Planning and implementing a DSN clinic in primary care

Carole Dempsey, Alison McHoy, Sara Da Costa

Introduction

This article discusses the implementation of pilot diabetes specialist nurse (DSN) led clinics in the primary care setting. These pilot clinics proved that such a project can bring great benefits to all those involved. However, a major contributing factor to their success was being able to work with a GP practice that was enthusiastic and motivated about the project. The authors were aware that not all practices would demonstrate any degree of motivation, hence developing the pilot project into a PCT-wide strategy was as much an exercise in marketing as it was in managing a major change within the diabetes team. Therefore, it was fundamental for the diabetes team and the major stakeholders to understand internal and external factors which influence diabetes care, and to feel involved in the development of diabetes care initiatives.

This article discusses the transfer of specialist nursing services from secondary care into the primary care setting. This service redesign was necessary for several reasons, including increasing numbers of people with diabetes, increasing waiting lists for specialist nursing appointments and increasingly inappropriate referrals to diabetes specialist nurses (DSNs).

The first phase of the project was to pilot a DSN clinic in primary care, with the following aims:

- to use DSN referral guidelines to ensure that patients are referred appropriately for specialist care review
- to enable more people with type 2 diabetes to be reviewed in primary care by accessing the clinic
- to up-skill practice nurses in order for them to manage patient treatment plans in line with National Service Framework (NSF) standards and new General Medical Services (nGMS) targets (Department of Health [DoH], 2001a; British Medical Association, 2003).

Inclusion and exclusion criteria

People with type 2 diabetes on tablet or insulin treatment, who require review because of deteriorating control (HbA_{1c}>7.5%), as per DSN referral criteria were deemed suitable (by the practice nurse) to be invited to attend the clinics.

The exclusion criteria for these DSN clinics were as follows:

- patients requiring insulin initiation (who should follow the existing integrated care pathway)
- practices which do not have a practice nurse with responsibility for diabetes
- practice nurses who do not have accredited diabetes training
- practice nurses who are not enabled to make clinical or referral decisions by their practice
- patients requiring annual review (should be provided by primary care, not specialist care).

The standards against which the pilot clinic were audited are shown in *Table 1*. These criteria also demonstrate the resources provided by the practice, in terms of having a practice nurse with updated knowledge in diabetes and authority to act. Working collaboratively, the DSN could build and up-skill knowledge, and leave a legacy of skills and a treatment plan which the practice nurse could implement. The practice also had to provide protected time and space. This was achieved by re-allocating two diabetes clinics per month,

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1 Diabetes specialist nurse led pilot clinics proved that such a project can bring great benefits to all healthcare professionals and people with diabetes involved.

2 It is important for all those involved in implementing any new care developments to feel part of the process.

3 Standards must be used to enable auditing of any new developments in the care of chronic conditions.

4 In setting up such new clinics it is also important to recognise individuals who are able to do the auditing and also run the clinic on a day-to-day basis, for example a practice nurse.

KEY WORDS

- **DSN led clinic**
- **Primary care**
- **Audit**
- **Diabetes**
- **Collaborative working**

Carole Dempsey and Alison McHoy are Primary Care Diabetes Specialist Nurses at Adur Arun and Worthing Teaching Primary Care Trust. Sara Da Costa is a Nurse Consultant in Diabetes at Worthing and Southlands Hospitals NHS Trust and Visiting Fellow, University of Brighton.

Table 1. Standards against which the pilot clinics were audited.

1. Each patient should have an individualised and systematic treatment plan as per the *National Service Framework for Diabetes: Delivery Strategy* (DoH, 2003) in which they have been involved in short- and medium-term goal setting.
2. Improved patient clinical outcomes (for example, HbA_{1c}, lipids and weight).
3. Earlier interventions by specialists.
4. Waiting times for specialist nurse review will be within 1 month of referral.
5. Practice nurse to manage access to clinic (using diabetes specialist nurse [DSN] referral criteria) and participate in every clinic; if unavailable the clinic should be cancelled as there must be a teaching opportunity each time. DSNs do not replace practice nurses.
6. Reduce inappropriate referrals to DSNs (and diabetes team).
7. Protected time and space for this specialist clinic.
8. Patients should receive specialist care closer to home, within their own practice as recommended by the Department of Health (2001b).
9. Increased skills and knowledge for practice nurses as identified in their personal development plan.
10. Patient, practice, and clinician satisfaction.

