Commissioning diabetes services for older people

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Article points

1. Increasing life-expectancy and an aging population has led to a rising population of older people with diabetes.
2. Good diabetes services for older people should provide high-quality care with timely access to services.
3. To ensure services meet the needs of the local population, commissioners of services for older people should undertake a needs assessment.
4. Multidisciplinary care teams need to work collaboratively to provide seamless, high-quality, person-centred care.

Key words

- Commissioning
- Diabetes care
- Older adults

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Diabetes is the most common long-term metabolic condition affecting older people (Sinclair, 2009). It places a burden on individuals, society and healthcare systems. With decreasing resources and an increase in the population with diabetes there is need for a systematic approach to commissioning diabetes care for older people. This article discusses the provision of effective diabetes care to reduce morbidity and optimise the health status and quality-of-life in the older person with the condition. Two publications will guide the discussion: *Commissioning Diabetes Services for Older People* (NHS Diabetes, 2010a) and the *Best Practice Guide: Diabetes* (British Geriatrics Society, 2009).

Older people represent the largest sector of the population with diabetes (Sinclair, 2009). Increasing life-expectancy and an ageing population has led to a rising number of older people with the condition. Specific issues for management in this population relate to age-related morbidity and disability, in addition to the higher incidence of type 2 diabetes (Krentz and Bailey, 2001).

The commissioning of diabetes services must cover the entire patient journey. Services commissioned within *Commissioning Diabetes Services for Older People* (NHS Diabetes, 2010a) and the British Geriatrics Society's (2009) *Best Practice Guide: Diabetes* will hopefully ensure that services are clinically safe, integrated and effective. However, services will need to be delivered using current resources, which will challenge service providers and require a review of services against these recommendations.

The fundamental elements of a good diabetes service for older people should be high-quality care with timely access to services (NHS Diabetes, 2010a). Services will need to be multidisciplinary and planned, ensuring that the older person is at the heart of the integrated service to improve diabetes care.

The challenges of diabetes

The incidence of type 2 diabetes rises steeply with age; in the UK it is estimated that the incidence increases from around 5% in those over 65 years of age to over 20% in those over 85 years (Gambert and Pinkstaff, 2006). This increasing incidence may, in part, be due to better detection rates, but also to the increasing life-expectancy of the aging population.

Prevention of type 2 diabetes through education on lifestyle and self-care to reduce the risks of diabetes, have the potential to reduce this incidence. The NHS Diabetes (2010a) publication *Commissioning Diabetes Services for Older People* recommends a pathway for raising awareness of diabetes and its pre-disposing factors, and initiating prevention strategies. Targeting obese individuals and those from black and minority ethnic

communities is desirable to identify people with diabetes earlier in their journey to prevent the development or progression of related complications. Increasing diabetes awareness within the community is laudable, but without the necessary resources and funding, these initiatives are unlikely to happen in the current financial climate.

Lifestyle factors in older age, such as decreasing mobility and physical activity, and poor diet resulting in obesity, can predispose older people to type 2 diabetes. However, it is not known whether there are specific changes to glucose metabolism due to the aging progress which also contribute to this (Sinclair, 2009).

Many older people have to face major lifestyle changes and morbidity, which can lead to symptoms of depression, which in turn has been linked to type 2 diabetes (Sinclair, 2009). Cognitive dysfunction can lead to an inability for the individual to self-manage effectively; poorly controlled diabetes can cause cognitive dysfunction, while improving diabetes control can ameliorate cognitive dysfunction (Sinclair, 2009).

Opportunistic screening in primary and secondary care settings have the potential to pick up new diagnoses. With the increasing population of older people who are at increased risk of diabetes, targeting nursing and residential care homes will identify new individuals with diabetes, giving the opportunity to reduce the risk of complications through improved diabetes control. Education of carers and healthcare staff on the broad spectrum of symptoms and presentation of diabetes in older people could improve the quality-of-life for many older individuals.

Many older people may have asymptomatic diabetes, but others may be experiencing symptoms as diverse as low mood, apathy, confusion, fatigue, blurred vision or thrush – which may be attributed to other causes. Symptoms may be confounded by other disorders: thirst may be blunted in older people, polyuria may be unrecognised in incontinence, and polypharmacy may affect appetite and be attributed to weight loss.

