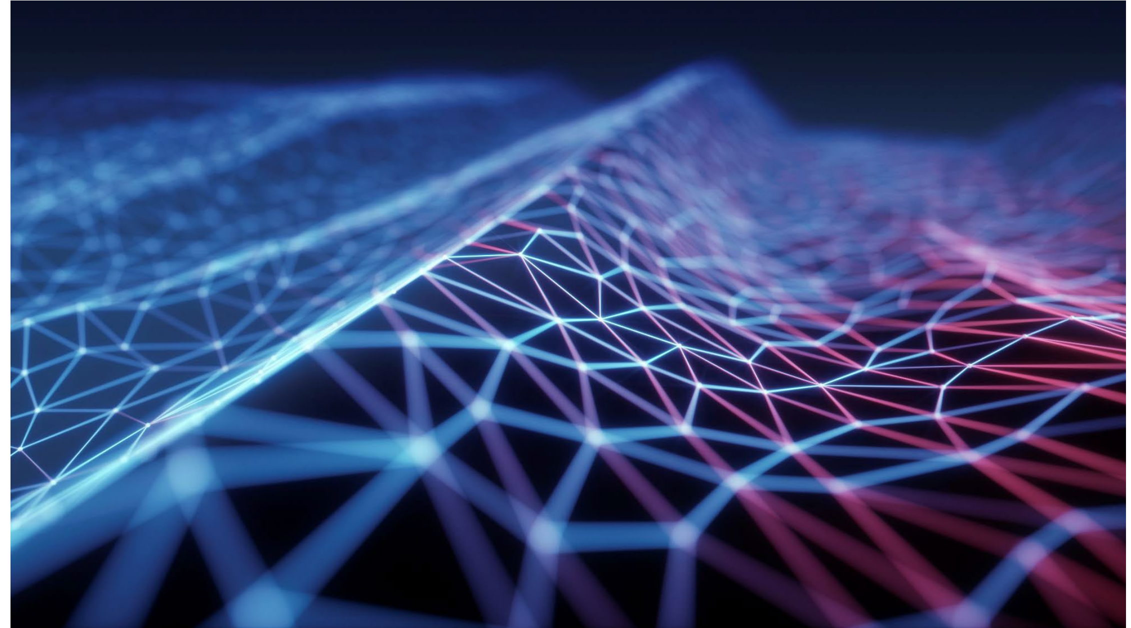

SCI DIABETES: MAKING IT WORK FOR PATIENTS

DR KASHIF ALI GP PRIMARY CARE LEAD DIABETES MCN

DASHBOARD

- APPROVED BY SCI-DIABETES AND SCOTTISH DIABETES GROUP
- ACCESS VIA SCI-DIABETES
- MEANINGFUL OUTCOME MEASURES (DIABETES IMPROVEMENT PLAN)
- COMPARISON ACROSS SCOTLAND / BOARDS / CLUSTERS / PRACTICES
- MEASURES ACCORDING TO RAG (RED, AMBER, GREEN) STATUS
- TREND DATA AND RUN RATE GRAPHS
- EASY TO AUDIT / CONDUCT SEARCHES / EXPORT LISTS
- COMING SOON- INTEGRATION VIA NEW GP SOFTWARE SYSTEMS

SCI-Diabetes - Dashboard

https://sci-diabetes1.mhs.scot.nhs.uk/sci-diabetes1/dashboard/ManageDashboard.aspx

SCI-Diabetes

Dashboard

Step 1: Select Dashboard: **Diabetes Care**

Step 2: Select Criteria - Data view: **Latest** Cohort: **Type 2 & Other 18+** Main domain: **S0070 - Greater Glasgow and Clyde - 49144 - DR I M MACDONALD & PTNRS** Comparator domain: **S0070 - Greater Glasgow and Clyde - S - Grey Cluster**

Step 3: View Selected Dashboard:

