DSN clinics in general practice: the Chichester experience so far

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ARTICLE POINTS

1 A PCT baseline diabetes audit highlighted service gaps.

2 Pharmaceutical company funding was secured for a 12-month project into DSN impact on diabetes control. This was undertaken through clinics in 4 local primary care practices.

3 Patients on oral hypoglycaemic agents with poor HbA_{1c} levels were targeted in the clinics.

4 Results so far suggest that monthly or bimonthly, rather than twice monthly, clinics are effective. Only select practices are in need of guidance and numbers attending clinics could be increased if inclusion criteria were broadened.

KEY WORDS
- **Audit**
- **Targets**
- **Clinic**
- **Insulin**
- **Interventions**

Introduction

Following the Audit Commission's publication 'Testing Times', a baseline diabetes audit was undertaken by the Western Sussex Primary Care Trust (PCT) to review their services. Both our audit and the Commission's showed similar service provision gaps. To tackle these gaps, the PCT was approached to fund additional DSN hours so practices could have a named DSN who would work with them to increase skills and quality of care within primary care. On refusal, funding was provided by a pharmaceutical company. This article discusses the audit results, steps taken to improve care by the provision of general practice clinics and their outcome to date.

'Testing Times', the report of a two-year survey, published by the National Audit Commission early in 2000, reviewed diabetes services in England and Wales. It described the provision of diabetes care, drawing on evidence from hospitals, general practices, health authorities and a large survey of people with diabetes. Amongst other findings, it discovered that little strategic planning was evident, despite existing services already being under considerable strain. More patients were being managed in primary care with primary care teams providing routine care for about 75% of their patients with diabetes.

National standards were reported to vary considerably, with four out of 10 practices lacking referral guidelines for diabetes and one-third of clinics being run by practice nurses alone. Health professionals delivering services in primary care did not always have the training or support they needed. Practice nurses providing diabetes care very often worked in isolation – some of these nurses had no formal training in diabetes care and those that had attended courses a number of years ago.

A baseline diabetes audit undertaken by the Western Sussex Primary Care Trust (PCT) highlighted service gaps similar to those highlighted in the Audit Commission report. It found that in some practices the prevalence of diabetes was lower than the national average, highlighting that a number of practice registers were incomplete. There was disparity in the quality of care provided and in educational standards – some nurses leading diabetes care, had no formal training in diabetes care and management. There was a lack of compatible information technology, leading to a lack of comparable audit data. Care of housebound patients was negligible and no practices offered patients personal diabetes management plans.

Alongside this, all practices required support in order to implement the National Service Framework (NSF) for diabetes.

When the *National Service Framework for Diabetes: Delivery Strategy* set targets to be achieved by March 2006 it was felt that additional DSN hours would be required to assist practices achieve the targets without adversely impacting on the existing DSN workload. We highlighted the following targets in a business case to the PCT:

- Practices have to ensure they have comprehensive up-to-date registers. Delivering diabetes care relies upon the establishment of effective registers.
- PCTs should ensure systematic treatment regimens are in place, which will be based on a diabetes record and

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care plan developed and agreed jointly by the patient.

- The NSF highlights the need for diabetes services to ensure there are enough staff with appropriate skills who are well led and supported to deliver high quality care.
- In addition, specialist diabetes teams should consider supporting the development of services in primary care through outreach clinics, providing advice, education and training as well as supporting protocol development and revision.

Current diabetes services

The current diabetes service provided by St Richards Hospital consists of a weekly diabetes outpatient clinic, which is consultant led. This point of care provides annual reviews and clinical management of complicated diabetes, joint antenatal and foot clinics. The Diabetes Centre is a nurse-led service providing education and clinical management of diabetes; primary care may access the Diabetes Centre without referral to a medical consultant. A specialist nurse and dietitian also hold one outreach clinic a month in a community hospital. The Diabetes Centre team runs an accredited diabetes care and management course as well as various study days. All of these services are struggling to meet the demands from primary care due to the increase in the incidence and diagnosis of people with diabetes.

