Diabetes services: Seamless or segregated?

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There has been much discussion about chronic disease management and the fact that many of these diseases, previously treated in a hospital setting, can now be managed in primary care (Lewis and Dixon, 2004). Despite this, rates of admission to hospital due to such diseases have been rising in recent years.

Hospital admission rates for chronic disease patients have been researched by a number of authors. Emergency admission rates for people with diabetes have been found to be higher in the older age groups than compared with asthma, for example (MacLeod et al, 2004; Parker, 2005; Billings et al, 2006). Emergency admissions are also higher in areas of social deprivation. The results of the research of MacLeod et al carried out in Scotland have been repeated by Saxena et al (2006) with regard to this correlation in the London area.

In the United States, Blustein et al (1998) have suggested that hospital admission rates are a marker for poor primary care. However, as Saxena et al highlight, the idea of avoidable admissions assumes that the provision of good primary care alone can decrease hospital admission rates. It is unavoidable that the prevalence of diabetes is higher in some areas compared with others. Areas with higher Asian populations, for instance, will experience higher levels of diabetes and coronary heart disease (Hippisley-Cox et al, 2004), which may also increase the numbers of admissions in such areas. The same principle applies for those areas with higher numbers of older people in their populations: old age increases their risks of requiring medical attention.

On the other hand, Rosenthal et al (1998) have suggested that the presence of depression is the most important determinant of admission to hospital in older subjects with diabetes. Likewise, in over 65-year-olds, falls are the most common cause of injury, and hospital admission for trauma and may account for more than 80% of fractures (AGS Panel on Fall Prevention, 2001). Some falls may be triggered by a number of diabetes-related problems e.g. hypoglycaemia, neuropathy, impaired vision etc, but others may be totally unrelated. Therefore, some admissions for the older person with diabetes are unavoidable and do not necessarily signify a poor standard of care in the community.

The bigger picture

There is no doubt that chronic disease represents a huge cost to the NHS and any strategies to reduce this cost are welcomed – one such strategy is to prevent hospital admissions. However, whilst focusing on hospital admissions, I feel that it is important to also look at the prevalence and cause of re-admissions to hospital, especially where older people are involved. From my own experience, I would suggest that closer communication between primary and secondary care professionals may prevent some of the early discharges that can result in some patients being re-admitted just a few days following their discharge. It is here where the work of the active case managers and rapid response teams will undoubtedly have an impact on re-admission rates. Unquestionably it is the GP, practice nurses, district nurses and community diabetes nurses who are better versed in the background and domestic requirements of a person with diabetes within their locality. Why is it, then, that secondary care staff fail to communicate with those same professionals

who are likely to know the intricacies of a patient's history and the risks and difficulties these patients will face when discharged, before those said patients are considered for discharge in the first place?

Patient focus

From a totally cynical viewpoint, premature discharges causing re-admissions provides further income for secondary care trusts, which inevitably depletes the resources available for primary care. No one would argue that diabetes is not a costly disease to manage, nor would anyone argue against the fact that the older a person gets, the more care he or she is likely to require. However, what is questionable is how comprehensively the needs of these people are being considered regarding their diabetes once they are deemed ready for discharge home. If they are fortunate enough to be admitted under the care of a diabetes team, then their diabetes is more likely to be considered a priority, the appropriate care given and their discharge timely and planned. In contrast, those with a limited knowledge of diabetes may fail to recognise the pitfalls of discharging such patients without consulting with the community professionals who care for these people on a daily basis.

In this modern era of viewing the health service as a market place with cost-cutting and value-for-money strategies, let us not lose sight of the most important aspect of these services: the patients. They deserve the best quality care available and this requires communication between all professionals. No one knows the patient better than the community staff who have, in most cases, cared for them over many years. Surely it makes sense to use this knowledge and expertise when planning a patient's discharge in order to ensure that a truly seamless service is provided, re-admissions prevented and resources used in a more cost-effective way. Lewis and Dixon (2004) have highlighted policies that are likely to hinder the management of chronic diseases; for example the focus on targets – particularly regarding waiting lists – driven by financial incentives that reward NHS trusts according to the number of episodes of care provided. Such incentives may cause hospitals to focus efforts on securing admissions to ensure their survival, but in my view this should be seen as an opportunity for both primary and secondary care professionals to work in closer collaboration to ensure the best possible diabetes care is provided for patients, rather than focusing on the political arena of financial gain. ■

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AGS Panel on Falls Prevention (2001) Guideline for the prevention of falls in older persons. *Journal of the American Geriatrics Society* **49**: 664–72

Billings J, Dixon J, Mijanovich T, Wennberg D (2006) Case finding for patients at risk of readmission to hospital: development of algorithm to identify high risk patients *BMJ* **33**(7563): 327

Blustein J, Hanson K, Shea S (1998) Preventable hospitalisations and socioeconomic status *Health Affairs* **17**(2): 177–89

Hippisley-Cox J, O'Hanlon S, Coupland C (2004) Association of deprivation, ethnicity, and sex with quality indicators for diabetes: population based survey of 53000 patients in primary care *BMJ* **329**: 1267–9

Lewis R and Dixon J (2004) Rethinking management of chronic diseases *BMJ* **328**: 220–2

MacLeod M, Yeung S, Sutton M (2004) The stability of emergency admission rates for chronic diseases as a clinical indicator. Available at: wwwindicators.scot.nhs.uk/Publications/Publications.html (accessed 20.11.2006)

Parker SG (2005) Do current discharge arrangements from inpatient hospital care for the elderly reduce readmission rates, the length of inpatients stay or mortality, or improve health status? *Copenhagen: WHO Regional Office for Europe Health Evidence Network report*. Available at: http://www.euro.who.int/HEN/Syntheses/dischargingelderly/20050928_5 (accessed 20.11.2006)

Rosenthal MJ, Fajardo M, Gilmore S et al (1998) Hospitalisation and mortality of diabetes in older adults. A 3-year prospective study. *Diabetes Care* **21**: 231–5

Saxena S, George J, Barber J, et al (2006) Association of population and practice factors with potentially avoidable admission rates for chronic diseases in London: cross sectional analysis *Journal of the Royal Society of Medicine* **99**(2): 81–9