

Developing new models of care

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Objectives

- New methods of delivering care to improve the patient experience
- Lessons learned over the last 2 years

Case studies

- Leicester
- Affinity Care (Bradford)

Disclosures

I have received an honorarium for presenting at this meeting

- The Westcliffe Partnership has received funding from: Abbott, AstraZeneca, Bayer, Boehringer-Ingelheim, Bristol Myers Squibb, Dawn, INRStar, Medtronic, Oberoi Consulting, Pfizer, Roche, Sanofi-Aventis, Servier
- Advisory roles: Abbott, AstraZeneca, Eli Lilly, Novo Nordisk, NAPP Pharmaceuticals Ltd, MSD and Roche
- Speaker fees: AstraZeneca, Boehringer-Ingelheim, Eli Lilly, Merck and MSD, Novo Nordisk, NAPP and Sanofi
- Consultancy: Abbott, AstraZeneca, Eli Lilly, Boehringer-Ingelheim, European Medtec, Merck and MSD, NAPP and Novo Nordisk
- I have also worked in a non-promotional capacity to support GP / PN education : Pulse, MIMS, medical updates, DPC, PCDS, Y&H Clinical Networks and PCDE
- Tutor: Primary Care Training Centre



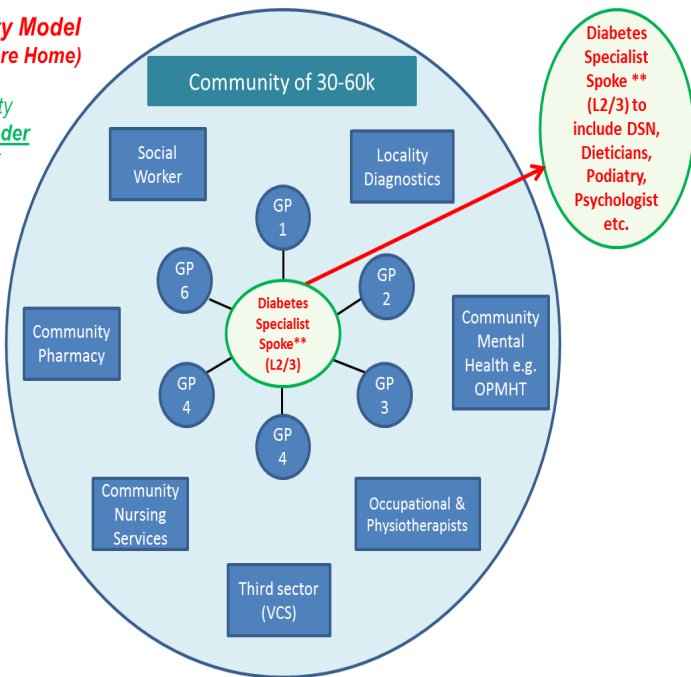
Prior to the pandemic the NHS was making good progress on care processes in England (T1D : 34% in 2016/7, rising to 42% in 2019/20; T2D : 48% in 2016/17, rising to 58% in 2019/20)

- 33% of people with T1D received the 8 care processes during the 2021/22 audit period, an increase of 22% compared to 2020/21
- 48% of people with T2D/other diabetes received all eight care processes during 2021/22, an increase of 30% compared to 2020/21
- We still have further to go to get back to pre-pandemic (still 21% lower on T1D and 17% lower on T2D than 2019/20)

Our Journey.....

Community Model (Primary Care Home)

**Community
Diabetes Leader
required**



Diabetes
Specialist
Spoke **
(L2/3) to
include DSN,
Dieticians,
Podiatry,
Psychologist
etc.

Locality Model



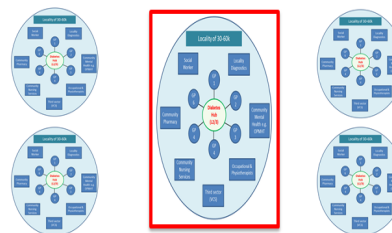
- **Locality Model of 130,000 – 180,000 population**

- **Split as North, Central & South**

- **Diabetes Specialist Hub**

- **Locality Diabetes Champion****

COMMUNITY SPECIALIST DIABETES SERVICE (CSDS)