Proposal

In June 2003 a business case was put to the PCT to fund additional DSN hours to increase the whole time equivalents to four. By dividing the PCT locality into four sectors (one DSN to each sector) the additional DSN hours would enable all practices within each sector to have a named DSN. The DSN would work with them to increase skills and quality of care within primary care.

Key outcomes/objectives of this role would be to:

- assist the practices to meet the NSF standards for diabetes
- assist the practice to meet the National Institute for Clinical Excellence guidelines
- facilitate practice development/ maintenance of active practice-based registers
- develop systems and facilitate the audit of outcomes
- promote collaboration between primary and secondary care
- promote and implement diabetes assessments, guidelines and pathways of care in primary care for patients with diabetes
- develop intermediate outreach diabetes care by running clinics with primary care
- promote diabetes education for those health professionals in primary care linked into personal development plans
- provide a competent named diabetes contact in each practice
- promote patient education
- reduce patient waiting times
- allow speedier review of type 2 patients on the register with HBA_{1c} >7%, blood pressure >140/80 mmHg or a last review >12 months ago to meet agreed targets
- to introduce mechanisms to increase patient concordance and/or reassess pharmacotherapy.

This proposal was rejected by the PCT who felt that it was more appropriate for them to appoint and manage such a post, preferring to have a dedicated staff member for this role. To date they have not appointed anyone.

In order to try to convince the PCT of the benefits such a post would bring, we secured funding from a pharmaceutical company for a 12-month project to assess the impact of a DSN on diabetes control within a selected group of patients working within a general practice clinic setting. We were interested to see if our interventions with regard to prescription changes, diet and lifestyle advice would help to achieve the desired target HbA_{1c}, and whether the practice staff would then follow the management plan set in place.

The project was presented at a meeting of diabetes leads and volunteers were sought. Four practices within the PCT

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1 Current services consist of a weekly consultant-led hospital outpatient clinic, a nurse-led diabetes centre, and a monthly community hospital outreach clinic.

2 As services were struggling to meet primary care needs, it was suggested DSNs be funded to work with primary care to increase skills and quality of care.

3 The PCT rejected this idea so the DSNs secured funding from a pharmaceutical company for a 12-month project to determine the benefits of DSN intervention on diabetes control in a general practice clinic setting.

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1 Four practices were identified and patients meeting inclusion criteria were found with the help of previous HbA_{1c} audit results.

who were keen to have DSN support within their clinic agreed to take part. Two surgeries wanted two sessions per month and two wanted one session per month, which was agreed, as were the criteria (stated below) for booking patients into the sessions.

From a previous audit we had a list of all HbA_{1c} results from tests done by each practice in the last year. This gave us a list of names and an idea of the levels of control achieved by each practice, as well as which patients needed to be seen most urgently. Of patients fulfiling the inclusion criteria, i.e. those with type 2 diabetes on oral hypoglycaemic agents with an HbA_{1c} >7%, the most poorly controlled were targeted first from the list of HbA_{1c} values.

Three DSNs took part in the project, each doing two clinical sessions per month. A management plan was devised

MANAGEMENT PLAN

NAME:-	**DoB:-**
Current Problem HbA1 HBGM Diet Exercise Other risk factors	
Current Treatment metformin sulphonylurea glitazone	
Lifestyle Advice given	
TARGETS After 1 year	**HbA1:-** **Others:-**
Stage 1	
Stage 2 At 3 – 6 months	
Stage 3 At 6 – 9 months	
Any Other suggestions	Repeat HbA1 6 months & 1 year. Forms given to patient **YES/NO**
Surgery Name	**DNS name:** **Date:**

Figure 1. The management plan template that was used in consultation.

(see *Figure 1*) to be completed by the DSN at the consultation (see *Figure 2*) to outline DSN intervention and the suggested treatment interventions with outcome targets for the next 12 months. A copy was to be kept by us for auditing at the end of the project.

Problems along the way

Six months into the project a number of problems have been encountered that may affect our ability to establish the benefits of DSNs working within general practice.

Although the administration staff who were responsible for making bookings were given explanations and written guidance on who to book on the clinics, inappropriate patients have been booked into the sessions, i.e. those newly diagnosed, those with well controlled HbA_{1c} <7%, patients requiring annual review, and people on insulin and/or attending the hospital clinic. This is thought to be mainly because staff lacked the time to identify suitable patients.

