulin, and to be key players in screening and in the provision of ongoing care to people with diabetes. The diabetes team is positively supporting the review and the reshaping of the existing service.

Patient empowerment

The baseline review highlighted the fact that patients were infrequently empowered for self-management and were generally referred to the DSN service for information. Most professionals did not feel confident or equipped with the skills or expertise to encourage or guide patients in this area. This aspect is being incorporated into all programmes of education, and a patient with diabetes will be invited to talk at each education session, to give his/her perspective of life with diabetes.

Patient education

Patient educational materials are currently under review. Plans are in progress to standardise the information given to patients. A wide range of topics will be available in the languages spoken throughout the locality, in written and audiovisual format, and will

also be easily accessible on the local website. A rolling programme of education is being developed for individuals with longstanding diabetes, in a similar format to the group education sessions for those diagnosed with type 2 diabetes, to enable them to dip into education as needed. The development of an 'expert patient group' is also in its infancy.

Professional education

This was a major issue throughout the baseline review. The vast majority of professionals have little access to programmes of education, particularly GPs, who also have the problem of securing locum cover (at a time when GPs are in shortage) and locum fees. In addition, service demands do not ensure that nurses will be released to attend study days, and funding for such activities is not always readily available.

The DSN service has provided various education sessions over the years for many healthcare professionals. Demands for the service have not always enabled programmes of education to be held as often as they would have liked, and although there was an opportunity to provide mentorship, this was not always sought within general practice. The provision of structured programmes of education for professionals will increase knowledge, develop skills and expertise, and increase confidence in the application of new skills to clinical practice. This will empower professionals, and thereby lead to the empowerment of patients.

Besides the multidisciplinary satellite course *Certificate in Diabetes Care* (Warwick University), other programmes of education and study days will be supported by robust mentorship programmes and clinical support. This will enable individual professional development, according to pace and level of practice. Overall, it will improve the quality of care delivered and help develop a skilled workforce.

- Study days will be tailored to meet the needs of all professionals, including nursing home staff, through targeted training of senior and permanent nursing staff, to enable the cascade of information to junior staff. Other staff will include health visitors, midwives and school nurses.
- A rolling programme of topic-related study days would be rolled out for all healthcare professionals, auxiliaries, care assistants and receptionists.
- Accessing NVQ training courses will enable healthcare assistants to be trained and updated as necessary.
- Master classes will provide professionals with an opportunity to learn from real situations.
- Advanced study days will be available to those interested in commencing patients on insulin, patient self-management and insulin pumps.

Equipment

A significant number of practices did not have the correct equipment to perform a thorough diabetes review of their patients. Although all practices were issued with a standardised glucometer more than 18 months ago, many are now using alternatives that are not included in external quality assurance programmes, highlighting the need for ongoing training. This is currently being planned following the restandardisation of glucometers throughout primary care.

Links with the biochemistry department have helped in the development of ongoing external quality assurance mechanisms for the glucometers. Missing equipment included monofilaments, glucometers, BMI charts and tuning forks.

IT and audit

Diabetes register: The lack of integration leaves general practice reliant on paper copies for feedback on patients from the hospital-based register. This feedback can be intermittent and lead to duplications or omissions in care. However, practices do appreciate the long-term benefits that an integrated register will bring. Continued promotion of the system and preparation of practice registers will continue.

Clinical information systems: Local IT systems have already been targeted to improve the quality of information held, and staff have been employed to integrate the community and hospital systems. Paper registers have been maintained in many practices, as IT systems were found to be too technical, not user friendly and too old to operate. A significant number of healthcare professionals also feel frustrated

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4 Equipment that was missing included monofilaments, glucometers, BMI charts and tuning forks.

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1 Patients' opinions are not routinely sought locally.

2 A practitioner's personal study supported the hypothesis that patients would like to receive their diabetes care under one roof within their general practice.

3 Seeking users' views is a recommended method of identifying areas of need and thoughts about existing services.

4 Allocation of the DSNs to groups of GPs and hence community nurses will help to provide more local services for patients.

by these systems, as they are inaccurate and often provide unilateral data.

Without an operational register, the risk of individuals not being recalled for care is increased. Further training and support in the use of clinical information systems is therefore being planned for practice staff.

Audit: Only a minority of practices are performing in-house audit and setting targets to improve the outcomes of diabetes-related care. This is not helped by the under-utilisation of IT systems. Currently, the local PCT does not require audit to show that targets are being met and there is no incentive, other than self-motivation, for practices to audit.

Audit assists future service developments. Incentive payments to practices to achieve goals in diabetes care would indirectly encourage them to improve the use of IT systems and perform audit; in turn, this will indicate whether targets are being met, thereby enabling benchmarking.

