New guidance from a group of diabetes organisations has identified how commissioners and hospital trusts can work together to reduce admissions associated with diabetes.

Reducing admissions for people with diabetes

**In this article...**
- Why admissions linked to diabetes need to be addressed
- Variations in diabetes admission rates
- Diabetes services associated with reduced admissions

**Author** Belinda Allan is consultant diabetologist at Hull and East Yorkshire Hospitals Trust.


Reversing the rise in emergency hospital admissions is an NHS priority. These admissions impact on elective capacity and waiting times and are unsustainable. The risk of hospitalisation for people with diabetes is almost twice that for others. Commissioners need to address admissions associated with diabetes and new guidance offers best-practice solutions.

The scale and cost of diabetes hospital admissions is enormous. The risk of hospitalisation for people with the condition is almost double that of those without (Moghissi et al, 2009).

Each year there are approximately one million hospital admissions where diabetes appears as a diagnosis, costing an estimated £2.51bn (Kerr, 2011). Of these, about 250,000 are in excess of the numbers expected for an age-adjusted population without diabetes. The estimated cost to the NHS of these excess admissions is around £686m each year, notwithstanding the personal cost to the individual (Kerr, 2011).

Knowing the age-adjusted prevalence of diabetes, the average excess length of stay, tariff uplift for urgent care and the higher cost of admissions that are emergencies allows the costs of caring for inpatients with diabetes to be estimated.

To address the problem, it is necessary to understand local population needs and the triggers for admission. Data on local activity patterns associated with admission can be found via the National Diabetes Information Service (tinyurl.com/NDIS-diabetes).

**Keywords:** Diabetes/Commissioning/Avoidable admissions

- This article has been double-blind peer reviewed
and National Diabetes Inpatient Audit (tinyurl.com/NaDIA-audit). These contain benchmarking data on overall diabetes admission rates and diabetes-specific admissions (diabetic ketoacidosis, hypoglycaemia, hospital admission rates of care home residents with diabetes and diabetic foot disease).

Ambulance trusts should have data on call-outs for severe acute hypoglycaemia, and carry-on rates to the emergency department (ED). The national register of patients with diabetes in Scotland (SCI-DC Network) provides comprehensive information on diabetes and links primary and secondary data.

Many pharmaceutical companies have population and case-mix adjusted diabetes admission data (derived from hospital episode statistics) at practice and clinical commissioning group level. This allows benchmarking to a CCG area and comparison with the non-diabetes population.

The whole system or pathway of care for those with diabetes must be understood. This is because triggers for admission need to be linked with the key decision points in GP surgeries, ambulance trusts, out-of-hours care, EDs and pre-operative assessment.

**Integrated diabetes care**

Last year, Diabetes UK published a document advising commissioners on the key components of an integrated diabetes service (Diabetes UK, 2013). This advocates:

- Structured education for those with type 1 diabetes; half of admissions with diabetic ketoacidosis are avoidable;
- A diabetes specialist multidisciplinary team including an open-access phone line for advice during sick days or when ketosis develops. Ideally, this should be 24-hour, seven-day a service. A national helpline run by specialist diabetes teams could deliver this but it will require political will and leverage to implement.

Commissioners should also consider:

- A diabetes inpatient team and diabetes specialist team to support emergency departments and emergency admission wards and to provide immediate front-door management;
- Diabetes management guidelines for diabetes inpatients undergoing surgery or planning surgery. Many junior doctors lack confidence in diabetes management (George et al, 2011), so it is essential that trusts provide mandatory training to all staff;
- A diabetes service for frail older people that supports diabetes education, foot care and management in residential and nursing homes, with staff training in identifying highest-risk residents. This could nearly halve admissions from homes;
- An emphasis on pre-discharge planning on wards to prevent readmission, including early referral to the diabetes team;
- A high influenza vaccination uptake and statin use in type 2 diabetes patients aged over 40 years, and benchmarking of Quality and Outcomes Framework data against comparator areas;
- Identification of patients admitted frequently who need intensive education and psychological support;
- Better working between clinical diabetes teams, mental health trusts and clinical psychology, particularly targeted at those at highest risk;
- Blood ketones testing in people with type 1 diabetes – this is an earlier and more accurate marker of metabolic decompensation than urine ketone testing;
- A hypoglycaemia management pathway in collaboration with ambulance trusts with a single point of contact, and a clearly defined “see and treat” policy with a low carry-on rate to the ED. It should also identify frequent callers who can be referred to their GP and specialist diabetes team for further support;
- A diabetes foot care service that includes a foot protection team for primary care, a hospital-based multidisciplinary foot team for the highest-risk feet and an inpatient podiatry service to ensure that expertise is available to ward-based nurses.

Allan et al (2013)