Challenges and benefits of integrated multidisciplinary services

The commissioning tool from NHS Diabetes (2010a) has the potential to ensure equity of access and care. A national framework should end the postcode lottery of diabetes care for older people, reduce variations in standards of care and improve the overall standard of diabetes care nationally (Audit Commission, 2000). However, commissioners will need to undertake a needs assessment to ensure that the service meets the needs of the local population (NHS Diabetes, 2009).

NHS Diabetes (2010b) recommends commissioning integrated services, which need to provide holistic care and support to the person with diabetes. To be fully integrated, services should be seamless and include teams from primary and secondary care, community services and social care all working together (NHS Diabetes, 2010b).

There needs to be improved communication, planning and information-sharing across the different teams to reduce fragmentation and duplication of care, and to make the best use of resources. The multidisciplinary care team need to be well coordinated to reduce inequalities in care and age discrimination. Older adult protection is an area of increasing concern, and clinicians must be trained to recognise and protect vulnerable adults.

Studies have shown that teams work well when they have clear objectives, when their emphasis is on high-quality care and there is active participation by all team members (Borrill et al, 2001). Effective multidisciplinary team working delivers higher quality care, and it has also been found to be a less stressful working environment, staff are more innovative and there is a lower staff turnover (Borrill et al, 2001). Successful implementation of integrated working will not happen without good leadership – leadership is key in times of change.

Good leadership can overcome the disadvantages to team-working, which can occur as a result of a lack of alignment with organisations' objectives or a team culture that believes it has "always done things this

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1. Focus groups for people with diabetes have an important role in ensuring services are planned and delivered around the individual, rather than for the convenience of the service providers.
2. If the older person with diabetes is unable to self-manage their condition, then the carer must be provided with the knowledge and education to enable the older person to be cared for safely, ensuring the best possible glycaemic control to optimise quality-of-life and reduce the risk of complications
3. Diabetes-related complications can impact negatively upon the quality-of-life for older people as many will have comorbidities, and many of these complications are preventable.

way". It takes time to support and nurture the members of a team.

Governance, clinical quality and data information management

Clear governance arrangements need to be in place to ensure the safety of people with diabetes (NHS Diabetes, 2010b). In addition to clinical governance systems and policies, the healthcare organisation must accept accountability and responsibility for its actions (NHS Diabetes, 2010b).

Clinical quality must be provided by trained and competent staff. The Royal College of Nursing and the Association of Diabetes Specialist Nurses published a competency framework for DSNs in 2004 that is a useful benchmark, and has since been updated (Training, Research and Education for Nurses in Diabetes-UK, 2010). The provider organisation must have a system in place to demonstrate that the care providers are competent to give the best quality care (NHS Diabetes, 2010b). The care pathway should be specific to identify the risks and needs of older people with a long-term condition. Data and information management must be secure and fit for purpose.

Assessment of services may be through user groups, their carers and clinicians (NHS Diabetes, 2009). Involvement of people with diabetes and the public is recognised as key in commissioning services (NHS Diabetes, 2010b). Focus groups for people with diabetes have an important role in ensuring services are planned and delivered around the individual, rather than for the convenience of the service providers.

The role of carers must not be overlooked – they should be included in all discussions with the individual with diabetes. If the older person with diabetes is unable to self-manage their condition, then the carer must be provided with the knowledge and education to enable the older person to be cared for safely, ensuring the best possible glycaemic control to optimise quality-of-life and reduce the risk of complications. It is also key that people with diabetes and carers know how to access services and support.

Audits provide information about individuals' needs and service provision, thus enabling service redesign. Audit should underpin all clinical work to benchmark services and check that local diabetes care is achieving the required standard.

Conclusion

Diabetes-related complications can impact negatively upon the quality-of-life for older people as many will have comorbidities, and many of these complications are preventable. Sinclair (1999) recognised over a decade ago that diabetes services needed reorganising. Commissioning diabetes services for older people gives the opportunity to design services in a systematic way along the patient journey. It requires an integrated multidisciplinary approach from health and social carers to provide a seamless, person-centred, quality service.

Robust systems must be in place to provide clinical governance and data information management. Clinicians must be adequately trained to provide best care. Audit must continue to inform care and services; there is no place for complacency, and only through acceptance of new ideas and sharing successes will services for older people become truly integrated. ■

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