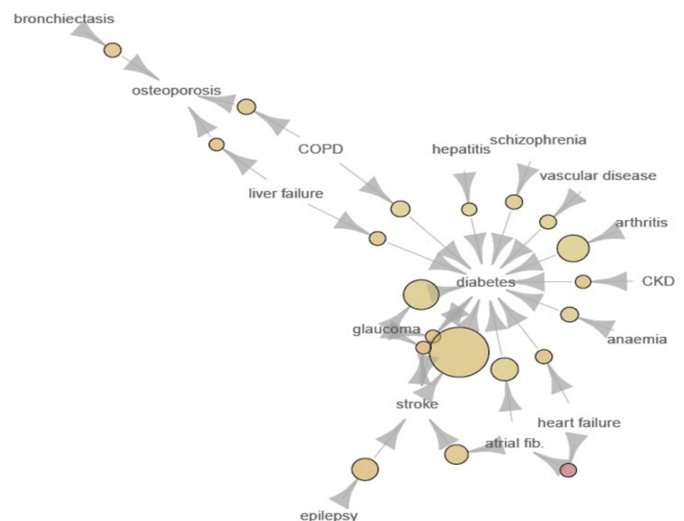
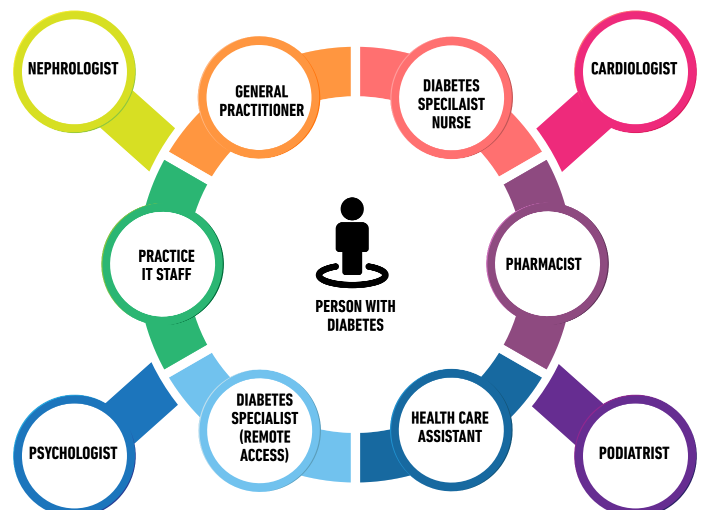
The Leicester Model of Enhanced Diabetes Care

- Nearly **5 million people** in the UK have Diabetes.
- Diabetes results in a 10-15 year reduction in life expectancy; **accounts for 12% of all NHS costs** (£10M) each year; increases the risk of stroke, heart disease, peripheral vascular disease, retinopathy and renal failure.
- Approximately **20% of the population** who have Type 2 Diabetes also have other/multiple long term conditions (MLTCS). This risk increases with age, to 65% of 65-84year olds.
- The most common **MLTCs are Diabetes, CHD, hypertension, CKD** – but clusters of disease are frequently seen.
- In a bid to reduce high costs and offer better care, **a new model of Diabetes care** has been trialled and evaluated. It is now implemented as routine care across Leicester/shire.

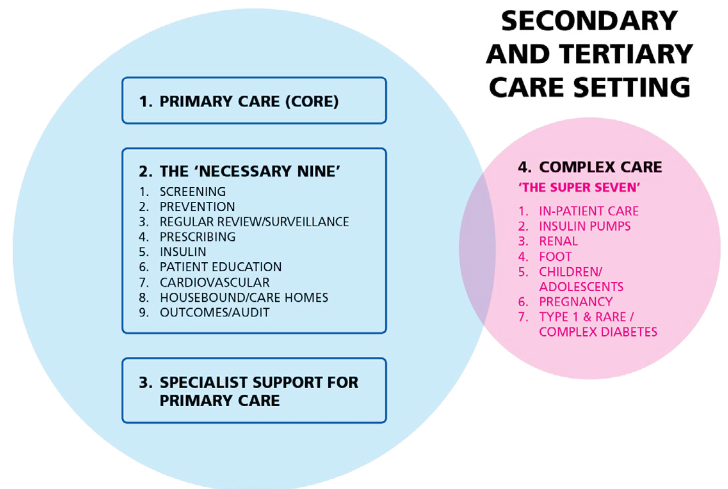


The Leicester model of enhanced diabetes care takes a collaborative, holistic approach to Diabetes and the management of MLTCs. It focuses on:

- Prevention.
- Inequalities in care.
- Increasing care standards, whilst reducing complications from care.
- Community-based care.
- Reduction in unplanned hospital admissions.
- Better in-patient care experiences.
- This **integrated model** of diabetes service provision covers **the entire care pathway** for children and adults with Type 1 (T1DM) and Type 2 (T2DM) Diabetes.
- It **co-ordinates** services around the patient, rather than by being split by service location.
- By moving key services from secondary care into primary and community care, and bringing **care closer to patients**, it delivers **improved care experiences** for patients, and **frees up time** within hospitals for more serious cases.



- The model features the ‘**necessary 9**’ (delivered by primary care teams and supplemented by locality based community diabetes specialists) and the ‘**super 7**’ (delivered by secondary / tertiary services.
- It is safe, clinically **effective and saves money**.
- It saves **£82** per annum per patient.
- If implemented nationwide, the model could save NHS **£276.2M** per year.



What is needed to implement the Leicester model?

- ☑ Primary care teams comprised of physicians, practice nurses, health care assistants and in some cases, pharmacists.
- ☑ Healthcare professional education (in the Leicester example delivered through EDEN: edendiabetes.com). Not a one-off course in diabetes, but learning embedded through mandatory monthly clinical updates, and facilitated meetings to discuss difficult clinical scenarios and recent developments in diabetes care.
- ☑ Primary care led audit of poorly controlled diabetes patients, and the delivery of appropriate care plans for these patients.
- ☑ Financial incentivisation over and above the pay-for-performance scheme available to all practices.

If you'd like to know more about how to use the Leicester Diabetes Model in your own service, please contact:

eden@uhl-tr.nhs.uk

FUNDED BY
NIHR | National Institute for Health and Care Research

Disclaimer: This study was funded by the NIHR Applied Research Collaboration (ARC) East Midlands. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care

References:

Seidu, S., et al. 2021. A cost comparison of an enhanced primary care diabetes service and standard care, Primary Care Diabetes, 15 (3), pp601-606. https://doi.org/10.1016/j.pcd.2020.10.011. https://www.sciencedirect.com/science/article/abs/pii/S1751991820302965

Brady, E.M., et al. 2021. Effectiveness of the Transformation model, a model of care that integrates diabetes services across primary, secondary and community care: A retrospective study. Diabet Med, 38: e14504. https://doi.org/10.1111/dme.14504. https://onlinelibrary.wiley.com/doi/10.1111/dme.14504