Impact of a practice nurse with special interest in diabetes

Lynne Jennings, Practice Nurse with Special Interest in Diabetes, Community Diabetes Team, NHS Birmingham East and North PCT

Practice nurse with special interest (PNSI) in diabetes is a new role developed by NHS Birmingham East and North (BEN) PCT to support GP practices that were not achieving acceptable levels of routine diabetes care.

Three such practices were identified from PCT data. The PNSI ran weekly clinics at each practice with the practice nurse and GP for several months from May/June 2007. Staff were trained to establish a diabetes register; to create a robust call, review and recall system; and trained to triage patients to community clinics and education sessions as appropriate.

In 2009/10 the QOF HbA_{1c} indicator was reduced from ≤7.4% to ≤7% (≤57 to ≤53 mmol/mol). The data presented here show the percentage achievement of the higher HbA_{1c} indicator for each practice between 2007 and 2008, and then for the lower HbA_{1c} indicator for each practice in September 2009.

Results

Practice 1 had a very proactive nurse, but the GP did not work to any diabetes guidelines. The PNSI has introduced the local diabetes guidelines and established weekly diabetes clinics. The practice has also employed two healthcare assistants to assist with taking blood samples and calling in patients.

Between May 2007 and December 2008 the percentage of people with diabetes with an HbA_{1c} level of <7.4% (<57 mmol/mol) increased from 1% to 40%. Follow-up data for September 2009 shows that the practice has now achieved 25% of patients with an HbA_{1c} level of ≤7% (≤53 mmol/mol) and 52% with an HbA_{1c} level of ≤8% (≤64 mmol/mol). The practice is now achieving 62% of patients with a blood pressure (BP) of ≤145/85 mmHg; 73% have a total cholesterol level of ≤5 mmol/L, 60% have had their feet examined and 51% have received testing for microalbuminuria.

Practice 2 did not have any structured routine care. The practice nurse was inexperienced and there was no lead GP for diabetes. This practice now has organised administration staff to identify which people with diabetes need to be recalled and reviewed. The practice nurse has undertaken the Warwick Certificate in Diabetes Care, and one of the GPs has recently started the course. This practice will consider offering an enhanced diabetes service within the next 12 months.

Between June 2007 and December 2008 the percentage of people with diabetes with an HbA_{1c} level of <7.4% (<57 mmol/mol) increased from 13% to 55%. Follow-up data for September 2009 shows that the practice has now achieved 22% of patients with an HbA_{1c} level of ≤7% (≤53 mmol/mol) and 42% with an HbA_{1c} level of 8% (≤64 mmol/mol). The practice is now achieving 57% of patients with a BP of ≤145/85 mmHg; 48% have total cholesterol levels of ≤5 mmol/L, 29% have had their feet examined and 44% have received testing for microalbuminuria.

Practice 3 had poor record-keeping and had patients with diabetes who had left the surgery but were still registered at the practice; 399 patients with diabetes were registered, yet there were only 304 patients. Coding for diabetes was incorrect and some patients had a code for diabetes when they should have been coded "impaired glucose tolerance". Several codes had been used for diabetes. No one in the practice took a lead role for diabetes.

Between June 2007 and December 2008 the percentage of people with diabetes with an HbA_{1c} level of <7.4% (<57 mmol/mol) increased from 5% to 54%. Follow-up data for September 2009 shows that the practice has now achieved 26% of patients with an HbA_{1c} level of ≤7% (≤53 mmol/mol) and 53% with an HbA_{1c} level of 8% (≤64 mmol/mol). The practice is now achieving 69% of patients with a BP of ≤145/85 mmHg; 69% have a total cholesterol level of ≤5 mmol/L, 49% have had their feet examined and 53% have received testing for microalbuminuria.

Conclusion

The data presented here demonstrate that the PNSI role had a profound effect on glycaemic control, and each practice has continued to improve their overall standard of diabetes care – even when the PNSI has left – because the practice staff have been empowered to take control of the diabetes care.

The role of PNSI can provide practical in-house support for GP practices that are not achieving an adequate standard of diabetes care. The PNSI is an important link between these practices and secondary and community diabetes services. ■