National Advisory Panel on Care Home Diabetes

A STRATEGIC DOCUMENT OF DIABETES CARE FOR CARE HOMES

Executive Summary

April 2022

Representative Bodies of the NAPCHD

DIABETES UK KNOW DIABETES. FIGHT DIABETES.	KING'S College LONDON	The Association for Clinical Biochemistry & Laboratory Medicine Better Science, Better Testing, Better Care
t·r·e·n·d™ DIABETES	directors of adass adult social services	JBDS-IP Joint British Diabetes Societies for inpatient care
O·P·D·N· Older People's Diabetes Network	Aston University BIRMINGHAM UK	CARE ENGLAND Representing independent care providers
Qni The Queen's Nursing Institute	hallmark care homes	BDA The Association of UK Dietitians
RCGP Royal College of General Practitioners	ABCD Association of British Clinical Diabetologists	UKCPA CLINICAL PHARMACY ASSOCIATION
DUETdiabetes	DISN UK GROUP SHARING BEST PRACTICE SINCE 2004	fDROP foundation for Diabetes Research in Older People

Contents

Working Group and Advisory Panel Members and Representative Bodies

Name	Organisation
Professor Alan Sinclair (Chair)	King's College, London and Foundation for Diabetes Research in Older People (fDROP)
Bridget Turner, Dr David Jones	Diabetes UK, London
Dr Umesh Dashora	East Sussex Healthcare NHS Trust, JBDS-IP and ABCD
Philip Newland-Jones, Helen O'Neil	University Hospitals Southampton NHS Foundation Trust (PN-J), South Tyneside and Sunderland NHS Foundation Trust (HO'N)and UKCPA
Dr Susannah Rowles	ABCD and Pennine Acute Hospitals NHS Trust
Lynne Reedman	DUET diabetes Ltd
Dr Kath Higgins	University Hospitals of Leicester NHS Trust and JBDS-IP
June James	Trend-UK
Prof Gerry Rayman, MBE	East Suffolk and North Essex NHS Foundation Trust and JBDS-IP
Prof Angus Forbes	King's College, London
Dr Ahmed Abdelhafiz	Rotherham NHS Foundation Trust and OPDN
Professor Martin Green, OBE	Care England
Julie Rayner	Hallmark Care Homes
Ann Middleton	PLWD and DRSG
Carolyn Newbert	PLWD and DRSG
Dr Susan Manley	University of Oxford, University of Birmingham and JBDS-IP
Dr Jason Cheung	Norfolk and Norwich University Hospitals NHS Foundation Trust and JBDS-IP
Gurpreet Kaur	Black Country and West Birmingham CCG and University of Worcester
Dr Daniel Flanagan	University Hospitals Plymouth NHS Trust and JBDS-IP
Philip Ivory	Lay member and person advocate
Erwin Castro	East Sussex Healthcare NHS Trust, JBDS-IP, and DISN
Dr Parijat De	Sandwell & West Birmingham NHS trust/JBDS-IP
Dr Kevin Fernando	Royal College of General Practitioners, RCGP
James Bullion	ADASS – Director, Association of Directors of Adult Social Services
Professor Peter Scanlon	Gloucestershire Hospitals NHS Foundation Trust
Dr Sally Thirkettle	Christie Pathology Partnership, Manchester M20 4BX, and Association for Clinical Biochemistry & Laboratory Medicine
Lara Ellison and Ruth Hammond	British Dietetic Association, Birmingham, UK
Jo-Anne Wilson, MBE	Queen's Nursing Institute (QNI), and Royal British Legion
Dr Sri Bellary	University of Aston and University Hospitals Birmingham NHS Foundation Trust
Laura English	Regulatory Policy Officer, Care Quality Commission (CQC)
Dr David Lipscomb	Sussex Community Foundation NHS trust
Dr Belinda Allan	Hull and East Yorkshire Hospitals NHS Trust and JBDS-IP

Background and Purpose

There is no doubt that older people living with diabetes represent a substantial global health burden in ageing societies. In those countries which provide residential care for people with disabilities or who are unable to look after themselves, residents with diabetes occupy more than one in four beds. These residents are a highly vulnerable group with challenging medical and nursing needs. Many are frail with and without dementia, and their diabetes condition is often complicated by high rates of hypoglycaemia and preventable and unnecessary hospital admissions for diabetes-related acute and chronic complications.

