

Gestational diabetes mellitus follow-up in primary care: A missed opportunity



In Research spotlight pieces, investigators reflect on the implications of a recent study for primary care

Andrew McGovern

Researcher in Primary Care, Department of Healthcare Management and Policy, University of Surrey

Lucilla Butler

Honorary Research Assistant, Department of Healthcare Management and Policy, University of Surrey

Neil Munro

Visiting Professor, Department of Healthcare Management and Policy, University of Surrey, and Associate Specialist in Diabetes, Chelsea and Westminster Hospital, London

Simon de Lusignan

Professor of Primary Care and Clinical Informatics, Department of Healthcare Management and Policy, University of Surrey

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Gestational diabetes mellitus (GDM) is increasingly prevalent, affecting 3–5% of pregnancies in the UK (Ben-Haroush et al, 2004) – perhaps unsurprisingly, given population trends in obesity. GDM increases the risk of subsequently developing type 2 diabetes more than seven-fold compared with women who have a normoglycaemic pregnancy (Bellamy et al, 2009). Early lifestyle and medical intervention substantially reduces this risk (Ratner et al, 2008). For these reasons, NICE (2008) recommends post-partum diabetes screening following GDM and annual screening thereafter if results are normal. Fasting blood glucose is the recommended screening test. We recently reported that there is a significant shortfall in this screening across England (McGovern et al, 2014). However, early identification of diabetes or a prediabetes state in this group of young mothers is important to minimise the long-term health consequences of this condition.

Current follow-up rates

Our retrospective cohort study used data from primary care records of practices across England collected for the QICKD (Quality Improvement in Chronic Kidney Disease) trial (de Lusignan et al, 2013) and considered the short-term follow-up of 788 women and the long-term (annual) follow-up of 718 women. Only 18.5% of the short-term follow-up group had blood glucose testing within 6 months of delivery. Annual recall rates for long-term follow-up were consistently low at around 20%. There was considerable regional variation in follow-up rates.

At least four key factors contribute to this situation:

- Women with GDM generally have poor awareness of the risk of diabetes (Kim et al, 2007) and are therefore less likely to return for screening.
- There is no consensus on whether primary or secondary care is responsible for short-term follow-up (Pierce et al, 2011), resulting in many women falling through the gap.
- GDM follow-up is typically not seen as a clinical priority in primary care (Hunsberger et al, 2012).

- There is often poor communication between secondary care and GPs: 18% of GPs report difficulties in finding out that women had GDM, citing communication from the hospital as the primary factor (Pierce et al, 2011).

The regional variation in follow-up we observed suggests that healthcare factors are more important determinants of this than are patient factors. Furthermore, it is worth observing that Australia has post-partum screening rates of 73%, where a GDM register is in operation (Morrison et al, 2009).

Strategies to improve monitoring

A key priority is determining the responsibility for short-term follow-up. Post-partum screening could be performed in either primary or secondary care depending on local services, but the responsibility must be clear. Additionally, mechanisms should be in place to follow up non-attenders. Better patient education in secondary care would help to emphasise the importance of returning for screening.

Communication between secondary and primary care must be improved and may require a new record strategy. The paper-based shared care maternity record may have had its day. Often data are not copied into the GP computerised medical record system and important data for long-term care may be lost.

Primary care is ideally placed to take responsibility for long-term annual follow-up. To ensure that screening is performed, GP practices could code and recall women with previous GDM using computerised annual alerts. Inclusion of GDM follow-up in pay-for-performance targets (e.g. the Quality and Outcomes Framework) would considerably aid this goal.

It is clear that improvements are needed. Lack of a cohesive screening policy leaves a large number of young mothers with undetected and untreated diabetes vulnerable to the associated long-term health consequences. ■