Dashboard	Data View	Patient Cohort	Region - Population	Compared with
Diabetes Care	Latest	Type 2 & Other 18+	49144 - DR I M MACDONALD & PTNRS as at 06-Feb-2021 19:05	S - Grey Cluster as at 06-Feb-2021 19:05
Change	Change	Change	516 patients	1811 patients

Pathways of Care		Measures of Care				Standards of Care		
Click on a measure below to view details		49144 - DR I M MACDONALD & PTNRS		S - Grey Cluster				
		Measure	Trend	Measure	Trend	Red	Amber	Green
1. Glycaemic Control								
1.1	HbA1c Recorded	86%		80.5%		< 75%	75-85%	> 85%
1.2	HbA1c < 58mmol/mol 1 year post diagnosis	62.5%		69.2%		< 70%	70-75%	> 75%
1.3	HbA1c < 58 mmol/mol	51.6%		50.8%		< 50%	50-55%	> 55%
1.4	HbA1c > 75 mmol/mol	18.9%		19.1%		> 25%	20-25%	< 20%
2. Cardiovascular Health								
2.1	BP Recorded	81.4%		72.1%		< 75%	75-85%	> 85%
2.2	BP <= 130/80mmHg	35.7%		34.4%		< 60%	60-75%	> 75%
2.3	Cholesterol Measured	68%		65.7%		< 75%	75-85%	> 85%
2.4	Statin use in > 50	70.4%		74.1%		< 60%	60-75%	> 75%
3. Kidney Health								
3.1	Albuminuria Screened	33.7%		41.7%		< 75%	75-85%	> 85%
3.2	eGFR Measured	89.3%		83.8%		< 75%	75-85%	> 85%
3.3	Albuminuria on AT2 Inhibitors	70.8%		76.1%		< 60%	60-75%	> 75%
3.4	Albuminuria and SBP > 130mmHg	65.5%		61.9%		> 40%	30-40%	< 30%
3.5	Albuminuria and HbA1c > 75mmol/mol	32.1%		24.5%		> 40%	30-40%	< 30%

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Dr MacDonald & ... | SCI-Diabetes - Da... | DOCMAN - Main ... | Document1 - Mic... | 18:18 10/02/2021

DASHBOARD: COMPARE YOUR PRACTICE TO YOUR CLUSTER DATA

SCI-Diabetes - Dashboard

https://sci-diabetes1.mhs.scot.nhs.uk/sci-diabetes1/dashboard/ManageDashboard.aspx

SCI-Diabetes

Dashboard

Funnel Plot to Identify Outliers

Pathways of Care: 1 Glycaemic Control

Measure: 1.3 HbA1c < 58 mmol/mol

Red	Amber	Green
< 50%	50-55%	> 55%

Domains	Q1/20 as at 04-Apr-2020 21:18	Q2/20 as at 04-Jul-2020 21:37	Q3/20 as at 04-Oct-2020 02:40	Q4/20 as at 02-Jan-2021 18:15
49200 - DR M J LEONARD & PARTNERS	66%	66%	66%	61.1%
49553 - DR A A FITCHETT & PTNRS	54.9%	53.8%	55.6%	53.5%
52151 - WAVERLEY PARK MEDICAL PTC	53.8%	52.3%	54.2%	52.5%
52429 - POLLOKSHAWS MEDICAL CTRE	53.4%	56.5%	55.9%	51.9%
S - Grey Cluster	52.1%	52.8%	53.4%	51%
49144 - DR I M MACDONALD & PTNRS	50.1%	49.9%	51.4%	51.7%
49712 - THE PARK SURGERY	48.4%	53%	54.7%	53.7%

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COMPARE WITH YOUR CLUSTER PRACTICES

SCI-Diabetes - Dashboard

https://sci-diabetes1.mhs.scot.nhs.uk/sci-diabetes1/dashboard/ManageDashboard.aspx