We have known for some time that there are considerable shortfalls in diabetes care within UK care home settings associated with sub-optimal treatment, poor clinical outcomes, poor quality of life, and reduced survival. The covid-19 pandemic has had dramatic effect on care homes causing a major increase in morbidity and mortality associated with a significant toll on both health and social care resources, and highlighted a wide range of health inequalities.

Local authorities, the NHS, and independent care providers many of which are represented by Care England, as well as by the National Care Association (NCA), play important roles in the way care is delivered in the community for the most vulnerable in society. The Care Quality Commission (CQC) has a key role in regulation of care homes and in assessing the quality of service provision. Guidance on managing diabetes in care homes has been available from Diabetes UK for more than a decade, but despite this whose recommendations were well received, implementation and uptake of this guidance has been variable. In addition, providing only clinical care recommendations may have a limited effect in enhancing care and that improvements in medical technology, communication between stakeholders, and workforce development of care staff are also important factors in bringing about more sustained positive changes.

Therefore, the NAPCHD was established as a multi-professional group of specialists working with PLWD and other key stakeholders in July 2020 with a key purpose of examining the whole area of diabetes care provision from a clinical care perspective to the perspective of existing communication channels between stakeholders, care home workforce development, community and primary care liaison, and the emergence of digital health support. By producing the ***Strategic Document of Diabetes Care*** by the NAPCHD initiative, we hope to provide a set of potentially implementable recommendations that will ultimately enhance the quality of diabetes care delivered and lead to important improvements in the wellbeing, quality of life, and clinical outcomes of all residents with

diabetes. We anticipated that this would require a fundamental change in care provision for residents with diabetes particularly those who require complex care interventions, and would represent ***a new model of health and social care*** for residents with diabetes in care homes.

Methods

Representation from key stakeholders was sought, a briefing paper prepared and after feedback and discussion, the key issues were identified and objectives defined. Eight subgroups comprising different stakeholder representatives (clinical and other professional groups) were chosen to undertake the work for producing the *Strategic document*. Each were provided with instructions on liaison with the chair and coordination deadlines for work produced, and given up to three topics to study (domains of interest) and report on. Communication was online at all times (at least three meetings of the national panel (organised by Orange Juice Communications, Northamptonshire), and three meetings of each subgroup with the Chair) in view of covid-19. The following 'Task Areas' were identified:

Task No.	Issue/Domain
1	(a) Philosophical Framework for the Project; (b) Principles of Good Diabetes Care – the role of Community Diabetology
2	(A) Ethics and equity of care, access to services, and related ethnicity (B): Principles of (a) Shared Decision-making, (b) Mental Health and Wellbeing, and (c) Emotional and Spiritual Wellbeing
3	Training and Education of Care Staff and related competencies
4	Acute illness care including (a) Infection management of Covid-19**;** (b) clinical biochemistry and haematology services
5	Systems enhancement and use of technology including data collection, storage and safe sharing, resident's plans and case records
6	Individualised glucose-lowering approaches: non-insulin glucose-lowering therapies; insulin therapy; safe glycaemic targets and monitoring
7	(a)Hypoglycaemia, (b)Foot Disease, (c)Eye Services, and (d)Hospital Admission Avoidance
8	Type 1 diabetes in care homes
9	Liaison and communication activities of care homes with particular reference to Adult Social Services (ASS)
10	The Elements of an Operational Policy for Care Homes
11	End of Life Care including advance care planning

A set of **5 starting questions** formed the basis of the work in most of the chosen **'Task' areas**' and these relating to a view of the current status of the issue/current practice; what are the deficiencies

of care, or needs or knowledge in this area, what key steps are needed to bring about worthwhile change, how can the key steps be realistically implemented, and what are achievable primary recommendations. Reports were edited and compiled by the chair and his team, and drafts circulated for comment prior to launch of the Strategy Document for Consultation.

Key Findings

- We found no evidence of an agreed framework (philosophical or clinical or operational) for managing diabetes, and little evidence of regular systematic and organised multidisciplinary audits of diabetes in UK care homes, or implementation of care home diabetes policies in a consistent manner.

