Multidisciplinary team working across primary and secondary care

Gill Freeman

The recent National Institute for Clinical Excellence (NICE) guideline for type 1 diabetes in adults (2004) says, 'the range of professional skills needed for the delivery of optimal advice to adults with diabetes should be provided by a multidisciplinary team (MDT)'. Such a team should include members having specific training and interest covering the following areas of care:

- education/information giving
- nutrition
- therapeutics
- identification and management of complications
- foot care
- counselling
- psychological care.

Education and information giving

So to whom do we look in our MDTs for these areas of care? Education and information giving is something that every member of the team must do. It comes more easily to some than to others, but, without passing on our knowledge, how can we move on? The person with diabetes is central to this role. In her article on page 128, Rosemary Walker refers to the NICE guideline where it outlines acquiring self-management skills and the 'educational exchange' that may take place in a consultation between a health professional and a person with diabetes. Who better to communicate with the professionals so that their invaluable experiences may be passed on and learned from?

The diabetes specialist nurse (DSN) has long been an educator both to primary and secondary care. Hall (2004) believes the role of the DSN in primary care, including education, will expand even further under the new GMS contract. Even those practices opting for a basic level of diabetes care will require education and training for appropriate referral to secondary care.

The practice nurse takes on an increasingly important role in diabetes. Many take sole responsibility for the clinic itself and are extending their role by training in areas such as insulin initiation. Of all primary care professionals, practice nurses probably see the person with diabetes most frequently and pass on their knowledge and experience daily. Increasing numbers are becoming nurse practitioners and taking the supplementary nurse-prescribing course.

Some GPs are also expanding their diabetes training to become GPs with a special interest (GPSI) in the condition, and will be a valuable information resource to other health professionals in the community.

District nurses spend a lot of time with people with diabetes, using their knowledge to teach insulin delivery. In many areas their work with diabetes is not autonomous, but with extended training this is beginning to change and they are adjusting doses and recommending changes of treatment regimens.

Diabetes facilitators provide crucial information on the interface between primary and secondary care. The diabetes facilitator role has been in existence for many years now although there are variations in the number of facilitators nationwide. Their remit is to standardise care across a district, so as to try and reduce variations in practice. This progresses naturally to education of health professionals. With their knowledge of both primary and secondary care, they are ideally placed to advise on ways in which the MDT can influence and improve the quality of diabetes care.

Primary care trusts (PCTs) that employ a diabetes facilitator view them as a valuable member of the MDT. Many

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primary care DSNs are now in a facilitation role to some degree.

Nutritional advice and therapeutics

With new insulin regimens good nutritional advice is vital, especially with the increasing popularity of continuous sub-cutaneous insulin infusion (CSII) and dose-adjustment/insulin requirements. Dietitians continue to support the team with their specialist knowledge and, in some areas, are also trained in insulin dose adjustment. There are never enough dietitians to go round, however, but they are ably supported by other members of the team, especially practice nurses and DSNs. This makes it imperative that we all share information so that our message is the same. Davies (2000) says that 'working together means acknowledging that all participants bring equally valid knowledge and expertise from their professional and personal experience'.

Pharmacists are emerging as valuable members of the MDT – acting as a resource to health professionals and to people with diabetes. They advise on medication, drug interactions and blood glucose monitoring. They also play an important educational role in the supplementary nurse-prescribing course, which will allow DSNs to take a more active role in therapeutics in conjunction with their consultant and GP colleagues.

Shifting responsibility

The specialist MDT is at the forefront in the management of complications as it also includes the podiatrist, optometrist and ophthalmologist, and members of the renal and urology teams. The 'diabetes team' was historically the name given to the hospital team – usually consisting of consultant, DSN, dietitian and podiatrist, but following the National Service Framework (NSF) for diabetes (2003) the responsibility for diabetes shifted from secondary to primary care.

There are now several primary care trusts that employ community diabetes teams consisting of similar personnel so that management as well as identification of complications can take place in primary care. This does not mean that the hospital team is redundant. As Rosemary observes from the NICE guideline (2004), they still have an enormous amount of work to do with many more complex cases requiring very specialised services.

Insulin treatment and delivery has changed fairly dramatically over the last few years. The advent of analogue insulins, both short and long acting, and the increase in the use of CSII means that the specialist secondary care teams are even more in demand as an expert resource. As discussed in Rosemary's article, the recent NICE guidance (2004) includes the uses of these new regimens in type 1 diabetes.

Counselling

Psychological and counselling input to our teams is a luxury. The NSF for diabetes (2003) stated that: 'a diagnosis of diabetes can lead to poor psychological adjustment, including self-blame and denial, which can create barriers to effective self-management'. NICE (2004) advises diabetes professionals to 'be alert to the development or presence of clinical or sub-clinical depression or anxiety' and to 'be familiar with appropriate counselling techniques' for people with psychological difficulties from different cultural backgrounds. How many of us feel that we have spent a day counselling and how much time do we really have for this?

Teamworking

So, this is the look of the MDT with a little help from NICE (2004). It is a large team with and inevitable overlap of roles and we must attempt to avoid being proprietorial. Diabetes UK (2002) advocates 'the working together of all people involved in diabetes care, regardless of their role, in a partnership where each person is fully aware of the roles and responsibilities of the other people involved'.

We must take care that despite the growth of the team and the diverse expertise involved, we do not stop communicating and learning from each other, the partnership that Rosemary mentions in her conclusio, really means just that. ■

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