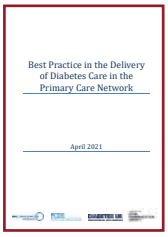
What and why

- The guideline *Best Practice in the Delivery of Diabetes Care in the Primary Care Network* gives evidence-based information, specific standards of care, population considerations, skill competencies and examples of good practice relating to the delivery of diabetes care within the Primary Care Network structure.
- The full guideline is available here.



Context

The landscape of diabetes care is changing, with growing diabetes prevalence, interest in type 2 diabetes remission, shift of management from glucose-centric to reducing disease burden, evolving technology and greater treatment repertoires.

The needs of people with diabetes are also changing to include:

- a younger population, who require earlier intensive management, including support with self-management
- a significant elderly/frail population with multiple co-morbidities needing particular attention to individualised care targets
- a need to reduce health inequalities in underserved populations.

For the delivery of optimal outcomes, there is a pressing need to effectively facilitate the flow of people with diabetes through the different areas of the NHS and wider social support services depending on their needs at the point of access to healthcare. Prior to the COVID-19 pandemic, work was started to look at the best way to deliver diabetes care within the recently formed Primary Care Network (PCN) structures in England. This was intended to give PCNs an opportunity to strengthen integration between primary, community and specialist care, and to provide diabetes services that address the holistic needs of the person with diabetes, including the specific needs of underserved populations, which has become increasingly relevant as we now look to reset diabetes services.

The events of the pandemic, not least with diabetes being an independent risk factor for mortality related to COVID-19 (Barron et al, 2020), underline the urgent necessity for all diabetes-related healthcare professionals to work together in a timely and effective manner to provide seamless care.

The document *Best Practice in the Delivery of Diabetes Care in the Primary Care Network* describes best practice in diabetes care within PCNs based on a review of current literature, identification of gaps in care and the sharing of good practice examples. This *How to* guide provides a summary of the key messages from the full guideline.

How will this guideline affect the person with diabetes?

- Ensure the delivery of appropriate, early structured education and management input, with improved early access to specialist services and the multidisciplinary team.
- Standardise the delivery of diabetes care, thus reducing variation.
- Facilitate a smooth flow of movement through the different levels of service depending on management needs at any one time point in a person's diabetes care journey.

How will this guideline affect primary care?

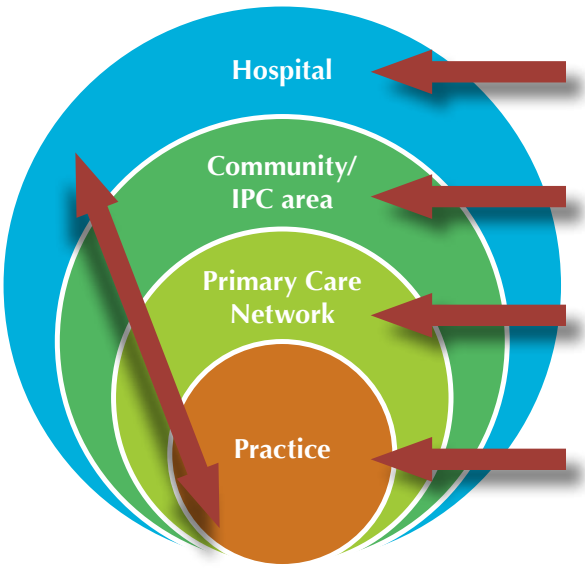
- Define standards for the management of different patient groups, as well as education and training of staff to ensure provision of high-quality, coordinated, patient-centred care across the board.

How will this guideline affect secondary care?

- Improve access to specialist services to those who require this.
- Develop working relationships with primary care, dissolving "siloed" working to better enable collaborative, coordinated, effective and patient-centred care.

Proposed key stages for PCNs

1. Formation of a **Diabetes Support Team (DiaST)** within the PCNs to enable timely access to appropriate care.
2. Ensuring healthcare professionals delivering diabetes care are appropriately **educated and upskilled in diabetes management**, which will be supported by the PCN DiaST.
3. Early referral and intensive treatment for people newly diagnosed with diabetes, including **attendance** at structured education.
4. A focus on holistic care: proposed care processes to address the need for holistic management and to **address long-term disease burden**.
5. **Focused care** to certain groups and underserved populations in their localities, including those with frailty, young adults, ethnic minorities, certain people with type 1 diabetes and those with learning disabilities.



Tiers of diabetes care

Tier 4: Secondary Care Trust MDT
Inpatient diabetes; foot diabetes MDT (with predefined criteria); type 1 diabetes; Stage 4 and 5 CKD; antenatal diabetes; children and adolescents.

Tier 3: MDT Integrated Care from Secondary Care Trust
Complex cases unsuitable for tier 2; targeted clinics (e.g. technology, post-MI); frailty tailored to population needs; renal disease up to stable Stage 4 CKD; type 1 diabetes needing community management (e.g. care homes, learning disabilities); People with an uncertain diagnosis (e.g. suspected LADA or MODY).

