Making integrated diabetes care work in the real world

Helen Mitchell, Johanne Bird

The Department of Health (DoH) defines integrated care as 'when both health and social care services work together to ensure individuals get the right treatment and care that they need' (DoH, 2006a). The White Paper titled 'Our health, our care, our say', which was published in January this year (DoH, 2006b), encourages front-line organisations to deliver integrated community services that help people to remain in control and live independent lives. In this article, the authors describe the benefits of integrated care and offer practical advice on how healthcare professionals can make it work in the real world.

Integrated care may be understood to mean different things to different people who work in diabetes care, such as:

- integration between services (a joined-up primary, secondary and tertiary care service, for instance)
- integration between team members (joined-up working between the various healthcare professionals involved in the care of people with diabetes, for example)
- integration in the sense of knowing what services are available for others to access.

For the purposes of this article, we aim to describe the 'grass roots' benefits to people with diabetes and healthcare professionals of having a truly integrated multidisciplinary approach to diabetes care.

Integrated care in diabetes

A recent report from Dr Sue Roberts, National Clinical Director for Diabetes, to the Secretary of State for Health (Roberts, 2006) states that:

'Commissioning high quality services that are properly patient focused, are integrated, multi-disciplinary and delivering care at the time and place people want is essential.'

However, it is almost 10 years ago that collaborative working by multidisciplinary 'agencies' was given priority in one of the Health Service Guidelines (Department of Health [DoH], 1997), yet today we are still led to believe, anecdotally at least, that integrated care is not the norm in many diabetes clinics across the UK.

Renders et al (2006) found that improvements in diabetes care can be facilitated by interventions such as dedicated clinics with a variety of healthcare professionals. This can contribute to an increase in sharing of knowledge, experience and understanding that is of potential benefit to all members of the team as well as the person with diabetes.

Article points

1. It is almost 10 years ago that collaborative working by multidisciplinary 'agencies' was given priority in one of the Health Service Guidelines.
2. Today, though, it still appears, anecdotally at least, that integrated care is not the norm in many diabetes clinics across the UK.
3. In Bradford, the benefits of an integrated care service seem to outweigh the difficulties associated with its implementation.
4. There are many pieces of practical advice that can help with setting up an integrated care service.

Key words

- Multidisciplinary team
- Shared clinics
- Communication

Helen Mitchell is a Diabetes Dietitian and Johanne Bird is Dietetic Lead for Diabetes, Bradford City tPCT.

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1. At Bradford, the benefits gained from integrating care – through improved clinical outcomes, patient satisfaction and healthcare professionals' job satisfaction – are considered to far outweigh the associated difficulties.
2. The ultimate goal of the multidisciplinary team clinic is to deliver a service at the right time, in the right place and for the right people.
3. Effective communication is fundamental to team work being productive, the authors believe.

Although there are many conceivable benefits of working alongside colleagues in shared clinics, such as reduced number of visits for people with diabetes, reduced waiting times to access allied healthcare professionals, and integrated care arrangements, we acknowledge that this can be difficult to organise in the first instance, especially if this is a new way of working for staff. Initially, some members of the multidisciplinary team (MDT) can feel threatened at the prospect of having other disciplines share a consultation, but this experience should be relished, we feel, as the opportunities for shared learning are immense.

Integrating health care across multiple disciplines is a large task to undertake in terms of coordinating services initially. However, the benefits gained through improved clinical outcomes, patient satisfaction and healthcare professionals' job satisfaction far outweigh the difficulties, or so it is thought in Bradford.

Multidisciplinary working in Bradford

A patient and public involvement event held in Bradford in 2000 titled *A Better Balance: Bradford Beating Diabetes Through Partnership* demonstrated that people with diabetes wanted a service that was convenient for them, that improved access to healthcare professionals and that was responsive to their needs. Since then, Bradford diabetes dietitians have been working towards a truly integrated diabetes service where multidisciplinary working is at the heart of service delivery.

Our MDT clinics are attended by many professionals, including GPs, practice nurses, diabetes dietitians, diabetes specialist nurses, podiatrists, optometrists and language support workers. The ultimate goal of the MDT clinic is to deliver a service at the right time, in the right place and for the right people: the 'one-stop shop' concept described in the National Service Framework for diabetes (DoH, 2003). Bradford's focus is on engaging people with diabetes and making clinical decisions as a team, with the person with diabetes being at the centre of the team. All healthcare professionals working in such teams share extended roles dependent upon individual skills. For example, the dietitian will also use his or her skills as a counsellor, teacher and education facilitator.

It must be realised that multidisciplinary working does not just mean getting a number of healthcare professionals to attend a particular clinic, at the same time, on the same day – each hiding away in his or her own consulting room and seeing separate lists of patients.

