The Type Two Diabetes Three Treatment Targets

NHS South West London

Practice Improvement Guide

For practices who wish to improve their three treatment targets attainment for their care of type two diabetes patients.

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Thanks also for the input of Dr Iolanthe Fowler, GP, Sheffield, SY ICB

The three treatment targets and this guide.

This guide aims to support practices to improve type 2 diabetes care. Practices who have used the method and process in this guide have dramatically improved their 3TT performance.

Recent statistics from Diabetes UK* state that there are a staggering 4.3 million people in the UK with diabetes with a further 850k people undiagnosed. This positions diabetes as perhaps the single biggest challenge the NHS faces with profound implications for patients with the associated complications of heart attacks, stokes, sight loss and nerve damage.

The type 2 diabetes three treatment targets are a useful proxy for the effectiveness of the diabetes model of care in practice. Further work by Diabetes UK shows that if diabetic patients aged 20+ met their targets for blood sugar, blood pressure and cholesterol the NHS would save £727 million in the next decade**. The targets provide a picture of care management not only at individual patient level but also for a practice overall. As such South West London and most other primary care systems have adopted these targets as the core measure of diabetes care quality.

A practice is likely to need to make improvements to several systems and processes to improve the three treatment targets. The extent of these changes depends on where a practice starts from, which is why this guide takes a flexible approach. While focused on type 2 diabetes, many of these recommendations will impact wider chronic disease management.

This document is funded by the Diabetes Treatment and Care Funding from NHS England.

If you are having any problems with format or the navigation functionality of this guide, we recommend using Adobe Acrobat Reader.

*Diabetes UK,. (2023) Number of People Living with Diabetes in the UK Tops 5 Million for the First Time, Diabetes UK, LONDON, [online], accessed April 2023

**Diabetes UK,. (2019) Meeting Type 2 Treatment Targets Could Save NHS Millions, Diabetes UK, LONDON, [online], accessed April 2023

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This practical guide all started from the question "How can we reduce variation in the quality of care for people with Type 2 Diabetes across South West London?". This is a complex question, and one that is shared across many other long-term conditions. I was part of a SWL team who took this question to Yale, and using a proven methodology were able to work with multiple local leaders, experts and key stake holders to drill down to the causes and evidence-based solutions provided. Working as a team, different members of the practice can be supported by the SWL team to embed these lessons; making best practice, usual practice. Diabetes is one of many long-term conditions, and the lessons from this guide could be used to improve the quality and length of life for many other patients.

Dr Sharvanu Saha
Clinical Lead for Diabetes, South West London Health Care Partnership

This comprehensive and evidence-based document helps to guide busy practice teams with practical steps and tools for running efficient practice processes and clinical delivery methods. There are suggestions on how practices can adapt and tailor these for themselves helping them to deliver more effective and efficient care, as well as utilising existing tools to aid continuous improvement. The guide is easy to read and provides each member of the practice team with bite sized areas for improvement; and the practical vignettes demonstrate the input from 'on the ground' clinicians actively delivering diabetes care.

From novice to expert this document offers something for everyone and is a must read for those aiming to improve outcomes for their patients.

Dipti Gandhi
Managing Partner, Clinical Pharmacist and SWL Primary Care Lead for Diabetes

London has some of the best diabetes outcomes and some of the worst in the U.K. The variation in diabetes care and outcomes is critical for us to understand and address to enable those living with diabetes to achieve the best experience possible. Any unnecessary variation needs to be a focus for our efforts. The Cochrane review *"Interventions to improve the management of diabetes mellitus in primary care, outpatient and community settings"* as long ago as 2001 highlighted not only the importance of the performance of health professionals in managing patients with diabetes but also the importance of systems of care, organisational interventions and of patient centred interventions "personalised care" in the improvement of care and outcomes.

Diabetes recently has more data and therefore more information than ever before to help inform us as to how to improve the care and support we offer. In these very challenging times it is more than ever essential to use this information to drive our care. The London network is excited to see this initiative and hopes to learn lessons applicable not only to the South West ICS but for the whole of London.

Dr Stephen Thomas
Consultant in Diabetes and Endocrinology, Clinical Director - London Diabetes Clinical Network

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This guide is in three sections: Getting Ready, Taking Stock, and Making Changes. We've designed it for you to work through in order, to help you make effective changes to your type 2 diabetes care.

The first two sections will help you create the best chance of success. They focus on getting the right people committed, putting a line in the sand regarding practice current state and agreeing actions. The third guides you through the following domains of interconnected system and process.

- Organisation and Process
- Data Foundations
- Consistency
- Consulting Approach
- Engaging Patients and the Community
- Leadership
- Training and Competencies

Success in such a complex area lies in first undertaking preparation and reflection. Through our guidance on Getting Ready and the self-assessment in Taking Stock, you'll develop a systemic view of your practice. You'll also be more able to identify your priorities.

If you're reading this guide as a PDF, use the links in the bottom right of the section pages to easily navigate backwards and forwards.

A glossary can be found on page 82.

Success in such a complex area lies in first undertaking preparation and reflection.

Getting Ready:
Find out how to set up your diabetes working group and its all-important meeting structure. This group will trigger and coordinate your improvements, supporting decisions with modest data.

Taking Stock:
Use our self-assessment tool to create a baseline of your current system and process. And follow our roadmap to help you and your colleagues visualise how improvements build and fit together.

Making Changes:
Delve deeper into the details on the improvement domains illustrated in Taking Stock. Informed by your self-assessment, you'll find guidance, tips and links for each domain.

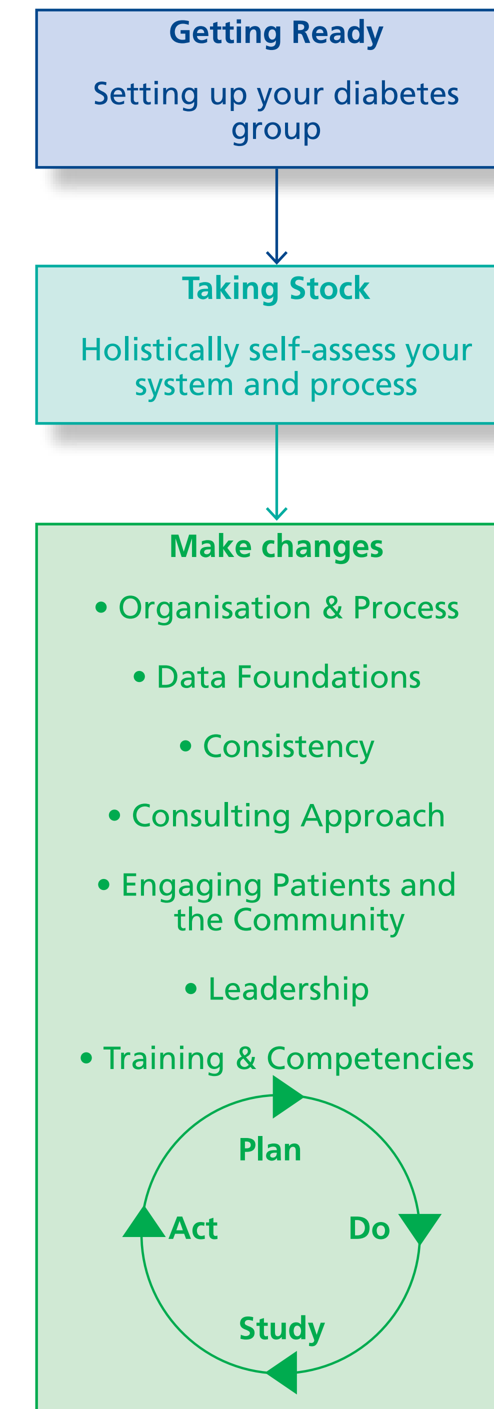

Figure 1: Using this guide

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How long might this take?

It took a number of months to undertake the whole process of improvement that we've based this guide on. That includes engagement, self-assessment and actually implementing the changes.

It may be tempting to skip the self-assessment stage and dive straight into the changes. This stage, and the discussions that arise from it, are crucial to your practice, though. They are what will build the understanding and consensus you need to plan, introduce and sustain the changes.

The timeline below shows one practice's journey, and its impact on the eight core care processes and three treatment targets. This practice moved from one of the lowest performing in their area to one of the highest.

Of course, every practice is different, and starts from a different place. Some will be able to do things quickly, others will need more time. Each will identify their own priorities through the self-assessment. You may find this timeline useful when planning out your own practice's work and managing expectations.

Finally, in the spirit of continuous improvement, remember that the use of self-assessment can be repeated periodically to help you take stock and refresh your approach.

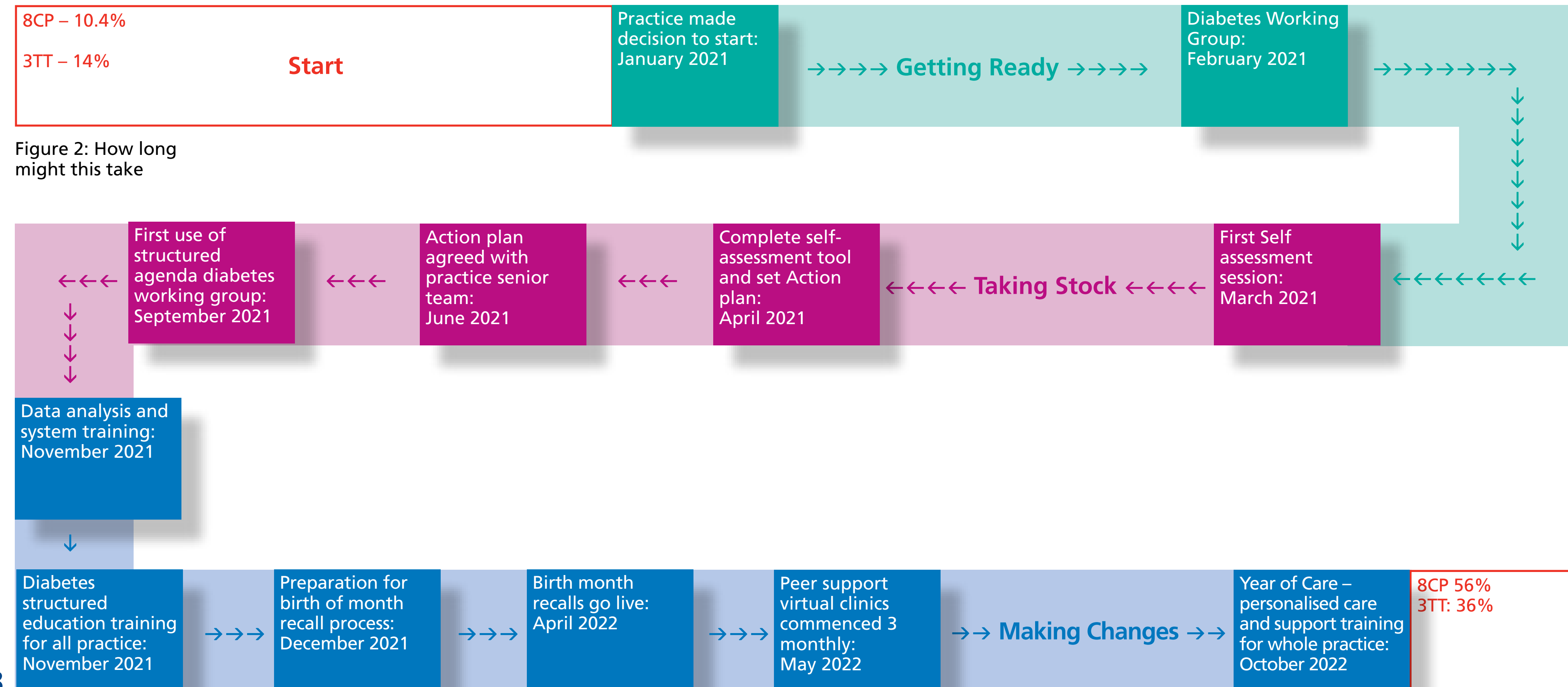
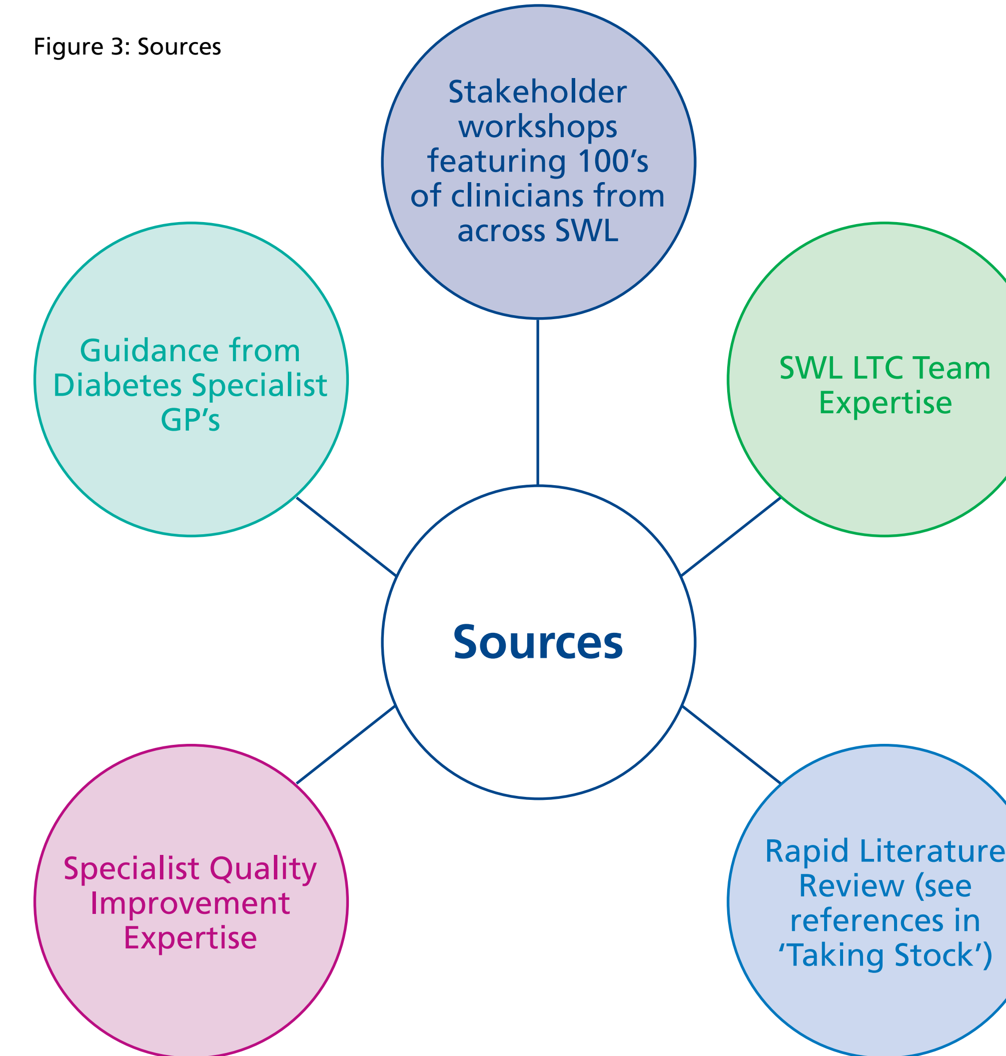


