Focusing on what really makes a difference

It was good to meet so many of you at our recent PCDS conference in Birmingham. Every session challenged us to think differently about the care we deliver, but far more important than what we learnt is what we have chosen to do on our return to our practices. I hope the action plans we scribbled so enthusiastically in our workbooks aren't lying unused but have been shared with our teams and are beginning to impact what we do.

Several presentations made me think hard about what we do in diabetes care that actually makes a difference. Often these are very simple things, such as managing blood pressure, giving smoking cessation advice and reinforcing education messages with a leaflet. Having identified these vital few tasks, we need to plan how we can ensure that, no matter how busy we are or how large the diabetes burden in our practice, we continue to make time to do these consistently.

Reducing diabetes-related amputation

Earlier this year, Diabetes UK highlighted that the number of diabetes-related amputations continues to rise, fuelled by rising diabetes prevalence. They challenged us to reduce the 135 diabetes-related amputations that occur each week, and this edition of *Diabetes & Primary Care* provides key pointers on how we might achieve this, with Catherine Gooday and Rachel Berrington's discussion of the new NICE NG19 foot guideline (page 278) and Karl Guttormsen and Samantha Haycocks' "In the consultation room" article (page 285).

The path to amputation often starts with a "high-risk" or "moderate-risk" (or often unassessed) foot developing minor ulceration or an infection. This is assessed and managed in primary care, ideally with referral to a multidisciplinary foot care team for outpatient treatment if possible; followed by, if the wound does not resolve, admission and treatment as an inpatient with offloading, intravenous antibiotics and attempts to improve circulation; and, when all these fail, amputation.

What part can primary care play in influencing this deadly progression? Some of the care that makes a difference should have happened years previously, early in the course of the diabetes, with tight glycaemic, blood pressure and lipid control, reduction of microvascular and macrovascular complication risk and optimisation of the glycaemic "legacy effect". The Quality and Outcomes Framework (QOF) rewards us for carrying out foot checks and classifying feet into risk categories, and this assessment is important if we use it to inform care. People with diabetes need education about foot problems so that they are more motivated to examine their feet regularly and seek advice as soon as they notice any changes. The *10 Steps to Healthy Feet* (available at: http://bit.ly/1LxARkg) and *What to Expect at your Annual Foot Check* (available at: http://bit.ly/1lHww9g) leaflets are readily available from Diabetes UK and are easy to distribute at every review. They can remind people of our often hastily delivered advice at the point when it actually matters: on the morning they blister their heel with new shoes or develop an ingrown toenail and need to decide what action to take. Hopefully, education will ensure they seek advice promptly.

When someone presents with ulceration or infection, every member of a team should know who needs referral, where to refer and how to take action with the appropriate sense of urgency, and which antibiotics to use, when and for how long. Most of these people will not present to the clinicians who lead their practice's diabetes service, so we need to educate colleagues that this can be an emergency.

Perhaps we need to ask challenging questions about our care. QOF searches identify those people who have not had a foot check in the last 12–15 months, and templates ensure that high-risk and intermediate-risk feet are coded. But are we, or our local footcare prevention teams, seeing these feet frequently enough to intervene effectively if the individuals with diabetes don't realise they have a problem? Have we done enough to raise awareness

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of foot problems? Are all our patients receiving care from the correct people? Do we know who has a history of ulceration or amputation? A significant number of people with previous diabetic foot ulceration will develop further ulceration within a year, and 80–85% of amputations follow ulceration (Singh et al, 2005; NICE, 2015a), so our next diabetes-related amputation is likely to come from this group. Most amputations are deemed to be preventable, but are our systems robust enough to optimise prevention? Should we be lobbying for locality multi-professional footcare teams? Once an amputation has occurred, have we made time for a Significant Event Analysis, which could identify things to do differently next time?

Safety netting and making a difference to retinopathy

New evidence that anti-vascular endothelial growth factor (anti-VEGF) drug treatment produces similar results to panretinal photocoagulation, at least in the first 2 years of proliferative retinopathy (Olsen, 2015), gives ophthalmologists and people with diabetic eye disease options. Currently, the 4 Nations Study Group is debating whether the screening interval should be lengthened for low-risk people with diabetes. A rapid literature review found only observational studies but supported consideration of a longer screening interval in people with type 2 diabetes with no existing background retinopathy, not on insulin therapy and with diabetes duration <10 years, but caution was advised about the impact that high attrition rates of some services may have had on the quality of the data, and validation in a UK cohort was advised (Leslie et al, 2013).

Retinopathy screening in the past few years has been a success story and has been demonstrated to reduce sight-threatening retinal problems by ensuring those who need intervention are referred to an ophthalmologist and receive appropriate treatment. Of all the screening we do, retinopathy screening comes closest to fulfilling the World Health Organization screening criteria. What really makes a difference, then, is increasing the number of people screened regularly and ensuring that those who are referred to ophthalmology attend.

