A community outreach service for vulnerable people with diabetes

Martin Jones[1] is Diabetes Outreach Dietitian; Julie Man[1] is Diabetes Outreach Podiatrist; Janet Ridout[1] is Diabetes Specialist Nurse; Silvia Hepburn[2] is Specialist Clinical Psychologist in Diabetes; and David Gable[2] is Consultant Diabetologist.

The Westminster Diabetes Centre, London, provides intermediate-level diabetes care in the community. The multidisciplinary team (MDT), consisting of consultants, nurses, dietitians, podiatrists and a clinical psychologist, identified four "hard-to-reach" groups of people within the local Westminster population who might fail to access healthcare through conventional clinics: the homeless (rough sleepers and those in hostels); those in community psychiatric care (such as community mental health teams); those who are housebound; and those who are in residential care or nursing beds.

In Westminster, as many as 3000 "hidden homeless" people live in temporary accommodation, along with about 150 rough sleepers. One study found that 44% of homeless people with diabetes had poor glycaemic control (HbA_{1c} >53 mmol/mol [>7%]; Hwang and Bugeja, 2000). Symptoms of severe mental health problems (such as schizophrenia or bipolar depression) can cause people to live chaotic and restricted lives and impair their ability to take in educational information, reducing adherence to diabetes treatments (Ciechanowski et al, 2000). If diabetes services are inflexible in their approach, it follows that people who cannot attend clinics as a result of being bedbound will not be able to access specialist care; an outreach service provides a solution to this problem.

Outreach service

The outreach team in Westminster developed a pathway to better accommodate people with complex needs. All referrals sent to the general clinic are triaged, and people with complex needs are then diverted to the outreach team. At the weekly outreach meeting, all referrals are triaged and each individual is allocated to a member of the team who acts as case manager, taking responsibility for facilitating and coordinating patient-centred care, including home visits where appropriate. Two case examples illustrate the pathway in action.

Ms X was a 65-year-old woman with type 2 diabetes who lived alone. She had limited cooking and food-hygiene skills. Her last HbA_{1c} was 69 mmol/mol (8.5%) taken 16 months previously. Ms X was referred to the specialist diabetes dietetic team by her GP, which identified Ms X as a vulnerable person with complex needs and referred her to the outreach team. The diabetes outreach dietitian was appointed as Ms X's case manager, who discussed her case with the outreach MDT. Ms X agreed to some dietetic goals and to an intervention by local occupational therapists to teach her food hygiene, preparation and cooking skills. A meals-on-wheels delivery was arranged, bringing her a hot meal daily. Three months after initial assessment, Ms X's HbA_{1c} was 50 mmol/mol (6.7%) and her quality of life had improved as a result of her new skills, improved diet and increased self-reliance.

Mr Y was a 69-year-old man with type 2 diabetes living in sheltered accommodation with an in-house warden. He had poor glycaemic control and peripheral neuropathy. A district nurse referred Mr Y to the diabetes team for an emergency podiatry assessment because he had a large neuropathic ulcer on his toe. As Mr Y was difficult to engage and refused follow-up podiatry appointments, his case was brought to the diabetes outreach team and the specialist diabetes outreach podiatrist took on the role of case manager. Following the outreach MDT assessment, Mr Y was given appropriate footwear and broad-spectrum antibiotics for suspected osteomyelitis. Two months after initial referral, Mr Y no longer had open foot lesions and he attended the clinic regularly.

Conclusion

The development of an outreach team in Westminster appears to have improved equality of access to specialist diabetes care for people who would otherwise have remained untreated. In its first year, the outreach service has facilitated 30 vulnerable people to attend conventional clinics with support, provided education to local services, prevented numerous hospital admissions and helped to reduce unnecessary diabetes-related distress and complications. ■

Ciechanowski PS, Katon WJ, Russo JE (2000) Depression and diabetes. *Arch Intern Med* **160**: 3278–85

Hwang SW, Bugeja AL (2000) Barriers to appropriate diabetes management among homeless people in Toronto. *CMAJ* **163**: 161–5

[1]Westminster Diabetes Centre, London; [2]Westminster Diabetes Centre and St Mary's Hospital, 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.