Figure 2: How long might this take

Sources used to develop this improvement guide

We at the South West London ICS Long Term Condition team created this guide. It captures our learning and experience in supporting practices to improve their type 2 diabetes model of care and, in doing so, their three treatment targets. It also pulls from the sources detailed below in Figure 3. Specific references can be found in the inside back cover.

Figure 3: Sources



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The Seven Domains:

Seven improvement domains provide the structure for the self-assessment tool later in this guide. They detail the interconnected system and process that typically forms the model of care for type 2 diabetes. To improve your model of care, view these domains together, rather than cherry-picking individual ideas.

Domain descriptions:

Organisation and Process:

How effective and efficient are our processes and use of resources?

Working to ensure: reception, back office and coordinating functions are as efficient as possible. Reducing variation of approach and achieving continuity where required. Optimising technology to reduce data-gathering burden and to make referral processes slick. Distributing workload across the year to suit practice capacity and population availability patterns. Ensuring a visible, reliable process for patient groups that fall outside of core practice, such as those in care homes or housebound.

Data foundations:

Do we have objective methods for prioritising care and understanding how effective our model of care is?

Working to ensure: the use of best available type 2 diabetes data methods to coordinate and prioritise. At patient level, using data to case find and prioritise those who need further input, based on the three treatment targets and/or eight core care processes. At practice level, using a modest set of metrics to signal the effectiveness of the type 2 diabetes model of care. Doing so will show how the practice is doing and help with the prioritising of improvement decisions.

Consistency:

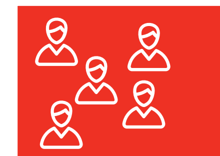
How consistent are we in our approach and how do we ensure we use the best models?

Working to ensure: fewer unwarranted variations of approach in the timing and form of general intensification, handover and signposting for treatments. Following the best available guidance, creating supporting documentation and systems, and engaging in regular discussion. Using medicines, diagnostics and referrals to specialists. Applying health education, promotion and prevention programmes. Working as a wider multidisciplinary team, involving healthcare assistants, nurses, pharmacists, social prescribers, wellbeing coaches, dieticians, physician associates and admin professionals.

Consulting Approach:

Are we making the most of our consultations?

Working to ensure: that touch points with patients with type 2 diabetes are as effective as possible. Ensuring clinicians have consistent beliefs and knowledge on type 2 diabetes care. Identifying and discussing clinical variation. Making sure the practice's use of care plans is effective with patients. Optimising goal setting, joint action planning, documentation and coordination techniques in consultations. Considering alternative consultation formats and using the latest preparation and pre-consultation data-gathering methods.



Engaging Patients and the Community:

Is our wider network and our community an asset in our model of care?

Working to ensure: the practice acknowledges that the time it spends with a patient is a tiny fraction of the time the patient spends living with diabetes. Investing in links with the wider health and social care network and community assets, to develop a more effective response and greater community wellbeing. Addressing inequalities and identifying and working with hard-to-reach groups through primary care networks. Making sure all communications channels (written, verbal and digital) suit their intended patient groups. Using direct digital channels, such as apps, for suitable patient groups.

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Leadership:

Is our leadership as supportive as possible?

Working to ensure: clarity of roles and responsibilities in leading on the type 2 diabetes system and process. Practice leaders formally supporting a diabetes specialist lead through documented strategy or meeting records. Developing an improved model of care for type 2 diabetes that includes investment in training, use of data, and protected time for improvement.

Training & Competencies:

Do we have up to date knowledge?

Working to ensure: clinicians have up-to-date understanding of the content, booking methods and options available for engagement and educational interventions. Regular training and access to supporting specialists for clinical leads. Training for non-clinical patient-facing staff in communications techniques and the practice model of care for type 2 diabetes.

The impact of type 2 diabetes patients on practice resources

From a practice perspective, you will know that a significant proportion of your resources goes towards type 2 diabetes patients. Despite your experience, the numbers can still be a shock. It's even starker when you consider you may also have large numbers of undiagnosed patients; across the UK there are an estimated 1 million undiagnosed people with diabetes*. In other words, approximately 20% of people currently with diabetes have not been diagnosed yet.

The following charts detail type 2 diabetes resource analysis from one practice. Your practice may have some demographic differences, but the headlines will still stand.

The charts show that type 2 diabetes is not only a serious diagnosis for patients, but will take up massive amounts of resource for your practice. **They show that your practice cannot be efficient without an effective model of care for type 2 diabetes.** Given your likely spend, it is in your practice's best interest to get on the front foot and invest in improving its own model of care.

Typical resource use headlines:

While type 2 diabetes patients account for 7% of your list…

… they account for 10% of patients who attend in a year

… they make up 16% of all consultations (all staff types)

This varies by age (see Figure 4), with type 2 diabetes accounting for 30% + of consults for those 70 years and older.

Figure 4 details the number of consultations for type 2 diabetes patients for a year, split by age group. The light yellow is the total number of all patient consults, for reference. The dark yellow is the number of patients with type 2 diabetes. This one single condition has a massive impact.

What would this look like in your practice?

* Diabetes UK (2019),. Us, Diabetes and a lot of facts and stats. Diabetes UK. [Online] https://www.diabetes.org.uk/resources-s3/2019-11/facts-stats-update-oct-2019.pdf

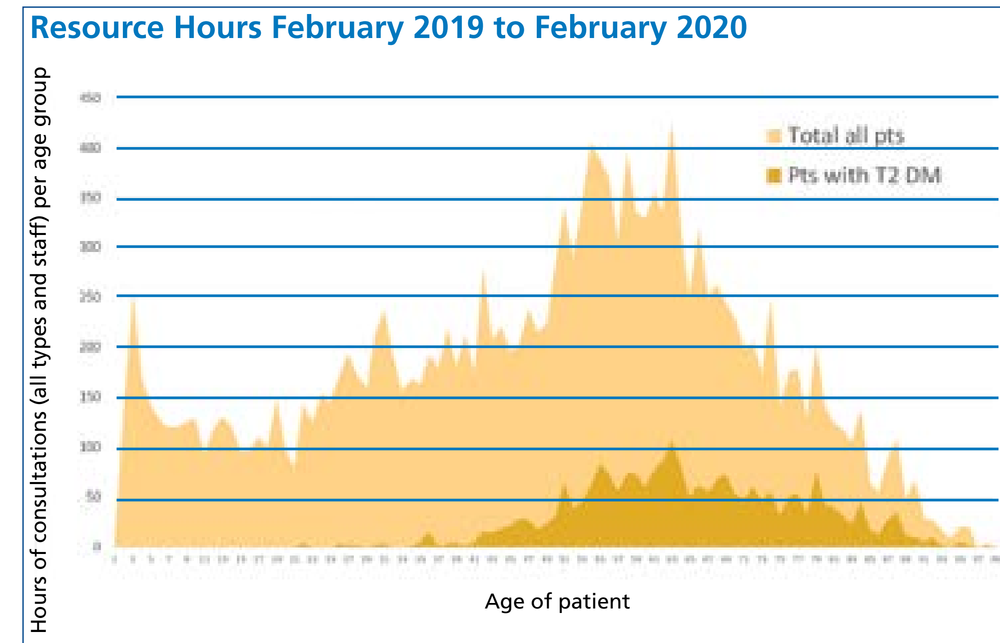

Figure 4: Type 2 Diabetes Proportion of Resources Type 2 Diabetes Patients

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20% of type 2 diabetes patients can account for 47% of all practice type 2 diabetes patient consults

Exploring resource use in more depth is enlightening. The following chart, Figure 5, sets out the resource use per type 2 diabetes patient. It shows that among type 2 diabetes patients, a small number account for a large proportion of practice resource use.

Each bar details the number of consults against the number of patients. The question is not only how we can be more effective with this handful of patients. But also, as this will be a rotating cohort, how do we stop type 2 diabetes patients progressing into this high attending group in the first place? How can our model of care be more effective earlier?

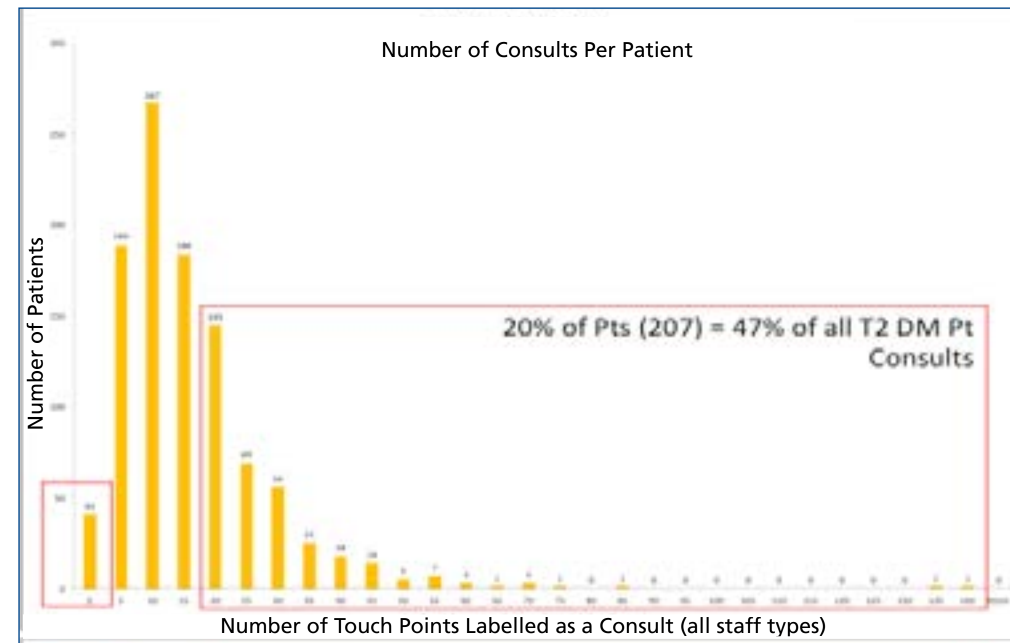


Figure 5: Proportion of Resource Use by No.Patients (one year)

Typical demand headlines:

Demands will increase for 50% of type 2 diabetes patients

A GP-led case categorisation[2] found that 50% of type 2 diabetes patients were likely to increase their demand on the practice over time (see Figure 6). This means they need more help or their needs become more complex. It comes on top of the challenge of already very high practice resource use. This percentage demonstrates the need for a better model of care. Would this be the case in your practice?

