The right care, at the right time, in the right place – can audit help?

Alison McHoy

Introduction

As a result of government initiatives, secondary care trusts face the challenge of shifting the focus of diabetes management towards primary care. This article describes how a diabetes team at Worthing and Southlands Hospitals NHS Trust used a patient questionnaire and audit to review current practice against existing standards, in order to identify ways in which the diabetes specialist nursing service could be developed to cope with increasing referrals, improve the health outcomes and patient experience, and help meet the short-term targets of the diabetes National Service Framework, less than two years away.

Our diabetes team is constantly evolving in response to the demands of local and national healthcare organisations or public opinion. Yet never before has the pace of change moved so fast. As a result of *Shifting the Balance of Power* (Department of Health [DoH], 2001a, 2002) and the new General Medical Services (GMS) contract (DoH, 2003a), like secondary care trusts throughout the country we face the challenge of shifting the focus of chronic disease management towards primary care, while also improving the health outcomes and experience of our patients.

The progressive rise in the incidence of diabetes mellitus worldwide has been reflected locally in the development of our diabetes team, and the increasing number of people with diabetes referred to the department each year.

Why was change needed?

At the end of 2003 we were beginning to see a noteworthy change in the quantity and quality of referrals to the diabetes specialist nursing team. Faced with the GMS contract in April 2004, and the short-term targets of the *National Service Framework (NSF) for Diabetes: Delivery Strategy* less than two years away (DoH, 2001b, 2003b), we envisaged that the diabetes service we were providing at that time would not be able to cope with the predicted increase in referrals – externally from primary care and internally from wards.

With no ring-fenced funding for diabetes care, and the prospect of being expected to achieve more with less, it was clear that previous efforts at service redesign and new ways of working were insufficient to meet future demand.

Diabetes is a key area

By May 2004, primary care trusts (PCTs) in Surrey and Sussex had produced the document *Transforming Care for People with Chronic Conditions in Surrey and Sussex*, which focuses on the active management of chronic conditions in partnership with service users.

The aim of this document is to:

> ***'… engage and enable all professionals to work across organisational boundaries to extend their capability and span of influence, creating a system and processes that support more integrated working.'***

Diabetes is highlighted as one of the five target disease areas in this document.

Amid negotiations at a strategic level between primary and secondary care making slow but steady progress, our department decided to use a patient questionnaire and audit to review specific issues of current practice against existing standards, in order to aid development of the way the diabetes specialist nursing service is managed in the future.

ARTICLE POINTS

1 Diabetes care is now high on the agenda of chronic disease management. Timely and appropriate referral to specialist care services is fundamental in helping patients achieve optimal control.

2 Listening to patient opinion locally via patient questionnaires can help to ensure that changes in service delivery remain patient-focused and community responsive.

3 Audit can help to review specific issues of current practice against existing standards, and identify ways in which a diabetes nursing service is managed in the future.

4 The provision of successful and effective care can only be achieved through closer partnerships between primary and secondary multiprofessional teams.

KEY WORDS

- **Diabetes service provision**
- **Secondary care**
- **NSF for Diabetes**
- **Patient questionnaire**
- **Audit**

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PAGE POINTS

1 One hundred patients attending the diabetes centre were asked where would they prefer to receive their diabetes care, and why.

2 Of the 98 respondents, 55% preferred to attend the diabetes centre, 22% were happy with joint care, and 22% preferred the primary care setting.

3 Reasons for preferring to be seen in primary care were convenience, accessibility, and the fact the GP/practice nurse was more familiar with their general health status than the diabetes centre.

4 Of those who preferred to visit the diabetes centre, many would go to their GP practice if they could expect to receive the same level of specialist expertise as at the diabetes centre.

5 Respondents would like to see: continuity in the health professionals seen; improved communication between primary and secondary healthcare professionals; and greater access to education and support.

Patient questionnaire

One hundred patients attending the diabetes centre, for either a group session or to see a health professional on an individual basis, were asked to complete a brief questionnaire exploring their perception of the diabetes service locally. A 98% response rate was achieved.

Questionnaire results

When asked where would they prefer to receive their diabetes care if they had a choice, and why, 55% of participants stated that they preferred to attend the diabetes centre, 22% were happy with joint care between primary and secondary care, and 22% preferred to have their care provided solely in the primary care setting (1% of questionnaires were not completed).

People with diabetes who favoured receiving their treatment in primary care generally cited convenience, accessibility, and the fact the GP and/or practice nurse was more familiar with their general health status than the diabetes centre as reasons for this preference.

However, many of the those who preferred to visit the diabetes centre stated that they would also like to go to their GP practice if they could expect to receive the same level of specialist expertise that they received at the diabetes centre. It is, therefore, not necessarily the venue or professional title that our patients value, but the quality of service and expertise that they receive – as well as having confidence in the person providing the care.

The questionnaire also asked participants what improvements they would make to local diabetes services if they could plan how diabetes care was provided. The majority of participants were happy with the care they received, irrespective of where they received it. However, three common themes emerged as to what improvements they would make:

- continuity in health professionals seen
- better communication between primary and secondary healthcare professionals
- more education and support, and greater access to it.

