Trying to get what your patients need

All health care professionals strive to improve their diabetes patients' care. Getting what your patients need, however, can seem a mammoth struggle. When doing nothing is not an option, how do you effect change for the better?

Taking an imaginary scenario as an example, Dr Rowan Hillson here provides practical advice on how you can take steps to ensure the best care for your patients and deal with any communication difficulties along the way.

Mike has type 1 diabetes. While running downstairs, he fell and fractured his tibia. He was taken to A&E where he was assessed by several nurses and doctors. After a long wait, X-rays showed a complex fracture requiring admission for surgical fixation. By the time Mike arrived on the ward, lunch had come and gone. The nurses were reviving an ill patient. When a nurse finally came to admit Mike, he was unconscious.

The orthopaedic doctor came promptly. Concerned that the coma may represent an undetected head injury, he booked an urgent scan.

Mike’s wife arrived at this point and asked why they weren’t treating Mike’s hypo. A finger-prick glucose level was 1.2mmol/L. Intravenous glucose restored normal consciousness.

Ava, the diabetologist, was fed up. She had been a consultant at St Swithin’s for six months. This was the third patient she’d reviewed for hypoglycaemia while in hospital. She’d found two patients with untreated diabetic foot problems; and, embarrassingly, one of her own patients had a recurrence of diabetic ketoacidosis on leaving ITU. The insulin infusion was stopped — ‘we don’t allow our infusion pumps off ITU’. All of these patients had an extended hospital stay.

St Swithin’s — these could include appointing a diabetes inpatient specialist nurse (DISN). How could Ava gain agreement for this post? Even better, could she persuade hospital management to appoint a full inpatient diabetes team?

While the example relates to hospital diabetes care, the principles outlined below can be applied anywhere.

How can you get what your patients need? There is no single solution. For every success, there are many setbacks. Successful qualities seem to be clarity of purpose, thorough planning, team work, patience, persistence, and, above all, passion.

The first step

Stop. Think.
• Where are we now?
• Where do we want to be?
• How are we going to get there?

If you are not clear about this, you will not convince others. It is vital to include the rest of your team (if there is one) in this process. Do not fear constructive criticism — welcome it. Discover any flaws in your plan early so you can improve it.

Maintain an up-to-date plan.

Seize opportunities

Funding opportunities may suddenly become available. So have a plan. Keep it up to date. Be direct, specific, and succinct. Summarise the problem and action required in a few clear sentences before going into detail. Most people will only read the first paragraph. Few will turn the page.

With each new opportunity, apply as requested, tailoring your plan as necessary. Complete all relevant sections.

Learn the system

If you are asking your organisation to make changes or spend money, you will need to put your plan through their system. So learn how it works — in your practice, department, community, clinical commissioning group (CCG), directorate, and hospital. As the changes you want to make get bigger and more expensive, you need to learn how the larger organisation works — in the UK this usually means the NHS. This has got a bit complicated!

Seek local or national quality improvement initiatives, e.g. commissioning for quality and innovation (CQUIN).

Learn what does your immediate chain of command and the people and roles that influence them. Try to attend unit/departmental/organisational meetings.

‘But I’ve got real work to do.’ You are showing that you are interested in the bigger picture. Get to know who’s who, what they do, and what is happening. Other people will start to recognise you. Be brave. Ask a question relating to your work area or patients. I usually asked a question with the word ‘diabetes’ in it.

Consider attending public meetings of your organisation, e.g. your hospital trust, CCG. Put faces to the managers. Who influences decisions? When does your organisation make money decisions, and how?

Can you contribute regionally or nationally? ‘Who me? But I’m only...’ Why not you? You are as important as everyone else. This gains you new contacts and networking, and may provide early warning of funding opportunities (avoid conflict of interest).

If comments are sought on general documents, respond, again including your area of concern. I used to search the document for the word ‘diabetes’. If it was there, I would check for accuracy. If it wasn’t, I would put it in, if relevant.

Chance meetings (‘corridor diplomacy’) may be an opportunity to flag up the issue. They are also an opportunity to gain allies (or to identify resistance). But don’t rely on verbal promises made in passing. Get it in writing.

