

Bringing specialist diabetes care to primary care

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It is well recognised that cardiovascular risk management and good glycaemic control are central to diabetes care (Stratton et al, 2000; Gaede et al, 2003). However, risk reduction is frequently not optimised in many people with diabetes for a number of reasons, including clinical inertia (Voorham et al, 2008) and poor adherence with treatment plans (Osterberg and Blaschke, 2005).

Even in the authors' practice, which was achieving full quality points for diabetes care, 10% of patients had three or more modifiable risk factors above recommended targets (HbA_{1c} <7.5% [<58 mmol/mol]; blood pressure <130/80 mmHg; total cholesterol <4 mmol/L and LDL-cholesterol <2 mmol/L) (NICE, 2009), and were therefore considered at high risk for developing macro- and microvascular complications.

In this practice, the traditional "one size fits all" approach to care frustrated both patients and healthcare professionals, and there was a strong desire to provide person-centred care close to home, with particular emphasis on reaching those who previously had not fully engaged with their diabetes management delivered at the GP practice or the secondary care provider.

Aim

The aim of the project was to evaluate the effects of providing specialist diabetes care

to a hard-to-reach cohort of high-risk people with complex diabetes in an already high-achieving general practice.

Method

Fifty people attended an initial joint consultation with a dedicated DSN and specialist GP team at the practice. Follow-up was arranged – either joint or individual consultations with the DSN or specialist GP dependent on the person's needs. Time was invested in building collaborative relationships through effective communication and partnership working, to engage the patient in developing and negotiating their own personal care plans.

Motivational interviewing encouraged patients to take an active part in decision-making and goal setting. Individually tailored education, supporting behaviour change and self-care, together with improved treatment adherence and evidence-based pharmacological interventions, were used to achieve individually agreed targets. Particular effort was made to ensure patients attended for follow-up, including the use of telephone consultations. As a result, the quality of the care improved, and inappropriate referrals to secondary care were reduced.

Results

Mean HbA_{1c} reduced by 1.1% (12 mmol/mol) and blood pressure by 16/4 mmHg.

Those with total cholesterol within target rose from 42% to 70% and LDL-cholesterol from 31% to 51%. Structured patient feedback revealed high satisfaction with consultation time, care close to home and joint consultations with the DSN and GP, resulting in consistent advice being given.

On average, a patient attended two joint and two single appointments with the patient journey costing less than half that of equivalent secondary care attendances.

Conclusions

This transferable, novel model for delivering personalised, complex care demonstrates improved outcomes can be achieved in primary care. Furthermore, this pilot study has shown that using a variety of consultation strategies and approaches to care can improve risk factors in those who are often difficult to engage. ■

Gaede P, Vedel P, Larsen N et al (2003) Multifactorial intervention and cardiovascular disease in patients with type 2 diabetes. *N Engl J Med* **348**: 383–93

NICE (2009) *Type 2 Diabetes – Quick Reference Guide*. NICE, London

Osterberg L, Blaschke T (2005) Adherence to medication. *N Engl J Med* **353**: 487–97

Stratton IM, Adler AL, Neil HA et al (2000) Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35). *BMJ* **321**: 405–12

Voorham J, Haaijer-Ruskamp FM, Stolk RP et al (2008) Influence of elevated cardiometabolic risk factor levels on treatment changes in type 2 diabetes. *Diabetes Care* **31**: 501–3

The IMPROVE™ Control Campaign

The Global Task Force on Glycaemic Control is a group of physicians and specialists in the field of diabetes from around the world that is working in collaboration with Novo Nordisk with the ultimate aim of identifying and developing practical solutions to the global problem of poor glycaemic control in people with diabetes. Since early 2008, the *Journal of Diabetes Nursing* has featured articles and submissions under the banner of IMPROVE™ Control – a global public awareness campaign focused on the need for improved control, as part of the Task Force's work. Throughout 2011, the journal will continue to bring you articles on the barriers to good glycaemic control, and submissions from you, our readers, outlining the strategies you have used to help people with diabetes improve their control.

For example, perhaps you have implemented a new educational session in your area that has helped break down barriers to control, or maybe you have set up a new referral pathway that has helped improve HbA_{1c} levels. The *Journal of Diabetes Nursing* would like to help you share your practical solutions for improving control, no matter how big or small, with other nurses working in diabetes. We encourage you to take part in this global initiative by calling 020 7627 1510, or emailing jdn@sbcommunicationsgroup.com.



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