New models of care & Triple Aim



Integrate disease management programs with ongoing primary care



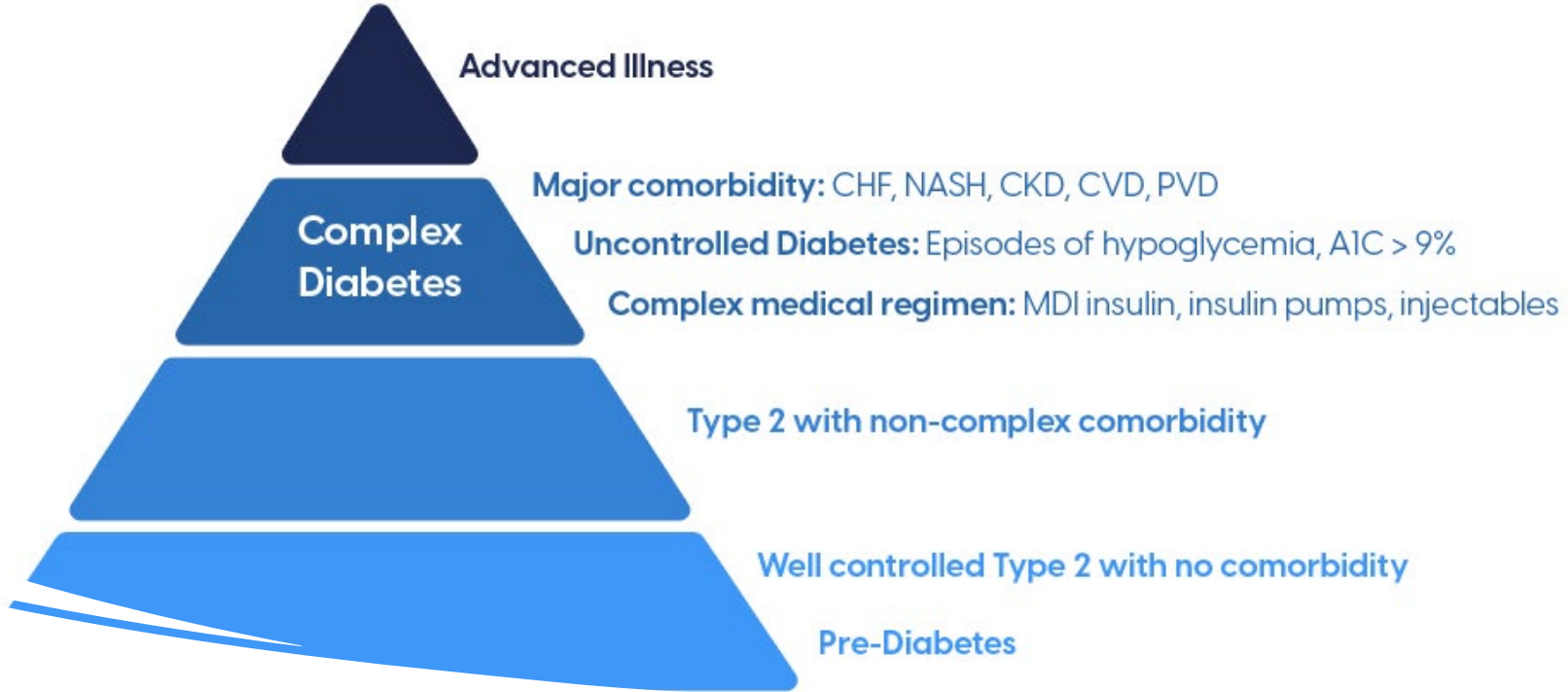
Utilize clinical support staff



Leverage technology



Enable pharmacists to make medication adjustments



Risk Stratification

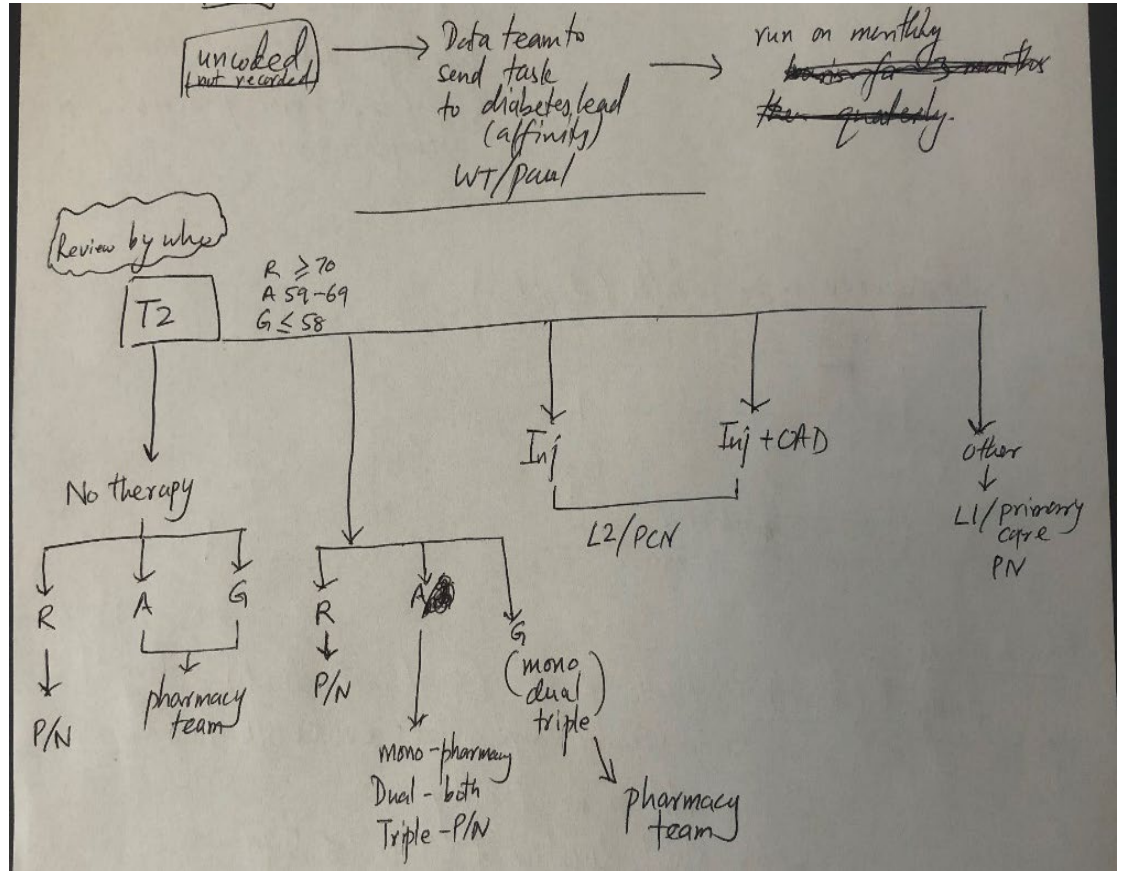
- People with ≥ 1 chronic health condition that can be improved or kept under control
- People who had suffered a one-time catastrophic health problem
- People with severe chronic conditions who cant be returned to good health and require expensive, continuous treatment