- There is insufficient use and deployment of specialised community and hospital diabetes services in care homes with evidence of regional variation.

- There is little knowledge and awareness among care home staff, diabetes teams, primary care and social services about the ethical principles of diabetes care for residents with diabetes, inadequate knowledge and experience of ethnicity-related issues that affect clinical and social care, and very limited evidence of awareness relating to emotional and spiritual well-being of residents with diabetes.

- There is a recognition by all stakeholders that the majority of care home workers have only limited access to highly structured and practical courses on training and in diabetes education.

- There is little knowledge across the health and social care sectors about the importance and principles of nutritional care in residents with diabetes. In view of the high prevalence of frailty, sarcopaenia, comorbidities and malnutrition, a shift is required from the standard healthy eating/weight loss approach to a more individualised nutritional plan.

- The recent covid-19 outbreak placed care homes at the epicentre of the pandemic and revealed significant shortfalls in care in how acute illness was managed and how care homes and key stakeholders communicated with each to optimise care.

- The covid-19 epidemic has stimulated the growth of digital health technology in communication between stakeholders and care homes. This momentum must be maintained to promote these developments particularly in relation to shared care records, data storage and safety, and the development of personalised care plans, which up to now are limited and not necessarily diabetes-focused.

- Whilst there is widespread recognition that care within these settings should be personalised and individualised, the application of this is only translated to a limited extent in planning and managing diabetes-specific care such as glucose-lowering medication review including deintensification, agreeing glycaemic and other metabolic targets, and hypoglycaemia and hospital avoidance strategies.

- Observationally, the rate of hypoglycaemia in care homes is high and its management is generally suboptimal and reveals evidence of a lack of awareness by care staff (in both nursing and non-nursing settings) of what defines hypoglycaemia, how to treat the

associated clinical sequelae, and when to ask for help or call an ambulance/999 for urgent treatment.

- There is a lack of an agreed structured national policy for managing diabetes-related foot disease or eye disease in care homes which is likely to lead to delays in preventative care, detection, and direct management all of which contribute to poor clinical outcomes for residents with diabetes.

- There is a profound need to learn about the prevalence and nature of type 1 diabetes in care home settings and how this condition can be managed optimally by an appropriately trained workforce supported by community diabetes services, other specialists and stakeholders.

- Closer working (integrated) between the NHS and Adult Social Services, local authorities and the CQC, including care providers and stakeholder groups will be a key factor in bringing about a culture change in the enhancement of the quality of diabetes care within care homes.

- An important message arising from this NAPCHD review is that all care homes should strive to have an agreed and workable Operational Policy for diabetes care which is regularly reviewed, identifies key roles of care staff, and outlines their relevant training and educational needs.

- There is an urgent need to disseminate recently created end of life diabetes care guidances throughout the networks of care home providers in order to foster collaborative work with palliative care specialists, hospices and other relevant agencies.

- There is an urgent need for more collaborative research in care homes involving all stakeholders by having larger RCTs of interventions, observational studies, and large database studies or use of registries: areas requiring study include glycaemic targeting for residents with different characteristics, influence of frailty, type 1 diabetes, dementia care, managing learning disabilities, and avoiding hospitalisation.

- Apart from local authorities (via DHSC) and the NHS, care homes have few other additional funding streams for undertaking activities such as audits, training and education courses for staff, and 'buy-ins' for exercise classes for residents – the new arrangements for ICSs and the EHCH initiative should provide opportunities for new funding to become available.

Primary recommendations

Task 1: (a) Philosophical Framework for the Project (b) Principles of Good Diabetes Care – the role of Community Diabetology

(1a). (1) The NAPCHD *Philosophical Framework* should be adopted in line with current developments in the care home sector and as a living and evolving document. (2) The framework can be used to plan new developments on clinical care protocols, preventative strategies, audit projects and participation of care homes and their residents in research.

(1b). We should aim to develop service specifications for delivering community-based diabetes care with an emphasis on care home provision and this should be considered as part of a multi-professional process promoted by stakeholders. This specification should address comprehensively the NICE Quality Standard on Diabetes Care and be suitable for inclusion into contracts with local authorities and ICS's in relation to diabetes care.