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1 An audit form to capture consultation data in real-time was developed and practice and DSN outcomes were identified via personal development plans and evaluated at the end of each consultation.

2 Significant infrastructure and the support of the practice were required to enable these clinics to take place.

3 This audit demonstrated how this model of delivering specialist diabetes care is feasible, resource-effective and efficient, while achieving local and national Government targets.

changing consultation times to 30 minutes per patient (compared with 10–15 minutes prior to this) and 30 minutes' reflection at the end of each clinic to revisit the practice nurse's personal development plan, and discuss treatment strategies and any other issues. Several meetings with the practice nurse and practice manager were needed to achieve this, and to adjust the computer templates to record these clinical interventions and plans.

The following measurement tools were developed for this audit: a patient satisfaction questionnaire (which was filled in prior to the consultation to assess the diabetes services currently in place and to inform on the patients' desired service developments), an audit form to capture consultation data in real-time, and practice and DSN outcomes were identified via personal development plans (PDPs) and evaluated at the end of each consultation.

Audit outcomes

Eight clinics were provided between September and December 2004, with 29 patients being seen. The following outcomes were achieved/identified.

- All standards (*Table 1*) were met.
- The need to include people with HbA_{1c} levels of >7.4% was recognised as patients seen with HbA_{1c} between 7.2% and 7.4% benefited from the specialist review due to other factors being identified by their practice nurse, their treatments changed and future actions elucidated.
- Significant infrastructure and the support of the practice were required to enable these clinics to take place. Without support, inappropriate referrals, non-attendance rates and clinician frustration are likely to rise.
- Collaborative working leaves a legacy of skills, contacts and networks which can be used to benefit patient care and outcomes.
- The DSN visiting the practices should be used as a resource, as other clinicians know when he/she is available and can consult with him/her. Many such consultations took place within the practice with district nurses and GPs present.
- As patients were all appropriate for specialist review, resourcing DSN clinics into primary care with this support is a good use of DSN time.

Audit summary

This audit demonstrated how this model of delivering specialist diabetes care is feasible, resource-effective and efficient, while achieving local and national Government targets. Standard 2 (*Table 1*) will be re-audited to see whether risk factors have changed again following these consultations; this is planned for 6 months.

The clinicians involved enjoyed the experience of collaboration, which improved patient care by earlier formal and informal consultations and systematic planning. Such clinical networks can only improve patient care and outcomes.

In the evaluation questionnaires, patients stated that their experiences of care in these DSN clinics were positive, and many wished to continue with these locally based sessions. Their views essentially support moving such specialist clinics closer to home as they are currently based in the hospital. Of 32 people invited to attend the clinics, one chose not to attend, while two could not attend due to illness. This is a much improved attendance rate compared with the DSN clinics in our diabetes centre.

Implementation of the primary care clinics

Primarily, it was important that the diabetes team had shared goals and a shared philosophy and vision. Although we have an excellent team, it was clear that not everyone fully understood the various local and national transformations in diabetes care, and it could not be presumed that everyone shared the same views and priorities.

Three team planning days were arranged over 3 months and were led by an independent facilitator who had previously been briefed on our needs. The core diabetes team who attended all 3 days included diabetologists, DSNs, receptionists and secretaries, and the team's nurse consultant, nursing assistant, podiatrist, and network manager. The main themes over the 3 days explored where we were, where we wished to be, and how we were going to get there. It was also valuable for the team to really get to know each other and to understand each other's roles. It encouraged all to look at organisational systems rather than individual issues.

During these 3 planning days other influential stakeholders were invited to various sessions. The diabetes team recognised that it was vital for these key people to be involved in decisions about the development of the diabetes service – not only to encourage a sense of ownership, but for the team to gain insight into their priorities and needs. Our guests included a local GP representative, practice nurses, dietitians, the medical secretary manager, the director of nursing, the clinical services director from secondary care, the PCT's director of modernisation and chair of the chronic disease management board. Most importantly, four patient representatives attended and contributed wonderfully.

The planning days enabled all those involved to feel part of the service development and set a foundation from which the service could progress with a tighter and shared vision. Yet, certainly for the DSN team, the days left many with a sense of unease and concern, with some not as concerned as to where we were going but rather how we were to get there.

