PCDS
Primary Care Diabetes Society

The latest news and views from the Primary Care Diabetes Society

State of the Nations survey update

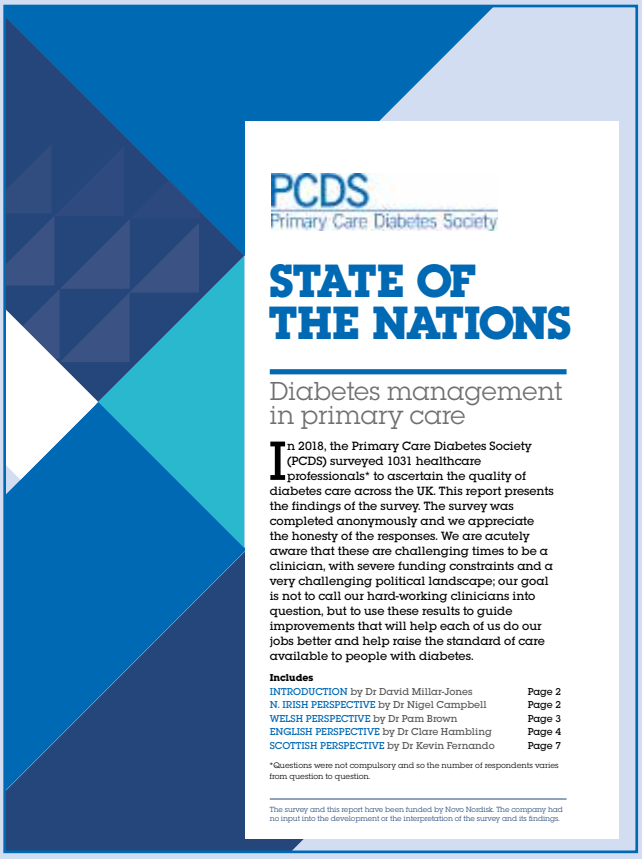
David Millar-Jones
GPSI in Cwmbran, Wales, and Chair of the PCDS

In September, the Primary Care Diabetes Society (PCDS) surveyed 1031 healthcare professionals to ascertain the quality of diabetes care across the UK. The survey was completed anonymously and we appreciate the honesty of the responses.

The PCDS is acutely aware that these are challenging times to be a clinician, with severe funding constraints and a very challenging political landscape; our goal is not to call our hard-working clinicians into question, but to use these results to lobby for improvements that will help each of us do our jobs better and help raise the standard of care available to people with diabetes.

Here we present the key findings from the survey and the perspective of a PCDS Committee member from each of the four nations.

The full findings of the survey will be published in the *State of the Nations* report, which will be available from 22 November at **www.pcdsociety.org**. The survey was funded by Novo Nordisk, but they had no input into the development or the interpretation of the survey or its findings. ■



PCDS
Primary Care Diabetes Society

STATE OF THE NATIONS

Diabetes management in primary care

In 2018, the Primary Care Diabetes Society (PCDS) surveyed 1031 healthcare professionals* to ascertain the quality of diabetes care across the UK. This report presents the findings of the survey. The survey was completed anonymously and we appreciate the honesty of the responses. We are acutely aware that these are challenging times to be a clinician, with severe funding constraints and a very challenging political landscape; our goal is not to call our hard-working clinicians into question, but to use these results to guide improvements that will help each of us do our jobs better and help raise the standard of care available to people with diabetes.

Includes

*Questions were not compulsory and so the number of respondents varies from question to question.

The survey and this report have been funded by Novo Nordisk. The company had no input into the development or the interpretation of the survey and its findings.

Visit the PCDS website at

www.pcdsociety.org

Information on how to join ● Committee member biographies ● Links to CPD activities
"Talking head" videos ● Details on research initiatives ● And much more

Key findings from the *State of the Nations*

Structured patient education

Many people with diabetes do not receive structured education about their condition

- Structured patient education (SPE) for type 2 diabetes improves glycaemic control and other risk factors, encourages a healthy lifestyle and enhances self-management. Nevertheless, about 1 in 10 (8.8%) respondents could not access SPE, while 1 in 5 (19.1%) did not have easy access.
- People from ethnic minorities (who are often at particularly high risk of type 2 diabetes), those who are working, and people in prison encounter particular problems accessing SPE.

Foot care

There is an urgent need to improve foot care

- Each week, about 140 people with diabetes have a leg, foot or toe amputated in England alone. Approximately 86 000 people with diabetes in the UK have foot ulcers at any time. Despite this, 2 in 5 respondents (38.3%) felt there was inadequate time for foot assessment and education.
- A quarter (24.9%) of respondents were unable to access easy-to-use referral pathways, while 1 in 3 (31.7%) did not feel confident determining a patient's foot-care risk.

Psychological support

Few people with diabetes receive the psychological support they need

- Depression and other mental health issue are common among people with diabetes. However, 1 in 5 respondents (19.5%) do not regularly screen for mental health conditions in people with diabetes.
- Only 1 in 20 (5.9%) respondents said that they have access to a mental health counsellor specialising in diabetes.

Pre-conception and pregnancy

Current services could leave pregnant women and their babies at risk

- Certain drugs used to treat diabetes and its complications are linked to an increased risk of complications if taken during pregnancy. Yet only a quarter of respondents had processes to ensure women taking these drugs used contraception (25.0%) or to avoid the medicines (28.7%) if there was concern that she could be pregnant.