In your opinion, are demands likely to increase?

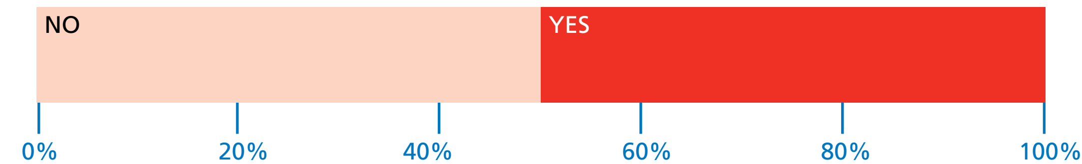


Figure 6: Increasing Demands

For >20% of these patients, the demand increase is likely to be substantial, as GPs categorised them as approaching 'cliff edge' episodes

A sense of urgency rises in many practices when they acknowledge the significant increase in demand and work related to this patient group. It becomes a priority, then, to invest time in examining and improving care processes for what is likely to be one of the highest volume conditions.

In your opinion, is this person approaching a rapid increase in demands (e.g. a cliff edge)

Figure 7: Rapidly Increasing Demands. A sample of 40 cases were reviewed and categorised, by senior practice clinicians, in order to understand the characteristics and themes of demand. The 40 cases were all type 2 diabetes patients. Split three groups (of escalating HBA1c). 1/3 HBA1c >=75 (working high to low), 1/3 <75 > 59 and 1/3 <=58.

Getting ready

Creating a diabetes working group

The single biggest thing you can do to improve your model of care is not a change in system and process, clinical working or innovation at all. Rather, it is embedding continuous improvement into your type 2 diabetes model.

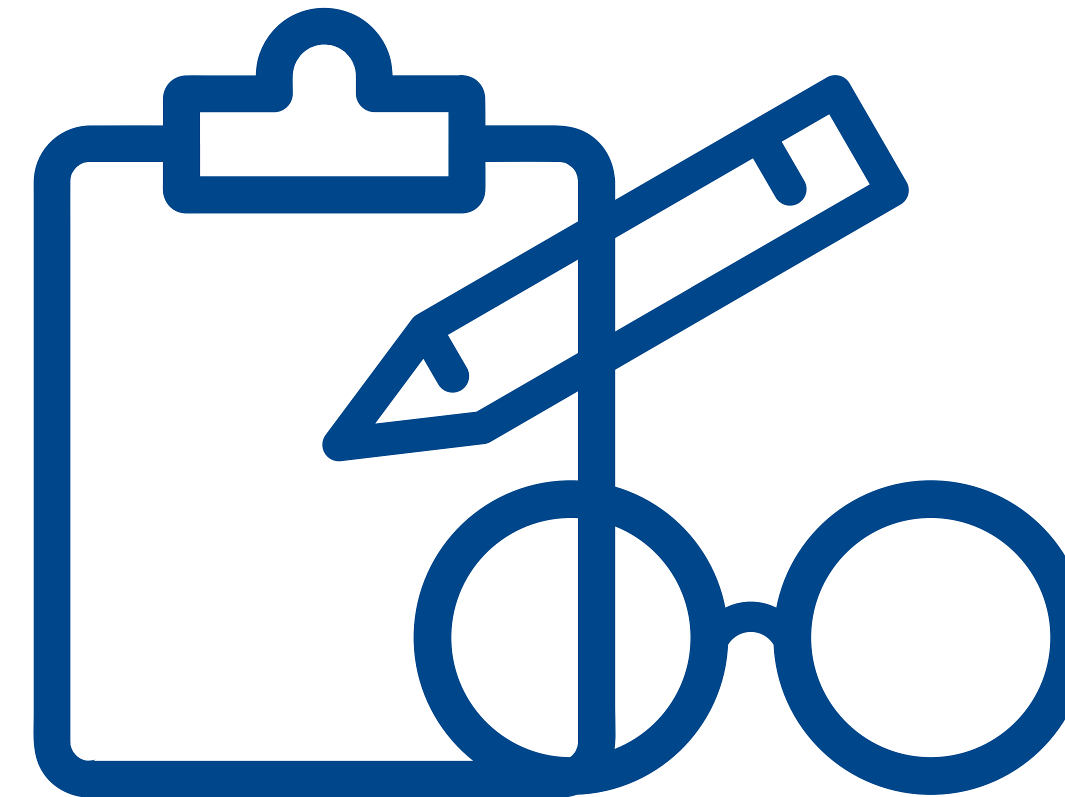
The first step is to create a diabetes working group. The group should meet monthly (at minimum bi-monthly). Its remit is not* to discuss individual patients, rather it is to discuss and improve your overall model of care for type 2 diabetes. This is a vital distinction. If you only work at the level of individual patients, you never break the cycle – the current patient is always replaced by another.

We suggest 45 minutes for each meeting and the attendance a minimum of:

- **GP diabetes specialist or lead GP;**
- **admin or back office lead (the person who coordinates recalls, etc);**
- **reception lead (if different to admin or back office lead);**
- **nurse representative;**
- **health care assistant representative (if they carry out type 2 diabetes tests and checks); and**
- **data lead, or someone who can produce data from your practice systems.**

To meet the requirements of the working group, the practice senior team will need to support it and allow it a large amount of protected time. They'll need to consider this investment against patient volume and likely use of capacity. As explored in the previous section, a high proportion of overall practice resources go into type 2 diabetes care. Viewed against this backdrop, investment in a diabetes working group becomes a much easier decision, its strategic importance much clearer.

* Of course, if you don't already have a forum for discussing the clinical approach at individual patient level, then structuring the meeting to have time for both would work.



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Aim of your diabetes working group:

1. Take stock of the practice system and processes for type 2 diabetes using our self-assessment (see page 28). It will provide you with a customised plan for potential improvement activities. It will also create a roadmap for your practice to visualise how improvements fit together.

2. Regularly assess how well your practice is doing using key metrics that your practice can collect itself. You'll keep track of your improvement and also keep people engaged over what can be a long journey.

3. Review progress of improvements against your plan. Did you complete the tasks you set yourself in the last meeting? Do you need any help from others? Did your changes make any improvement (objectively measured using your metrics in the previous aim)?

Structure of your diabetes working group meeting:

Table 1 on the following page shows an example agenda for your diabetes working group. This agenda is for use after you've completed the self-assessment. It's followed by a list of definitions for the metrics suggested. Use the agenda as a basis for your own, or photocopy/print it as a starting point.

Keep people engaged over what can be a long journey

Table 1:

Type 2 Diabetes Working Group – Agenda

Date: **Time:**

Attendees:

Chair:

Item	Topic	Actions	Who	When
1	Outline of agenda and any AOBs (note this meeting is not for discussion of individual cases).			
2	How are we doing? Review of practice type 2 diabetes model of care metrics (should all be displayed on a run chart): • % of recalls in birth month (or similar smoothing methodology) • 8 core care processes overall % (all type 2 diabetes pts) • 3 treatment targets overall % (all type 2 diabetes pts) • Type 2 diabetes prevalence actual • Type 2 diabetes prevalence expected • Education programme referral rates • Educational programme completion rates • Progress for QoF			
3	Risks and countermeasures emerging (for processes not patients):			

Improvement Actions (from your Self-Assessment):

Table 1: Example Type 2 Diabetes Working Group Agenda

Area of improvement	Descriptions	Who	When	Status: Started	Status: MIdway	Status: Complete	Status: Being used
A							
B							
C							
D							
E							
F							
G							
H							
I							

How to use the agenda:

Use the agenda opposite to structure your diabetes working group meetings. We've designed it to help you be consistent with topic areas, such as reviewing measures, and to keep track of development actions.

Take care to think about how the group is working. Be aware of power dynamics in the room, who is speaking, who is listening (or not!), and who are the decision makers. The group will be most effective when everyone is trusted and listened to.

Be aware of power dynamics in the room, who is speaking, who is listening (or not!)

Table 2: Annotated Example Type 2 Diabetes Working Group Agenda

Type 2 Diabetes Working Group – Agenda

Date: **Time:**

Attendees:

Chair:

Item	Topic	Actions	Who	When
1	Outline of agenda and any AOBs (note this meeting is not for discussion of individual cases).			
2	… doing? Review of …e 2 diabetes model …rics (should all be …n a run chart): …lls in birth month … smoothing …ogy) …e processes overall % … diabetes pts) …nt targets overall % … diabetes pts) …betes prevalence …betes prevalence … programme referral …al programme …n rates …or QoF			
	…ountermeasures … for processes not patients):			

Begin to develop your set of type 2 diabetes metrics. If possible use admin or data support to produce each metric. Turn the monthly data into a run (line) chart and explore the chart each meeting. As you develop each measure, add further charts. You are looking for positive trends long-term, rather than reacting to individual data. See Table 3 on page 21 for detail.

Time to explore any system and process risks that have emerged, e.g. failure in the recall system. Note: Patient specific issues should be discussed in other existing forums.

Improvement Actions (from your Self-Assessment):

Table 1: Example Type 2 Diabetes Working Group Agenda

Area of improvement	Descriptions	Who	When	Status: Started	Midway	Complete	Being used
A							
B							
C							
D							
E							
F							
G							
H							
I							

List down the development actions you generated from your self-assessment. It is OK to use more than one line on a development area. For example, there may be two or three actions that need to be completed before you can issue each patient a copy of their care plan in an Annual Review.

Don't forget that an action is not really an action unless the 'who' and the 'when' is clear.

For each action you can indicate the status of the actions by shading in the appropriate box.

Measures definitions:

Refer to the table opposite for definitions, collection and display prompts for each measure used in the agenda. The idea is to create a helpful, objective viewpoint for the working group, rather than a record for judgement by others. From this, the group can understand how effective the current model of care is and how reliable key processes are.

The default display prompt is a run chart. More on run charts can be found here:

Perla RJ, Provost LP, Murray SK The run chart: a simple analytical tool for learning from variation in healthcare processes BMJ Quality & Safety 2011;20:46-51.

