

Improving access to diabetes care in a primary care trust

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Introduction

In light of the implementation of the new General Medical Services (GMS) contract and the diabetes National Service Framework (NSF) delivery strategy, it is essential that all patients with diabetes receive high-quality, structured care. This is an account of how a primary care diabetes nurse improved access to structured care for patients with diabetes in Bradford City Teaching Primary Care Trust.

The *NSF for Diabetes: Delivery Strategy* (Department of Health, 2003) and the new GP contract has placed primary care trusts (PCTs) at the forefront in the commissioning and delivery of diabetes care. Throughout the UK, PCTs will be addressing implementation and delivery of health care, sensitive to local and individual healthcare needs – ensuring that care provision is accessible, efficient and of a high standard (DoH, 1998), in line with local clinical governance delivery mechanisms. Implementation of the NSF standards will be a real test for PCTs, and to ensure that improvement in diabetes care is achievable, the Government will need to provide adequate resources to deliver the services required.

Before the publication of the *NSF for Diabetes: Delivery Strategy*, no real framework existed to facilitate and support structured care for people with diabetes. While this document has given little directive regarding exactly how the standards are to be delivered, it does encourage PCTs to consider the development of services to people with diabetes, which should mirror local health care needs to reach all local priority areas.

Bradford City Teaching Primary Care Trust (tPCT) recognised the challenge to address this and the need to focus on diabetes as a local priority (Small and Proctor, 2001).

The creation of the tPCT in Bradford City has provided an opportunity to address the key challenges involving key stakeholders, PCTs and other organisations.

Bradford City tPCT profile

In the UK, people of African or Indian descent are at particular risk of developing diabetes – reported rates in these populations are at least four times higher than in Caucasians (Chaturvedi et al, 1994).

Bradford City is one of three PCTs in Bradford and it serves a population of approximately 147 000 people of mixed ethnic backgrounds. The majority of these (55%) are of South Asian origin (Bradford City tPCT, 2002). Of these 147 000 people, approximately 6500 were reported as having diabetes in 2002 – a prevalence of 4.4%.

Bradford City tPCT serves two of the top five most deprived wards in England, which have high rates of unemployment and poor quality housing. The higher prevalence of diabetes in groups with lower socio-economic status has been well documented (Evans et al, 2000).

Robinson et al (1998) also argued that increased social deprivation is related to poorer diabetes control, and anecdotal evidence and data generated from the baseline review in our study seems to confirm this.

Studies by O’Gara (2000) suggested that the majority of people with type 2 diabetes are more likely to receive all their care within general practice rather than in secondary care centres, and Greenhalgh (1994) demonstrated that patients receiving unstructured care had poor health outcomes.

ARTICLE POINTS

1 Primary care trusts are at the forefront of commissioning and delivery of diabetes care.

2 Prevalence of diabetes is higher in groups with a lower socio-economic status.

3 Severe recruitment and retention issues impact on the delivery of chronic disease management.

4 A baseline review was necessary to establish current levels of diabetes services provision.

5 Quality diabetes care is dependent on well organised and systematic service delivery.

KEY WORDS

- Primary care
- Diabetes
- Diabetes National Service Framework
- Baseline review
- Structured diabetes care

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PAGE POINTS

1 Staff recruitment and retention issues in Bradford City tPCT led to the birth of the '3S' model and the establishment of a Nursing Support Team.

2 The aim of the NST was to support GP practices in the delivery of health care, alleviating the burden placed on them.

Bradford City tPCT comprises 40 GP practices, of which more than 50% are single-handed and have severe staff recruitment and retention issues impacting on the delivery of chronic disease management. Of all the general practices, 35% are without a practice nurse. Practice nurses have a great deal to offer in meeting the modernisation agenda in primary care. It was with this in mind, and in recognition of the health and social challenges within the trust, that Bradford City became a teaching PCT in April 2001. Meeting these challenges and the need to recruit and retain high-quality primary care professionals were high priorities.

The staffing issues meant that the trust was facing a potential 'workforce time bomb', and this led to the birth of the '3S' model (Figure 1) and the establishment of a Nursing Support Team (NST). The team consisted of a coordinator, a nurse practitioner, four practice nurses, ten staff nurses and two healthcare assistants, employed on a full- or part-time basis. The aim of this new initiative was to support GP practices in the delivery of health care, alleviating the burden placed on them. The tPCT recognised that the team would need

preceptorship, and academic and clinical support to develop and maintain the skills required for the job. This was facilitated through the support of the teaching trust.

This creative initiative enabled salaried GPs and all healthcare professionals employed by Bradford City PCT to work in the secure culture of a PCT contract; with the support of a coordinator and mentorship; and with the stimulation of a challenging work environment and a culture which encourages personal and professional development, nurturing new team members through a supportive structure which is achieved through the tPCT ethos and close links with the University of Bradford.