The questionnaire thus provided us with a clear example of patients placing value on the interpersonal relationships with healthcare practitioners rather than biomedical targets.

Audit

The document *Transforming Care for People with Chronic Conditions in Surrey and Sussex* recommends:

> ***'…offering the "right care at the right time in the right place", utilising the most appropriate expertise, and building on the strength of primary care, while ensuring acute services provide what only they can.'***

In light of this, a one-month snapshot of 73 inpatient and outpatient referrals to the diabetes specialist nursing team was audited to assess their quality, appropriateness, and timeliness. Were we seeing the right patients, at the right time, and in the right place?

Aims of the audit

From the audit findings we hoped to identify possible gaps in service provision and areas for development, including new ways of working, and to establish outpatient and inpatient criteria for referring patients to the diabetes specialist nursing team. We were aware that while referral criteria can aid the decision-making process with respect to referrals and management of human resources, care must be taken to ensure that patients continue to have choice.

Audit findings

Although the audit data are still being processed and evaluated, preliminary results can be reported.

The findings highlight the varying levels of competence and confidence in dealing with diabetes among professionals in both primary and secondary care. While many doctors and nurses are proficient in the delivery of diabetes care, others appear to lack the resources (whether knowledge-based, structural or human) to achieve the level of care specified by the National Institute for Clinical Excellence (NICE), the diabetes NSF and the new GMS contract.

The details received with inpatient referrals were generally poor, with 68% of staff providing less then 50% of the standard information required for the diabetes team to adequately process a

request for a ward visit. Despite insufficient details, all patients were reviewed.

However, following the ward visit 37% of referrals were deemed inappropriate, based on experiential knowledge and whether the diabetes specialist nurse (DSN) was able to take an active/decisive role in determining events. The time spent going to a ward and establishing that there was no need for DSN input (resulting in the referral being deemed inappropriate) equated to approximately 7.5 hours of wasted DSN time in the month audited.

Identifying standards for appropriate referral has been the most difficult part of the audit process for outpatient referrals, and has made us look closely at the service we provide now and should be providing in the future.

Of all the outpatient referrals in the audit period, 94% were referred either for insulin transfer or review of insulin regimen, reflecting the majority of our annual workload. Sixty per cent of all the outpatient referrals were assessed as appropriate for specialist care review, 11% could have been dealt with in primary care, and 29% lacked sufficient information to identify why the patient was being referred, or which individual or group session, if any, was required.

It has been estimated that at least 30 minutes was spent on each inappropriate or incomplete referral, liaising with the patient or primary care health professionals to obtain vital patient information that had not been provided, in order to establish need or give advice.

It has further been estimated that the inappropriate inpatient and outpatient referrals created at least 14.5 hours of DSN or secretarial work – time that could have been spent in more productive ways.

Implications for practice

Undertaking a patient questionnaire and the referral audit has enabled us to explore critically what we do on a daily basis. We provide a variety of nurse clinics and group sessions, and the audit has reiterated the need for standard referral criteria, to ensure that the referral process is time efficient and patients are not batted around between healthcare professionals while referrals are being processed.

The final referral criteria will be amalgamated into our integrated care pathways, which are currently being written, and incorporated within the National Booking Programme (DoH, 2003c).

For our department, the audit has shown that the majority of referrals are appropriate and timely. These findings, combined with the questionnaire results, have prompted us to begin to address where specialist diabetes services may best be located.

Future projects

In addition to compiling standard referral criteria, providing education, and re-auditing (work currently in progress), a pilot study in which the nurse consultant or DSN facilitates a diabetes specialist clinic in a GP practice is to commence in September. This study aims to increase patient access to specialist care closer to home, ensuring that referrals are more timely, appropriate, and convenient for the patient, while providing the opportunity to enhance the knowledge of healthcare professionals working in primary care.

This venture is currently in an embryonic stage of development. If the pilot study proves successful – in terms of partnership working, patient and health professional satisfaction, biomedical outcomes, and cost and time efficiency – such a project will only be able to be rolled out as a trust-wide initiative if adequate resources and infrastructure are in place. Fundamentally, this will require the DSNs involved to have the autonomy to work as independent expert practitioners.

With increased patient involvement and empowerment high on the agenda (DoH, 2001c), there is no place for ownership disagreements between primary and secondary care in self-management models. 'Shifting the balance of power' should not result in a dilution of specialist expertise in diabetes at the expense of patients receiving the care nearer to home.

It is essential that we work together in partnership across organisational boundaries to break the historical barriers that may prevent patients receiving the right care, at the right time, in the right place, and by the right person. ■

PAGE POINTS

1 With the focus on increased patient involvement and empowerment, there is no place for ownership disagreements between primary and secondary care in self-management models.

2 Diabetes health professionals in primary and secondary care need to work together to break the barriers that may prevent patients receiving the right care, at the right time, in the right place, and by the right person.

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