# Admissions avoidance in diabetes: guidance from the Joint British Diabetes Societies Inpatient Care Group

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Diabetes remains one of the most prevalent long-term conditions that we all face. The latest estimates from the International Diabetes Federation suggest that 382 million people had diabetes in 2013 and by 2035 this will rise to 592 million.[1] In the UK it is estimated that almost 3 million people already have the condition.

In addition to the numerous challenges that outpatients with the condition face, diabetes is associated with an almost doubling of the risk of hospitalisation when compared to someone without diabetes.[2] Data from the 2012 National Diabetes Inpatient Audit (NaDIA) showed that the mean prevalence of diabetes in hospitalised patients was 15.2% (range 5.5–31.1%).[3] NaDIA also confirmed previous work that showed that people with diabetes spend longer in hospital than those without diabetes,[4] but also showed that unlike those without diabetes, emergency admissions were far more common. Data from 2009/10 suggested that together these, and other, factors cost the NHS an estimated £2.51 billion per year.[5]

## 'Prevention is better than cure'

The saying goes that 'prevention is better than cure', and with these data in mind it would seem to make sense to try and prevent hospital admission if at all possible to reduce the burden on the health economy. It is therefore with some anticipation that the latest in the long line of guidelines produced by the Joint British Diabetes Societies Inpatient Care Group (JBDS) has been launched.[6] It has taken a long time in gestation because of the breadth of areas needed to be covered, the need to integrate with other guidance, and the changing landscape of the NHS.

Belinda Allan, Mike Sampson and colleagues are to be congratulated in producing a summary of the evidence-based economic arguments that are needed to convince the many non-clinical managers who make most of the decisions on how to run and prioritise care in today's NHS. In particular, the authors focus on several aspects of variations and inequalities in diabetes care across England that lead to these increased costs.

## Reducing variations in care

Prior to the introduction of the other JBDS guidelines, there was often a variation in the care offered to people with diabetes between hospitals admitted for the same condition. JBDS has produced guidelines that have reduced these variations in care (all freely available at www.diabetologists-abcd.org.uk/JBDS/JBDS.htm). At the Diabetes UK Annual Professional Conference in 2013, Mike Sampson presented data that showed that almost every diabetes team knew of the suite of JBDS guidelines and that most trusts had either adopted them or adapted them. This was in large part because teams agreed with their contents and (with the exception of the perioperative guideline) were relatively easy to implement. It is hoped that the widespread adoption of the guidelines standardises and improves the care people receive.

In this respect, the current admissions avoidance document is somewhat similar to those that have preceded it in that it aims to reduce these variations in care. The previous guidelines were, however, clinical. They were aimed at helping those 'at the front door' manage the common conditions occurring on the wards on a daily basis. The new guidelines in development – managing steroid induced hyperglycaemia, the use of variable rate intravenous insulin infusions in medical inpatients, and discharge planning – continue this trend.

This is where the current admissions avoidance guideline differs. It is not clinical, but collates data from numerous sources to highlight variations in practice and, where the evidence exists, highlights examples of care that have successfully helped to avoid admissions. Importantly, the document also speaks in a language less familiar to clinical teams, but very understandable to commissioners – cost and money.

## Call to commissioners for better services

The current guideline is aligned with the document produced by Diabetes UK earlier in 2013 that was designed to give commissioners all they needed to know about what the components of an integrated diabetes service should be.[7] That document, which had great support from several of the relevant bodies involved, summarised the components of the 'whole systems approach' to diabetes care. In particular, it emphasised the goal of integrating services and what could be improved by providing the Clinical Commissioning Groups with sufficient information to make the patient journey a smooth one. They advocated several aspects: provide services close to where patients live; provide services without duplication or gaps; provide integrated primary and secondary care services; ensure that the multidisciplinary team is competent and available; and support self-management.[7] The document focused, however, on the bigger picture, e.g. screening for diabetes, making sure that key care processes were carried out for all people with diabetes, and reducing the risk of complications from diabetes. Only a part of that document was focused on admissions avoidance and inpatient care.

