

DIABETES INTEGRATION BRIEFING FOR HEALTH AND WELLBEING BOARD MEMBERS

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DIABETES BRIEFING

This briefing is one of four to help you as a health and wellbeing board (HWB) member to improve the wellbeing of local people with, or at risk of, diabetes. This briefing explains the importance of integrated diabetes care and coordinated care for people with diabetes, and what you can do to promote this.

Integrated diabetes care

- An integrated care pathway, which is focused on improving health outcomes and quality of life in partnership with people with diabetes, is the best way of delivering diabetes care.
- There is strong national and international evidence that demonstrates the potential to improve both the quality of diabetes care and save money through integration
- Diabetes is a complex condition which needs the input and skills of healthcare professionals across primary, community and specialist care working in a multidisciplinary way.

The main aim of integrated care must be that services meet the needs of people with diabetes rather than those of service providers. Better integration should result in:

- **Higher levels of satisfaction.**
More positive feedback and fewer complaints, particularly about lack of coordination and poor communication between parts of the system.
- **Reduced rates of admissions and readmissions.**
Over 15 per cent of hospital beds are occupied by people with diabetes and this is increasing. More people with diabetes are admitted as an emergency and they have greater lengths of stay than people without diabetes.
- **Reduced rates of complications leading to diabetes-related disability**

1 IN 5
PEOPLE IN
CARE HOMES HAVE
DIABETES

1 IN 7
HOSPITAL BEDS
ARE OCCUPIED BY
PEOPLE WITH
DIABETES

Many people with diabetes will also need the support of social care as they become older and self management becomes more challenging, and also due to disabilities resulting from diabetes complications. Over 20% (and up to 27%) of residents in older people care homes in the UK have diabetes and a similar proportion may have undiagnosed diabetes. In many cases older people with diabetes in care homes receive poor care and even die prematurely.

Integrated care provides benefits for everyone, but it can particularly improve outcomes for

- children and young people with diabetes
- pregnant women with diabetes,
- people with severe mental health problems,
- people with several co-existing conditions (co-morbidities)
- people living in hostels, rough sleepers
- prisoners
- older people
- people in care homes.

What you can do as a member of a Health and Wellbeing Board

HWBs have a duty to promote integration and are well placed to bring people together and provide a forum for challenging barriers to coordinated care.

- You can help develop the long term vision that is required to introduce fully coordinated care and can help to initiate the changes required to achieve this.
- You can ensure there is integrated diabetes care across health services to reduce expensive and life-threatening complications and disability through the process of developing the joint health and wellbeing strategy and JSNA.
- You can support the development of longer term and more integrated budgets across health and social care to commission services for people with diabetes and other long-term conditions.
- You can look critically at rates of hospital admission and readmission for people with diabetes.
- You can make sure children with Type 1 diabetes are receiving the support they need to participate fully in all aspects of school life.

Integrated diabetes care in Wolverhampton

Wolverhampton has been delivering an integrated diabetes model of care for many years, supporting the development of primary care led services. Strong relationships have been developed across the local health system leading to a very advanced system for integrating diabetes care. The key features of their model are a strong network governance and the use of IT. A locally developed algorithm uses data to stratify patients according to risk. The results are then used to outline to GPs what should be done to improve care for a particular person. Wolverhampton highlights the importance of self management in diabetes and that their emphasis is on delivering specialist care in partnership with primary care according to the clinical needs of the patient.

North West London Integrated Care Pilot

The North West London Integrated Care Pilot was a 12 month project drawing together primary, secondary, community, social and mental health care to work in an integrated way. It focused on the delivery of diabetes and elderly care in a population of 200,000. It aimed to improve care for adults with diabetes and for all people over 75 years of age. The aims were to cut hospital use by 3 per cent over five years and nursing home admissions by a tenth, while reducing the annual cost of services for people with diabetes and older people by 24 per cent over five years. Early results suggest the number of non-elective medical admissions among the 28,000 patients aged 75 and over fell 6.6 per cent compared with the same period in 2010-11. Admissions for such patients at practices in North West London boroughs not covered by the pilot rose 6.5 per cent. They estimate that patients avoided 304 admissions over six months. The financial framework provided a degree of alignment of financial risk and profit sharing across the provider organisations.

Checklist

- Are there clearly defined integrated pathways of care for people with diabetes locally, including a pathway for people at high risk of diabetes?
- Do you know what people with diabetes see as possible gaps or a lack of integration across services in your area?
- How do you ensure that you hear and understand the points of view, of people with diabetes (and other long-term conditions)?
- Are there regular opportunities to develop a shared understanding of needs and services in relation to diabetes across health, local authority, community and voluntary sectors?
- What are the main obstacles to integrated care for people with diabetes in your area? And what could you do to tackle any of these obstacles?
- What is the evidence of improved coordination between health and social care locally?
- Have you identified vulnerable groups that may particularly and urgently need services to be integrated and person-centred so that they can better access services?
- Are you aware of examples of practical delivery models for integration?
- Do you understand the opportunities and challenges in relation to commissioning non-traditional providers to support self-management?

Key resources and references

The principles of integrated diabetes care have been clearly described in

Best practice for commissioning diabetes services. An integrated care framework.

www.diabetes.org.uk/Documents/Position%20statements/best-practice-commissioning-diabetes-services-integrated-framework-0313.pdf

Diabetes UK has investigated areas that have made significant progress towards delivering integrated diabetes care. The report shares key lessons to overcome barriers and improve the delivery of diabetes services in their area

Improving the delivery of diabetes care through integration.

www.diabetes.org.uk/integrated-diabetes-care

National Voices

National Voices have produced a narrative for person-centred coordinated care.

www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf

The Faculty for Public Health has resources on a range of issues including food, the environment, transport and obesity that demonstrate an integrated approach to improving people's health

www.fph.org.uk/integrated_approach_needed_to_improve_health

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And ask to speak to a member of the Policy and Public Affairs Team



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