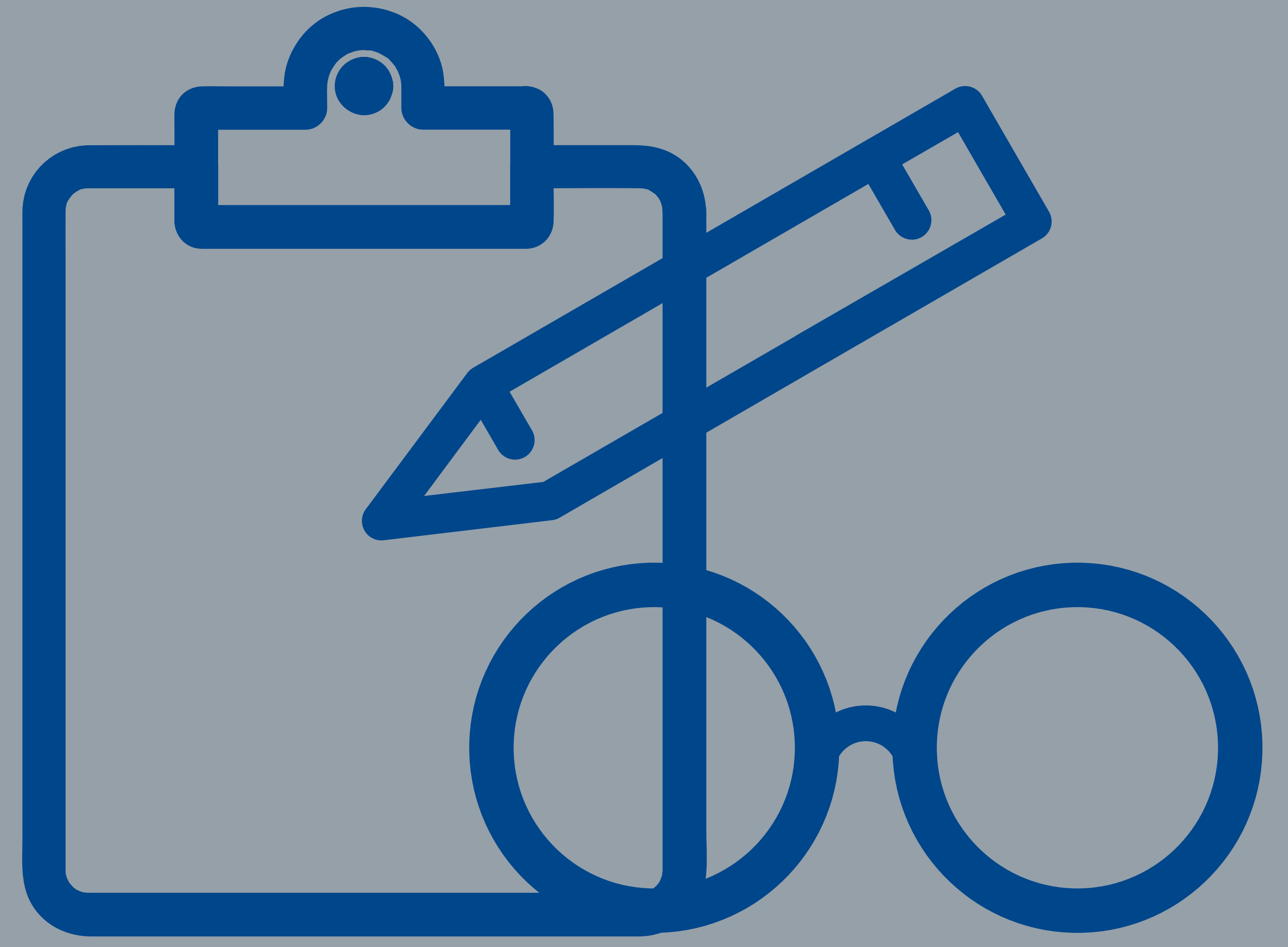
https://qualitysafety.bmj.com/content/20/1/46

	Measure:	Definition:	Notes:	Collection:	Display:
1	% recalls in birth month	(No. of type 2 diabetes patients who received their AR within birth month / No. of type 2 diabetes patients due their AR within birth month) x 100	% recalls in birth month is a way of smoothing work out across the year to ease pressure. If another smoothing strategy is used, then measure the adherence to that plan in the same way. (No. of AR carried out in the period / No. of AR due in that period) x 100	Monthly reporting. First day of the month, reporting on the previous month.	Display on a run chart. Build up data points over time.
2	8CCP % (8 Core Care Processes)	(No. of patients who have had all type 2 diabetes 8CCP completed within the past QoF Yr / Total No. of type 2 diabetes patients) x 100	Eclipse, and similar systems, have inbuilt functionality to produce this metric. By monitoring over the year you can see your progress build.	Monthly reporting. First day of the month, reporting on the previous month.	Display on a run chart. Build up data points over time.
3	3TT % (Three Treatment Targets)	(No. of patients who meet all three of the type 2 diabetes treatment targets / No. of T2 DM patients) x 100 HbA1c <=58 BP <=140/80 Cholesterol <= 5mmol/l and/or Statin prescribed	Eclipse, and similar systems, have inbuilt functionality to produce this metric.	Monthly reporting. First day of the month, reporting on the previous month.	Display on a run chart. Build up data points over time.
4	Type 2 diabetes prevalence	(No. of patients with a type 2 diabetes diagnosis / Total No. of patients) x 100		Monthly reporting. First day of the month, reporting on the previous month.	Display on a run chart. Build up data points over time.
5	Type 2 diabe-tes expected prevalence	Expected diabetes %	Supplied by Fingertips data. This data may not match your practice or PCN foot print exactly, but will give you useful comparison with your actual prevalence. To give you an understanding of the volume of patients you might be missing.	Yearly	Display on a run chart. Build up data points over time
6	Education programme referral rate	(No. patients referred to education programme within 12 months of diag-nosis / No. patients eligible for referral within 12 months post diagnosis) x 100		Monthly	Display on a run chart. Build up data points over time.
7	Educational programme completion rate	(No. patients completing structured education with one year of referral / No. patients referred in the same period) x 100	Data can be sourced from the commissioners of structured education in your area.	Rolling yearly figure calculated monthly.	Display on a run chart. Build up data points over time.
8	QoF Progress (Quality and Outcomes Framework)	(Total diabetes QOF points achieved / total available) x 100			Display on a run chart and build over time.

Table 3: Measures Definition Table

The idea is to create a helpful, objective viewpoint for the working group, rather than a record for judgement by others.

Taking Stock

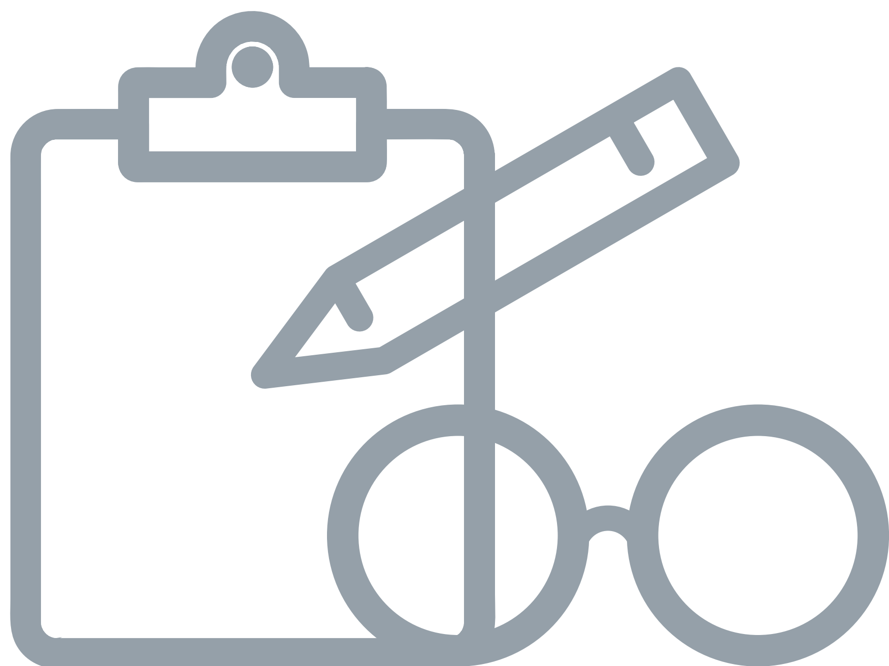


Self-assessment tool

We've created a self-assessment tool for you to examine your current system and process for the care of people with type 2 diabetes. It will lay the foundation for your work in this area going forward.

The tool is designed to:

- **provide an engaging way for you and your working group to create a current state review;**
- **support you to identify possible changes and create a simple roadmap to bring them to life;**
- **act as the basis for reviewing the status of your improvements of system and process; and**
- **help match the improvement areas you identify with local support available.**



How to use the self-assessment tool:

1. Complete it as a group – ideally your working group plus a few others. Part of the value of the process is the discussion and critique it generates, as well as the improvements you identify. Having someone external to facilitate can help.
2. Allow yourselves around two hours to complete it. You could do an hour one week, followed by a second hour the next week.
3. Give everyone in the meeting a copy of the self-assessment to scribble on. The leader can write on a master copy.
4. Assess the level of maturity of your system and processes using our matrix structure. It's split into the seven domains we introduced earlier: Organisation and Process; Data Foundations; Consistency; Consulting Approach; Engaging Patients and the Community; Leadership; and Training and Competencies. Each has four statements describing it with increasing levels of maturity – from Intermediate to Established to Mature, ending with Advanced (a stretch for most practices).
5. Read each statement and decide whether it applies to your practice. In doing so, you will systematically assess your system and process, taking into account a wide range of influences.
6. Indicate the level of maturity either by:

a. statement – using colours to indicate whether you meet it (green); it's a work in progress (yellow); or you don't meet it at all (no colour). See Figure 8; or

b. identifying which statement most closely matches your level of maturity.

7. Be honest. Consider, for example, whether a process works at all times or whether it's reliant on one individual and their knowledge. As a test, ask yourselves: would you worry about something happening while a specific team member was on holiday? Remember, it's not a competition. You're creating your own benchmark, so the outputs are only of value to you if you're truthful.
8. Use the self-assessment at intervals over your improvement journey to take stock and re-assess your plans.

Figure 8: Example completed self assessment

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Table 3: South West London Type Two Diabetes Quality Improvement Guide Self Assessment Tool (V1)
(Downloadable and printable version available in the appendices)