Communication – or, rather, effective communication – is fundamental to team work being productive, we believe.

Healthcare professionals may choose to set aside designated time within the clinic to discuss people with diabetes and their management. However, Bradford diabetes dietitians have found that this does not always lead to improved care and thus we prefer to hold clinics where the GP, the nurse and the dietitian all see the person with diabetes at the same time so that all the healthcare professionals are privy to any information that is divulged by the person with diabetes, therefore enabling informed decisions to be made about their diabetes management. It can be surprising how much a person may edit his or her 'story' by the third time of recounting it to a healthcare professional; accordingly, the usefulness of our advice can be severely diminished if we are not informed of all the pertinent facts. Obviously, people with diabetes do not deliberately give minimal information but they can feel they are not being listened to if they are being repeatedly asked the same questions.

In Bradford, a satellite clinic team working at Wrose Health Centre and Leylands Medical Centre has been granted a place on The Health Foundation's *Shared Leadership For Change* award scheme. This team consists of Dr Brian Karet (GP with a Special Interest), one of the authors (HM; Diabetes Dietitian), Beverley McDermott (Diabetes Specialist Nurse), Liz Crampton (Practice Nurse) and Julie Whitingslow (Podiatrist); administrative support is provided by Gill Parry and Mary Hanley.

While we always considered ourselves to be effective as working as an MDT, this award has given us the opportunity to develop our skills further. An aspect of this is that our routes of communication are now improved, as we have become much more aware of the need to disseminate information to colleagues regarding outcomes of interventions that they may have played a part in at some stage. For example, at the initial consultation one of the authors (HM) may provide dietary and lifestyle advice for the reduction of blood pressure to a person on multiple antihypertensive drugs and, after further follow-up at the clinic undertaken by colleagues, would be informed of the individual's current medication needs. This helps to provide job satisfaction, while at the same time reducing conflicting messages that people with diabetes may receive, as all information is given to all healthcare professionals concerned.

Practical advice

To conclude, we offer a selection of advice on integrating care that we have collected from colleagues working in different MDTs.

- Identify the disciplines required to make the service viable and ensure that they are on board from the service planning stages.
- Ensure that physical facilities are adequately provided (such as number of rooms and chairs).
- Establish a dedicated language support service with appropriate languages at each clinic where necessary.
- Ensure that all members of the MDT keep up to date with current practice to ensure correct and consistent messages and to prevent confusion for the person with diabetes and conflict within the team.
- Agree resources to be used within the service and decide if they are to be developed in-house or sourced from a reputable organisation.
- Provide access for all healthcare professionals to up-to-date clinical records and ensure that all members of the team have computer access.
- Decide on and document a clear pathway of referral between clinics and disciplines.
- Engage all members of the team and encourage a willingness to discuss concerns.
- Ensure that appropriate patients are booked into specific clinics when relevant healthcare professionals are present, as current service levels are unlikely to be able to provide input from all disciplines on a weekly basis.
- Everyone needs to be willing to be a team player and agree to a shared vision of the service.
- Have respect for other colleagues and their skill base and also realise personal limitations.
- All MDT members need to have a good sense of humour!

This practical advice for integrating care can be condensed into a mnemonic, which is shown in *Table 1.* ■

Department of Health (DoH; 1997) *HSG (97)45: Key features of a good diabetes service.* DoH, London

Department of Health (2003) *National Service Framework for Diabetes: Delivery Strategy.* DoH, London

DoH (2006a) *Integrated care.* DoH, London. http://www.dh.gov.uk/AboutUs/DeliveringHealthAndSocialCare/TheHealthAndSocialCareSystem/HealthAndSocialCareSystemArticle/fs/en?CONTENT_ID=4105341&chk=izOBrI (accessed 29.08.2006)

DoH (2006b) *Our health, our care, our say.* DoH, London

Renders CM, Valk GD, Griffin S et al (2006) Interventions to improve the management of diabetes mellitus in primary care, outpatient and community settings. *The Cochrane Database of Systematic Reviews* Issue 3

Roberts S (2006) *Turning the corner: improving diabetes care.* DoH, London

Page points

1. The multidisciplinary team at Bradford has gained an increasing awareness of the need to disseminate information to colleagues regarding outcomes of interventions that they may have played a part in at some stage.
2. This helps to provide job satisfaction, while at the same time reducing conflicting messages that people with diabetes may receive, as all information is given to all healthcare professionals concerned.

Table 1. Practical advice for integrating care.

Identifying team and disciplines involved in delivering care
Teamwork
Shared respect for each healthcare professional's role

as easy as

A shared vision
Being aware of personal role limitations
Communication and feedback as the key to service development
Dedicated rooms, resources and venue