

Thinking creatively to make a difference

Welcome to this summer issue of the Journal. “What summer?”, you may ask. However, I remain very optimistic that we will see the return of the yellow, blazing ball that should be in our skies right now!

The recent weather has at least allowed me plenty of time for reading, and so I wish to share with you some of my reflections. Over recent years, I have spent much time looking into ambulance call-outs for hypoglycaemia. Some five years ago, here in Somerset we had a call-out rate of approximately 720 visits each year just to attend episodes of hypoglycaemia. When the data was interrogated, the vast majority of those were to the elderly frail, either at home or in care facilities. We subsequently strove to raise the awareness of this across all sectors of the health community. Through education and support, we encouraged GP practices to audit regularly for those at risk of hypoglycaemia in this elderly frail category, and supported them with the proactive de-escalation of hypoglycaemic agents.

The result has been an amazing 50% reduction in ambulance call-outs – we now consistently have a call-out rate of 350 visits per year for hypoglycaemia. Not resting on our laurels, I have recently undertaken a further review of the call-outs that we now see. The overwhelming theme emerging is that of attending people with mental health concerns – either severe mental illnesses or diabetes distress. This cohort mainly has type 1 diabetes, although we are also seeing a cohort with pancreatogenic diabetes (type 3c). Many of these individuals require several call-outs each year, so are very intense users of this service.

Consequently, and while planning on how we can now support this group, I was very interested to read Dorothy Frizelle’s [comment piece](#) in the Journal. Her thought-provoking reflections on the lack of diabetes psychologists within the diabetes multidisciplinary team (MDT) really resonated with me. Her challenge regarding the affordability

of a psychologist was of particular interest, as she highlights the impact they demonstrably have on both “soft” and “hard” diabetes outcomes.

Reflecting on our ambulance data, I was struck by the sheer cost of call-outs and the admissions to hospital that they often result in. When calculating the cost of employing a psychologist, we also have to consider the wider picture, including where savings can be calculated. I have, all too often, heard the argument that the diabetes service would shoulder the costs, while the savings would be seen elsewhere. However, we all need to challenge this viewpoint and utilise all available data to support embedding psychologists in diabetes services, so that we can enjoy the massive impact that they can make. So, well done, Dorothy, for providing me with another argument to support my latest quest to raise the profile of diabetes psychologists and focus our combined efforts towards employing one in our MDT!

Since my last editorial, I am sure we are all now feeling the effects of the lack of GLP-1 receptor agonist availability. With no end yet in sight, we are all doubling our efforts to provide lifestyle support and/or the addition of other medication classes. Vinod Patel’s Journal Club on [“Back to basics – an update on lifestyle factors”](#) and David Morris’s [“Making the most of SGLT2 inhibitors in primary care”](#) are, therefore, both very timely. To support people further, we have in Somerset developed a leaflet offering advice on how to help combat the issues people may face when they are unable to obtain their GLP-1 RA. You can access it [here](#).

At a time when we are really feeling the impact of this GLP-1 RA issue, I must highlight the huge advances that are taking place in this therapy class and point you to our [ADA conference highlights](#). When the stock supply issues are finally over, we will see a plethora of new dual and triple incretin medications, along with more oral GLP-1 RA medications. The future is indeed bright – we just have to hold our breath for now! ■



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