(1b) That a representative writing group of stakeholders should consider preparing a statement on how acute hospital-based admissions of residents living with diabetes can be minimised and what criteria should trigger hospital admission when it is required. These criteria will include: residents who are at imminent risk may be developing diabetic ketoacidosis or hyperosmolar hyperglycaemia

state, repeated moderate to severe hypoglycaemia, development of a new diabetes-related foot ulcer, and other acute illness states where existing resources are not sufficient to provide continuing care – please see Appendix A.

Task 2: (A) Ethics and equity of care, access to services, and related ethnicity; (B): Principles of (a) Shared Decision-making (b) Mental Health and Wellbeing, and (c) Emotional and Spiritual Wellbeing

Task 2 (A): Ethics and equity of care, access to services, and related ethnicity

ICS's with support via the EHCH Framework to promote greater partnership working between care homes and adult social care services, and primary care and specialist services; this could only benefit and improve the delivery of high-quality diabetes management and care in care homes. This framework allows more input from primary care and community services to deliver care in care homes.

Development of training for care staff related to specific areas of diabetes care that have both cultural and ethnicity-related considerations supported by new workforce initiatives (via local authorities/DHSC), ICS's, and possibly Patient Safety Collaboratives (via AHS networks).

A resident's diabetes care plan should consider cultural sensitivity and have lower thresholds for intervention where necessary.

Local authorities (via DHSC) should ensure that as many resources as possible are available to match the cultural diversity of the population it serves.

Each care home to have ready access to both standard community-based services and specialist services with each service employing the technology that combines medical records between different stakeholders and facilitate ready access through agreed sharing to these where appropriate.

Task 2 (B): Principles of (a) Shared Decision-making (b) Mental Health and Wellbeing (c) Emotional and Spiritual Wellbeing

2(a) To examine the possibility of organising a 2023 National Diabetes Care Home Audit of diabetes care in care homes followed by further audits every 5 years which is supported and promoted by stakeholders, with funding via the DHSC, the ICS arrangements, and Patient Safety Collaboratives (via AHS networks).

2(a) To support developments that advance the topic of shared-decision making and others within the *Strategic Document of Diabetes Care*.

(2b) To promote a National Survey of Care Homes which addresses varied topics such training and education of staff, mental health & well-being.

Task 3: Training and Education of Care Staff and related competencies

To develop a set of national training standards and competencies for varying levels or grades of staff (as indicated above) that will require collaborative working between the stakeholders. This could be led by the NAPCHD stakeholders or a newly created group. Funding could be via the DHSC (via workforce development initiatives) in collaboration with local ICS's with liaison with the EHCH work stream.

With appropriate funding being available from adult social services and the ICSs, to establish a Care Home Training & Education Group in each Region which will be responsible for inspecting and/or delivering, diabetes training and education to care homes within that Region.

Stakeholders to collaborate to influence local authorities, Patient Safety Collaboratives (part of AHS networks) the EHCH initiative to identify new funding for these regional groups which may need to be preceded by a business case.

Task 4: (a) Acute illness care including (b) Infection management of Covid-19 (c) clinical biochemistry and haematology services

4(a)

There is a need to identify funding for the provision of mandatory diabetes educational and training sessions for care home staff on a regular basis nationally. This can be approached by stakeholder discussion with local authorities and adult social care services, ICSs, and Patient Safety Support Groups (via AHS networks.

An A4 laminated sheet describing all the **alerts** should be made available to all care homes. Examples include: red foot, drowsy patient with high glucose, altered behaviour with low glucose, safe glucose targets and triggers for action – see Appendix A. These can be summarised for attention in a resident's care plan.

An implementable and written policy on hypoglycaemia management coupled with a hypoglycaemia box available in key areas which is checked by care home staff daily.

All care homes should have a link telephone number to access diabetes specific advice at least at all working hours of the week.

4(b)
A mandatory funded training programme accessible by each care home to have staff trained in blood glucose testing, ketone testing, and other clinical biochemistry and haematology sampling. This can be supplemented by training in newer systems such as flash glucose monitoring (FGM).

The NADCHD stakeholder initiative to develop a suitable audit tool to test the regular compliance of care homes with good clinical practice and related standards for clinical biochemistry and haematology – see Appendix A.

There is a need to promote further pilots of POCT in care homes and the value of 'Virtual ward' initiatives which could be linked to local community diagnostic hubs.