The JBDS guideline limits itself to this latter area. While still addressing the commissioners, it deliberately limits itself to those areas that people with diabetes most frequently access when using emergency services and

hospital care. It is a call to commission better services for these areas which have, until relatively recently, been neglected.

## Counting the cost

Is this approach likely to cost money? Like many things in the NHS, where a little bit of investment can pay large dividends relatively quickly, there seems to be the same 'no money to spend now to save later' attitude that commonly prevails.

I believe that with diabetes this approach is likely to be short sighted. This is because of the unrelenting rise in the numbers of people with the condition. If some investment in the infrastructure for diabetes care is put in place now, then we will be in a better position to deal with the consequences of the rising tide of complications that we are likely to face in the coming years.

Currently, many teams are just 'firefighting'; it seems that, under the constant reminders of the current financial and corporate pressures, just doing the day-to-day commitments makes life for those of us caring for people with diabetes very hard work. Many will recognise the lack of 'joined up thinking' between agencies – primary care, ambulance trusts, and hospitals. The changes needed to integrate services seem small, but the barriers to overcome them are seemingly huge. By acknowledging the JBDS admissions avoidance guideline, by agreeing to working together to find solutions to these difficult problems, then commissioners and clinical teams can try to overcome the 'corporate inertia' that surrounds us.

Using Marion Kerr's data,[5] even if any changes implemented were to lead to a 5% sustained reduction in admissions and associated costs, they may still save £125 million pounds per annum. It is unlikely that any intervention will take that kind of ongoing investment. Thus, once the changes are made and are seen as routine standard of care, cost savings will be cumulative. Several examples of these small changes exist but there is room for improvement: better education for primary care staff so that they know how to access the advice of specialist services to prevent admission; integrating IT services to help to identify those who use ambulance services most frequently; having a 24-hour manned telephone service able to provide help to patients and care givers; making sure that there are sufficiently staffed diabetes specialist teams to see inpatients in a timely fashion and facilitate discharge; having an integrated transitional service; commissioning a fully functional foot service; having the ability to provide appropriate ongoing structured education; education of surgical staff to no longer deny day case surgery to those with diabetes; and so on.

The list is understandably long, but diabetes affects so many people in so many ways that all of these areas need to be addressed at the same time, and not in a piecemeal fashion. Commissioners need to work together with the clinical teams to come to an agreement about what needs to be done to improve their local service, but the JBDS guideline also sets a standard to which all commissioners and service providers should aspire. Eliminating the variations in the standards of care is the goal.

## Your data are needed

How could the document have been improved? The authors were limited by something not in their control – a lack of data. Much of the evidence for cost saving comes from extrapolating from small studies. Making an intervention that prevented admission in a few dozen individuals, and then using that data to suggest it may become nationwide standard of care is possible for individual teams. However, while we can hope that these small numbers will influence policy makers, there is a fear that they will dismiss these as 'not applicable to us'. Thus, there is an implicit plea in the document to all teams who do have something they do that seems to have worked – e.g. improved the care of people with diabetes, maybe prevented admission and thus saving money – publish your data! The more evidence that is available, the less the commissioners will be able to resist.

## And finally ...

Of course, if you are reading this then the admissions avoidance document is probably not aimed at you. It is aimed at the managers in hospitals and commissioners: those people who ultimately control the purse strings, and thus have the power to change the system. The implementation of many of the recommendations will only occur when systemic changes are put into place, and that may require some investment. However, your job is to point them in the right direction. Send them a copy of the document, make a noise, be an advocate for those people with diabetes who, without us to champion them, may not have a voice.

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## Declaration of interests

Dr Dhatariya has been an author on several previous JBDS Inpatient Care Group (JBDS-IP) guidelines. He is also on the steering group for the JBDS-IP. He has received travel expenses from Diabetes UK to allow him to attend the guideline writing meetings and also from others to speak at events promoting the guidelines.

## References

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