Diabetes 3TT	Intermediate:	Established:	Mature:	Advanced:
Organisation and process How effective & efficient are our processes and use of resource	There is a reception protocol that details the appropriate appt types for PWD [4], including non-GP HCPs. We have a reliable process for annual reviews for housebound and care home PWD.	Previous statement + We regularly use systems for coordinating recalls with PWD. Annual reviews are 'smoothed' over the year – for example triggered by birth month [13] or similar planned distribution. We seek to reduce the rate of personalised care adjustment (exception reporting).	Previous statement + Digital solutions are in place to remove the non-clinical tasks from, and coordinate annual reviews [9]. Results and information are shared in advance of annual reviews, utilising digital technology and PWD self-reporting (e.g. BP and Glucose) where possible [14]. We have an effective process for follow up PWD who don't respond to annual review requests. We have mechanisms, such as patient co-design groups, to improve our T2DM services.	Previous statement + Recalls are reviewed, coordinated and combined [4] [13] with other scheduled interventions (from other conditions / jabs / health checks etc) before sending. All of our LTC data gathering is done in the same appointment for multi-morbity patients. Relational and informational continuity is reliably maintained [8]. With our PCN we have developed and put in place locally integrated new models of care that address the fragmentation of the local provision of complex care - this could be generally for those with multiple chronic conditions and / or the frail for example. We invest time in working with providers of specialist services regarding the transition of diabetes services between specialist services (such as an inpatient stay) and primary care.
Data foundations Do we have objective methods for prioritising & understanding the effectiveness of our care?	We know and have discussed as a senior team our previous year's diabetes QOF and NDA performance. As a PCN we have access to population health data and have identified segments of our population that feature inequalities.	Previous statement + We understand the cost (to the practice) of our current approach to managing PWD. We audit and act upon the quality of care process coding [14]. We track the % of PWD attaining the 8CCP and 3TT over time such as monthly on a run chart [16].	Previous statement + We use real time data such as using Eclipse, or similar, on a weekly basis to case-find for care intensification and monitoring of PWD [3]. We also use data systems such as Eclipse, or similar, to prioritise focus on diabetes care processes and treatment. Helping with resource allocation and quick wins towards achieving QOF. We use mandatory fields in annual review templates to ensure things are not missed [14].	Previous statement + We track (on a graph) the current gap between our current and expected T2 diabetes prevalence [14], the rate of completed full personalised care review cycles, the rate of personalized care adjustment (PCA) and the number of PWD who compete structured education programmes [18]. We have designed junior clinical or non-clinical roles to use Eclipse or similar, to organise our case finding and annual review activities [3] in order to remove the administrative burden from senior clinicians
Consistency How consistent is our approach?	Clinicians have access to NICE guidelines on the appropriate intensification of treatments and referrals to specialist services.	Previous statement + We have discussed as a team the appropriate general intensification and handover points for treatment, diagnostics, referrals and involvement of non GP professionals – including the wider MDT such as physician's associates, HCAs, nurses, pharmacists [10], social prescribers, wellbeing coaches, dietitians and admin.	Previous statement + We have defined, in the form of a written practice protocol and / or pathway, the timing and form of general intensification and handover points for treatment [1] [12] [14], such as medicines, diagnostics, referral to primary and secondary care specialists [2], use of health promotion, prevention programmes such as NDPP [26], MDT reviews [4] and the involvement of non-GP HCPs such as physician's associates, HCAs, nurses, pharmacists [10], social prescribers, wellbeing coaches, dietitians and admin. We have reviewed our pathway for efficiency and reliability gains – using Quality Improvement (QI) and / or Lean Thinking as prompts. The pharmacist role (if applicable) is expanded so that they attend MDT meetings, conduct reviews on diabetes and cardiovascular related drugs and undertake signposting [10]. We have systems for ensuring practice pathway and protocols are accessible to clinicians. The PCN has discussed and agreed how to best use the ARRS roles to help the network of practices be more proactive with LTC management inc T2 DM.	Previous statement + We work to improve the quality of our referrals to specialist services [26]. We have a process for auditing our working against our pathway or protocols (we do what we say we do in relation to intensification, MDT working, personalised care planning etc) [10]. We have developed new models of care to engage difficult to reach segments. We have systems, that support clinicians in following agreed pathways, such a decision support tools. Group consults. We use MDT consultations [4], that on occasion also include community and secondary care specialists. The PCN has integrated ARRS roles, into the microsystems of each practice, so they help the network of practices be more proactive with LTC management inc T2 DM.
Consulting approach Are we making the most of our consultations?	Clinicians discuss complex PWD together in structured meetings at least once per month. We have access to social prescribers / wellbeing coaches and other ARRS roles through our PCN. We use HCAs and nurses in our diabetes care. We reliably refer PWD to diabetes structured education (such as DESMOND) through Book and Learn [19]. People at risk of diabetes (inc non-hyperglycemic diabetes) are referred, where appropriate, to the NDPP [26].	Previous statement + Clinicians are consistent in the view that diabetes can often be put into remission [9]. PWD are given a copy of their care plan [14]. For PWDs with multiple conditions there is a single care plan [6]. We reliably inform PWD of the choice and functionality within Book and Learn as part of our process for diabetes structured education [3].	Previous statement + PWD are offered emotional and psychological support on diagnosis and referral to self-management education [10]. We have access to in-house or local group consultations [26]. We assess MH and/or diabetes distress [27] annually. We have access to in-house or local group consultations [26]. A PWD's wider self-management knowledge and skills (nutrition, exercise, self-monitoring [15] etc.) are assessed annually. We use longer appts where beneficial [9]. Structured education is also suggested to family members [19]. We hold high quality conversations with PWDs about the benefits of structured education including expert patient programmes [20].	Previous statement +: We use a full personalised care planning approach. It includes preparation, goal setting, joint action planning, documenting, coordinating [6] [7]. We use a scoring instrument, such as PAMS, to track a PWD's knowledge, skills and confidence [6] [5]. We have systems of pt follow-up to check a pt's understanding of annual review actions and outcomes [25] [6]. Clinicians meet quarterly to discuss diabetes care (beyond problem-solving complex cases) and check each other's approach and understanding. We conduct multi-morbidity annual reviews.
Engaging Patients and the Community Is our community viewed as an asset in our model of care?	We have a PPG group, which has discussed either diabetes care specifically or more generally for those with LTCs.	Previous statement +: We reliably use digital platforms (such as You & Type 2) for PWD communication. We have worked as a practice to create a set of tailored messages for different PWD groups. Some senior team members have allocated time in their portfolio to connect with their communities [14]. We have mapped out links to community groups and services that can help PWDs with the wider determinants of health. We have had a discussion, as a senior team, about improving communications with PWD.	Previous statement +: The practice works to improve the health literacy of PWD [4]. We signpost device manufacturer helplines [15] both verbally and in written guidance. We strategically view our community as an asset in the health of the population we service. This view is written and agreed in our long-term plans. We work with the community to address the issue of food security, if applicable [14]. We have documented our near term plans for improving communications with PWD, and follow up on them in senior team meetings.	Previous statement +: We review PWD information for format and language. We use colour and display information visually [4]. We have a diabetes PWD reference group and use their feedback to improve system and process. We have a diabetes communication strategy, [3] detailing formats and content that fit the needs of the local population – not only for the management of existing PWD but also for proactive activities. We use online platforms, such as GPdoc, to facilitate networks between PWD [15]. We actively engage and support the community, including schools and community groups, to contribute to the wider determinants of health. This engagement and support can take the form of the use of facilities, greater practice links, and practice-based groups (such as gardening or walking). It may also include community and practice champion programmes. We invest time in working with providers of specialist services (such as an inpatient stay) on the transition of diabetes services between them and primary care.
Leadership Is our leadership as supportive as possibel?	There is a senior clinician with responsibility for diabetes [6].	Previous statement +: We have an identified lead for recalls and annual reviews. We have short-, medium- and long-term plans of diabetes improvements [23] that fit the needs of our local population. PCN members are consistent on the role that PCN plays in addressing inequalities and gaps in efficacy for pt segments less well served by traditional models – such as young adults, BAME people, and people with learning difficulties [21].	Previous statement +: We hold monthly or bi-monthly diabetes working group meetings to review our progress against improvement plans. The group also reviews key diabetes team metrics, such as 8CCP rolling %, 3TT figures, AR within birth month rates, etc. We have the skills to complete quality improvement projects and have a history of being able to follow through full PDSA cycles [16]. There is consistent trust across all GPs in the competencies of non-GP colleagues [1]. Our PCN has detailed and agreed plans that address inequalities and gaps in efficacy in services for traditionally less well served segments. These plans may take the form of wider network	Previous statement +: We have set aside time for the senior leadership team to learn and reflect on our leadership [22]. Senior team members have received leadership training.
Training and Competencies Do we have up to date knowldege?	Reception staff are trained in which appts to book for PWD [4] when considering the need and practice factors such as clinical skill mix and continuity.	Previous statement +: Reception staff have been trained in diabetes basics. HCPs (GPs and nurses) working with PWD attend twice yearly educational training by secondary care diabetic specialists [17]. All PWD-facing staff are trained in process and aims of the Book and Learn system.	Previous statement +: All members of the diabetes healthcare team, including non-clinical, are familiar with the content and format of structured education [19], such as DESMOND. Non-clinical pt-facing staff have been trained in the role (timing, scope and form) of all professionals involved in diabetes care. At least one clinician and a member of key admin staff have received training in Eclipse (or similar). Community and secondary care diabetes specialists conduct reviews or participate in joint consultations at the practice at least twice a year.	Previous statement +: All clinicians involved in the care of PWD are trained in personalised care planning and are clear on their role within it [7]. Reception, admin, HCAs and other PWD-facing staff are trained in communication techniques to increase engagement with PWD. Reception staff are trained in appropriate appointment types for multi-morbidity reviews. Clinicians are trained in conducting multi-morbidity annual reviews. The lead diabetes clinicians have at least 10 hours training per year [2]. Locum cover is provided for those attending training [6].

References can be found on the inside back cover of the main document

Prioritising the improvements you've identified

Based on the statements that your practice did not meet in the self-assessment, you can begin to prioritise your improvement areas. There are two ways of doing this. The first is to use a complexity/benefit matrix. The second is to identify a critical path.

1) Complexity/benefit matrix:
This matrix (see Figure 9 below) helps you prioritise changes by their complexity and their possible benefit. Both the Y axis (complexity) and the X axis (possible benefit) start at medium – as all changes are complex and all are worthwhile in some way.

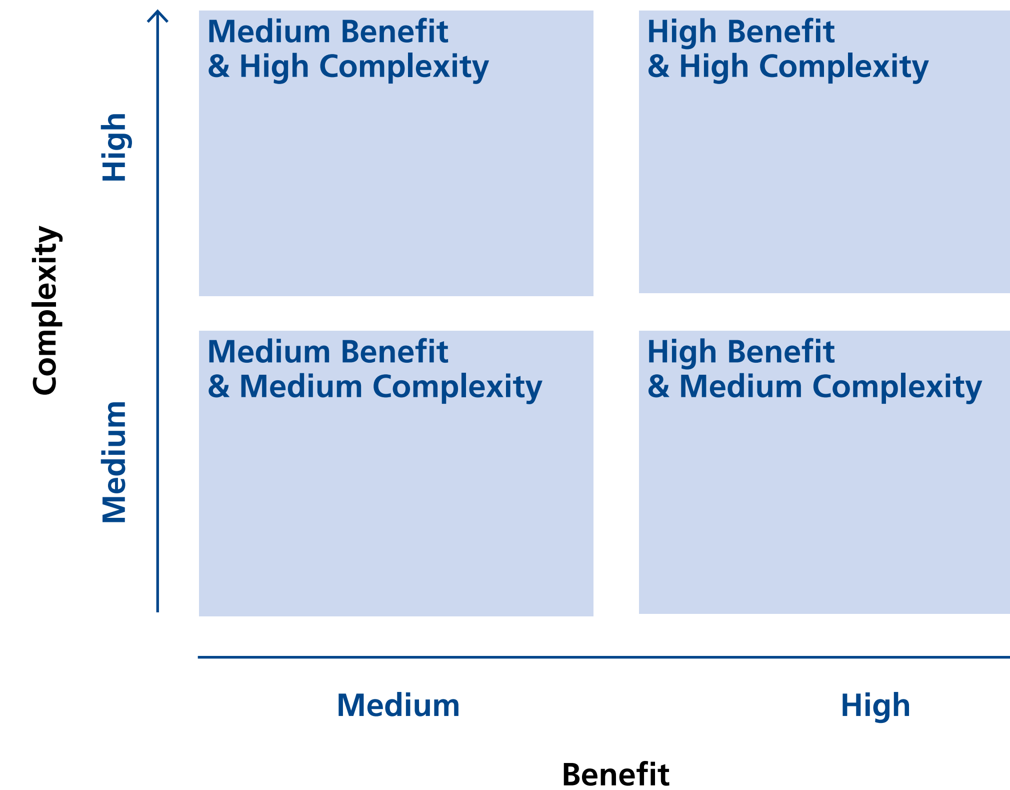


Figure 9: Benefit/complexity grid

Consider how much each change would improve your type 2 diabetes system and process, and how complex it would be in the context of your practice. Position each on the matrix – see the examples in Figure 10 below.

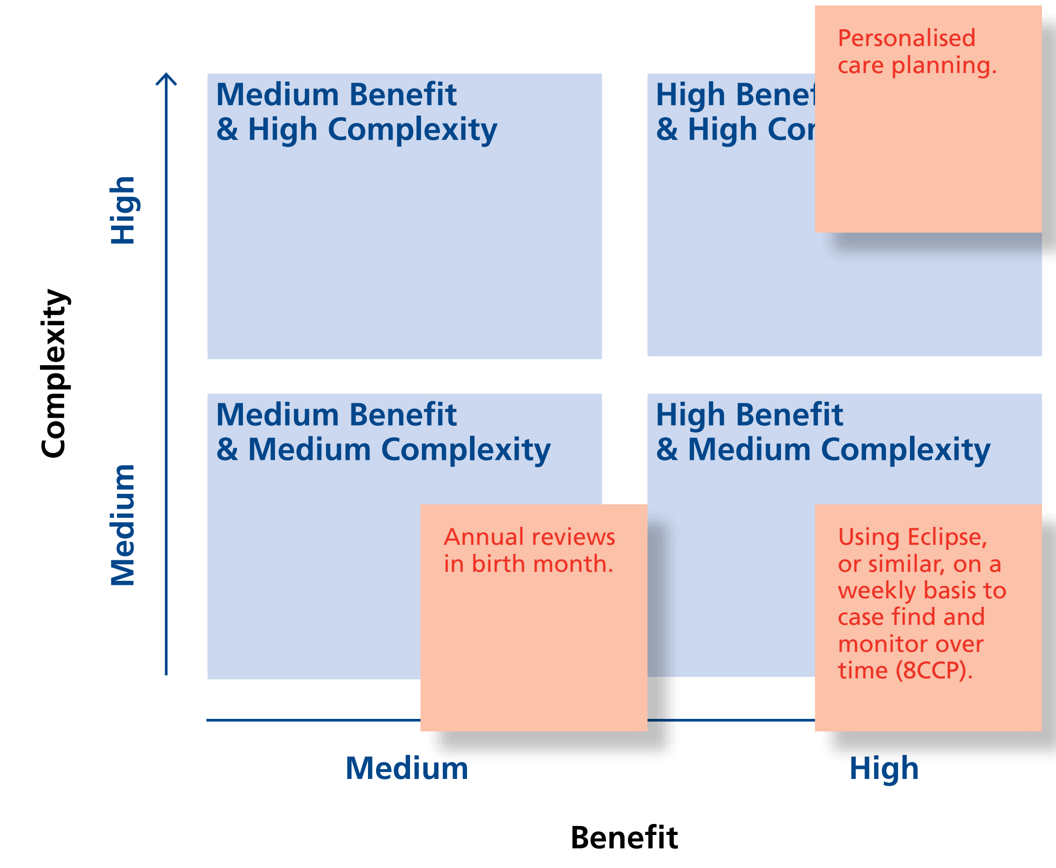
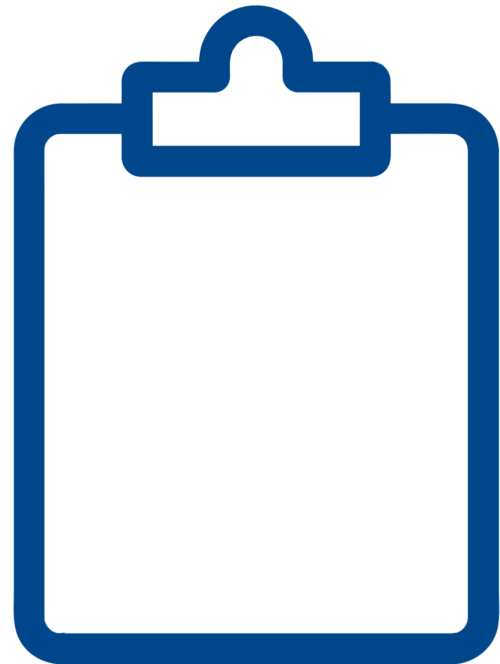


Figure 10: Benefit/complexity grid examples

Figure 10 positions personalised care planning to the top right – highly complex but also potentially high benefit. Not only does it require changes to the processes of recalls, care planning documentation and diagnostics gathering, but it also needs clinicians to change their consulting methodology and working patterns. Sorting annual reviews by birth month, in comparison, is positioned as medium benefit and medium complexity. It is still a challenge, requiring changes to processes, but does not require clinicians to adjust their annual review methodologies and practices.

