Community diabetes: an East London perspective

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J R Soc Med 2005;98:96–100

SUMMARY

The rising prevalence of type 2 diabetes in the UK has necessitated a change in the delivery of diabetes care, with a shift of focus from hospital to community. The National Service Framework for Diabetes has enshrined this approach, and the new General Medical Services (GMS2) contract rewards primary healthcare professionals for developing high-quality diabetes care. New approaches cross the primary/secondary care divide and are patient focused. The evolution of diabetes care in the UK is illustrated by service developments in Newham, East London.

INTRODUCTION

Management of chronic disease exercises the minds of policy-makers in healthcare systems throughout the world. If the dire predictions of many agencies are borne out, type 2 diabetes will soon be one of the most pressing public health issues in both developed and developing countries.¹ In the UK, the estimated prevalence of type 2 diabetes ranges between 2% and 4%,² although in South Asians and some other ethnic groups the prevalence is much higher (~6%)³ and is predicted to rise sharply.¹ Diabetes increases mortality and morbidity from vascular complications,⁴ and early intervention to address vascular risk factors can substantially reduce the burden of disease.⁵ This article reviews some of the newer models of diabetes care being practised in the UK, with experience of the Newham Diabetes model as an illustrative case.

THE DRIVERS FOR CHANGE

The conventional model, whereby large hospital diabetes clinics see all patients with diabetes in a district from diagnosis to death, is now recognized as unsustainable. With the rapidly increasing prevalence of the condition in the UK, it has become clear that new ways of providing diabetes care are required. There is a general acceptance that huge 'cattle market' diabetic clinics offer little reward for either patient or clinician, and that secondary care should concentrate on disorders that require special expertise, such as diabetic complications, diabetes in pregnancy or type 1 diabetes.

Several districts have been rising to this challenge, and diabetes care in the UK is evolving. The previous reflex response of 'diabetic-refer' is being replaced with a partnership between primary and secondary care—an approach enshrined in the Diabetes National Service Framework (NSF) and driven in many areas by primary care 'champions' for diabetes, as part of managed clinical networks.⁶

Whereas the Diabetes NSF came with very little additional funding attached, a potential driver for change in England and Wales is the new General Medical Services (GMS2) contract for primary healthcare providers. This now offers financial rewards for the delivery of ambitious clinical targets. The 99 points for diabetes compare favourably with those on offer for coronary heart disease (101 points)—a condition that has generally received far more public attention and funding. Whilst the GMS2 contract has had some initial difficulties, it does highlight chronic disease management and should reward primary care practitioners for high-quality clinical care of people with diabetes.

Many patients prefer their diabetes care to be provided locally, by health professionals with whom they are familiar. In addition, with most funding streams and commissioning of services being regulated by primary care trusts, there is a strong incentive to develop enhanced primary care services for diabetes.

MODELS OF DIABETES CARE

In the traditional district hospital diabetes clinic, non-attendance rates are typically high and poor communications from the hospital discourage the primary care team from taking an active interest. In recent years more imaginative models have been devised, often out of necessity through unsustainable pressures on secondary care services.

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Shared care—‘sharing’ or ‘passing the buck’?

Discharge of patients to a primary care service with no training, poor support and lack of rapid access to specialist advice has been shown to result in poorer care.⁷ In contrast, discharge to structured clinics with ongoing specialist support, education and communication has substantially improved outcomes.^{8,9} Many units in the UK operate a ‘shared care’ policy, with annual reviews undertaken in the hospital diabetes clinic and intervening reviews performed in primary care.^{10,11} Such models are likely to become unsustainable with the predicted epidemic increase in diabetes prevalence, particularly in inner city areas with high ethnic minority populations.

Diabetes ‘outreach’ clinics were in vogue some years ago, although many of these clinics had little educational role and simply delivered a secondary care clinic in a primary care setting. Outreach clinics are rarely cost-effective unless used as an educational tool—i.e., for imparting diabetes knowledge to primary care.

Intermediate diabetes care

Several areas have developed the model of intermediate diabetes care, with its additional tier between the general practitioner (GP)/nurse-led primary care clinic and the hospital diabetes clinic (Figure 1). Hospital diabetes services are provided for complex patients or patients with special needs, and the intermediate care clinics facilitate primary care management of diabetes. This type of intermediate care may be delivered by various healthcare professionals (see below), in several different settings. The clinics may be held within designated practices or health centres in the area, in the local diabetes centre or in a community hospital. Such clinics can offer a range of diabetes services, from comprehensive diabetes management for patients attending practices with scanty diabetes care, to commencement of insulin for patients attending practices that can provide most care but lack the skills for insulin commencement. This model has the advantage of delivering some uniformity of diabetes care across a locality, being easily accessible for local patients and reducing the burden of unnecessary referrals to secondary care.