‘They’ are people

Decisions about health care services, whether in primary, community or secondary care, are made by people. You feel stressed. So do they. Health care professionals are trained to protect patients. We may feel we have to
fight managers to get better care for our patients. Managers also want patients to have good care – work with them, not against them.

Learn from others
How do your senior colleagues get what they need for their patients? Ask them to talk you through successful bids and share lessons learnt the hard way. People like giving advice. Be aware that colleagues also want a slice of the financial cake to help their patients. Would a joint initiative be possible?

Seeing is believing
A patient had a rare diabetes variant with multiple life-threatening admissions, acquiring over 20 volumes of notes. The tertiary centre advised a new and expensive treatment but there was no funding. I staggered into the chief executive’s office with the mountain of notes and explained the problem. Funding was found and the patient received the treatment.

Patients’ stories
A patient’s story makes it real (protect patient confidentiality). Within your organisation, a real patient’s story may engage budget holders. This appears to have happened nationally:

‘Mavis Skeet... died of throat cancer in June 2000... Mrs Skeet should have had an operation to reverse the disease the December before she died. Over five weeks, four separate appointments were booked... Each one was cancelled... Her condition deteriorated... the tumour had become inoperable...

‘Tony Blair was briefed about Mavis Skeet...’

‘The key to improving inpatient diabetes care is having a dedicated, determined and passionate team who are prepared to work differently, meet regularly to problem solve and innovate, and to continually review the service by regular audit of the outcomes to evidence and sustain improvements or re-innovate and change tack when necessary.’

Box 1. Summary of a scheme at Ipswich Hospital NHS Trust which improved inpatient diabetes care

The Diabetes Inpatient Care and Education programme, Ipswich Hospital NHS Trust

‘The Diabetes Inpatient Care and Education (DICE) project was planned to reduce harm to patients with diabetes in Ipswich Hospital by establishing a fully-staffed, proactive inpatient diabetes team focused on improving care through innovation and implementation of new systems of care. These aimed to increase specialist surveillance of patients with diabetes, improve staff knowledge and awareness of the condition, and evaluate its effectiveness by continuous audit. Innovative strategies and tools included an admission avoidance service, algorithms for admission units, the DICE Care Pathway, an innovative referral system (the Diabetes Patient At Risk score), use of web-connected blood glucose monitors, strategies to prevent nocturnal hypoglycaemia, a junior doctor induction programme, and a foot protection pathway. Overall, hypoglycaemic rates reduced by 25% but severe hypoglycaemia fell by 46%.14

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Gerry Rayman – Gerry.Rayman@ipswichhospital.nhs.uk

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Business cases or plans
Not all service improvements require this. You and/or colleagues may realise that there is a better way of doing part of your job(s) that can be achieved without external discussion or further funding. If this is indeed so, go for it. Measure relevant aspects before and after your change, to confirm it worked.

For many changes that need money, some organisations now require business cases. This immediately puts many people off: ‘I’m too busy’; ‘I don’t know how’; ‘I’m not a businessman. I’m a clinician.’ Gain support from a management colleague and produce the business case together.

The national standard is the ‘five case model’ in the ‘Green Book’:

• ‘The Strategic Case
• ‘The Economic Case
• ‘The Commercial Case
• ‘The Financial Case
• ‘The Management Case’.1

The ‘Green Book’ is complex and some sections may not be relevant to your plan. You may find the Royal College of Radiologists guidance helpful. Ask a colleague locally or nationally to share his/her successful business case.

Search the internet. Review the literature. Contact relevant author(s). The following have helpful resources: Diabetes UK,7 the Association of British Clinical
Mike could have suffered irreparable harm. If you know what could improve patient care—wherever you work—you must act.

Build local evidence. Learn from others within and outside your organisation. Do your homework. With your team, senior colleagues, managers, produce a clear, well-evidenced improvement plan—direct, specific, and succinct.

Find out who does what in your system. Ensure you know them—and they know you.

Present your plan through the proper channels in your organisation, while recruiting allies throughout the system.

Never let a possible opportunity for support or funding pass you by. Be ready to apply—and to tailor your application precisely to match this particular opportunity.

References


10. Boxes 1 and 2 summarise examples of schemes that improved inpatient diabetes care. There are other successful schemes nationally.