We'll take a deep dive into the type and complexity of changes for each domain later in this document.

2) Critical path
The benefit/complexity matrix method above assumes all the possible improvements are independent of each other. The critical path method assumes the opposite: that there are interdependencies between improvements. It sees a more effective, or even critical, sequence between them.



Consider how much each change would improve your type 2 diabetes system and process, and how complex it would be in the context of your practice.

This approach mirrors our experience at the South West London Health and Care Partnership's Long Term Conditions programme team in supporting practices to improve their system and processes – in particular with type 2 diabetes.

Figure 11 below illustrates the critical path emerging from the team's work on type 2 diabetes. Treat it only as an example for consideration, as the path is highly dependent on the starting point of each practice.

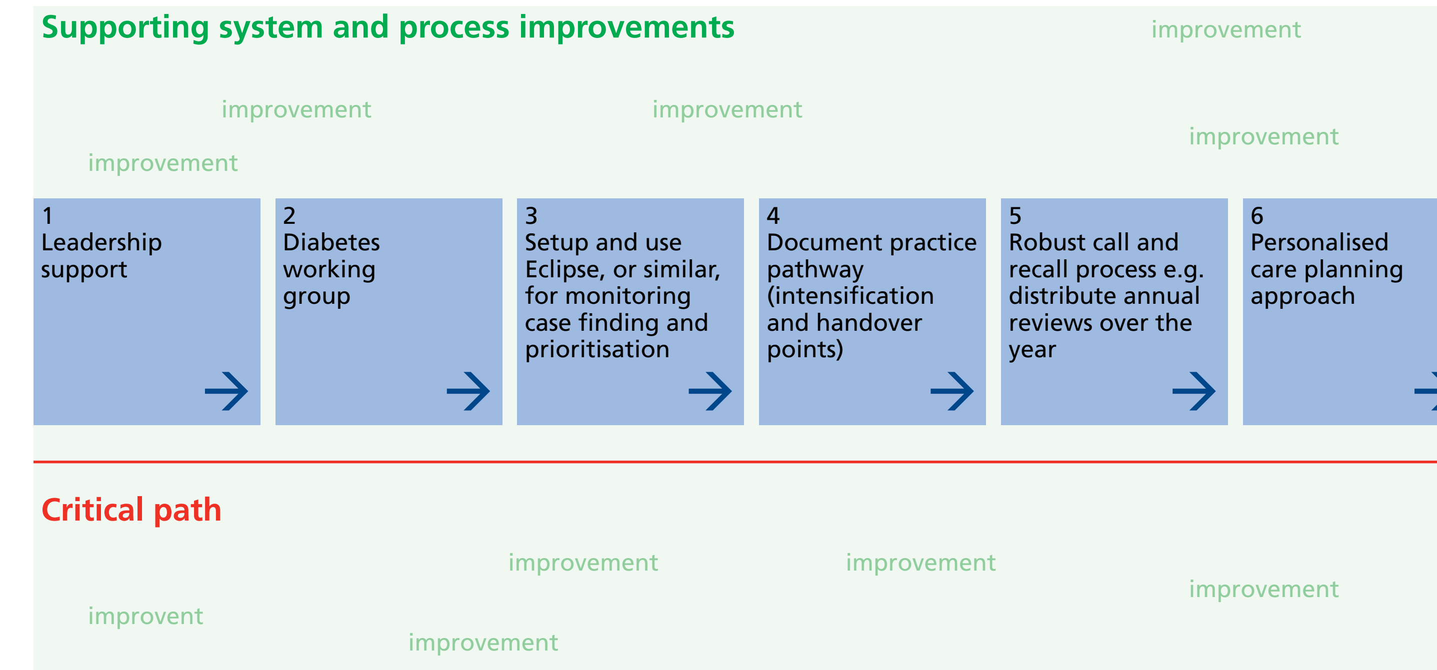


Figure 11: Example critical path

The steps in Figure 11 explained:
1) Without leadership support, improvement activities are difficult and likely to fail. The practice senior team need to be consistent and visible in committing resource to the working group. Their meeting minutes should document this commitment.

2) As established in Getting Ready (see page 16), the foundation for all improvement work is the diabetes working group. The group will identify and keep up the pace of improvements.

Without leadership support, improvement activities are difficult and likely to fail.

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3) Next, strengthen your data foundations. Institutionalise the use of data-driven methods to case find, prioritise and monitor macro trends. Apply these methods to the three treatment targets (3TT) and the eight core care processes (8CCP).

4) Variation of approach is the next consideration. Maintain documentation on general intensification and handover points. This way, the practice's approach is not in someone's head but is discussed and documented.

5) Carry out reliable annual reviews. Smooth their distribution over a year to avoid peaks and troughs (or a format that suits your specific population), reducing pressure points. This process is also a good test of your practice's reliability – whether you're consistent in doing what you say you do over time.

6) Personalised care planning involves realigning consultations and annual reviews in a more holistic way. Focus as much on the person's context and non-health needs and preferences, as the clinical status of their condition(s).

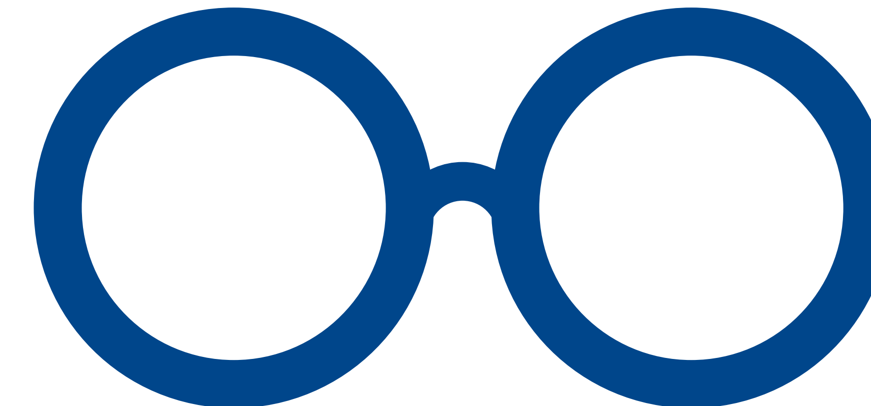
The above critical path is for illustrative purposes and therefore limited in scope.

Support in your system

Most integrated health systems offer support to general practices on a wide range of improvement topics. Primary care support teams, variation teams and long term condition teams tend to deliver this support. It's also enabled through primary care transformation committees, or similar.

Here at South West London integrated care board, our Long Term Condition team has developed a support menu. Structured around the same seven domains as our self-assessment tool, the menu provides specific support for these improvement priorities. It includes up-to-date options specific to South West London integrated care board, as well as those that are nationally available. Your own integrated care board will no doubt have support available too.

Further detail on support can be found in the appendices.



Most integrated health systems offer support to general practices on a wide range of improvement topics.

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Domain	Support Menu:				
Organisation & Process	**Call and Recall** Process improvement support to streamline and smooth call and recall processes Process mapping, measurement and project management support to ensure all eight core care processes tests and checks are complete and acted upon.				
Data Foundations	**Support Software** Risk stratification and proactive care monitoring software and tools. Software: Eclipse/Primis/Sollis/Ardens Tools: UCLP/SEL/specific EMIS searches.	**Practice Model of Care Insights** Questioning the current model through demand categorisation and segmentation. Clinician-led questioning and insights into effectiveness of the current model of care. Creation of practice insight analytics pack.	**The Practice Cost of Diabetes Care** Understanding the cost of the current model of care Data analysis support to produce cost and resource use profile. Aimed at understanding the proportion of practice resources used in the care of people with diabetes.		
Consistency	**Improvement** Efficient, reliable pathways within practice. Ensuring the practice is consistent and effective in its approach. Quality improvement and measurement support.	**Digital Solutions** Systems that enable the interrogation of data to understand consistency of approach. Such a Patient Leaf.			
Consulting Approach	**Personalised Care Planning** Implementing personalised care and support planning Support to understand and implement the pre, post and new consulting approach to annual reviews. Including digital platforms such as You&T2.				
Engaging Patients & Community	**Community Asset Development** Mapping out and engaging links in the community Support for practices to begin to engage their community in developing its own capacity for healthy living.	**Communications Strategy** Expert to support to develop a communications strategy for patients with type 2 diabetes and other long term conditions.	**Patient Engagement** Training for reception and admin teams in patient engagement techniques. Training in the latest comms techniques, both digital and face to face, for improving response to recall requests.		
Leadership	**Leadership Development** Leadership development training for primary care network leaders and practice partners. Places on leadership development programmes designed to develop competencies in network working and new models of multi-disicilinary team working and proactive care.				
Training & Competencies	**Clinical Training Up to Date** Such as Cambridge Diabetes Education Programme. Training for clinical staff in up-to -date.	**Condition Guidance** Guidance on factors adding to complexity, such as frailty. **Peer Network Support** Closer working with local specialist teams and practices Arranging of virtual or joint clinics and case reviews.	**Diabetes Medication Use** Ensuring best practice medications use. Access to training and refreshers on medications best practice.	**Structured Education** Ensuring the most effective referrals Training in options and functionality of Book & Learn, and also the content and options within structured education.	**Holistic Support** Wider support knowledge Updates on what else is available to support people with diabetes such as emission programmes, digital innovations, exercise schemes and remote monitoring.

Figure 12: South West London Support Menu for Practices

The domains in depth

The seven domains we refer to throughout this guide capture the complete picture of the system and process of type 2 diabetes care. Read on for detailed descriptions of each, as well as sources of further information and implementation considerations.

For the numbered references, see Table 4 on *page 83.*

For glossary see *page 82.*

Organisation & Process

How effective and efficient are our processes and use of resources?

Reception, back office and coordinating functions should be set up to be as efficient as possible. This way, you'll reduce variation of approach, have slick referral processes, and achieve continuity where it counts. Optimising your use of technology will ease the burden of data-gathering and help you distribute work across the year. All of this will ensure you provide a visible and reliable process for patient groups that fall outside of core practice processes too.

Intermediate

a) There is a reception protocol that details the appropriate appt types for PWD[4], including non-GP HCPs.
Reception work has become more complex in recent years. Reception staff not only document the patient's request. They may also need to signpost to an ever-widening range of clinicians and internal and external professionals. Long-term conditions add another layer. Patients no longer see just one or two clinicians. They may see a clinical pharmacist, GPs, nurses, healthcare assistants, and a social prescriber. Reception staff need guidance on who to book in with at which point in the patient's journey.

In some cases, a new starter learns much of the reception role from experienced staff in a 'see one, do one' way. There is merit to this, but it does leave the door open for unwarranted variation in approach. A better place to be is to document the process in protocols or standard operating procedures. After all, if you haven't written it down, how can you tell how reliable your reception allocation is? This way, you can audit against the protocol.