Task 5: Systems enhancement and use of technology including data collection, storage and safe sharing, resident's plans and case records

NAPCHD stakeholders to support the NHSX-directed digitisation of health and social care to improve the quality of diabetes care delivered in care homes via local authorities (via the DHCS budget), ICS's, the EHCH and Ageing well initiatives.
To support NHSX via the EHCH and Ageing Well processes with DHSC support (via the Adult Social Care reform white paper) to develop a national learning strategy for care staff in the area of digital health and technology.

To move towards developing an initiative to create a national care home diabetes MDS with both clinical and social care elements which can ensure provision of personalised diabetes care along with support for other actions in the area of shared care records, multidisciplinary audits, and the digitisation of community diabetes services.

Task 6: Individualised glucose-lowering approaches: non-insulin glucose-lowering therapies; insulin therapy; safe glycaemic targets and monitoring

The choice of a glucose-lowering agent should at all times be individualised and based on patient preference, comorbidity and frailty profile, presence of risk factors for hypoglycaemia such as poor nutrition or renal impairment, risk-benefit analysis for treatment, and whether or not the resident is in an end of life situation.

The responsible clinician to undertake a regular functional status, comorbidity and medication review (minimum every 6 months) to ensure that current glucose-lowering treatment has not substantially increased the risk of hypoglycaemia, that there has been no significant deterioration in glycaemic control (please see Table 1 below), and that the health status of the resident is stable.

Each care home should be issued with copies of the proposed glycaemic and monitoring recommendations and given instructions when to seek additional support from the GP or community nursing and diabetes teams. This will include any residents who have had a substantial change in their health status where targets and therapies may not be appropriate at that time, when there are repeated episodes of mild hypoglycaemia or one episode of serious hypoglycaemia requiring ambulance or medical professional call out, when glucose levels are consistently out of target ranges, or the nutritional status of a resident has changed to a degree that causes care staff concern.

Task 7: (a)Hypoglycaemia, (b)Foot Disease, (c)Eye Services, and (d)Hospital Admission Avoidance

7 (a): Hypoglycaemia

Funding to support mandatory training of care staff in basic diabetes care that includes hypoglycaemia management and glucometer training. This will require discussion and liaison with local authority adult social services (via the DHCS) and the ICSs framework. In addition, Patient Safety Support Groups via the AHS network may offer an additional source of funding for this recommendation.

Reinforce the NAPCHD guidance for care homes to promote the availability of a fully functional 'hypo box' within each care home.

Every care home to have guidance or a separate policy on hypoglycaemia management.

7 (b): Foot Disease

To develop a national training & education programme (both online and face to face) for care staff in the areas of diabetes foot care prevention and treatment. Funding would need to be pursued with local authority adult social services as part of workforce development, and as part of future interactions with ICSs. Patient Safety Support Groups (via the AHS network) may also be able to assist in creating a new funding stream for this recommendation.

Each care home to undertake (a) regular reviews with local diabetes teams of cases where a resident living with diabetes-related foot ulceration is admitted into hospital; (b) audits of diabetes foot care within their care home; (c) developing a diabetes foot care policy. This would require each care home to identify these activities as part of an operational policy for diabetes care with extra funding being sought from local authority adult social services, ICSs and potentially Patient Safety Support Groups (via the AHS network.

7 (c): Eye Services

Each district to have (a) a domiciliary optometry services to care homes and appropriate facilities in place in each care homes for an optometrist to perform an assessment of eye health; (b) a locally-negotiated and funded contract in place to underpin an ICS-led (district-wide) eye service to care homes.

Consideration of a national programme of training and education of care home staff possibly led by one or more NAPCHD stakeholders about the importance of detecting low vision and the major eye problems encountered by residents with diabetes eye problems. Funding to be sought from relevant adult social services budget in discussion with ICSs and Patient Safety Support Groups (via AHS networks).

7 (d): Hospital Admission Avoidance

To agree a ICS-led (district-wide) policy to improve inter-relationships (by enhanced technology (dedicated phone lines or daily monitored e-mail inboxes) between hospital staff, primary care, community matrons, community diabetes teams and care home staff to bring about a more consistent, more collaborative, and strategic approach to preventing and reducing unnecessary hospital admissions of residents with diabetes.