T2D risk stratification

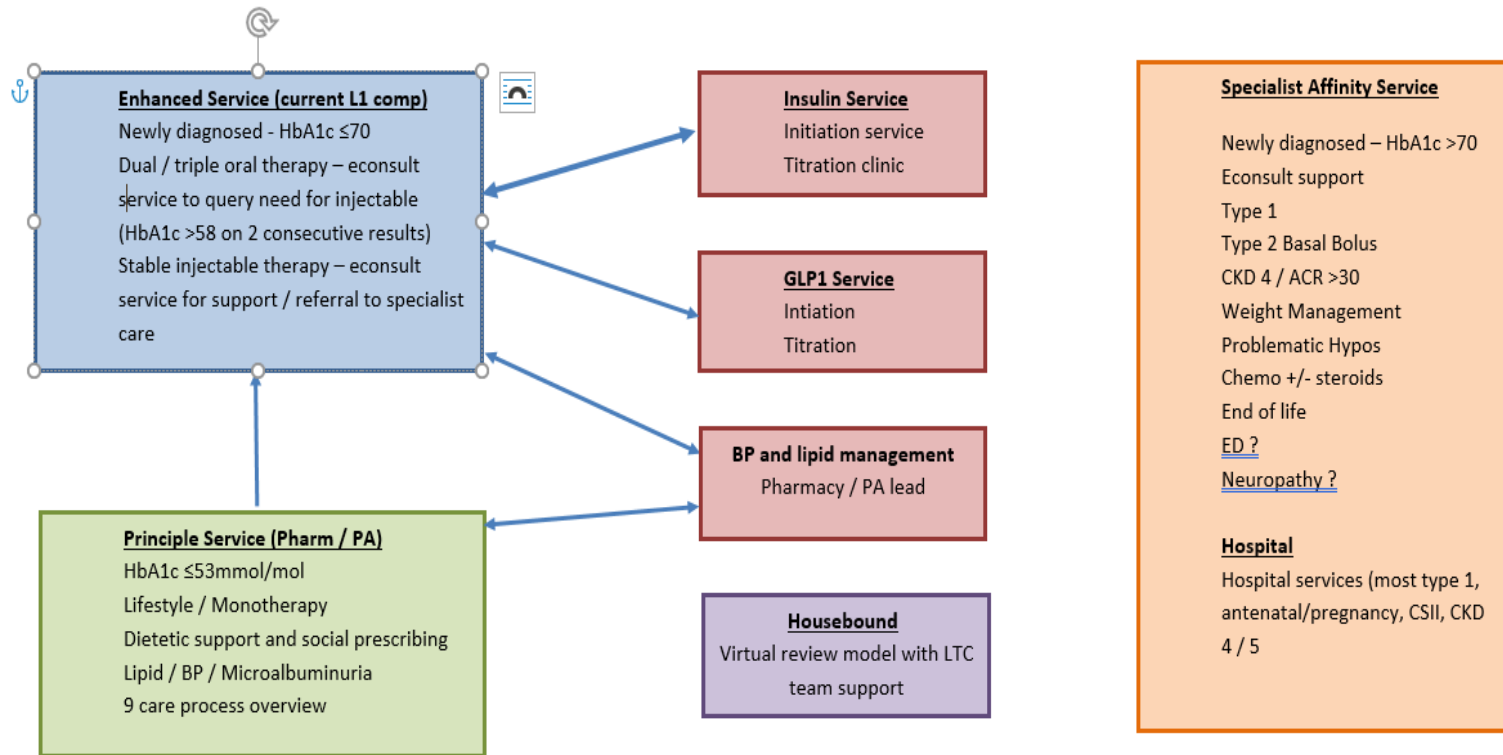
Data included up to 23 Jun 21

Name	Count	%	Last Run	Flags
10 TYPE 2 DIABETIC PATIENTS ON OTHER THERAPY COMBINATIONS	20	0.2 %	24 Jun 2022 14:26	
3 DIABETIC PATIENTS RECEIVING NO THERAPY	157	1.7 %	24 Jun 2022 14:26	
3.1 Hba1c <=58mmol	140	1.5 %	24 Jun 2022 14:26	
3.2 Hba1c 59-69 mmol	12	0.1 %	24 Jun 2022 14:26	
3.3 Hba1c >=70mmol	5	0.1 %	24 Jun 2022 14:26	
3.4 Hba1c IFCC not recorded	0	0.0 %	24 Jun 2022 14:26	
5 TYPE 2 DIABETICS	524	5.6 %	24 Jun 2022 14:26	
5.1 Hba1c <=58mmol	322	3.5 %	24 Jun 2022 14:26	
5.2 Hba1c 59-69 mmol	90	1.0 %	24 Jun 2022 14:26	
5.3 Hba1c >=70mmol	109	1.2 %	24 Jun 2022 14:26	
9 TYPE 2 DIABETIC PATIENTS ON OADS ONLY	286	3.1 %	24 Jun 2022 14:26	
9.1 Hba1c <=58mmol	161	1.7 %	24 Jun 2022 14:26	
9.1.1 Metformin or Sulphonyurea or SGLT2 (Mono Therapy)	85	0.9 %	24 Jun 2022 14:26	
9.1.2 Metformin or Sulphonyurea or SGLT2 combination of (Dual Therapy)	23	0.2 %	24 Jun 2022 14:26	
9.1.3 Metformin & Sulphonyurea & SGLT2 (Triple Therapy)	2	0.0 %	24 Jun 2022 14:26	
9.1.4 DPP-4 therapy	51	0.5 %	24 Jun 2022 14:26	
9.2 Hba1c 59-69 mmol	64	0.7 %	24 Jun 2022 14:26	
9.2.1 Metformin or Sulphonyurea or SGLT2 (Mono Therapy)	18	0.2 %	24 Jun 2022 14:26	
9.2.2 Metformin or Sulphonyurea or SGLT2 combination of (Dual Therapy)	11	0.1 %	24 Jun 2022 14:26	
