Delivering a diabetes dietetic service across primary and secondary care

Helen Mitchell

Bradford is the most socially deprived area of West Yorkshire (Noble et al, 2007) and has a diabetes prevalence of 5.3% (Bradford Observatory – Public Health, 2009). To meet the needs of this demographic, Bradford Teaching Hospitals NHS Foundation Trust has developed innovative diabetes dietetic services, including supermarket tours, a diabetes weight management programme and one-to-one appointments allowing self-referral for some services. Many of these facilities involve multidisciplinary teams and good communication between specialist and community diabetes care. This article describes the dietetic services in Bradford as an example of integrated care.

Article points

1. For many years, Bradford diabetes dietitians have been delivering dietetic services across both primary and secondary care. However, the emphasis now is to provide the majority of these services closer to local communities and people's homes.
2. Within Bradford, innovative services have been developed to increase service capacity, be culturally acceptable and accessible and also enable people to self-refer so that they can access services in a timely manner.
3. One team of diabetes dietitians providing input across the primary and secondary care interface has numerous benefits.

Key words
- Dietetics
- Education
- Service provision

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The diabetes National Service Framework (Department of Health [DH], 2001), and the DH (2006) White Paper *Our Health, Our Care, Our Say: A New Direction for Community Services*, highlighted the growing need for services to be available to facilitate an individual's ability to self-manage their condition. Furthermore, these documents are the driving force behind the shift in service provision, taking diabetes back to primary care, nearer to people's homes. In addition, the much anticipated NHS Diabetes collaborative document *Diabetes Without Walls* guide for PCTs will "underpin the commissioning of fully integrated multidisciplinary diabetes care across primary, community and secondary care" (DH, 2010).

For many years, Bradford diabetes dietitians have been delivering dietetic services across both primary and secondary care. However, with the new, ongoing district-wide service redesign, the emphasis is now, more than ever, to provide the majority of these services closer to local communities and people's homes.

Demographics of Bradford

The Yorkshire and Humber Public Health Observatory estimates the prevalence of diabetes within Bradford district to be 5.3% of the current population, equating to approximately 26 000 people with diabetes. It is projected that the total population of Bradford will grow from 502 000 to 650 000 by the year 2030 (Bradford Observatory – Public Health, 2009), therefore predicting an additional 10 000 people with diabetes over the next 20 years.

Ethnic communities represent 24% of the total population of Bradford district compared

Page points

1. High levels of social deprivation exist within Bradford – the district ranks as the thirty-second most deprived area out of 354 areas, making it fall within the most deprived 10% of local authorities nationally, and the most deprived area in West Yorkshire.
2. Much has been done to include services that engage hard-to-reach communities and people who do not access traditional healthcare services for a range of reasons: immigrants who are not aware of services they can access, communities who would traditionally use faith healers or alternative therapies, and those who do not realise the importance of diabetes management.

with a national average of only 13% (Bradford Observatory – Public Health, 2009). Of these ethnic communities, the majority of people are from Asian sub-groups, black sub-groups and Eastern Europe (particularly from Poland, Czech Republic and east Slovakia). High levels of social deprivation exist within Bradford – the district ranks as the thirty-second most deprived area out of 354 areas (Noble et al, 2007), making it fall within the most deprived 10% of local authorities nationally, and the most deprived area in West Yorkshire. Such demographics have obvious implications for language provision, culturally acceptable services and advice, and overall access to services.

Due to the high prevalence and incidence of type 2 diabetes in Bradford, it would be impossible to be able to see all people with diabetes at diagnosis and thereafter as needed if dietetic care was restricted to one-to-one clinic consultations only. Within Bradford, innovative services have been developed to increase service capacity, be culturally acceptable and accessible, and also enable people to self-refer so that they can access these services in a timely manner. Much has been done to include services that engage hard-to-reach communities and people who do not access traditional healthcare services for a range of reasons: immigrants who are not aware of services they can access, communities who would traditionally use faith healers or alternative therapies, and those who do not realise the importance of diabetes management.