All care homes to establish and adopt in liaison and discussion with stakeholders, a unified approach to regularly reviewing 'at-risk' patients to prevent hospital admission.

All care homes to access an education and training programme for care home staff in the area of hospital admission avoidance with protected time and mandatory training and to obtain support from all relevant stakeholders to negotiate a contract with local authorities and the local ICS for funding this learning.

Task 8: Type 1 diabetes in care homes

One or more NAPCHD stakeholders to consider developing care standards for type 1 diabetes in care homes which should set the minimum standards necessary for a care home to be able to safely accommodate a resident with type 1 diabetes within an individualised care model approach.

To develop a local implementation plan, setting out a care pathway from pre-transition to admission and ongoing care, including referral pathways. This will involve identifying key roles of staff within an integrated working model of care, and setting core care parameters and targets focussing on risk minimisation.

Consider the development of a special interest group in each district with multiple stakeholder representation to have oversight of the process and monitor performance in care delivery which may involve appointing clinical champions, undertaking audit activities, and reviewing complex cases. Funding to be sought from local authority adult social services and the relevant ICS.

Develop an effective model for supporting and educating care homes' staff in managing residents with type 1 diabetes which involve skills training, and appointing 1-2 care staff as local care home champions. This may be part of a wider initiative to provide mandatory training and education for care staff in diabetes care funded via representation to local adult social services (via DHSC budget) and the relevant ICS.

Task 9: Liaison and communication activities of care homes with particular reference to Adult Social Services (ASS)

To recommend that Adult Social Services assessors/practitioners contracts officers allocated to care homes undertake appropriate diabetes training and be aware of NAPCHD guidance on diabetes care and thus acquire the knowledge needed to confidently act in placing a person with diabetes.

To recommend that pre-placement assessment forms that are undertaken include diabetes as a specific section with 3-4 key areas of enquiry including treatment-related issues such as hypoglycaemia, presence of frailty and/or chronic renal disease, malnutrition or history of diabetes foot disease.

To recommend that GPs, other community nursing (including diabetes specialist nurses) and allied professions, and care homes create a local care home diabetes interest group (supported by Adult Social Services and the relevant ICS) to improve care delivery to care homes as a way for preparing to participate fully in the Ageing Well and EHCH programmes.

Task 10: The Elements of an Operational Policy for Care Homes

As part of ICS roll-out across the country, and the Ageing Well (including EHCH) framework initiatives, diabetes care in care homes should be part of a broad strategy development agenda. and represented by one or more stakeholders on a district/regional Residential Care Home Board.

One or more NAPCHD stakeholders to consider liaising and collaborating with the CQC to undertake focussed inspections on diabetes management in care homes and consider creating a national action plan in this area. Potential funding via local authorities, ICS's and Patient Safety Collaboratives (via the AHS networks).

All care homes to consider locally adopting the 2010 Diabetes UK national guidance on operational policy development in line with the recommendations in this *Strategic Document*.

Task 11: End of Life Care including advance care planning

A stakeholder initiative that enforces the need among all stakeholders including care homes, community health and adult social services, and diabetes specialist teams, to ensure that there is a consistent approach to maintaining quality of care delivery of diabetes EOLC in care homes using the updated guidance by Trend Diabetes released in November 2021.

The development of a negotiated contract with local authorities and the local ICS supported by a AHS network if available, with promotion by NAPCHD stakeholders to include diabetes EOLC (including training and education of care staff) in any service specification for diabetes care.

Conclusions

- There is an important need to develop better local and regional coordination and communication between all key stakeholders involved in providing diabetes specialist care (e.g. hospital specialist teams, community diabetes teams), and care homes.
- There is a clear need for an organized and structured training and educational programme in diabetes for care staff (and healthcare staff generally) which would raise the quality of care provided and upskill the workforce.
- All new developments in advancing and planning diabetes care practices in care homes should attempt to meet the key requirements of the *NAPCHD Philosophical Framework* in order to provide a high standard for clinical care protocols, preventative strategies, audit projects, and research participation.
- There is a need to produce a considered individualised and personalised care plan for each resident with diabetes to minimise risks and enhance their quality of life and well-being.
- We recognise the importance and added value of good communication channels and enhanced liaison between stakeholders in managing both acute illness and overall diabetes care in residents with diabetes brought about by the emergence of a new technology platform.
- The development of the Integrated Care Systems (linked via the Primary Care Networks), the Enhanced Health in Care Homes programme and the Ageing Well initiative provide high level opportunities at a national level to include provision for new diabetes care strategies in care homes. At a local level, this integrated collaboration would have the potential for enhanced diabetes care being available to care homes. *See Figure 1 below.*
- The need for more focused and well-designed clinical and social care interventional research involving care homes is an urgent priority. The NAPCHD and other stakeholders should support this area to be part of research priority streams of major funders such as the NIHR and major Pharma.