Tier 2: PCN DiaST team – *See dedicated section.*

Tier 1: Practice-based team
Ensuring a basic level of care is offered to everyone with diabetes, including: lifestyle advice; encouragement to attend structured education; foot examination/care advice; lipids and BP management; basic CKD management; initiation of oral medications and injectables (depending on competency); basic pre-conception advice; signposting to other support services (e.g. smoking cessation, wellbeing advisors, retinopathy, periodontal, weight management services); mental health and emotional wellbeing screening.

Recommendation: PCN Diabetes Support Team (DiaST)

This will be a new enhanced tier within a PCN, providing care with an MDT approach.

- As a gold standard, practitioners within the team should include:
  - ✓ A GP with an extended role (GPwER) in diabetes.
  - ✓ A Practice Nurse with special interest in diabetes.
  - ✓ A Clinical Pharmacist (RPS Advanced Stage 2).
  - ✓ A Community/Intermediate Diabetes Specialist Dietitian.
- Access to mental health services should be available and overarched by strong communication links with wider community support services, to include IAPT.
- Practitioners will manage their own case load and referrals for complex cases unable to be managed at tier 1 and/or not meeting individualised treatment targets.
- Care at this level includes GLP-1 receptor agonist initiation, insulin initiation and multiple morbidity review.
- All new diabetes cases from within the PCN should be referred here to access dietary support, education and support for type 2 diabetes remission, where appropriate, and to triage their care to the correct tier/services.
- Women of childbearing potential and all young adults with diabetes should be seen within this tier.
- Practitioners will also provide support and supervision for care homes and diabetes advice for others in the community MDT (e.g. district nurses/active case managers).
- The DiaST is to have responsibility for appropriate diabetes-related education and clinical governance of other HCPs within the PCN.

Recommendation: Structured education

At diagnosis, early two-week referral and attendance at structured education for dietetic input, individual goal setting and the opportunity of exploring remission of diabetes. Offer of an annual "Refresher" structured education update.

Recommendation: HCP education

PCN-led and -monitored training/upskilling of dedicated HCPs involved in the delivery of diabetes care.

- The guideline supports a "train the trainer" approach where, at each level of care, practitioners have the opportunity to be mentored alongside accredited training from the tier above.
- This continuous education will ensure that all HCPs are upskilled to provide up-to-date, high-quality, evidence-based diabetes care across the board.
- All levels will have dedicated protected learning time to deliver and/or undertake this training, with consideration of options to provide backfill for HCPs' protected learning time and cover for clinics.
- Education will need to be funded by the PCN.
- Education and training should include clinical skills, evidence-based medicine, development of knowledge of diabetes management strategies and exploring behaviour change models.
- HCPs caring for people with diabetes should have demonstrable competence for the level at which they are practising.

Recommendation: Audit

Both local and national audit of PCNs will be essential to ensure improvements in and reducing variation in standards of diabetes care.

- In addition to participation in the National Diabetes Audit (core audit) and local dashboard data, PCNs will be asked to annually collate qualitative data to allow measurement and reflection on holistic parameters (e.g. completed CPD hours).
- A qualitative assessment tool will be developed and piloted with PCNs to ensure data collection is not cumbersome.
- A National Enhancing Diabetes Services (NEDS) team will review collated data and share areas of excellence and look at barriers to good care and how best to overcome these, producing a bi-annual report.

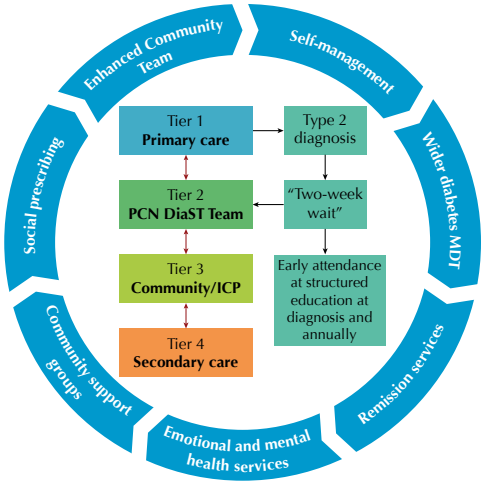
Recommendation: Core and enhanced care processes

The proposed care processes complement QOF indicators to provide comprehensive care for those living with diabetes, with long-term disease burden borne in mind.

Core Care Processes (performed and/or recorded annually as a minimum)	Enhanced Care Processes (performed and/or recorded annually as a minimum)
• HbA_{1c} • Lipid profile • Blood presure • Urine albumin:creatinine ratio • eGFR • Attendance at structured education • Vaccinations as per national programmes • Foot surveillance/risk stratification • BMI • Mental/emotional wellbeing screening	• Pre-conception advice for women of childbearing potential • Sexual health review (both men and women) • Attendance at retinal screening • Attendance for peridontal care • Frailty assessment • Physical activity assessment • Nutrition assessment • Smoking status

Recommendation: Joined-up care

Joined-up working across all wider support services with the person with diabetes at the centre of care, enabling bidirectional flow through the tiers as appropriate during a person's health condition journey.



The healthcare journey for the person with diabetes

Reference

Barron E, Bakhai C, Kar P et al (2020) Associations of type 1 and type 2 diabetes with COVID-19-related mortality in England: a whole-population study. *Lancet Diabetes Endocrinol* **8**: 813–22

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