Primary care services

One-to-one clinic consultations

All GP practices across Bradford have dietetic input, the frequency of which is dependent on the number of people on their diabetes register. The majority of the clinics are joint multidisciplinary consultations with the practice

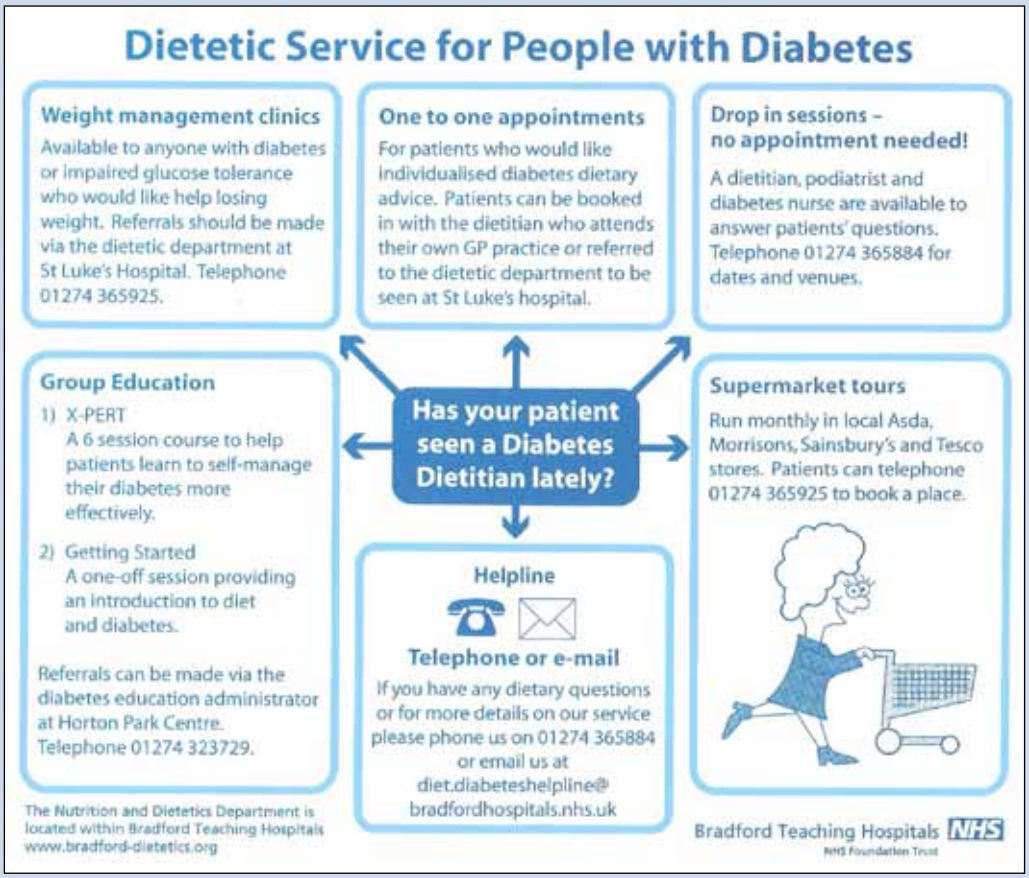

Figure 1. Bradford dietetic services information leaflet.

nurse or GP, or both. *Figure 1* summarises the dietetic services available in Bradford.

Drop-in sessions

Originally set up to target people with diabetes who do not engage with the traditional health care setting, drop-in events are run three times a month at various community locations throughout the Bradford area, such as libraries, mosques, temples, churches, supermarkets, and community and leisure centres. People do not need referral to attend and can speak with a diabetes dietitian or nurse who will then signpost to other services as necessary.

Supermarket tours

Tours are held at local supermarkets (Asda, Morrisons, Sainsbury's and Tesco) at nine locations across Bradford each month. People are able to refer themselves to these tours and are actively encouraged to bring a family member or friend. Supermarket tours last approximately 1.5 hours and are an excellent way of teaching hands-on, practical information, such as reading and interpreting food labelling, understanding about how individual foods fit into the eatwell plate model, and learning about portions and cooking methods.