Documenting appointment types for type 2 diabetes patients benefits the diabetes team too. It serves to reduce variation of approach in the wider practice, as it requires the team to agree in writing who should be doing what and when.

Finally, you own what you create. So, to make uptake of the protocol as smooth as possible, involve both reception and clinicians in its creation.

b) We have a reliable process for annual reviews for housebound and care home PWD.
Reliability means having confidence that the process in question does what it says it does. If clinicians don't have to worry about it, then you're doing it right.

The components to reliability include:

- **documenting the process in a protocol or standard;**
- **auditing it periodically to assess if it is reliable and effective; and**
- **improving or iterating the process and updating the protocol based on audit findings.**

People in care homes and who are housebound can fall into the trap of being out of sight, out of mind. Their needs may be drowned out by on-the-day appointment requests and the drive for greater access. Primary care network models of care home provision can reduce individual practice pressure. Despite this, deliberate focus and enquiry, as detailed above, are still neccessary to assess reliability.

Established

c) We regularly use systems for coordinating recalls with PWD.
You might organise recalls on paper – in a notebook or on index cards. Or you may use one of the many electronic options available. Either way, it's a system. As we already established: when it comes to reliability, the key is visibility and confidence in the process. If, for example, one staff member manages the system and no one else can pick it up easily in their absence, the system is vulnerable. How do you know how well it is performing?

Given its importance, many practices are moving to electronic systems for planned recall. These systems smooth your work over the year. They also make recalls more visible, with easier reporting on performance and reliability. A practice can ascertain very quickly whether it successfully recalled the people it intended to in a given period of time. It can also establish the status of its communication attempts.

As with care home monitoring, the key principles are:

- **documenting your system in a protocol or standard that is visible to many;**
- **auditing it periodically to assess if it is reliable and effective; and**
- **improving or iterating the process and updating the protocol based on audit findings.**

d) Annual reviews are spread over the year – triggered by birth month[13] or similar planned distribution.
The concept of distributing – or smoothing – annual reviews over the year is gaining prominence in general practice. Unlike much (but not all) of your reactive, on-the-day work, you can position this work to suit periods of greater capacity. At they very least, it will help you avoid last-minute rushes, like in the runup to the annual quality and outcomes framework deadline.

What this means in reality differs by practice and by population served.

If, for example, one staff member manages the system and no one else can pick it up easily in their absence, the system is vulnerable.

How do you know how well it is performing?

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Many practices use the birth month method, completing annual reviews for all patients within the month of their birth. This method lends itself to being able to measure. As a result, it can increase visibility of the percentage of patients' annual reviews on a rolling monthly basis.

Some practices plan all their annual reviews for spring and early summer, when they have better staff availability. This way they also help elderly patients avoid the winter period. They then 'mop up' any outstanding annual reviews in autumn, combining it with the flu jab if the patient is eligible.

Other options include an intensive push in spring, prioritising remaining patients the rest of the year using the eight core care processes. Population characteristics may mean many patients are not available at certain times of year. Many people of South Asian descent, for example, take extended breaks abroad visiting family. A practice would build its recall system, then, to avoid these periods for these patients.

Whatever the method of smoothing, the objective is the same: to avoid peaks in workload and to be more patient friendly. Ideally, this process is not done in isolation, but alongside considerations for all long-term conditions. To make it as effective as possible, analyse your practice staff availability trends. For example, plot on a bar chart the number of unplanned, patient-facing sessions your GPs worked over the past 12 months by week. It will tell you where you tend to have the most capacity, and where you don't. The process is even more effective if you begin to smooth out troughs in your capacity over the year too, like times of holiday or training. More detail on improving call and recall can be found in the appendices.

e) We seek to reduce the rate of personalised care adjustment (exception reporting).

It is common for practices to use a threshold of three recall communication attempts as their limit for annual reviews. After that, they draw a line under a patient and concentrate on those who do engage. There is a risk here, though, that a patient then attends at a later date with more complex needs, using even more practice resources. It may be in the practice's best interests long-term, then, to persevere with engaging the patient and, in time, reduce the rate of exception reporting.

In weighing up this issue, you could look into the effectiveness of your engagement techniques, such as the channels and messages you use. We will explore this area later in the Engaging Patients and the Community domain.

Mature

f) Digital solutions are in place to remove the non-clinical tasks from annual reviews and to coordinate them[9]. Results and information are shared in advance of annual reviews, using digital technology and PWD self-reporting (e.g BP and glucose) where possible[14]. We have an effective process for follow-up PWD who don't respond to annual review requests.

It may help to think of an annual review like a formula one pitstop. Pitstops have been improved to the point where four tyres can be changed in seconds. They have achieved this through a technique called setup reduction. It splits tasks into internal and external categories. Tasks that have to be done at the time of the pitstop are internal. Tasks that can be done beforehand, outside of the pitstop, are external. This way, it leaves as much time as possible to do the real value-adding tasks face-to-face.

In the context of annual reviews, this technique would mean you gather diagnostics and information before the review. You then concentrate the review itself on joint decision-making and what matters to the patient. Doing so can have the added benefit of giving the patient time to digest their diagnostic results before their annual review, putting them more in control. We explore this method in detail in personalised care planning in the Consulting Approach domain.

Technological developments in this field have been rapid. Systems such as You & Type 2 enable you to digitally communicate diagnostic results in a personalised and educational way. SMS systems like Accurx allow you to template personalised messages with supporting information links. Patients can now view clinical comments on diagnostics through remote access to healthcare records. For those using remote glucose monitoring devices, their data is available to clinicians. And through access systems like E-Consult, you can send data-gathering templates to patients in advance, allowing them to self-report weight, blood pressure and more.

Of course, not all these technologies suit all patients. It is a case of segmenting your diabetes or long-term condition patients and considering what works for each group. The rewards are big and long-lasting, though. The pressure of long-term conditions on practices is not going away quickly, but these methods can ease it. They can also help shape the relationship between patient and practice for years to come. If you set precedent and expectations with new or younger patients, remote access and self-monitoring become part of the process. And many will welcome and thrive with a light touch review.

g) We have mechanisms, such as patient co-design groups, to improve our T2DM services.

Including patients in co-design can offer energising new perspectives and innovative models. Co-design requires a genuine starting position of equality between professionals and patients, though. It is harder to set up than it is often perceived. For a good summary of the differences between co-production and more basic patient consultation, see this blog from Professor Malby from the Health Systems Innovation Lab at London South Bank University: https://beckymalby.wordpress.com/2015/11/08/17

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h) We review, coordinate and combine recalls[(4) (13)] with other scheduled interventions (from other conditions, jabs, health checks, etc.) before sending. All our LTC data-gathering is done in the same appointment for multi-morbidity patients.
Patients with type 2 diabetes often have other conditions and health needs. As a result the same patient may receive multiple requests from a practice, for diagnostics, jabs, health checks and other annual reviews. Not only can this be frustrating, time consuming and potentially confusing for the patient, but it is also a waste of precious practice resources.

By taking time to view the patient as a whole, you can condense this fragmented series of small interventions into fewer, more holistic ones. Combining and synchronising health checks, jab schedules and multi-morbidity annual reviews can save you and the patient lots of time.

Advanced data analysis and multi-disciplinary team working are key here.

i) We reliably maintain relational and informational continuity[(8)].
Continuity is now widely recognised as an important factor in patient care. While a straightforward concept, it can be deceptively difficult to apply – for two reasons:

1. **Continuity, in the majority of practices, is a finite resource. With part-time working rising and opening times increasing, it cannot be given to every patient. The question then becomes: who needs continuity, and do you have the system and process to offer it?**
2. **It is challenging to put in place and maintain system and process to achieve continuity for those who need it. It requires changes, including the use of codes and flags, and great consistency from reception and clinical staff alike.**

Continuity is a useful metric. The ease of measuring it depends on your coding of appointments. If the quality of coding is poor, you will often need to clean data before you can determine levels of continuity.

The graph below, in Figure 13, shows a continuity analysis of 40 type 2 diabetes patients, over a range of HBA1c levels. It details the number of appointments the patient had in the previous year, against the number of clinicians they saw. Note the wide range of continuity across the patients. This practice is not reliably achieving continuity.

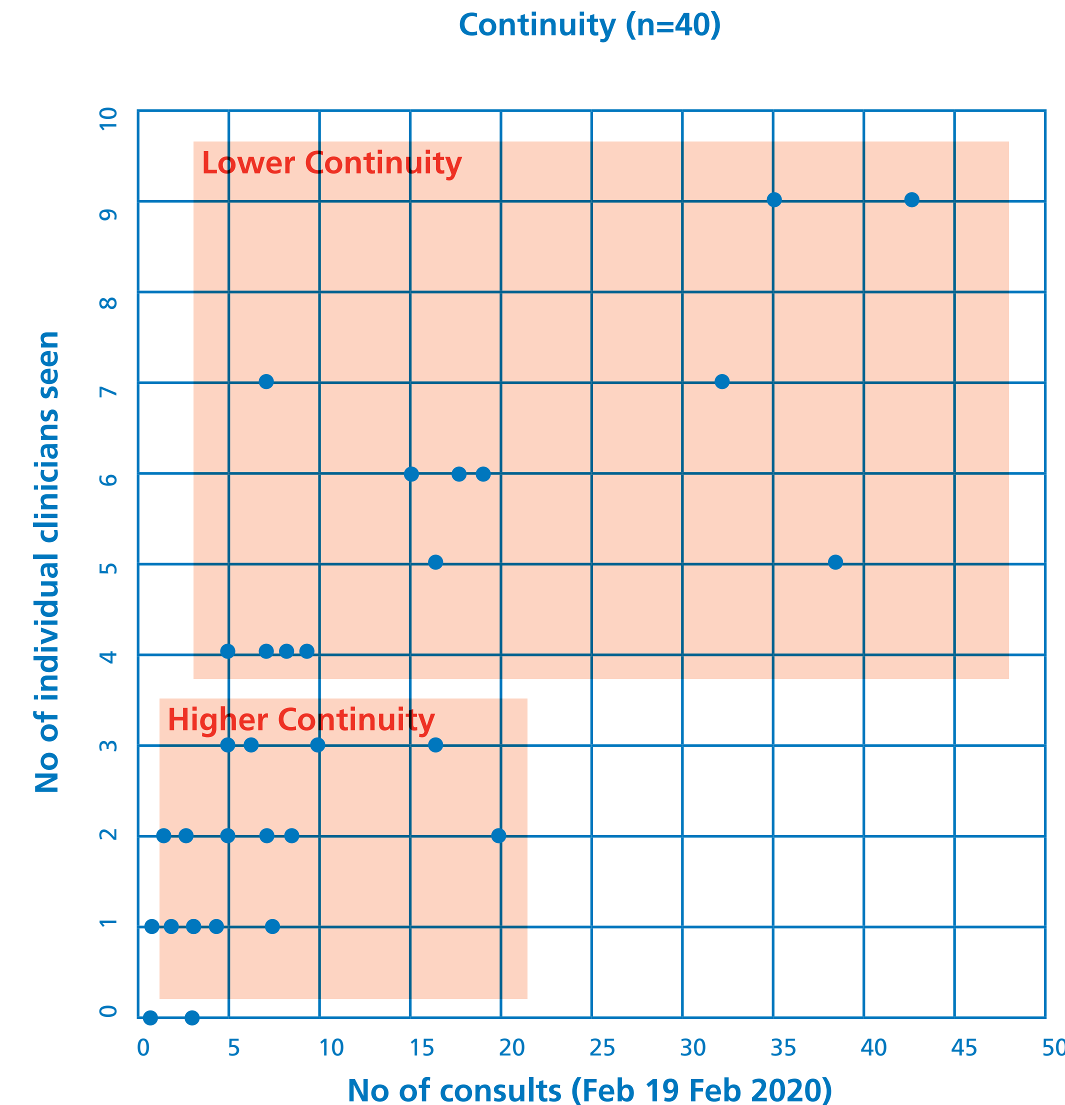

Figure 13: Continuity

If continuity is finite, to be consistent a practice needs to plan and be explicit in its decisions on which patients should have it. It is useful to consider the two types of continuity:

1. **Relational continuity refers to individual patients and individual clinicians. Patients see the same clinician so that the clinician can understand the patient clinically and contextually. This way the patient also forms trust with the clinician.**
2. **Informational continuity refers to the reliability of information exchange. As a practice clinician hands over a patient, they include what is important to the patient's story in the notes. The subsequent clinician can then pick up the patient seamlessly.**

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There are lots of good sources of information on continuity in general practice, including:

Continuity of Care and the Patient Experience from the Kings Fund:
https://www.kingsfund.org.uk/sites/default/files/field/field_document/continuity-care-patient-experience-gp-inquiry-research-paper-mar11.pdf

Improving Access and Continuity of Care from the Nuffield Trust:
https://www.nuffieldtrust.org.uk/files/2019-01/continuing-care-summary-final-.pdf

j) With our PCN, we have developed and put in place locally integrated new models of care that address the fragmentation of the local provision of complex care. These models could be for those with multiple chronic conditions and frail people, for example. We invest time in working with providers of specialist services (such as an inpatient stay) on the transition of diabetes services between them and primary care.
The primary care network has gone beyond plans and discussion. It has in place genuinely new models of care. These include providing new or additional services. They also include simplifying – by defragmenting and integrating – care for complex patients.