New roles in community diabetes

New roles for healthcare professionals in diabetes have helped to dismantle the barriers between primary and secondary care. A new breed of consultant in diabetes has developed—‘community diabetologists’, who spend part of their time in primary care. The work of community diabetologists may embrace a strategic role in service development or project management, hands-on care, and provision of advice and problem-solving sessions.

Figure 1 The intermediate care model

The traditional role of diabetes specialist nurses has been to support secondary care services, educating patients and starting insulin therapy. More recently, community diabetes nurses have been helping practices to provide diabetes services or officiating at intermediate care clinics. Some areas have ‘primary care diabetes facilitators’, whose main role is to develop diabetes clinics in general practices.

Diabetes is a popular specialty for ‘GPs with a Special Interest’ (GPSIs). Previously, a GP who wanted to gain expertise in diabetes care would usually become a clinical assistant in a hospital diabetes clinic; today, accredited training specifically for GPs is becoming more widely available.

Training underpinning diabetes care

Most diabetologists recognize that part of their role is to help educate primary healthcare professionals in diabetes management, and many contribute heavily to teaching and training in the community. Nevertheless, this can be difficult to deliver adequately in view of the other demands on a consultant physician’s time, and with the developing role of the GP specialist there is a need for formal clinical and practice based training in diabetes. Warwick Diabetes Care has been in the vanguard of developing accredited

diabetes training courses,¹² and its Certificate in Diabetes Care is highly regarded.

Patient involvement

In a modern local diabetes service the patient is seen as an active participant rather than a passive recipient of care. 'Expert' patients make an important contribution to local diabetes networks and can advise other patients on how best to access services and manage their diabetes.

EVOLVING DIABETES CARE: THE NEWHAM EXPERIENCE

The diabetes service in Newham provides an example of how the difficulties facing diabetes units today can be addressed by an integrated approach. Newham is an East London borough with a population of around 260 000. The area presents enormous challenges in being culturally diverse, with more than 200 languages spoken, and afflicted by high unemployment and social deprivation. Two-thirds of the population are of Afro-Caribbean or South-Asian descent.

The scale of the problem

In 1996, when the first of the current diabetes consultants was appointed, the diabetes service was close to collapse. There had been no permanent consultant in post for nearly a year, there were over 40 new diabetes referrals each week and new patient waiting times were approaching two years. Outpatient clinics were booked for 30 patients per doctor, with little time to see patients adequately. The three community diabetes specialist nurses were overwhelmed and demoralized. There was no specialist diabetes pregnancy service or dietetic or podiatry provision, despite the borough having twice the national amputation rate. As with most district general hospitals, diabetes had no identified funding: it was subsumed into the hospital general medicine budget. At the time, diabetes was not perceived as a national priority and the Local Diabetes Services Advisory Group had long since stopped meeting.

Building the service

Raising awareness of diabetes

To raise the profile of diabetes the hospital grand rounds and audit meetings were used to present figures on local prevalence of diabetes, its complications, their effect on hospital length of stay and how this could be reduced with a new post of hospital diabetes nurse. The hospital chief executive, the director of public health, and the chief executives and chairmen of the health authority and the community trust were each lobbied with local data on diabetes prevalence, demand for service, current capacity,

national recommendations for staffing levels and ideas on improvements. The Local Diabetes Services Advisory Group was resurrected to focus on clinical priorities and its representation was widened to include patients and other stakeholders. Pharmaceutical companies provided initial funding for staff-grade and diabetes specialist nurse posts.

In 1997 the second consultant was appointed and the two worked closely together, taking every opportunity to inform people of the dire local diabetes situation.

Crossing boundaries

We realized that service improvement and resources relied on engaging primary care. We arranged a meeting with local interested GPs, presenting figures on service demand and capacity, and proposed the post of community consultant to support primary care diabetes—one of the first such posts in the country. This meeting proved to be a major catalyst for service improvement. It led to the creation of an integrated Diabetes Working Group, comprising GPs, consultants, diabetes specialist nurses, patients, and commissioning and service managers from primary and secondary care. The group produced a three-year strategy document with a clear framework for service development. Whilst there was little funding available at the time, when funding did eventually emerge it was put against the next agreed priority.