A minimum data set is being developed for use within general practices, which will reflect the data used in the NSF for Diabetes. This will help standardise care, facilitate audit and integrate the local diabetes register.

Patients' views

Evidence from a previous review of the opinions of service users of the diabetes services performed as part of the National Clinical Governance programme, identified that they were generally happy to receive care from the specialist services. Patients' opinions are not routinely sought locally; one example, which was part of a practitioner's personal study, was found. The findings of this study supported the hypothesis that patients would like to receive their diabetes care under one roof within their general practice. It is, however, acknowledged that when asking patients about the type of care they would like to receive, responses usually indicate that they are generally happy with their current service.

Seeking users' views is a recommended method of identifying areas of need and thoughts about existing services (Audit Commission, 2000). This highlights that patients need to be fully informed and involved in all stages of all care processes. An 'expert patient group' is in the development stages; this will form part of the pilot scheme with the DoH, which is further supported in the NHS plan (2000). A user survey is also being planned on a large scale, and people with diabetes have been invited onto development groups and educational programmes.

Future development plans

(1) A comprehensive paper was jointly produced by the members of the diabetes team (employed by SMPCT and SMUHNT). The paper highlighted how local people could have faster access to equitable and quality care, and speedier access to specialist services within the community, as supported within the NHS Plan (DoH, 2000). The paper competed against many other bids for tier-2 funding, and was successful in securing a substantial amount of funding. This will enable local service developments within diabetes to take place, from which patients will directly benefit. It will also aid implementation of the proposal and its recommendations in the future.

Plans will focus on two separate areas of development in tandem, allowing routine, structured annual review of patients to be cared for in the community. Locally, this will free up more than 1200 follow-up appointments per year, currently used for routine annual review in secondary care, and will also allow space for rapid referral of more complex patients to specialist care. In more detail:

- One part of the development will be to work with those practices identified as currently providing diabetes care, to ensure a minimum standard of care, support and audit of practices. Once a practice is accredited, secondary care will be able to discharge patients back into primary care with an agreed management plan. This will be supported by clinical support in practice and structured programmes of education such as the *Certificate In Diabetes Care* (Warwick University). This is a multidisciplinary satellite course, from Warwick University, which will be available locally to any health professional within primary care.
- The second area is the development of an intermediate tier of care, provided within the community, and supported by a DSN, dietician, podiatrist and GP with a special interest in diabetes. The pilot scheme will offer a service for practices

that cannot currently offer an in-house service to their patients. It will enable care to be more equitable across the PCT and, at the same time, remove routine care from the hospital system. This will allow patients with more complex needs to access the hospital specialist services quickly, as waiting times will be reduced. Patients seen within this system will have a management plan discussed and agreed for future management, which will be shared with respective practices. In the long term, all patients will have quicker access to a multidisciplinary team within the community and in the hospital.

(2) The baseline review has helped to identify how capacity could be increased within general practice, namely by reviewing the services already present and redirecting and streamlining as necessary.

(3) Allocation of the DSN service to groups of GPs and community nursing teams will help to provide more local services for patients. It will also improve communication between members, promote better team working and integration of services, and help to clarify the role and responsibilities of each member of the diabetes team in the provision of care to the elderly and the housebound.

(4) The baseline review will be repeated in 5 years time.

Sharing findings

'*The provision of diabetes care depends on a positive culture of change, requiring recognition, adjustment and effective management*' (Shaw, 1999).

The findings were disseminated widely to all healthcare professionals in both the hospital and community sectors. This took the form of presentations, enabling questions to be answered. A full and final document has also been produced, and is available in hard copy or over the local intranet to all local personnel working for the acute and community trusts.

This document clarifies how the recommendations set out in the report address the NSF for Diabetes standards (DoH, 2001). Individual practice feedback reports have also been developed to assist practices in planning diabetes care according to the level of care provision currently being provided. A newsletter for patients, which describes the baseline review, has been developed and will be available in all local general practices.

Conclusion

The baseline assessment was very successful and has provided a detailed picture of the current service provision within general practice. It has helped secure funding and a commitment from the PCT to restructure the service, re-deploy resources more efficiently, and support professional development, recognising that education is key to the provision of quality clinical care. These developments will facilitate integration of services between the hospital and community sectors, and thereby ensure that the provision of care to patients is efficient, of high quality and provided locally. ■

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1 A newsletter for patients, describing the baseline review, will be available in all local general practices.

2 The baseline assessment was a very successful exercise.

3 It has helped to secure funding and a commitment from the PCT to restructure the service, re-deploy resources more efficiently, and support professional development.