The NAPCHD has also identified six specific areas of recommendation or change which in our view can be actioned relatively quickly and without significant funding being required to bring about implementation – 'quick win' scenarios. These are:

- **Distribution of Care Home Diabetes Packs to all care homes in 2022**

  Each care home should be issued with:
  Pack 1**:** copies of the NAPCHD emergency 'alerts' laminates (1 a-c) and Appendices A (Clinical and Management Resources of Information) and B (Assessments and Schedules) within a single package
  Pack 2: copy of the Diabetes UK 2010 Care Home guidance, and the NAPCHD Executive Summary within a single package

- **That a representative writing group of stakeholders should consider preparing a statement on how acute hospital-based admissions of residents living with diabetes can be minimised (and avoided) and what criteria should trigger hospital admission when it is required.**

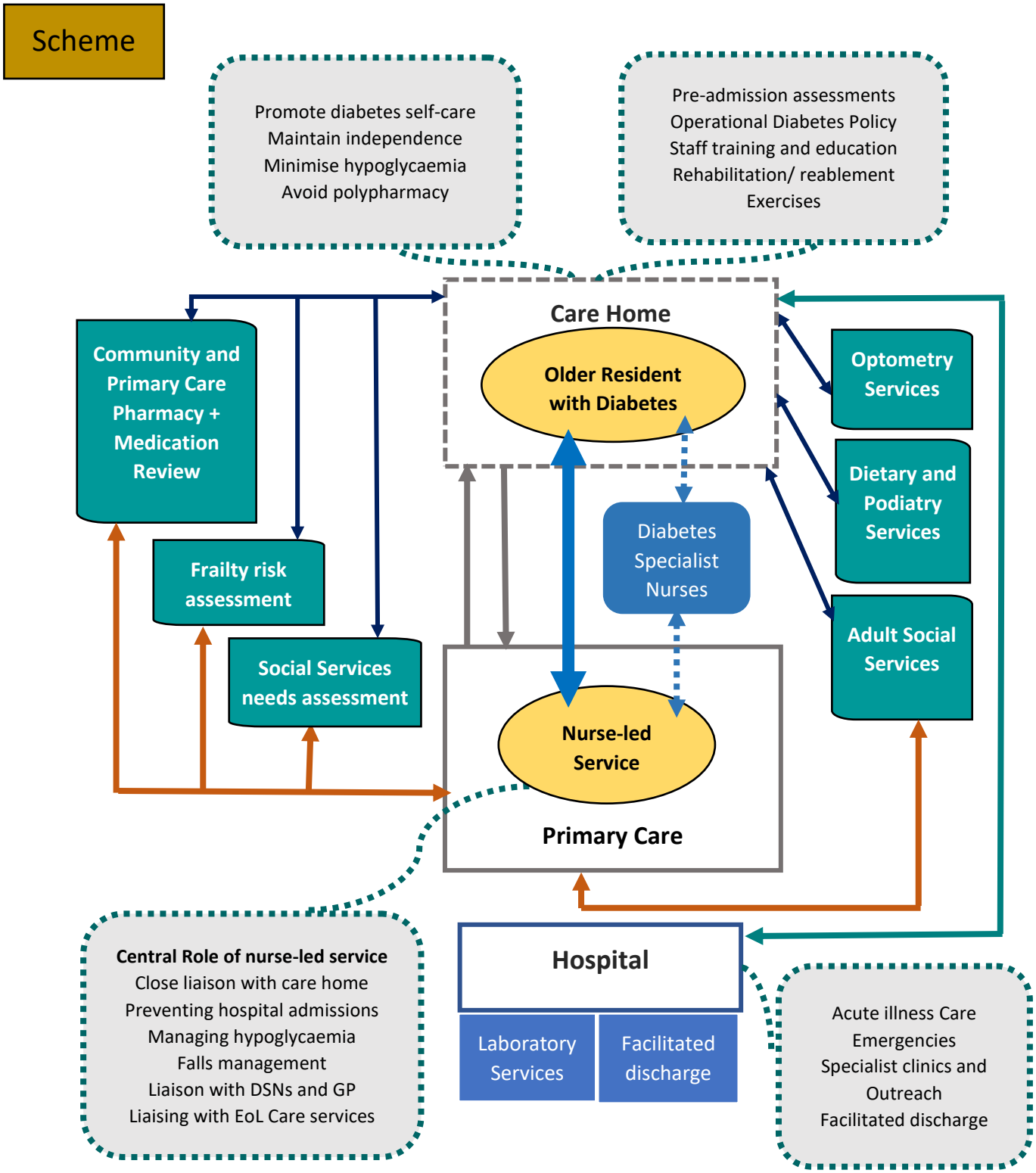
- **Create a sample diabetes-related pre-placement assessment form to be incorporated into existing templates on local authority and care provider systems.**