SCI-Diabetes

Dashboard

Step 1: Select Dashboard: **Diabetes Care**

Step 2: Select Criteria - Data view: **Latest** Cohort: **Type 2 & Other 18+** Main domain: **S0070 - Greater Glasgow and Clyde - 49144 - DR I M MACDONALD & PTNRS** Comparator domain: **S0000 - Scotland**

Data view: Latest

Patient cohort: Type 2 & Other 18+

Main domain:	View mapping of GP Cluster to GP Practice. GP Cluster id	**Comparator domain:**	View mapping of GP Cluster to GP Practice. GP Cluster id
Select from your populations:		Select from your populations:	
Region:	S0070 - Greater Glasgow and Clyde	Region:	S0070 - Greater Glasgow and Clyde
Type of population:	GP Practice	Type of population:	GP Cluster
Name of population:	49144 - DR I M MACDONALD & PTNRS	Name of population:	S - Grey Cluster

Set As Default Display Dashboard Reset

Domain Demographic Comparison

Step 3: View Selected Dashboard:

Dashboard	Data View	Patient Cohort	Region - Population	Compared with
Diabetes Care	Latest	Type 2 & Other 18+	49144 - DR I M MACDONALD & PTNRS as at 06-Feb-2021 19:05	Scotland as at 06-Feb-2021 19:05
Change	Change	Change	516 patients	283047 patients

Pathways of Care Measures of Care Standards of Care

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COMPARE PRACTICE POPULATIONS ACCORDING TO AGE /SEX/ SIMD DATA

MONITORING OF “PROCESSES OF CARE” IN PATIENTS WITH T2DM

% monitored
100
95
90
85
80
75
70
65
60
55
50
45
40
35
30
25
20
15
10
5
0

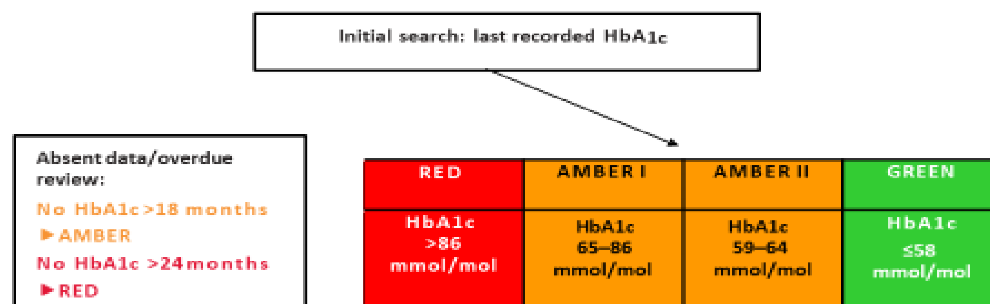
18/Q1 18/Q2 18/Q3 18/Q4 19/Q1 19/Q2 19/Q3 19/Q4 20/Q1 20/Q2 20/Q3 20/Q4 21/Q1 21/Q2