If our local retinopathy screening services have capacity problems and recall times are not optimal, we need to be proactive in flagging this up. We may identify people who were never referred for screening at diagnosis, and every practice will have people who do not attend; these people may have undiagnosed or untreated eye disease. Common reasons cited for non-attendance include not receiving the invitation, being unwell, being too busy and being on holiday (Sachdeva et al, 2012). Most of these can be overcome with a bit of effort on our part. Some services re-invite all non-attenders, but in some cases only after 12 months. Finding non-attenders and helping them return to the screening programme immediately can be done opportunistically when each letter arrives, when we undertake diabetes reviews or initially with a "search and rescue" approach. Going forward, we can put in place systems to request a further appointment when people don't attend and add alerts to electronic records so that we can reinforce the importance of attendance each time they are seen in surgery. Perhaps even more important is to identify and follow up those with retinopathy who do not attend ophthalmology – these people have a high risk of visual loss and need early review in secondary care.

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NICE guideline on type 2 diabetes

This long-awaited NICE guideline on type 2 diabetes in adults was published on 2 December (NICE, 2015b). The emphasis on empowerment of people with diabetes and on individualisation of care is to be applauded, and the guideline targets clinical inertia, with thresholds for intensification of therapy of 48 mmol/mol (6.5%) for monotherapy initiation and of 58 mmol/mol (7.5%) for first and second intensification. This will prove challenging. A 53 mmol/mol HbA_{1c} target for people receiving sulphonylurea (SU) monotherapy rather than the 48 mmol/mol target for those on monotherapy with other drugs acknowledges and will help reduce the hypoglycaemia risk associated with SUs.

Sadly, the PCDS's feedback at the second consultation has fallen on deaf ears. The requirement for an HbA_{1c} reduction of 11 mmol/mol (1.0%) and 3% weight loss to continue with glucagon-like peptide-1 receptor agonist therapy beyond 6 months remains. These drugs are recommended only if people meet the BMI and other requirements for initiation and if triple therapy is ineffective, poorly tolerated or contraindicated, and their use is only recommended in combination with metformin and an SU. Sodium–glucose cotransporter 2 inhibitors have been added at first and second intensification for those who are able to tolerate metformin, and in combination with insulin, but they are not recommended for those intolerant of metformin unless they are also on insulin. The Medicines and Healthcare products Regulatory Agency (2015) warning of the risk of euglycaemic ketoacidosis is included.

Thank you

As I approach the end of my first year as Editor-in-Chief, I would like to thank my deputy, Jane Diggle, for sharing the workload and working alongside me so enthusiastically throughout 2015, and also to Colin Kenny, Gwen Hall and Eugene Hughes for their generous advice, support and wise counsel based on their past years at the helm of the Journal. Jane and I want to say a big "thank you" to the editorial and publishing team at SB Communications Group for all their hard work and support – they are responsible for commissioning the articles, helping to make the content readable, informative and factually correct, and ensuring we all meet our deadlines. A daunting array of tasks, achieved with great professionalism.

At the recent PCDS conference, we were able to personally thank some members of our Editorial Board for the energy, enthusiasm and creative ideas they have provided during the year, and we would like to extend our thanks to those unable to attend but who continue to give their time to peer review papers and write for us.

Finally, throughout the year, we have been challenging you to make changes in many different areas of diabetes care. Listening to you at the conference, we were excited to hear how you continue to improve the care you deliver, and how you care about the improvements you achieve. We hope you will continue to share your enthusiasm and knowledge about what works (and what doesn't) with us through the pages of the Journal in 2016. ■

Leslie R, Todkill D, Mistry H et al (2013) Rapid literature review: would changing diabetic eye screening intervals from the current annual recommendation lead to changed clinical outcomes? University of Warwick, Coventry. Available at: http://bit.ly/1lHp6Ts (accessed 24.11.15)

Medicines and Healthcare products Regulatory Agency (2015) *SGLT2 Inhibitors (Canagliflozin, Dapagliflozin, Empagliflozin): Risk of Diabetic Ketoacidosis*. MHRA, London. Available at: http://bit.ly/1GJvzAb (accessed 24.11.15)

NICE (2015a) Diabetic Foot Problems: Prevention and Management (NG19). Available at: http://www.nice.org.uk/guidance/ng19 (accessed 24.11.15)

NICE (2015b) *Type 2 Diabetes in Adults: Management* (NG28). NICE, London. Available at: www.nice.org.uk/guidance/ng28 (accessed 02.12.15)

Olsen TW (2015) Anti-VEGF pharmacotherapy as an alternative to panretinal laser photocoagulation for proliferative diabetic retinopathy. *JAMA* 13 Nov [Epub ahead of print]

Sachdeva A, Stratton IM, Unwin J et al (2012) Diabetic retinopathy screening: Study to determine risk factors for non-attendance. *Diabetes & Primary Care* **14**: 308–16

Singh N, Armstrong DG, Lipsky BA (2005) Preventing foot ulcers in patients with diabetes. *JAMA* **293**: 217–28