Insulin safety

There is scope for further improvement regarding insulin safety

- Only half of respondents (50.3%) had undertaken new or refresher training on insulin safety in the last 12 months, probably reflecting competing priorities and time pressures.
- People with diabetes seem to be missing out on simple checks, such as of insulin injection sites. Insulin injection can cause localised fat losses, lumps under the skin and local allergic reactions. Furthermore, harm from injections can be a contributing factor to unstable control and hypoglycaemia. Yet 1 in 6 (17.2%) respondents admitted that they do not check injections sites. ■

National perspectives on the findings

Northern Ireland

Dr Nigel Campbell

General practice in Northern Ireland is under considerable strain. Retiring GP principals can no longer find replacements and many practices are folding with patients being divided among neighbouring practices. The problem is worse in rural areas and in the west of the province, where there are more single-handed, or small group practices. The absence of a working Northern Ireland Assembly also adds to the sense of crisis. Primary Care needs investment and political leadership if it is to survive. Smaller practices are being driven into larger groups where in-house

diabetes clinics will need more than one specialised GP provider.

There has been a strong working relationship between primary and secondary care in the past in Northern Ireland with little need for intermediate care. Not now though, as each becomes more stretched just trying to meet the demands of their own sector. Diabetes care is suffering as a consequence.

There is a plan in place under the guidance of a province-wide Diabetes Network, with several strands (reflecting priority areas), which is beginning to make meaningful changes to service provision and delivery. This has the support of all levels of government and healthcare providers and is a welcome, good news story in the bleak political climate. Funding has been identified and is now beginning to flow. ■

Wales

Dr Pam Brown

Wales is fortunate to have experienced primary care and community teams who are passionate about delivering quality diabetes care. However, primary care struggles with recruitment, retention and early retirement, making succession planning difficult and resulting in workload pressures and serious time constraints in delivering diabetes care. Escalating prevalence of diabetes and increasing complexity of cases is causing gaps to develop between what is achievable and what we aspire to deliver. No sickness or holiday contingency cover is possible in most areas. Availability of resources, both people and funding, are not evenly distributed across the principality.

Individual Health Boards control which enhanced services to fund, with several funding only the basic 'Gateway' module and not incentivising initiation or follow up of GLP-1 analogues or insulin. Some practices continue to deliver these services without funding, which is increasingly hard to justify given that: workload is high, these have historically been secondary care services, and colleagues in other parts of Wales receive funding for the same work. This has resulted in unequal care, patient inconvenience and the stretching of secondary care beyond capacity, making joint clinics and telephone advice less accessible in many areas. More equitable enhanced service funding may be agreed soon.

Healthcare professional education on newer drugs is available but workload and capacity make it difficult for people to attend. It is hoped that PCDS's online journal and education, such as the 'Six Steps to Insulin Safety' and Welsh Government-funded modules, will help provide accessible education.

Despite these and other challenges, primary and community teams across Wales must be congratulated for remaining enthusiastic and continuing to deliver quality diabetes care – care which no survey can fully capture. With additional resources we look forward to doing even better in the future. ■

England

Dr Clare Hambling

The National Diabetes Audit continues to demonstrate significant variation in diabetes care across England. In a drive to improve standards and consistency in care for people with diabetes, NHS England has implemented a transformation programme as part of a Diabetes Treatment and Care Programme, targeting four particular areas:

- increasing the uptake of structured education;
- improving achievement of the NICE-recommended treatment targets;
- reducing the number of lower-extremity amputations by improving access to multi-disciplinary foot care teams;
- reducing lengths of hospital stays by improving access to specialist inpatient support.

In addition, the NHS Right Care diabetes pathway aims to focus on reducing variation and inequality in diabetes care.

This investment for diabetes care is very much welcomed but it should be noted that the transformation money was allocated through a competitive bidding process, with applications made by Sustainability and Transformation Partnerships (STPs). Not all STPs presented applications for each of the four elements and, among those that did, not all were successful in receiving transformation funding. However, in many parts of England, transformation programmes are being implemented and all are aimed at improving the care of people living with diabetes. Although programmes are locally determined and the specifics of each not known, common themes are likely to include elements such as improving access to specialist support, incentives for primary care to improve the achievement of treatment and care metrics, and healthcare professional education. ■

Scotland

Dr Kevin Fernando

Primary care diabetes services in Scotland are in a period of transition. QOF was abolished during 2016 and a new Scottish contract was introduced during April 2018 to allow GPs to re-configure their roles to "expert medical generalists" and to focus on the management of chronic disease (including type 2 diabetes), medical complexity and multimorbidity. However, aspects of the new contract remain aspirational, such as the promise of a pharmacist and pharmacy technician in every practice in Scotland within the next 3 years to assist with chronic disease management. We also await the results of the 2017 Scottish Diabetes Survey to see if the reductions in recording of BMI, blood pressure and cholesterol seen in the 2016 report have continued. These reports will help leaders and governance teams in each NHS board to develop plans to improve the care and outcome for those with diabetes in their respective regions.

Within 5 years I would like to see greater collaboration between Scottish primary care diabetes services, allied healthcare professionals and health and social care partnerships to deliver the best possible diabetes care for individuals living with diabetes. This will require more direct lines of communication between primary, intermediate and secondary care as well as increase in funding for primary care by way of local enhanced services for advancing the prevention agenda, the provision of in-house structured patient education and initiation of injectable medications in the community. A lack of funding for the latter as well as a relative de-skilling of primary care given the explosion in new diabetes therapies has driven an increase in secondary care diabetes referrals.

I should add that My Diabetes My Way is one of the key strengths of Scottish diabetes services. It is an NHS Scotland interactive diabetes website to help support people who have diabetes as well as their family and friends. Despite the above, the appetite for self-management has increased in those with diabetes in Scotland, partly driven by increased awareness of pressures in primary care. ■