Quarter

%HbA1c %bp %cholesterol %creatinine %albumin
%foot %bmi %smoking %all8done

USING THE DASHBOARD TO PRIORITISE RECALL

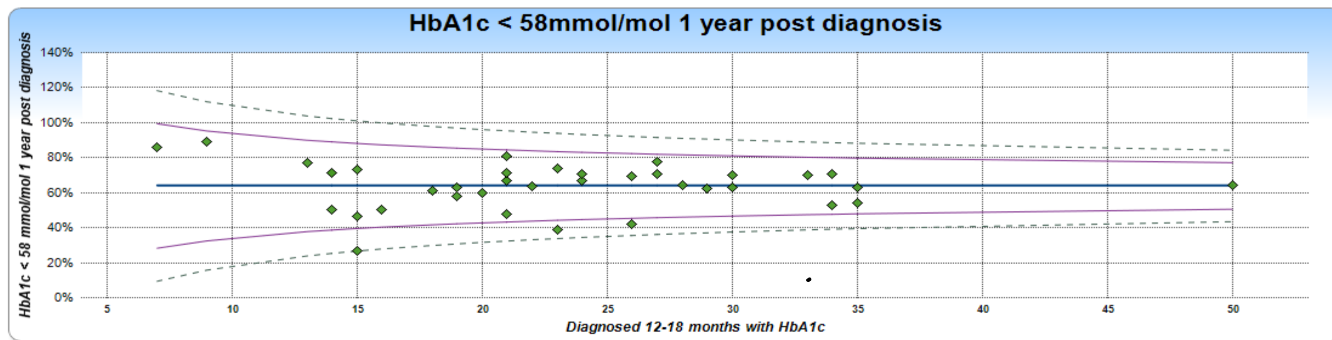
Diagram 1. Stratifying prioritisation groups (Adapted from the ABCD recommendations for triage of patients during Covid Recovery[1])



ADDITIONAL SEARCHES on amber/green groups to identify risk factors that may alter risk category and prioritisation (based on Risk factors [see Box B])[2]		
Blood pressure:	≥160/100 mmHg ► RED	141/81–159/99 mmHg ► AMBER
Diabetes complication:	Retinopathy/High-risk foot ► RED	
CKD:	eGFR <45 mL/min/1.73 m² ► RED	eGFR 45–60 mL/min/1.73 m² ► AMBER
CVD/HF/ stroke: Assess CV risk factors to decide if ► RED or ► AMBER category. For example, may need additional therapy:	Not on statin but established CVD (excl. haemorrhagic stroke) ► RED	Not on statin despite ≥40 years ► AMBER
BMI:	≥40 kg/m² ► RED	≥30 kg/m² ► AMBER
Other Risk Factors:	Planning Pregnancy Recent admission in last 12 months (Diabetes or acute CV event) HbA1c <48mmol/mol in Frailty and on sulphonylurea or insulin ► RED	Frailty /Cognitive Impairment Requiring additional support e.g Significant mental health illness Learning disability BAME Groups ► AMBER

Dashboard

Funnel Plot to Identify Outliers



Pathways of Care: 1 Glycaemic Control

Measure: 1.2 HbA1c < 58mmol/mol 1 year post diagnosis

Red	Amber	Green
< 70%	70-75%	> 75%

Domains	Q1/20 as at 04-Apr-2020 21:18	Q2/20 as at 04-Jul-2020 21:37	Q3/20 as at 04-Oct-2020 02:40	Q4/20 as at 02-Jan-2021 18:15
Bearsden/Milngavie Cluster	93.3%	88.2%	73.3%	60%
Eastwood 2 Cluster	90.9%	81.8%	60%	71.4%
NW - Dumbarton Road Corridor Cluster	86.2%	79.2%	80%	61.1%
Inverclyde East Cluster	85.7%	71.4%	57.1%	47.6%
West Renfrewshire 2 Cluster	82.1%	88%	50%	26.7%
NW - A Cluster	81.8%	75%	50%	71.4%
NW - Hyndland and West End Cluster	81.8%	81%	66.7%	63.2%

COMPARE CLUSTER DATA

SCI-Diabetes - Dashboard

https://sci-diabetes1.mhs.scot.nhs.uk/sci-diabetes1/dashboard/ManageDashboard.aspx

SCI-Diabetes

Dashboard

Step 1: Select Dashboard: **Diabetes Care**

Step 2: Select Criteria - Data view: **Latest** Cohort: **Type 2 & Other 18+** Main domain: **S0070 - Greater Glasgow and Clyde - 49144 - DR I M MACDONALD & PTNRS** Comparator domain: **S0070 - Greater Glasgow and Clyde**

Step 3: View Selected Dashboard:

Step 4: View Measure of Care - 1.2 - HbA1c < 58mmol/mol 1 year post diagnosis

Previous Next

Run-rate Graph

Calculation

HbA1c < 58mmol/mol 1 year post diagnosis	49144 - DR I M MACDONALD & PTNRS as at 06-Feb-2021 19:05		Greater Glasgow and Clyde as at 06-Feb-2021 19:05	
Diagnosed 12-18 months with HbA1c	8		893	
HbA1c < 58 mmol/mol 1 year post diagnosis	5		567	
Measure of Care	62.5%		63.5%	
Standard of care met	< 70%		< 70%	
Trend over the last 12 months		Trend -4.37 percent/month		Trend -0.96 percent/month

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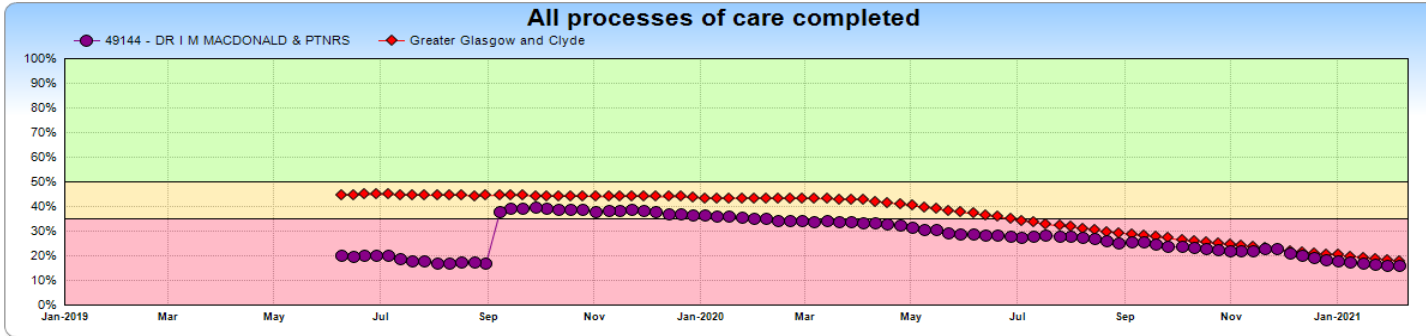
MONITOR TRENDS

Dashboard

Run-rate Graph



Calculation

All processes of care completed	49144 - DR I M MACDONALD & PTNRS as at 06-Feb-2021 19:05		Greater Glasgow and Clyde as at 06-Feb-2021 19:05	
Patient cohort in the domain.	516		59913	
All required process of care completed within required timescale	81		10620	
Measure of Care	15.7%		17.7%	
Standard of care met	< 35%		< 35%	
Trend over the last 12 months		Trend -1.49 percent/month		Trend -2.27 percent/month

Actions Available

Include patient contact details in download list.

What do you want to see?	Number of Patients	Actions

PROCESSES OF CARE

SCI-Diabetes - Dashboard

https://sci-diabetes1.mhs.scot.nhs.uk/sci-diabetes1/dashboard/ManageDashboard.aspx

SCI-Diabetes

Dashboard

Actions Available

Include patient contact details in download list.

What do you want to see?	Number of Patients	Actions	
Education			
Attended structured education	2	Display	Download
Participated and completed structured education	2	Display	Download
Participated but did not complete structured education	0	Display	Download
No record of attending structured education to date	514	Display	Download
Declined structured education	0	Display	Download
Engaged (HbA1c and Retinal Screening)			
HbA1c recorded in the last 15 months and retinal screening recorded within the required timeframe	388	Display	Download
HbA1c not recorded in the last 15 months or retinal screening not recorded within required timeframe	115	Display	Download
18-25 HbA1c or DRS Not Recorded		Display	Download
HbA1c or DRS Not Recorded SIMD1	7	Display	Download
HbA1c or DRS Not Recorded SIMD2	17	Display	Download
HbA1c or DRS Not Recorded SIMD3	16	Display	Download
HbA1c or DRS Not Recorded SIMD4	41	Display	Download
HbA1c or DRS Not Recorded SIMD5	34	Display	Download
Processes of Care			
All required process of care completed within required timescale	**81**	Display	Download
Required process of care not all completed within required timescale	435	Display	Download
My Diabetes My Way			
Registered on My Diabetes My Way	99	Display	Download
Actively using My Diabetes My Way	19	Display	Download
Not registered on My Diabetes My Way	417	Display	Download
Care Plan Summary			
Care Planning Summary used to support self management	13	Display	Download
No record of Care Planning Summary	503	Display	Download
Full History			
Full history for this measure of care		Display	Download

