Commentary

**Diabetes and Community Nursing**

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**Conflicts of interest**

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Abstract

The rising prevalence of diabetes particularly in older people is placing an unsustainable burden on district and community nursing teams. District and community nurses now handle complex diabetes management, including insulin administration, glucose monitoring, foot screening, and patient education, despite workforce shortages. Hospital discharges often add to their workload, as many people with diabetes lose confidence in self-management and rely on district and community nurses for insulin injections. Without proper training and support, district nurses struggle to provide holistic care, leading to poorer patient outcomes. To address this, better collaboration between hospital teams, diabetes specialists, and primary care providers is essential. Investing in nurse education and technology, such as continuous glucose monitoring, could reduce home visits and ease the pressure on district nurses while improving diabetes care.

Introduction

The prevalence of diabetes in the UK has doubled every 20 years since the end of World War II. Diabetes UK estimates that nearly 4.6 million people have been diagnosed with diabetes, with an additional 1.3 million living with undiagnosed type 2 diabetes (Diabetes UK, 2025). Several factors contribute to this increasing prevalence, including the obesity epidemic, changes in diet and physical activity, population growth, longer survival due to improved treatments, and earlier diagnosis. Additionally, an ageing population plays a significant role, as type 2 diabetes incidence rises with age. Currently, half of all people with diabetes in the UK are over 65, and a quarter are over 75. With increasing life expectancy, diabetes rates are expected to rise most rapidly among those over 60 (International Diabetes Federation, 2021). It is estimated that 10-15% of older adults have diabetes, with up to a quarter of nursing home residents affected (Andreassen et al., 2014; Resnick et al., 2008).

While diabetes is becoming more prevalent, its management is also growing more complex. Advances in oral and injectable therapies for type 2 diabetes, innovations in insulin treatments, and new technologies enabling real-time glucose monitoring have improved glucose management and reduced long-term complications (Gregg et al., 2016). However, these advancements also place additional burdens on people with diabetes and healthcare professionals, who must keep up with rapidly evolving treatments.

Diabetes in older people

Managing diabetes in older adults presents unique challenges, including multimorbidity, geriatric syndromes, cognitive impairment, and frailty (Mattishent et al., 2019). Effective care requires a multidisciplinary approach, with district and community nursing teams playing an increasingly vital role. These teams now undertake responsibilities traditionally handled by diabetes specialist nurses (Nikitara et al., 2019), such as diagnosis, prescribing and administering diabetes medications, glucose monitoring, foot screening, and patient education (Kenealy et al., 2004; Snell et al., 2022; O'Flynn, 2022). Through a holistic approach within the home setting, district and community nurses not only support physical health but also address psychosocial needs, empowering patients to take responsibility for their care (Siminerio et al., 2007; Ramadan, 2023).

The effect of diabetes on community nursing workload

The growing demands of diabetes management are placing significant strain on district and community nursing teams. As their roles expand and caseloads become more complex, the number of qualified district nurses has declined, leading to workforce shortages and gaps in care (The Queen's Nursing Institute, 2019; Senek et al., 2020). As a result, diabetes care is at risk of becoming task-oriented, limiting a holistic approach and ultimately worsening patient outcomes (Gregory, 2020).

A 2023 survey of 159 district and community nursing teams highlighted the impact of diabetes on their workload (Martin et al., 2024). On average, 16.4% of their patients had diabetes, requiring daily visits lasting 15 minutes or more. Many patients needed multiple visits per day, with three-quarters requiring insulin or other injectable therapies. A third of insulin-administering teams managed patients on intensive regimens of three or more injections per day, while 83% supported continuous glucose monitoring. Most teams reported that diabetes-related workload had increased to unsustainable levels.

Several factors contribute to this growing burden. Hospital admissions in older patients often lead to a loss of confidence and independence in diabetes self-management (Surkan and Gibson, 2018). Many individuals who could self-administer insulin before admission are unable to do so after discharge. In hospital settings, responsibility for insulin injections shifts to staff, and upon discharge, patients often are not re-taught how to administer their insulin. Additionally, insulin is frequently initiated during hospital stays without sufficient time for education. The expectation that district and community nurses will take over insulin administration post-discharge fails to account for the impact on their workload (Martin et al., 2024).

Reducing the workload while improving patient experience

Addressing this crisis requires a collaborative approach involving three key groups: people with diabetes, community nursing teams, and hospital teams (Martin et al., 2024). Interventions should start in the hospital, where comprehensive assessments before discharge can determine whether insulin remains necessary in the community and whether regimens can be simplified.

Before delegating insulin administration to community nurses, hospital staff should assess whether the person with diabetes or a family member can manage it. While some individuals are unwilling to administer insulin, appropriate diabetes self-management education may help overcome their concerns. Others may be physically unable to do so due to poor dexterity, eyesight, or cognitive impairment, but in many cases, an informal carer could take on this role (Mattishent et al., 2019; Ramadan, 2023). The Diabetes Attitudes, Wishes, and Needs (DAWN) study found that family members of adults with diabetes wanted to be more involved in care but often did not know how to help (Kovacs Burns et al., 2013).

Ongoing review of insulin needs is crucial, and district and community nurses play a key role in this, supported by diabetes teams and general practitioners. However, district and community nurses require adequate training in diabetes management, which is currently limited. Insufficient education leads to poor communication with patients and carers, resulting in less effective diabetes control and higher glucose levels (Nam et al., 2011).

Leveraging technology, such as continuous glucose monitoring (CGM), could reduce home visits and help identify patients who no longer require insulin (Martin et al., 2024). Remote monitoring in collaboration with diabetes nurse specialists could optimize care while alleviating the strain on district and community nursing teams.

There is no doubt that diabetes is placing an unsustainable burden on district and community nursing. However, better collaboration between hospital staff, diabetes specialist teams, primary care providers, and district and community nurses can lead to more effective care plans (Martin et al., 2024). By improving coordination and investing in education and technology, we can enhance patient outcomes while easing the pressure on district and community nursing teams.

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