The primary care lead devised a GP incentive scheme with three levels of care (Figure 1) linked to accreditation of GPs and an annual performance audit by the primary care trust. A new community consultant would support the system and assist practices to move to a higher level. Most practices were level 1—often single-handed GPs working from poor premises and lacking the infrastructure to support their own diabetes clinic. To address this we planned locality clinics in each sector of the borough, run by GPSIs and supervised by the community consultant, supported by community diabetes specialist nurses, dietitians and podiatrists and with retinal cameras available.

Difficulties and pitfalls

Short-termism and frequent organizational changes are familiar to clinicians working in the NHS. Despite changes from fundholding to primary care group to primary care trust, the Diabetes Working Group has remained active throughout. Most of the achievements have been led by clinicians, with no designated managerial role, despite their busy clinical and teaching commitments. After a few developments there can be the misconception that diabetes is 'sorted' with no long-term plan of how to sustain progress, and momentum can be difficult to maintain. The service requires dedicated management and

Box 1 Staffing in Newham diabetes unit 2004

Consultants	5	Information technology officer	1
Associate specialist	1	Diabetes project manager	1
Diabetes specialist nurses	12	Patient representatives	3
Primary care trust lead	1	Health advocates	4
GPs with a specialist interest	2	Administrative assistant	1
Podiatrists	3	Clinical assistant	1
Dietitians	3	Research fellow	1
Diabetes midwife	1		

administration—all the more important as the service grows—and must transmit a clear consistent message.

Newham Diabetes Service today

The Diabetes Working Group has met every two months since 1997 and is chaired by the diabetes champion. The Local Diabetes Services Advisory Group, chaired by the community consultant, focuses on clinical matters and protocols and brings issues to the Working Group for implementation. Both groups have patient representatives. Diabetes has been actively supported by the primary care trust and the hospital trust.

Staffing has improved considerably (Box 1) and recruitment has become easier. Waiting times for consultant appointments have been slashed, although increasing demand continues to be a challenge. The hospital clinics take place at the diabetes centre and use a single real-time district database that currently holds details on over 12 000 patients.

The community consultant supervises a triage system ensuring that referrals are appropriately directed, using a single multidisciplinary referral form. General practices have been assigned according to the level of care they provide; at initial audit 37 practices were at level 1, 16 at level 2 and 13 at the most advanced level 3.

The first locality clinic opened in August 2003 and more are due to come on stream. There is one clinic session per week staffed by two GPSIs supervised by the community consultant, a diabetes specialist nurse, a dietitian and a podiatrist; a retinal camera is on site. The locality clinic is linked to the district diabetes database, which also processes clinic letters as in the hospital clinics. This link was installed by joint working between the information technology departments of the primary care trust and the hospital. In its first year the locality clinic saw 305 new patients and 166 follow-up attendances. This has relieved pressure on the hospital clinics, which can now see complex cases more rapidly. In future, as more locality clinics become

established, the hospital clinic should be able to discharge uncomplicated patients to the locality clinics for routine follow-up.

Specialist diabetes services have been developed for pregnant women and adolescents and for patients with cardiac and foot complications. Every hospital ward has diabetes-trained link nurses. A regular newsletter keeps health professionals abreast of service developments. Practice nurses are supported by an individual 'buddy system' with the diabetes specialist nurses and workshops. Pre-surgical clinics improve glucose control in patients awaiting elective surgery. The diabetes database is planned to link into the new electronic patient record.

The service has been tailored to our local multiethnic population, with leaflets on how to manage diabetes during Ramadan and novel workshops on diabetes during the pilgrimage of Hajj. The service has developed the 'My Diabetes' resource pack and a patient-held record that has been adopted by many others throughout the country. Regular mobile 'MOT' screening days are held throughout the borough to identify new cases. A support group—Diabetes Newham—has been initiated for new and established patients as well as for children with diabetes and their parents and carers. Storytelling groups use health advocates to encourage non-English-speaking Asian patients to discuss how diabetes has affected their lives. A website for patients and health professionals is in preparation.

CONCLUSIONS

The increasing burden of diabetes, particularly in multi-ethnic communities, poses a huge challenge to healthcare providers. Diabetes care in the UK is evolving, with primary care becoming its focus for the majority of patients, and secondary care providing support for complex cases. The Newham experience has demonstrated that diabetes services in a deprived multiethnic area can be substantially improved by joint planning between primary and secondary care and patients. The next stage is to evaluate whether such service models can reduce mortality and morbidity. In addition, measures aimed at prevention of diabetes are clearly needed if the services are not to be submerged by a tidal wave of new cases diagnosed each year.

Diabetes has been in the vanguard of partnership approaches to chronic disease management in the UK. In many areas, diabetologists, nurses, general practitioners and patients have broken down barriers and developed integrated services in partnership, and such an approach can provide lessons for the management of many other chronic diseases.

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