

A case control study of use of the Failed Access Score for determination of failed access to structured diabetes care: the WICKED project

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Abstract

Failure of access to structured diabetes care is associated with adverse outcome. There is no known validated data tool to identify access failure and thus we have developed a Failed Access Score (FAS) and have examined its associations.

The FAS is part of the WICKED project (Wolverhampton Interface Care, Knowledge Empowered Diabetes), and consists of three key care processes in diabetes: namely HbA_{1c}, urinary albumin:creatinine ratio and retinal screening. A retrospective case control study in a single GP practice was undertaken on all the patients (n=478) failing two or more parameters over 15 months. They were compared to those with no access failure matched for age, gender, ethnicity and type of diabetes.

Among the 51 cases with a FAS ≥ 2 , two or three process measures were absent in 84% and 16% respectively. Excluding service failure, this was due to non-attendance in 35% but otherwise associated with other clinical constraints in 41% (mental health, house bound, palliative care, multi-morbidity) and their deprivation index was significantly higher ($p < 0.01$). Extrapolating to the whole health economy (n=16 644), 2362 (14%) would have a FAS of ≥ 2 of whom 968 (6%) would have failed access in association with these constraints.

In conclusion, it is possible to identify people who are failing access to structured diabetes care using readily available data calculated as the FAS score. Failed access is not usually due to patient default or disengagement but rather, in almost 65%, either due to significant clinical disadvantage or pure failure of service. Copyright © 2014 John Wiley & Sons.

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Key words

access; diabetes; care delivery

Introduction

Diabetes care is a growing concern in a financially challenged NHS.¹ To achieve the benefits of structured diabetes care, patients must access it.² Despite heavy diabetes expenditure,³ the National Diabetes Audit shows⁴ that diabetes processes are not being fully delivered. Lack of access to diabetes care is a crucial component of that failure.⁵

Access, and equity of access, to care is not only a fundamental ethical principle in any health care system,^{6,7} but failure of access is associated with adverse outcome.^{8,9} Access to health care has been defined in various ways ranging from a narrow concept of service entry¹⁰ to the multi-dimensional concept of uptake, process, quality, availability and utilisation of the service.¹¹ Determining and addressing factors resulting in poor patient access might improve health care delivery and outcomes. Significant variables associated with failed access are well

recognised and include ethnicity¹¹ and deprivation.¹² However, mechanisms for targeting individuals with access failure, over and above simple call–recall systems, and understanding and addressing crucial constraints are not systematically in place.

There is no known validated tool to identify failed patient access to diabetes health care. Within the validation process of our local diabetes data set,¹³ a scoring system was used to assess the level of access of patients to diabetes services – predominantly as a mechanism to determine those who were or were not still active participants in local diabetes care in order to maintain the epidemiological accuracy of the local diabetes register. We have now undertaken a case control study of patients with diabetes, identifying and comparing those with complete or incomplete access criteria according to this score, the Failed Access Score (FAS).