Sessions were not always filled due to staff not being able to identify suitable patients, patients not keeping their appointment or cancelling too late to offer a slot to another patient. Patients are usually offered another appointment but those who have not attended have a poor record of attending clinic appointments in general.

In some cases there has been little or no patient contact with a practice nurse or general practitioner other than by management plan. By comparison, in one practice the general practitioner often intervenes to advise on treatment change based on the blood results done for the clinic before the DSN gets to see the patient.

Finally, there are dwindling numbers of people who meet the inclusion criteria.

What have we learned?

In two out of three practices the practice nurses have not been present or directly involved in clinics and it is felt that this is a lost learning experience for them. The fourth practice nurse, however, is actively involved and present at each clinic. The

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1 A management plan was completed by the DSN at each consultation to outline interventions made and suggested, and give targets for the next 12 months. A copy was kept for audit at the end of the project.

2 Problems encountered included inappropriate bookings, patient non-attendance or late cancellation, lack of conformity in implementation and a limited number of people meeting project criteria.

Figure 2. A management plan was devised, which was to be completed by the DSN during consultation with the patient at the clinic

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1 Sessions that are monthly or on alternate months would have been sufficient for each practice.

2 Only select practices are in need of guidance.

3 Changing the criteria to be more inclusive would increase the number of people able to participate.

4 DSNs welcomed the experience in primary care and patients the opportunity to receive specialist care. Many patients had considerable updating of self-management, injection technique and devices, and blood testing equipment.

5 Funding, while restrictive, has enabled us to continue with our existing Diabetes Centre commitments while supporting four primary care clinics.

DSN should not be seen as someone who comes in and does the diabetes clinic once or twice a month.

Sessions that are monthly or on alternate months would have been sufficient for each practice. We plan to continue visiting the four practices we are currently working with to maintain consistency of data and because we have made a commitment to them. As a result of this finding, however, we will reduce the clinic frequency by half. We may also include clinics in four further practices to complete the project.

Only select practices are in need of guidance – i.e. those where there is currently little in the way of protocols or trained and motivated staff. Jointly agreed care pathways would enable primary care staff to manage and refer appropriately to secondary care.

Changing the criteria to be more inclusive, i.e. patients on insulin (especially those who have not had contact with the Diabetes Centre recently), and to raise the HbA_{1c} level to over 7.5%, would increase the number of people able to attend the clinics. As this is a pharmaceutical company-funded project we have been constrained to only see those on oral hypoglycaemic agents. This has prevented us from including other patients who would benefit from a consultation with a DSN and from undertaking alternative ways of working a with larger number of patients, i.e. group education sessions and insulin conversions.

Anecdotally, this project has been useful in many ways for the DSNs taking part who have had very little recent experience in working in primary care. They have said that they are now 'seeing things from a different perspective'. Patients' perception has been that they 'welcome the opportunity to receive specialist care'.

Many patients taking insulin had not been seen at the hospital for many years and were in need of considerable updating in self-management, injection technique and devices, as well as blood testing equipment.

Some general practitioners have commented that 'we are much more interventionist than they would have been' in changing or rationalising drug regimens. Interestingly, a few patients who were quick to blame their poor control on the shortcomings of the hospital had been seen recently in the Diabetes Centre where they had had blamed it on poor general practitioner care!

Conclusion

Whilst funding the project through a pharmaceutical company has meant restrictions, it has allowed us to continue with our existing commitments in the Diabetes Centre while supporting four primary care clinics. Whether we will establish what we set out to prove remains to be seen. ■

I would like to acknowledge other participants in this project: Lorraine Avery, Consultant Nurse, and Sara Moore, Diabetes Specialist Nurse, at the Diabetes Centre in Chichester. Also GlaxoSmithKline and Aventis who funded the project.

Audit Commission (2000) *Testing Times. A review of diabetes services in England and Wales*. Audit commission, London

Department of Health (2003) *National Service Framework for Diabetes: Delivery Strategy*. DoH London

Coming next month . . .

Look out for Vivien Aldridge's Seamless Care in Diabetes supplement, focusing on the delivery of integrated care to people with diabetes.