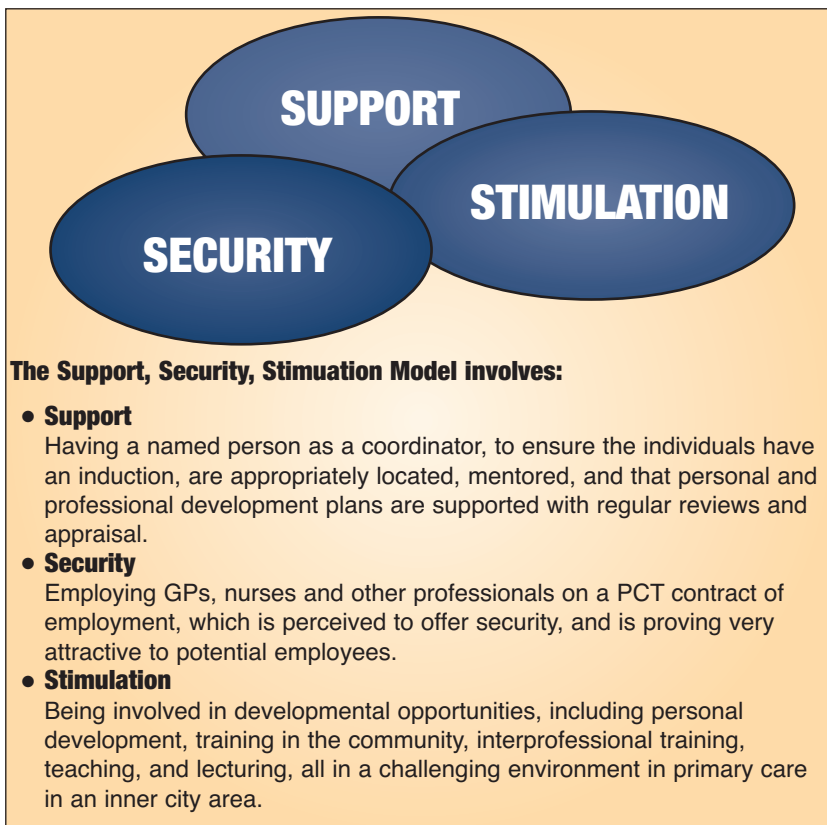
At the time of writing, the NST consisted of 26 healthcare professionals of varying designations, including three language-support workers. Following a recent review of the scheme, further improvements are being made in the re-organisation of the service, allocating nurses to locality teams. A senior nurse will have an overall leadership and development role, including service development within the GP surgery, thereby encouraging closer integration, continuity of care and a sense of ownership within the practice (Stinson et al, 2004). In addition, this will provide regular support to GPs in the expansion of service provision and in meeting PCT plans and quality and outcomes framework targets in chronic disease management.

In order to ascertain the levels and provision of diabetes care currently being delivered across the tPCT, a baseline review was required – one of the key steps documented in the NSF delivery strategy (DoH, 2003).

Baseline review

The baseline assessment was undertaken in June 2002. Each practice was informed by letter of the author's role within the PCT, and the rationale for the need to establish diabetes service provision within the GP practice. Subsequently, practices were contacted to arrange convenient appointment times. As both clinical and administrative information was required, the practice manager and the practice nurse were invited for interview.

Figure 1. The '3S' model developed to address Bradford City PCT's staff recruitment and retention issues.



Data were obtained using a semi-structured questionnaire to document evidence of standards of service such as diabetes register, diabetes qualifications held by practice nurses, practice protocols and time apportioned to diabetes consultations (Table 1).

Results

Of all GP practices, 55% had designated diabetes clinics, with allotted consultation times varying from 10–30 minutes. The remaining 45% delivered diabetes care 'ad hoc', reporting no structure or systematic call-recall system in place, and with an incomplete or lack of a diabetes register.

Of the practices that did have a designated diabetes clinic, 80% reported that their diabetes registers were up to date. The Audit Commission's *Testing Times* report demonstrated a variation in the standards of diabetes care delivered, highlighting the lack of structured programmes of care and education for people with diabetes (The Audit Commission, 2000). One of the key interventions of the NSF Standard 4 is to provide structured care programmes to people with diabetes (DoH, 2001)

A large proportion of those without any structured care were single-handed GP practices. The provision of practice nurse support under the 3S model has since helped to alleviate some of the problems faced.

Practices struggled to identify specific patient groups:

- 18% were able to identify patients who were housebound or in residential/nursing homes.
- 37% were able to identify those who received an annual review.

All GP practices had access to podiatry services, dietetic provision, and retinal screening via the district-wide optometry based programme.