For this reason a fourth and separate planning day, specifically for the DSNs, was held. This was also run by an independent facilitator but with the purpose of ensuring a defined action plan at the end of the day, identifying who was to do what and by when. This day culminated with a 6-month strategy for setting up the primary care DSN clinics, writing a curriculum for structured patient education, and the restructuring of DSN appointments. This day turned out to be motivating and productive.

Selling the concept

At this point in our journey we had been able to convey the principal plans for diabetes care across the healthcare community to our primary care colleagues, but we still needed to specifically 'sell' the concept of the primary care DSN service (including joint clinics, hand-held notes, and ongoing structured education) to local GPs and practice nurses. Therefore, we decided to hold an open evening in a local hotel that was sponsored by four pharmaceutical companies to cover costs.

Out of 24 practices invited, representatives from 19 attended. The evening included presentations from our network manager and nurse consultant on the launch of hand-held notes and on the pilot primary care DSN clinics. It also involved an element of group work which was beneficial in enabling GPs and practice nurses to share their ideas with the diabetes team and to evaluate how the service could enhance the care they currently provide. The evening was also beneficial in managing expectations and for visualising how the role could be implemented in the practices.

Attendees were requested to complete a questionnaire at the end of the evening to establish their practice needs and to express whether they were interested in taking

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2 It was decided to hold an open evening in a local hotel, which was sponsored by four pharmaceutical companies to cover costs, in order to convey to all relevant healthcare professionals the principal plans for diabetes care.

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1 It was important from the outset to acknowledge the differences between working in the secondary care setting of the diabetes centre and primary care.

2 Working collaboratively with practice nurses will help achieve our aim of providing a consistent approach to diabetes care and a sharing of skills. The practice nurse has a greater knowledge of his/her individual patients' needs, and can provide valuable information to support the referral to specialist intervention.

3 The role of the primary care DSN will be to develop practice nurses to maximise their potential and impact on diabetes care in practices and in the community.

the project further within their practice. This resulted in 15 practices expressing an interest on the night and a further three by email.

Discussion

Two of the authors [CD and AM] started new posts as primary care DSNs in August this year. It was important from the outset to acknowledge the differences between working in the secondary care setting of the diabetes centre and primary care; therefore, our first priority was to identify key people within the PCT. In order to understand their role in the organisation of care for people with diabetes, we have arranged meetings with the Director of Modernisation, Head of Commissioning, Head of Clinical Governance, and senior nurses responsible for clinical audit and services within the PCT.

We will also be members of the local diabetes NSF implementation group, and its workforce and training subgroup, and will present progress and matters arising to the chronic disease management board. The purpose of attending these meetings will be to improve our understanding of the organisations and processes involved in service planning and decision making. It will also provide the opportunity for us to market ourselves and the diabetes service, and take patient experiences into decision-making arenas.

Starting our new roles in mid-August has meant our initial progress with regards to meeting practice nurses and GPs has been slow. We recognise that although diabetes is a top priority to us as specialist nurses, it is not necessarily a priority in GP practices, explaining why some have been slow to respond to our request for meetings. Staff summer holidays and the demands on services will also have contributed to these delays. However, we feel confident that we will achieve our aim of ten clinics in primary care by November 2005, and are encouraged by the excellent response at the launch evening.

Our first visit to a GP practice was successful, and dates have been arranged for fortnightly DSN clinics from October. The success of the multidisciplinary meeting was attributed to the practice nurse who had provided information about the service to the GPs before the meeting. They were equally enthusiastic about the service and the future provision of ongoing structured education for their patients.

The future

The provision of DSN clinics in primary care will involve commitment from the practice to meet the criteria evaluated in the pilot project. The practice nurse responsible for these clinics must have up-to-date training, and this can be accessed locally via diploma or degree modules validated by the University of Brighton, or via a Royal College of Nursing accredited short course.

Working collaboratively with practice nurses will help achieve our aim of providing a consistent approach to diabetes care and a sharing of skills. The practice nurse has a greater knowledge of his/her individual patients' needs, and can provide valuable information to support the referral to specialist intervention.

The role of the primary care DSN will be to develop practice nurses to maximise their potential and impact on diabetes care in practices and in the community. Personal development plans will be used to help and support practice nurses to identify their learning needs. This re-design of the DSN team will provide integrated diabetes care, and improve outcomes for patients through education and support of primary care colleagues. ■

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