

Integrated Community Diabetes Model: Future of Diabetes Services and Way Forward?

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Prevalence of diabetes is increasing. Diabetes is more prevalent in the socially deprived, ethnic minority population (based on continuing rise in elderly population, growing obesity and BME groups). Compliance is a major stumbling block in the management of most long-term conditions including diabetes. The impact on primary care is significant with difficulty in managing the above increasing numbers, reducing HbA1c, other complications and maintaining skills in diabetes. As a result, diabetes care is full of gaps and duplication in service – there is inability to build capacity and capability in primary care and to progress towards better management of diabetes patients.

The idea is to improve collaboration and integration between acute, community and primary care services and reduce acute activity. Thus, along with care closer to home & upskilling, outpatient service redesign is going to be a key component of any such new model. The model needs to provide enhanced specialist support, education and upskilling of primary care. This would help support primary care to manage more complex diabetes cases and in turn stem the number of patients being referred for secondary care services.

There is an urgent need to commission Multi-disciplinary integrated specialist community diabetes service and designed in such a way that bring specialist clinical knowledge and skills directly into partnership with Primary Care in a community setting.

The typical model could provide for joint diabetes clinics,

virtual clinics, case notes review with GP practices every 2-3 months (practices themselves identify difficult or poorly controlled diabetes patients) for a one-off advice and management plan by an assigned team of consultant and diabetes specialist nurse. Wherever possible, telephone and email enquiries should ideally be dealt within the same day, with a maximum turnaround time for non-urgent enquiries of two working days.

Out-patient attendances have been shown to be reduced with a reduction in elective first and follow up outpatient activity and therefore there should be substantial cost savings. Inpatient elective and non-elective emergency datasets have also shown a reduction in the total number of admissions relating to diabetes with hypoglycaemia and ketoacidosis. There is also evidence that appropriate use of blood glucose testing strips and use of cost-effective NPH insulins can be made according to agreed formulary. Patient satisfaction survey results have also shown significant benefits relating to quality of service, overall satisfaction, education and self-empowerment and care closer to home.

This would be a novel concept of chronic disease management: specialists going out to patients rather than the traditional way of hospital-based care. Patient should remain at the “heart” of project. This integrated approach to management targets improvements in diabetes service through upskilling of knowledge – a basic concept likely continue to yield results in future. The concept is simple, cost-effective, sustainable and can be adopted by any Trust-CCG very easily.