Initially, some suspicion existed from the practice staff, who regarded the interview as a 'PCT policing' exercise. This was soon dispelled when a full explanation was provided. A minority of staff responded negatively when approached in terms of change and the implementation of designated diabetes clinics within their

Table 1. Examples of questions asked during the interviews

- Do you have a designated diabetes clinic?
- Can your practice identify patients with type 1 and type 2 diabetes?
- Can you identify those patients who are housebound or living in residential/nursing homes?
- Do you have a practice diabetes register?
- Do you currently have a practice diabetes protocol?
- How much time is allocated for each diabetes appointment?
- Do you have access to podiatry/dietetic services?
- Do the patients with diabetes receive an annual review?

practice, a common response being: 'We have tried it before and it was unsuccessful'. However, the overall response was very positive, with participants welcoming the support and assistance to set up structured diabetes clinics.

The lack of clinical information systems within the practices made the identification of people with diabetes laborious and time consuming.

Implementation

Processes were implemented to identify or update the diabetes practice population. These included identifying diabetes patients by prescription requests, hospital correspondence and discharge letters. In addition, a manual search of the medical records was undertaken with the support of the PCT pharmaceutical and diabetes team. A sound infrastructure underpins systematic and quality diabetes care and it is essential that this fundamental and basic requirement is in place before primary care clinics can be implemented.

Due to lack of consistency and user friendly diabetes clinic templates, a tPCT template was developed.

Education/training

Data from the baseline review reported that 50% of all practice nurses within the GP practices had undertaken an accredited course in diabetes management. All qualified members of the tPCT and NST working within the diabetes clinics have completed or are currently planning to undertake a course in diabetes management.

The appointment of a nurse consultant in diabetes has strengthened the service by

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2 The remaining practices delivered diabetes care on an 'ad hoc' basis.

3 A large proportion of the health centres without structured care were single-handed GP practices.

4 The overall response to the interviews was very positive, with participants welcoming the support and assistance to set up structured diabetes clinics.

5 Data from the baseline review reported that 50% of all practice nurses had undertaken an accredited course in diabetes management.

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ACKNOWLEDGEMENT: The author would like to thank all those who participated in the baseline review, and all colleagues involved in the study - in particular the Nursing Support Team.

providing expert education training and leadership. To address educational issues relevant to all healthcare professionals across the three Bradford PCTs, an education strategy group was formed.

The tPCT 3S model supports the professional development of healthcare staff. Local educational events organised by tPCT and delivered to multi-professional groups provide up-to-date evidence to clinical practice, and are enhanced by the provision of resource packs for each practice (including documents on local contact numbers, the local diabetes protocol, investigative procedures, referral forms and a list of recommended opticians in the Bradford area).

Language support

A high percentage of patients in Bradford City tPCT do not speak English as their first language. This created communication difficulties for both the patient and healthcare professional. It was not uncommon to rely on practice staff or relatives to translate. The lack of translation skills and issues around confidentiality were obviously a great concern, leaving the quality of the consultation to be questioned. To address this issue, the tPCT has appointed language-support workers with accredited qualifications in translation skills to work specifically in diabetes. Additionally, two language-support staff and two Asian-speaking nurses have since joined the NST.

Conclusion

The baseline assessment was successful and provided valuable data on the current service provision to people with diabetes in general practice.

Results have helped to secure funding and investment in additional services and expansion of dietetic and podiatry service provision. The baseline review also enabled the author to prioritise the need for the implementation of structured diabetes care within a primary care setting.

The NSF for diabetes calls for a change in the way diabetes care is delivered - that is, in a structured and systematic way (DoH, 2001). The importance of implementing structured care to people with diabetes in

a designated clinic is obvious, as previous studies have clearly demonstrated that good quality care in general practice is dependent on well organised and systematic service delivery (Griffin, 1998). This will ultimately reduce the burden placed on the already under-resourced satellite services and secondary care within Bradford.

This article highlights the difficulties faced by many inner city PCTs in terms of meeting the NSF standards and how these have been addressed in Bradford city tPCT. The introduction of creative and innovative initiatives has helped to alleviate some of the problems faced.

The survey demonstrated a wide variation in standards and resources within general practice. It is only with the additional resources, the provision of structured care incorporating a systematic call/recall and through collaborative working that we have been able to increase the proportion of practices with structured clinics from 55-84%. Future projections are that all GP practices will have a structured diabetes clinic in place by winter 2004. In addition, 100% of practices now have clinical IT systems in place with training needs identified to ensure that an integrated and sustainable infrastructure is achieved. The introduction of the new GMS contract, with particular reference to the Quality and Outcomes Framework, will hopefully maintain the motivation of the practices to make further progress to achieving the NSF standards.

Future goals include:

- Improving access for patients with diabetes who are housebound or living in residential/nursing homes
- An audit of diabetes clinics before and after the new GMS contract
- Undertaking a patient satisfaction survey
- Implementing patient group education programmes.

In their article, Small and Proctor (2001) have demonstrated that primary care organisations in Bradford have a track record of collaboration and innovation. By working in a flexible, dynamic and creative way, there is a real commitment to focusing on the priorities of the local population and to learning together to address them. ■