

Diabetes Specialist Outreach Team (DSOT)

“Action taken now could produce demonstrable clinical and financial benefit within the next 5 years” (Baxter et al., 2016)

Project Aim

Improve care of people with diabetes:

- Who do not or cannot access traditional services
- With recurrent hospitalisation due to diabetes
- With poor composite measures of HbA1c, BP and Cholesterol

How?

A multidisciplinary team comprising psychologist, DSN and GP was formed. Diabetes support workers joined the MDT later.

Case finding was through primary care searches and secondary care referral.

The searches were carried out via remote access of practice records. Identified patients were assessed (remotely) and where necessary, a proposed medicines management plan was suggested with next steps recorded in the primary care record to be actioned by practice staff.

Some patients required follow-up DSOT contact and this was usually by telephone initially. The team focused on contact and engagement, offering a period of intensive support. When face to face contact was required this was flexible and was provided in the hospital, community or surgery. Further support included psychological assessment and intervention along with staff/carer education and support where applicable.

Early Results

1. Evaluation data from initial primary care remote searches and intervention for three ‘pilot’ practices covering 11% of CCG population, showed that following DSOT input there was:

1. A 45% improvement in 3-targets results (BP, HbA1c and cholesterol)
2. A 36% drop in “HbA1c over 100mmol/mol”

3. A 51% reduction in “No HbA1c recorded for over 15 months”

General practice welcomed this intervention as it saves time in consultations and assists in providing a quality focused, holistic and time efficient service.

2. Secondary care referrals from any practice in the CCG area

HbA1c > 100 mmol/mol

Excluding those already reported on in the primary care searches above, 43 additional people with HbA1c >100 mmol/mol despite previous intervention were referred to the DSOT in 12 months.

Following DSOT intervention:

- 25/43 (58%) achieved HbA1c less than 100mmol/mol (range 49-95, median 80). This represents a significant decrease in risk of all complications: “For a decrease of 11 mmol/mol HbA1c there is a 37% drop in microvascular complications” (Baxter et al., 2016)
- 33 people improved their HbA1c results from baseline overall; 77% of those referred
- After 12 months, 15/43 people remain under DSOT care, 26 were discharged to routine follow up care and 2 others no longer fall within search criteria (1 died, 1 moved)

Referrals for recurrent diabetes-related admissions

65 people in total had had 2 or more admissions for diabetes-related conditions within 12 months, in the year preceding and the current year of the project.

20/65 individuals were referred to the DSOT. To date, the number of admissions in people who received DSOT intervention has dropped from 48 to 27. This represents a saving of 21 diabetes-related hospital admissions.

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Remote Medicines Optimisation

An additional medicines optimisation audit was carried out at one practice by the DSOT. The audit replicated a remote medicines review and optimisation in all those with type 2 diabetes in a practice. The goal was to review current therapy and outcomes for individual patients and switch or stop ineffective or inappropriate medication to more cost-effective alternatives. In a practice with 700 people with diabetes a remote search was performed for those receiving:

1. GLP-1 therapy with neither weight loss (3%) nor HbA1c reduction (11mmol/mol) 9 months after commencement
2. DPP4i or SGLT2i with last recorded HbA1c over 64mmol/mol
3. Lantus / Levemir with last two recorded HbA1c over 64mmol/mol

From these particular searches, two thirds of those identified had changes recommended. This translates to a potential saving of over £13,500 per year in the practice which represents 5.7% of the CCG population.

Patient Testimonial

“Mark”

“Mark” had a history of recurrent diabetic ketoacidosis admissions, and was a frequent non-attender at the diabetes outpatient clinics. His HbA1c was over 100 mmol/mol. Some engagement work through the DSOT from psychology was offered on the wards during admissions. Over the following year, Mark has seen a sustained drop in his HbA1c of 20mmol/mol, he has had no further admissions and is regularly attending joint nursing/psychology diabetes appointments and engaging more with diabetes care.

“Margaret”

“Margaret” has learning disabilities and lives in residential care. She had had three admissions in the previous two months (both DKA and hypos); 8 admissions in the previous year. Since October 17 after home visits and phone calls, she has had no admissions and HbA1c is 67mmol/mol.

“Target the high risk population, attempting to improve HbA1c control as much as possible in order to achieve the largest benefit, both clinically and financially”

Baxter et al (2016) Estimating the impact of better management of glycaemic control in adults with Type 1 and Type 2 diabetes on the number of clinical complications and the associated financial benefit. *Diabet Med.* 33(11):1575-1581.