All y reports	439	4.7 %	24 Jun 2022 14:26	
DM Any injectable therapy including GLP-1	121	1.3 %	24 Jun 2022 14:26	
DM Any OAD therapy	403	4.3 %	24 Jun 2022 14:26	
DM Therapy (ALL)	461	4.9 %	24 Jun 2022 14:26	
DM Therapy DPP-4	130	1.4 %	24 Jun 2022 14:26	
DM Therapy DPP4 (All inc. combi)	131	1.4 %	24 Jun 2022 14:26	
DM Therapy DPP4 and Metformin COMBI	1	0.0 %	24 Jun 2022 14:26	
DM Therapy DPP4 and Thia COMBI	0	0.0 %	24 Jun 2022 14:26	
DM Therapy GLP-1	6	0.1 %	24 Jun 2022 14:26	
DM Therapy Insulin and GLP-1 COMBI	0	0.0 %	24 Jun 2022 14:26	
DM Therapy Intermediate acting Insulins	19	0.2 %	24 Jun 2022 14:26	
DM Therapy long actin Insulins	56	0.6 %	24 Jun 2022 14:26	
DM Therapy Meglitinides	0	0.0 %	24 Jun 2022 14:26	
DM Therapy Metformin	324	3.5 %	24 Jun 2022 14:26	
DM Therapy Metformin and SGLT2 COMBI	0	0.0 %	24 Jun 2022 14:26	
DM Therapy Metformin and Thia COMBI	0	0.0 %	24 Jun 2022 14:26	
DM Therapy other inc. Acarbose	2	0.0 %	24 Jun 2022 14:26	
DM Therapy Pre-Mixed Insulins	32	0.3 %	24 Jun 2022 14:26	
DM Therapy SARA Insulins	50	0.5 %	24 Jun 2022 14:26	
DM Therapy SGLT2	103	1.1 %	24 Jun 2022 14:26	
DM Therapy Short/RA, Long acting/Int acting or premixed insulin	119	1.3 %	24 Jun 2022 14:26	
DM Therapy Sulph	106	1.1 %	24 Jun 2022 14:26	
DM Therapy Thia	23	0.2 %	24 Jun 2022 14:26	
Heart Failure	41	0.4 %	24 Jun 2022 14:26	