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SEARCH POPULATION LISTS AND EXPORT TO SPREADSHEET

SCI-Diabetes

49144-DR I M MACDONALD & PTNRS

STATUS:GREEN

File transferred within last 24 Hours...

Main Menu | User | Help | Dashboard | Print | Default | Export CSV | Logout (ALI, Kashif)

Navigation | MCN Report Comparison > 1. Processes of care

- MCN Report Comparison
  - 1. Processes of care
  - 2. HbA1c early control
  - 3. HbA1c overall control
  - 4. Current smokers
  - 5. CVD indicators
  - 6. Ulcer management
  - 7. Eye screening
  - 8. Renal disease
  - 9. CSII therapy
  - 10. BMI control
  - 11. Education
  - 12. Disengaged

MCN Report Comparison - 1. Processes of care

1. Percentage of people with diabetes who receive all recommended (up to 9) processes of care measurements for diabetes in the prior 15 months - adjusted for and presented in defined age ranges.

Annual assessment of the following processes of care is important to ensure effective screening for microvascular complications and assessment of cardiovascular risk factors. These include; weight (and BMI measurement), blood pressure, smoking status, HbA1c, urinary albumin test, serum creatinine, cholesterol level, retinopathy screening and foot risk stratification.

View MCN Quarterly Report

☐ Include only patients whose main "Domain of Care" matches this domain.

☐ Include Practice ID.

Click on a row to view the list of patients. The list will appear below. View Methodology for calculation details.		DR I M MACDONALD & PTNRS as at 10-Feb-2021 17:57:35			Greater Glasgow and Clyde Q4/20 as at 1-Jan-2021 00:00:00		
		Total	Met Criteria		Total	Met Criteria	
Categories for this measure							
	Type 1 & Other Age 0-11 Receive all	1	100 %	1	252	95.6 %	241
	Type 1 & Other Age 12-17 Receive all	2	0 %	0	385	2.1 %	8
	Type 1 Age 18+ Receive all	41	19.5 %	8	6273	13.4 %	840
	Type 2 & Other Age 18+ Receive all	518	7.9 %	41	59899	12 %	7160
Additional categories							
Patients who did not receive all age appropriate process of care (poc) measurements.							
	Type 1 & Other Age 0-11 POC incomplete	0					
	Type 1 & Other Age 12-17 POC incomplete	2					
	Type 1 Age 18+ POC incomplete	33					
	Type 2 & Other Age 18+ POC incomplete	477					

Type 2 & Other Age 18+ POC incomplete

Patient ID/CHI	Name	Born	HbA1c	Weight (BMI)	Blood Pressure	Smoking Status	Retinopathy Screening	Urinary Albumin Test	Creatinine	Total Cholesterol	Foot risk
0101295219	[illegible]	01-Jan-1929 (92y)	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Met	Not Met	Not Met
1006575405	[illegible]	10-Jun-1957 (63y)	Met	Met	Met	Met	Met	Met	Met	Met	Not Met
1210555433	[illegible]	12-Oct-1955 (65y)	Met	Met	Met	Met	Not Met	Met	Met	Met	Met
2003818359	[illegible]	20-Mar-1981 (39y)	Met	Not Met	Not Met	Not Met	Not Met	Not Met	Met	Not Met	Not Met
1504786149	[illegible]	15-Apr-1978 (42y)	Met	Met	Met	Not Met	Not Met	Not Met	Met	Met	Not Met
0101568851	[illegible]	01-Jan-1956 (65y)	Met	Met	Met	Met	Not Met	Met	Met	Met	Met

