Success of a community MDT in diabetes management

Anju Gupta is a GPSI Diabetes, Adeel Ansari is a GPSI Diabetes, Ravali Goriparthi is a GPSI Diabetes, Elaine Whitlock is a Nurse Consultant, and Khash Nikookam is Consultant Endocrinologist, Integrated Diabetes Service, Barking and Dagenham Community Health Services

In Barking and Dagenham, 9305 individuals (6.12% of total population) had a diagnosis of diabetes in 2011; this prevalence is greater than the England average of 5.50% (NHS Information Centre, 2011). The higher prevalence of diabetes in deprived areas is well documented in the literature. This is further compounded by poor health behaviours (e.g. higher than average prevalence of smoking and obesity) among the population. These factors have contributed to difficulties in achieving good glycaemic control in this area.

According to the 2007 *Managing Diabetes, Improving Services for People with Diabetes* report (Healthcare Commission, 2007), the overall performance in diabetes care in Barking and Dagenham did not meet "minimum requirements" or "reasonable expectations of patients and the public". In this diabetes service review undertaken by the Healthcare Commission, all 152 new primary care trusts (PCTs) participated. They rated 78.3% of London strategic health authority PCTs as "fair", 11.2% as "good", 8.6% as "weak" and 1.9% as excellent.

The Integrated Diabetes Service

The Integrated Diabetes Service (IDS)was introduced in 2008 as an intervention to manage the care of high-risk people with diabetes in the community. The model is based on the principles of a comprehensive, integrated service providing a seamless care pathway between primary, specialist and secondary care services. It ensures fast and efficient processing of referrals from several community-based sources (e.g. GPs, practice nurses, community matrons, integrated care teams and podiatrists) for advice and management planning, and facilitates increased specialist input into primary care settings.

The current team structure is one consultant endocrinologist, one nurse consultant, three GPs with special interest (GPSIs), four DSNs, two specialist dietitians, one psychologist, two podiatrists and one healthcare assistant. The consultant endocrinologist provides the vital link between the primary and secondary care pathways. The entire team come together for a 4-hour session once a week (the complex care clinic) to provide comprehensive care to people with poorly controlled diabetes, often with complex psychosocial and physical comorbidities. The complex care clinic enables access to a high-quality multidisciplinary team (MDT) in a community setting, in a single appointment. This ensures that there is no unnecessary gap or duplication in service provision between primary and secondary care. As a community-based, easily accessible service, the IDS is envisaged to reduce interpractice variability in the borough.

Pilot audit

We randomly selected 20 patients who were seen in the complex care clinic during July and August 2010. One patient with type 1 diabetes was excluded; the remaining 19 had type 2 diabetes and were included. All patients received some input from the MDT.

We compared the average HbA_{1c} level and weight for the period 2009/2010 (the preceding 2 years) with the most recent recordings in 2011. We found improvements, with an average HbA_{1c} level reduction of 0.6 percentage points (6.6 mmol/mol) and average weight reduction of 1.18 kg.

Conclusion

The service is still in its infancy and the wider, long-term impact on diabetes care in Barking and Dagenham is yet to emerge. However, our pilot audit shows that the provision of MDT input, covering all of the bio-psycho-social aspects of diabetes care can afford better glycaemic control and improved metabolic profile for people with poor diabetes control. ■

Healthcare Commission (2007) *Managing Diabetes, Improving Services for People with Diabetes.* Healthcare Commission, London

NHS Information Centre (2011) *QOF Prevalence Data Tables 2010/11.* NHS Information Centre, London

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 2012, 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.