Risk Stratification → Workforce



Affinity Diabetes Care Model



Affinity PCN 'Diabetes Model'

Features

- PHM and Risk Stratification approach
- Focus on 'low risk' cohort
- S1 searches – easy to export
- Guidance on matching this cohort to the wider primary care workforce (pharmacist, PA and new diabetes PNs)
- 'high risk' cohorts / complex multi-morbidity → In-house specialist team (+/-MDT)
- Separate 'case finder' search and QIAs
- Monthly Diabetes team meetings
- Bespoke S1 module for PCN diabetes caseload (circa ~4200)
- Dedicated 'Diabetes admin' team
- Dedicated 'L2 helpline' (Insulin pts)
- Innovative 'automated' recall system

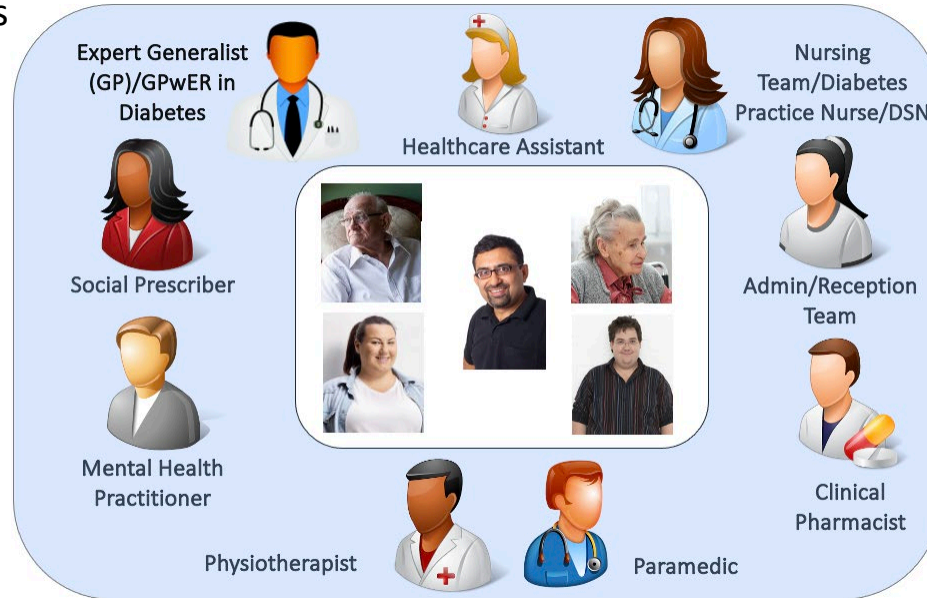
Team effort

Lead diabetes reviews
Patient engagement
Smoking cessation referrals
Weight management referrals