PATIENT LISTS TO ENABLE PRIORTISATION

SCI-Diabetes Dashboard Part 2 - Using the Dashboard

https://vimeo.com/339976600

SCI-Diabetes

DASHBOARD

PART 2: USING THE DASH BOARD

SCI-DIABETES TEAM 2019.1

1 year ago | More

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EASY TO FOLLOW VIDEO TUTORIALS ON VIMEO

ADA/EASD Professional Practice Committee (PPC) adaptation of Davies et al.

American Diabetes Association.

FIRST-LINE Therapy is Metformin and Comprehensive Lifestyle (including weight management and physical activity)

INDICATORS OF HIGH-RISK OR ESTABLISHED ASCVD, CKD, OR HF†

CONSIDER INDEPENDENTLY OF BASELINE A1C, INDIVIDUALIZED A1C TARGET, OR METFORMIN USE*

+ASCVD/Indicators of High Risk

- Established ASCVD
- Indicators of high ASCVD risk (age ≥55 years with coronary, carotid, or lower-extremity artery stenosis >50%, or LVH)

EITHER/OR:
- GLP-1 RA with proven CVD benefit[1]
- SGLT2i with proven CVD benefit[1]

If A1C above target

If further intensification is required or patient is unable to tolerate GLP-1 RA and/or SGLT2i, choose agents demonstrating CV benefit and/or safety:

- For patients on a GLP-1 RA, consider adding SGLT2i with proven CVD benefit and vice versa[1]
- TZD[2]
- DPP-4i if not on GLP-1 RA
- Basal insulin[3]
- SU[4]

+HF

Particularly HFrEF (LVEF <45%)

SGLT2i with proven benefit in this population[5,6,7]

+CKD

DKD and Albuminuria[8] → NO (see below)

PREFERABLY

SGLT2i with primary evidence of reducing CKD progression

OR

SGLT2i with evidence of reducing CKD progression in CVOTs[5,6,8]

OR

GLP-1 RA with proven CVD benefit[1] if SGLT2i not tolerated or contraindicated

For patients with T2D and CKD[8] (e.g., eGFR <60 mL/min/1.73 m²) and thus at increased risk of cardiovascular events

EITHER/OR:
- GLP-1 RA with proven CVD benefit[1]
- SGLT2i with proven CVD benefit[1,7]

NO

IF A1C ABOVE INDIVIDUALIZED TARGET PROCEED AS BELOW

COMPELLING NEED TO MINIMIZE HYPOGLYCEMIA

DPP-4i	GLP-1 RA	SGLT2i	TZD
If A1C above target	If A1C above target	If A1C above target	If A1C above target
SGLT2i OR TZD	SGLT2i OR TZD	GLP-1 RA OR DPP-4i OR TZD	SGLT2i OR DPP-4i OR GLP-1 RA

If A1C above target

Continue with addition of other agents as outlined above

If A1C above target

Consider the addition of SU[4] **OR** basal insulin:

- Choose later generation SU with lower risk of hypoglycemia
- Consider basal insulin with lower risk of hypoglycemia[9]

COMPELLING NEED TO MINIMIZE WEIGHT GAIN OR PROMOTE WEIGHT LOSS

EITHER/OR:
- GLP-1 RA with good efficacy for weight loss[10]
- SGLT2i

If A1C above target

- SGLT2i
- GLP-1 RA with good efficacy for weight loss[10]

If A1C above target

If quadruple therapy required, or SGLT2i and/or GLP-1 RA not tolerated or contraindicated, use regimen with lowest risk of weight gain