- **Ensuring that all UK care homes receive a 1-2 page summary of the updated Trend Diabetes 2021 guidance which summarises all the key actions required in managing EoL care for residents with diabetes.**

- **Establish a 'Training and Education Pilot' using the NAPCHD proposals for care staff within a group of care homes by agreement with owners and managers.**

- **The NAPCHD, working in close liaison with Electronic Care Record companies, will seek to cooperate to produce a 'template' design for a minimum data set of key diabetes indicators for inclusion into their current generic records that many care homes are using. We can also explore the involvement of new digital platforms such as the QUIC (Quality in Care) application which can aid performance against guidelines monitoring, and quality benchmarking.**

Figure 1: A Community-based Integrated Care Model for Care Home Residents with Diabetes



Essential Factors
Personalised Care Plan
Structured education and training for care staff
Responsive and accessible integrated primary and community care
Facilitated discharge from hospital
Structured medication review
Coordinated care and information sharing using digital network
Responsive and flexible commissioning of services
Adult Social Services needs assessment and critical events risk assessment
Care Home diabetes policy
Access to specialised services including laboratory services

Key Stakeholders
Older resident with Diabetes Mellitus
Family and carers
Community Services: End of life care, optometry; foot care; pharmacy; dietitian
EHCH initiative
Primary Care, practice and PCN pharmacists, practice nurses
Care Home Manager and Care Workforce
Hospital-based Diabetes Specialist and Geriatrician
Adult Social Care and local authorities
Integrated Care Systems (ICSs)
Community/ District Specialist Diabetes Nurses

Abbreviations

ABCD	Association of British Clinical Diabetologists
AHS	Academic Health Science
ASS	Adult Social Services
BAME	Black, Asian and Minority Ethnic
BDA	British Dietetic Association
BGM	Blood Glucose Monitoring
CCG	Clinical Commissioning Group
CH	Care Home
CN	Clinical Network
CQC	Care Quality Commission
DHSC	Department of Health and Social Care
DISNUK	Diabetes Inpatient Specialist Nurses UK
DoH	Department of Health
DSN	Diabetes Specialist Nurse
EHCH	Enhanced Health in Care Homes
EOLC	End of Life Care
*f*DROP	Foundation for Diabetes Research in Older People
GI	Gastro-intestinal
GP	General Practitioner
HbA1c	Glycated haemoglobin
HCA	Health Care Assistant
HCP	Health Care Professional
ICS	Integrated Care System
IDOP	Institute of Diabetes for Older People
JBDS-IP	Joint British Diabetes Societies for Inpatient Care
MDS	Minimum Data Set
MHRA	Medicines and Healthcare products Regulatory Agency
NAPCHD	National Advisory Panel on Care Home Diabetes
NICE	The National Institute for Health and Care Excellence
OPDN	Older Peoples Diabetes Network
PCN	Primary Care Network
PCR	Polymerase Chain Reaction
PLWD	Person Living with Diabetes
POCT	Point of Care Testing
QNI	Queen's Nursing Institute
RCGP	Royal College of General Practitioners
RCT	Randomised Controlled Trial