Clinic lead
Prioritisation
Recalls
HCA support

Virtual Clinic
Clinical reviews
Education
Data

Support with general
health and wellbeing



Care Coordination
QOF
Local searches
Recalls

Prescribing
audits/optimisation:
BP Clinic
Lipids optimisation

Outreach to support engagement

Events & On Demand
Diabetes & Primary Care
Learning Hubs
CPD resources

“How to...” series
“Need to know...”
“At a glance” fact sheets

Covid resource hub
Easy to do audits

Diabetes Distilled

PCDS Entry Level Module Series

This resource will explore and focus on 2 of 15 core processes recommended for PCDS to concentrate on. Recommended by NICE, core processes used in the Diabetes Audit and the

How to DIAGNOSE AND TREAT HYPERTENSION IN TYPE 2 DIABETES

by Jane Diggle, Specialist Diabetes Nurse Practitioner, West Yorkshire

Measuring blood pressure

- Measure BP at least annually in a person without previously diagnosed hypertension or renal disease.
- Use validated equipment.
- Select the correct cuff size (refer to table).
- Promote a relaxed and temperate environment.
- Measure BP in both arms.
- Check pulse rate and rhythm. Do not use electronic BP monitor in the presence of an irregular pulse.
- Measure BP in both arms. Repeat if difference between arms is >15 mmHg and, if difference remains >15 mmHg, use the arm with the higher reading for subsequent BP measurements.
- In people with hypertension and diabetes, measure standing as well as seated BP. If BP falls by ≥20 mmHg on standing, review medication, measure subsequent BP with person standing, and consider orthostatic hypotension.

What and why

- This document does not cover people with type 1 diabetes, children or women during pregnancy.

Upper arm

17–22 cm
23–32 cm
33–42 cm

The bladder of the cuff must meet the arm at the midline.

Diagnosing hyperten

Clinic BP ≥140/90 mmHg

Offer ambulatory BP monitoring (ABPM) to confirm diagnosis of hypertension. If unsuitable for ABPM, offer home BP monitoring (HBPM). Refer to Box A.

Box A

ABPM

- Use ABPM to confirm a diagnosis of hypertension.
- Ensure at least two measurements per hour are taken during waking hours (e.g. between 8 a.m. and 10 p.m.).
- Use the average value of at least 14 measurements.
- If ABPM is not tolerated, use HBPM.

HBPM

For information on how to monitor BP correctly at home and a diary sheet for recording measurements:

– The basics explain –
– Diary: 14 days/2 weeks

- For each BP reading two consecutive measurements are taken, at least 1 minute apart, and with the person at rest.
- BP is recorded twice in the morning and once in the evening, and if BP is recorded continue at least 4 days, ideally 7.
- Discard measurement if the person is unwell or has not rested for at least 5 minutes before the measurement.

Clinic BP from 140/90 mmHg to 159/99 mmHg, and subsequent ABPM daytime average or HBPM average from 135/85 mmHg to 149/94 mmHg

Clinic BP ≥160/100 mmHg but <180/120 mmHg, and subsequent ABPM daytime average or HBPM average ≥150/95 mmHg

Diagnose

Stage 1 hypertension
Stage 2 hypertension

Stage 1 and 2 hypertension

- Investigate for target organ damage (e.g. kidney damage, retinopathy, left ventricular hypertrophy).
- Complete all of the tasks listed in Box B.

Stage 3 hypertension

- Assess risk.
- Consider referral to specialist services without ABPM.
- Repeat clinical measurement.
- Refer for retinal haemorrhaging, heart failure, confusion (e.g. labile pulse), and other complications.

HOW TO DELIVER BEST PRACTICE IN DIABETES CARE ACROSS PRIMARY CARE NETWORKS

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: [https://www.nice.org.uk/guidance/ng116](#)

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 experience.

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/rural 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 meet 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 “silos” working to better enable collaborative, coordinated, effective and patient-centred care.

Proposed key stages for PCNs

- Formation of a **Diabetes Support Team (DiST)** within the PCNs to enable timely access to appropriate care.
- Ensuring healthcare professionals delivering diabetes care are appropriately **educated and upskilled in diabetes management**, which will be supported by the PCN DiST.
- Early referral and intensive treatment for people newly diagnosed with diabetes, including **attendance** at structured education.
- A focus on holistic care: proposed care processes to address the need for holistic management and to **address long-term disease burden**.
- 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 Treat 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 Treat
Complex cases unsuitable for tier 2; targeted clinics (e.g. technology, post-MI; frailty) not suited 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 DiST 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.

Q&A