PREFERABLY

DPP-4i (if not on GLP-1 RA) based on weight neutrality

If DPP-4i not tolerated or contraindicated or patient already on GLP-1 RA, cautious addition of:

- SU[4] • TZD[2] • Basal insulin

COST IS A MAJOR ISSUE[11,12]

SU[4]	TZD[12]
If A1C above target	
TZD[12]	SU[4]
If A1C above target	

Insulin therapy basal insulin with lowest acquisition cost

OR

Consider other therapies based on cost

1. Proven CVD benefit means it has label indication of reducing CVD events
2. Low dose may be better tolerated though less well studied for CVD effects
3. Degludec or U-100 glargine have demonstrated CVD safety
4. Choose later generation SU to lower risk of hypoglycemia; glimepiride has shown similar CV safety to DPP-4i
5. Be aware that SGLT2i labelling varies by region and individual agent with regard to indicated level of eGFR for initiation and continued use
6. Empagliflozin, canagliflozin, and dapagliflozin have shown reduction in HF and to reduce CKD progression in CVOTs. Canagliflozin and dapagliflozin have primary renal outcome data. Dapagliflozin and empagliflozin have primary heart failure outcome data.
7. Proven benefit means it has label indication of reducing heart failure in this population
8. Refer to Section 11: Microvascular Complications and Foot Care
9. Degludec / glargine U-300 < glargine U-100 / detemir < NPH insulin
10. Semaglutide > liraglutide > dulaglutide > exenatide > lixisenatide
11. If no specific comorbidities (i.e., no established CVD, low risk of hypoglycemia, and lower priority to avoid weight gain or no weight-related comorbidities)
12. Consider country- and region-specific cost of drugs. In some countries TZDs are relatively more expensive and DPP-4i are relatively cheaper.

† Actioned whenever these become new clinical considerations regardless of background glucose-lowering medications.

* Most patients enrolled in the relevant trials were on metformin at baseline as glucose-lowering therapy.

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OBESITY AND /OR CV DISEASE

IF KNOWN CV DISEASE, CHOOSE SGLT2I OR GLP1 RA WITH PROVEN CV BENEFIT.

*ALTERNATIVE TO METFORMIN IF CONTRAINDICATED OR NOT TOLERATED

FIRST LINE	**METFORMIN**	***SU**	***SGLT2i (if BMI>30 or CV disease)***	
SECOND LINE	**SGLT2i**	**SU**	**DPP4i**	**Pioglitazone**
THIRD LINE	**GLP1 RA**	**3rd agent from 2nd line**	**O.D. insulin**	

B - INTENSIFICATION

1st line agent
Arrange 3/12 HbA1c

Emphasise the benefits of achieving and maintaining healthy BMI

A+C -MONITORING

Target HbA1c achieved (eg <53 mmol/mol)
Arrange 6-12 monthly HbA1c
If HbA1c above target, back into Rx algorithm

2nd line agent
HbA1c 3/12

3rd line agent
HbA1c 3/12

Treatment failure ie HbA1c drop <5.5mmol/mol, therefore stop RX and consider alternative from Rx line

4th line agent (typically need specialist support)
GLP1 or basal insulin start (with cDSN support)*
HbA1c 3/12

Insulin intensification beyond basal insulin ie introduction of prandial or premix regimes (case reviewed by specialist)*

* consider referral to specialist dietician when commencing insulin

NEXT STEPS……

- FAMILIARISE/USE SCI-DIABETES
- QIA: Audit, Student/ST projects/ Appraisal
- PRIORITISE RECALL: High HbA1c, CV disease, DKD, "At risk"
- PRACTICE "MDT": Admin, Practice Nurse, GP, Pharmacist ?Role for HCAs + "non-experts"
- "CTACs / Monitoring Hubs" in time may allow more time to focus on mangement

THANK YOU

SCI-Diabetes

NHS
Greater Glasgow
and Clyde