Helpline

The dietetic service has a telephone and email helpline for members of the public and healthcare professionals to contact the team with their questions and queries regarding diet and diabetes.

Structured education

Like many areas of the UK, Bradford offers the X-PERT education package, which consists of six 2.5-hour group sessions run over consecutive weeks. In addition, the service offers Getting Started, which is an in-house education programme and is a stand-alone 2-hour session aimed at people with diabetes who cannot commit to a 6-week programme, or those who are unsure of group education and would like a taster session. Both education programmes are currently run in English and a variety of south Asian languages.

Diabetes weight management programme

A specialist weight management programme is offered for people with diabetes with clinics held in community locations. The programme is based on individualised, calculated energy prescriptions to promote safe and continued weight loss, while also taking into account the potential need for dose adjustment of their diabetes medications to prevent hypoglycaemia associated with a reduction in total calories and carbohydrate intake.

Education talks

Over time, strong links have been forged with community health development workers, representatives of places of religious worship and community leaders, and these people are often asked to deliver educational talks to community groups, which contain a drop-in session so that people can obtain individualised advice after first participating in a group discussion or listening to an information session.

Resources

Numerous written and audio resources for people with diabetes are developed and produced within the dietetic team that are available for use by other healthcare professionals to support them in their roles.

Diabetes bulletin

An evidence-based, diabetes-specific dietetic bulletin is produced on a monthly basis for all primary care diabetes professionals working within the Bradford area to help educate and provide a sound knowledge base for the team's multidisciplinary colleagues. Recent topics have included the role of antioxidants, carbohydrate load and distribution and omega 3 and 6 fatty acids.

Secondary care services

To echo the White Paper *Our Health, Our Care, Our Say* (DH, 2006) it is key that those people who require access to highly specialised dietetic input, for example

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2. A specialist weight management programme is offered for people with diabetes with clinics held in community locations.
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paediatrics, adolescence, pregnancy, CSII therapy, gastroparesis, professional sporting management and renal disease, are seen within the secondary care domain.

Integrated care in Bradford

The European Working Party on Quality in Family Practice (Kvamme et al, 2001) looked at what was needed to improve the quality of care at the interface between primary and secondary care. They stated that the following areas are key for effective delivery of care between general practice and specialist services: leadership, shared care approaches, task division, mutual guidelines, patient perspectives, education, team building, cost-effectiveness and communication.

Bradford diabetes dietitians are a large team of dietitians specialising in diabetes management, employed by Bradford Teaching Hospitals NHS Foundation Trust (BTHT) and providing dietetic services to secondary care at BTHT and primary care as commissioned by the local PCT. The ability of one team to provide input across the primary and secondary care interface has numerous benefits, including:

- Consistency of local guidelines or protocols and therefore consistency in the advice that is given to individuals, verbally and in written or audio format.
- Strong governance structure.
- Ability to easily signpost people to other, more appropriate dietetic services that we offer as a team.
- Use of primary and secondary care skill mix for research or audit.
- Ability to call on experienced dietetic staff delivering specialist services to provide clinical supervision to other members of the dietetic team, and other healthcare professionals within the multidisciplinary team.
- Use of secondary care dietetic services as a training ground for new or junior members of the team.
- Ability to offer rotational posts within the team, across primary and secondary services to promote the dissemination of specialist information out into primary care.

While the team strongly believes that the provision of services across the primary and secondary interface by one united team can enhance the care of people with diabetes, there is still the need to continue to evaluate and audit these services to ensure that they meet the needs of their local population.

Conclusion

Bradford diabetes dietitians have successfully engaged with all multidisciplinary stakeholders across primary and secondary care to develop and provide innovative services for local people, creating a seamless service, delivered by highly trained, dedicated and enthusiastic staff.

The team aims to build on the foundations of the current service structure to develop diabetes dietetic-specific, person-centred outcome measures to further evaluate the success of the current interventions. This will also help to develop new initiatives, as necessary, to cope with the predicted increase in the diabetes population and the ever-changing demographics of a multicultural city such as Bradford. ■

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