A multidisciplinary integrated diabetes care team

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In 2007, integrating services between the hospital and the community was identified as important for people with diabetes in East Cambridgeshire and Fenland (ECF). With no major hospital within the area, referrals went to five secondary care units. There was little continuity of care – people with diabetes had regularly reported that they were seen by a different doctor, nurse or dietitian. A joint diabetes clinic was established in April 2008 (but with no funding agreed) in one of the local community hospitals for ECF residents. The feedback from attendees of the clinic was positive and, as a result, in April 2009 funding was granted for this pilot project and new team members were appointed.

The multidisciplinary integrated care team

The new integrated care team consisted of: 3.4 whole-time equivalent (WTE) DSNs, 1.0 WTE specialist podiatrist, 1.0 WTE specialist dietitian, 2.0 WTE care technicians, 0.3 WTE consultant diabetologist and 0.72 WTE admin support. It was agreed that the new integrated care team would be based together in one office to improve communications between the healthcare professionals.

Pilot service

Virtual clinics

A virtual clinic consists of the GP practice staff and specialist team meeting to discuss individuals and make suggestions to possible changes in treatment or lifestyle. One or more members of the specialist team attended each virtual clinic.

Education

The specialist podiatrist has been delivering teaching sessions in the GP practices, ensuring that the foot checks conducted at the practice annual review are all up to the same standard, and that the staff have a better understanding of when to make specialist referrals. This often allows for earlier discharge or less frequent hospital visits.

The specialist dietitian started carbohydrate-counting workshops, which help to promote self-care. These sessions are also offered to other healthcare professionals.

The whole team has been involved in educating staff from local care homes. This education involves an overview of diabetes management. At these sessions, individuals' medication and blood glucose results are reviewed.

Outcomes of the pilot

The clinical outcomes after 6 months (Simmons and Hollern, 2010) were reviewed to determine further funding requirements. These outcomes included:

- There were 521 people seen by the service.
- There were 648 clinic appointments in GP surgeries or community hospitals.
- Mean weight reduced from 95.6 to 90.6 kg.
- Mean HbA_{1c} level reduced from 9.7 to 8.4% (83 to 68 mmol/mol).
- Forty-two people had medication changes resulting in a saving of £47 352.91.
- Seventeen people were thought to have avoided admissions due to changes in medications.
- Four people had reductions or withdrawal of district nurse support as it was no longer necessary.
- The estimated cost savings from the specialist podiatrist was approximately £64 500 over a 6-month period.

Conclusion

After much discussion and review of the 6-month data, it was agreed by the project management office (a group of senior staff from all organisations tasked with looking at ways of improving cost-effectiveness in many long-term conditions) to continue with the project. The service is developing in other areas of Cambridgeshire and again expanding the team within ECF after close working with some of the local GP cluster groups.

What has been key to this project is the interworking within the different specialties of the integrated team and of the interworking between organisations. ■

Simmons D, Hollern H (2010) *It's Time for Integrated Care for People With Diabetes.* Cambridgeshire Community Services NHS Trust, St Ives, Cambridgeshire