Reflecting on achievements and planning for optimal care

Working predominantly in the English primary care system, this is a time of year when, albeit momentarily, I can steal a brief pause for breath to reflect on projects and workstreams before we go again for another year of striving to deliver the best possible holistic diabetes management and support.

One of my current roles as a Primary Care Network (PCN) DiaST (Diabetes Support Team) Lead began just over a year ago. I was employed on a one-year contract with "COVID Recovery" monies to help re-set and enhance diabetes services across a PCN. At that time the Quality and Outcomes Framework (QOF) for England and Wales had been stepped down for a second year, and the *Diabetes is Serious* report was being launched by Diabetes UK (2022), which highlighted that one in three people living with diabetes had had no contact with their healthcare team over the previous year. Within my own PCN, 44% people were classified as being at particularly high risk of adverse diabetes outcomes and, within this population, just under 14% had not had a diabetes review for over two years, with one in four (26%) having had no contact in over a year.

From April 2022, over-arching our workstreams within the PCN was the re-start of QOF. Locally the Integrated Care Board (ICB) introduced the Primary Care Quality, Recovery and Resilience Scheme (PQRRS) as a diabetes-focused pay-for-performance scheme that went beyond QOF by including the recording of BMI, eGFR, urine ACR, alcohol consumption and frailty status, and by encouraging the inclusion of a discussion on emotional and mental well-being in consultations. For me, the latter was a very welcome addition, evidenced by a survey by the Primary Care Diabetes Society (Seidu et al, 2022) which estimated that just under half of GPs and practice nurses reported more mental health concerns in people with diabetes following the COVID-19 pandemic, and that 30% reported significantly more mental health problems. Exception code reporting, as allowed in QOF, was not an option in the local scheme.

QOF and other pay-for-performance schemes have their critics – should the metrics and care delivery we are encouraging simply be part of routine care? A recent article by Morales et al (2023) used a controlled interrupted time series analysis to determine whether the withdrawal of QOF in Scotland in 2014 had an impact on recorded quality of care, compared with England where the scheme continues. Review of data to 2018 showed that there were reductions in recorded care in 12 out of 16 quality care indicators. The authors do question if the care had actually been delivered and that the "tick boxes" were simply not completed, but of concern is that the largest reduction was for mental healthcare planning and foot screening.

Three articles within the current issue of this journal – Diabulimia: Psychological perspectives on management; Mental health in vulnerable people: warning signs and strategies to improve health outcomes; and Preparing parents for the prospect of the neonatal unit: the role of the diabetes specialist nurse – serve to underline the importance of considering mental and emotional needs. This aspect of care needs to be fundamentally embedded within our consultations and services, and certainly should not be an area that is allowed to wane.

Also within this issue, the latest Journal Club commentary from Dr Daniel Flanagan reminds us that diabetes foot admissions remain high and that we must continue to focus on basic clinical care; a drop-off in recorded foot screening with the absence of QOF in Scotland (and this before COVID-19) is, therefore, significant.

The highlighted article, by Morales et al (2023), does conclude that, "Changes to pay for performance should be carefully designed and implemented to monitor and respond to any reductions in care quality." Within the local PQRRS scheme that I have described, PCNs were

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also set the challenge of specifically identifying the cohort that they were "hardly reaching", and which was, therefore, seeing reductions in care quality. This linked well with the DiaST role of encouraging PCNs to "support underserved groups and different populations in their localities".

This out-reach workstream has been ably supported by the IT leads at the ICB who provided the most excellent, effective, contemporaneous diabetes dashboards so that we could identify this population. For the PCN, it was our persons under the age of 50 years living with any type of diabetes, and so was based on age rather than social deprivation, ethnicity or frailty status. When type 2 diabetes develops in individuals at an earlier age, the progression of microvascular and cardiovascular disease can be more rapid than in those with later-onset type 2 diabetes. Regular reviews for these complications are essential so that evidence-based preventative and treatment strategies can be utilised, as necessary.

Through a full PCN multidisciplinary team approach to include work with administrative and IT support, the learning disabilities team, social prescribers, mental health workers, neighbourhood health coordinators, local community support groups and beyond, we have reached out to this cohort through:

- Local education and engagement events at, for example, sports days and local community centres.
- Bespoke remote interventions to encourage uptake of diabetes reviews.
- Diabetes reviews being offered within extended hours services, to include evenings and weekends.
- Promotion of opportunistic diabetes care.

And the results? Aside from the very real differences that we have made to individual lives (see *Box 1*), we have seen within the PCN an 11% reduction in persons with diabetes considered to be at high risk. Only one in ten have not had a review in the last year, which is encouraging, but 8% have not been seen for over two years, which remains a challenge to look to overcome.

We had been concerned that, as the number of care processes increased, we might expect a drop in persons achieving all three treatment targets for blood pressure, lipids and HbA_{1c}. As more measurements are taken, often more dyslipidaemia, hypertension and hyperglycaemia may be found, but treatment targets have remained consistent, and we feel that the use of PCN-created "at a glance" treatment pathways and other mentorship educational activities and resources have helped to avoid this potential increase.

As we continue to work in challenging times, I hope for all of us that we are able to find some time, as individuals and in teams, to pause and reflect on achievements (of which there will be many), and be able to plan clear future pathways of optimal care and workforce well-being. ■

Box 1. Making a difference to individual lives.

Please meet James.

James has type 1 diabetes (diagnosed 4 years ago) and works on a zero-hour contract. His wife is unwell in hospital and they have twin boys, aged 7 years. James had not had a diabetes review for 3 years. Somehow he avoided any diabetes admissions on a twice-daily insulin mix regimen.

After being identified as someone within a cohort that was being underserved by the Primary Care Network, James was offered an appointment in the extended hours on a Saturday: he started isCGM, his insulin regimen changed to basal–bolus and education was given. His time in range increased from 0% to 68% at present. He has been referred to a specialist team.

Diabetes UK (2022) *Diabetes is Serious*. Diabetes UK, London. Available at: https://bit.ly/3o9ddLG (accessed 13.04.23)

Morales DR, Minchin M, Kontopantelis E et al (2023) Estimated impact from the withdrawal of primary care financial incentives on selected indicators of quality of care in Scotland: controlled interrupted time series analysis. *BMJ* **380**: e072098

Seidu S, Hambling C, Holmes P et al; PCDS Research Group (2022) The impact of the COVID pandemic on primary care diabetes services in the UK: A cross-sectional national survey of views of health professionals delivering diabetes care. *Prim Care Diabetes* **16**: 257–63

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