Data Foundations

Do we have objective methods for prioritising care and understanding how effective our model of care is?

Using the best available data methods to look at type 2 diabetes care allows analysis at both patient and practice level. At patient level, you can use data to case find and prioritise patients whose eight core care processes **signal** that they need further input. At practice level, metrics can indicate how effective the model of care is currently, and guide improvement decisions.

Intermediate

a) We know and have discussed as a senior team our previous year's diabetes QOF and NDA performance.
The Quality and Outcomes Framework and National Diabetes Audit provide useful signals to practice senior leaders on the effectiveness of their diabetes model of care.

How much these signals are heard among the noise of other practice business varies. To make sure that your practice hears them, include them in the agenda for the senior team. Doing so will maintain focus on the diabetes model of care and support for its working group (see page 18).

You can drill down and explore your NDA data through this *quarterly dashboard* produced by NHS England

b) As a PCN, we have access to population health data and have identified segments of our population that feature inequalities.
One of the main aims of primary care networks is to enable the use of population health data. This data highlights wider local health needs and inequalities. As a practice seeking to improve your type 2 diabetes care, understanding your populations in such detail is critical. Many primary care networks are beginning to either commission their own data or access data by local agreement.

Established

c) We understand the cost (to the practice) of our current approach to managing PWD.
Looking at the current type 2 diabetes approach through a cost lens can help gain senior leadership support. Earlier, in Figure 4 (see page 13), we showed an example of the resource used for patients with type 2 diabetes, as a proportion of overall resource.

Figure 12 below simplifies this.

% of Total Appointments Feb 2019 to Feb 2020

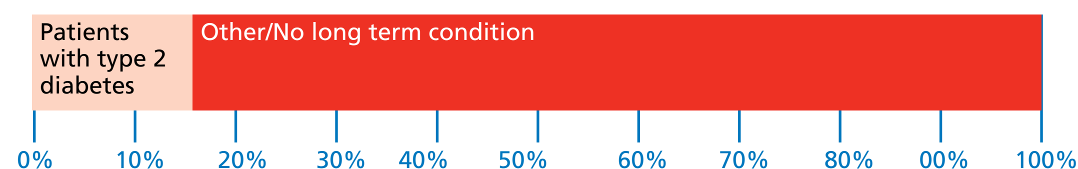

Figure 14: Practice Resource

It is a huge proportion of the practice's work, its might, efforts and dedication, especially when you consider for most practices type 2 diabetes patients account for only 5% of their list.

In this example, 16% equals 14,539 appointments, of all types. Using a cost figure of £30 per appointment, this number results in a spend of £436k per year. That's £872k in two years. Or £2.2 million in five years. Purely from a financial perspective, it is clearly in your practice's best interest to look at your type 2 diabetes model of care carefully, and to invest in improving it.

d) We audit and act upon the quality of care process coding[14].
Data mining and data analysis tools are becoming increasingly available to general practice. They open up new opportunities to understand demand. They help practices to segment, prioritise and manage patients better. And they make data-driven decisions on new models of care. To capitalise on these features relies a practice to have a strong foundation of high quality care process and activity coding.

A regular, integral audit is the cornerstone of improvements to coding. Of course, to do this you need a standard to audit against. All clinicians and professionals accessing the system will need to agree on expectations at the outset.

In investing time to systematically audit and improve coding, you strengthen your decision-making. You also future-proof your data as new analysis tools are created.

e) We track the % of PWD attaining the 8CCP and 3TT over time, such as monthly, on a run chart[16].
The type 2 diabetes three treatment targets are a timely and repeatable way of understanding how well your practice is doing in terms of its diabetes model of care.

Plotting and referring to the 3TT and 8CCP over time is much more effective than viewing the figures once a year.

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The eight core care processes complement these targets. They provide measures for processes that contribute to the targets' outcomes. Again, they are repeatable and easy to access.

Using these outcome and process metrics can help focus your practice team on how you are doing. They give you a useful guide on whether your practice is improving. Given the prevalence of type 2 diabetes in most populations, these measures are most useful if they're visible to staff on a graph. Plotting and referring to them over time is much more effective than viewing the figures once a year. A busy practice may forget what happened with core processes a year ago.

To plot the eight core care processes and three treatment targets over time, use a run chart (line graph). Build it up with monthly, or even weekly, data, generated using type 2 diabetes management tools such as Eclipse. It could be as simple as drawing a chart on graph paper, displaying it in a staff area and adding the data each month. Being able to see the trend over time is far more powerful than just the base figure or even an average. It gives context, allowing you to understand and interpret what came before.

Figure 13 below shows an example of a run chart featuring the three treatment targets. You can see how a practice can plot its improvement in a motivational way. The key here is making the measurement visible. To help with problem solving, you could also add further lines featuring the individual targets.

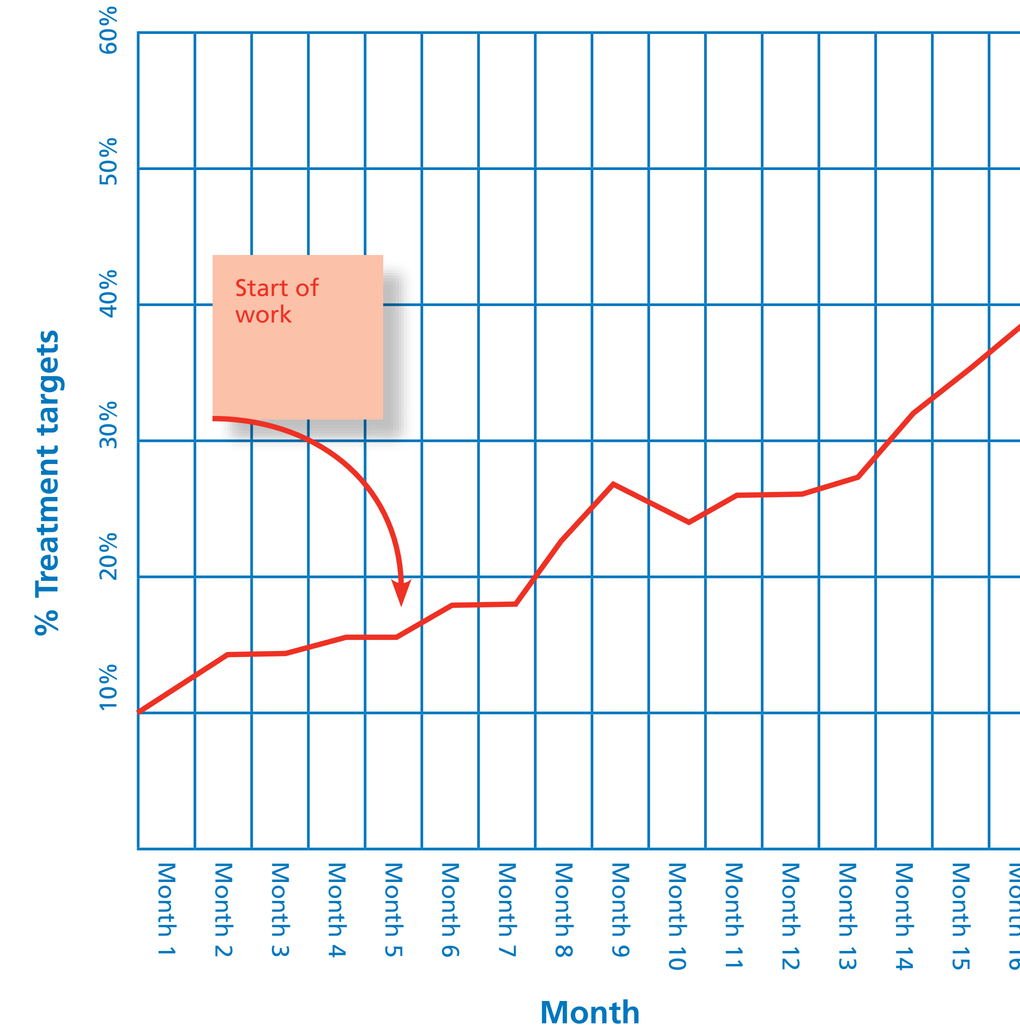

Figure 13: Three Treatment Targets Run Chart

Read more on run charts and how to interpret them in this BMJ article from Perla, Provost & Murray: https://qualitysafety.bmj.com/content/20/1/46

For definitions and more information on reporting these metrics, see Table 3 on page 23.

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f) We use real-time data from Eclipse or similar, on a weekly basis to case find for care intensification and monitoring of PWD[3].

&

g) We also use Eclipse, or similar data systems, to prioritise focus on diabetes care processes and treatment. Doing so helps with resource allocation and quick wins towards achieving QOF.
Across many of the domains, the key to improving care is the use of real-time data. Data systems and search tools, such as Eclipse, Ardens and UCLP tools, can revolutionise the way a practice monitors and organises its core processes. It is useful to look at these systems in terms of their frequency– see figure 16.

Item	Frequency:	Activity:	Description:	Typical systems:
1	Quarterly/ monthly	Case finding to raise eight core care processes attainment	Regular proactive engagement (not just annual reviews) and completing missing eight core care processes. With junior clinical or back office staff (within a GP determined framework) organising activity periodically	Eclipse
2	Monthly	Creating a reliable, smoothed annual review process	Identifying and organising annual reviews scheduled for the following month, and triggering diagnostics collection (if applicable). Using care coordinators, healthcare assistants or other back office staff to engage patients using mixed channels	Ardens Templates and EMIS/ System 1 Searches
3	Monthly	Reporting rolling three treatment targets and eight core care processes performance	Calculating the three treatment targets and eight core care processes performance so that the practice knows how well it is doing. Plotting on a run chart for visibility to practice staff – see page X	Eclipse
4	Monthly/ weekly	Risk stratification prioritising of patients for additional engagement and care intensification, based on individual three treatment targets metrics and inequalities risk’	Regular and reliable system-based prioritisation of patients for engagement outside of the annual review process. Ideally organised by back office or junior clinical staff (within a GP determined framework)	Eclipse/UCLP tools.

Figure 16: Data interrogation frequency

To make the most of the above systems, you’ll need to prioritise two things.

1. **Regularity and reliability**
   Institutionalising the use of data systems in this way can create a regular drumbeat in a practice’s long-term conditions care model. It also removes ways of working that are reliant on the memory of one or two individual staff, instead applying processes reliably and systematically.

2. **Junior clinical or back office staff using the systems**
   See section j under Advanced on page 52.

h) We use mandatory fields in annual review templates to ensure things are not missed[14].
Many parts of general practice use mandatory fields in their templates. Annual reviews, and other scheduled interventions, should also use them as standard. These templates are easily available and can quickly help with eight core care processes attainment.

You may use pop-up templates on a campaign (or push) basis on subjects like smoking status. They can be programmed to pop up when a patient contacts a practice. Or to alert a nurse, healthcare assistant or GP if a patient has a non-scheduled consultation.

Each template needs to be carefully designed and upheld. After all, pop-ups are easy to ignore. Buy-in needs to start at the top, with senior GPs using them. As a diabetes working group, you need public support from the senior team, with audits and reports on who is using the templates.

Advanced

i) We track (on a graph) the current gap between our current and expected T2DM prevalence[14]. We also track the rate of completed full personalised care review cycles, the rate of personalised care adjustment (PCA), and the number of PWD who complete structured education programmes[18].
As we’ve established, the use of data is not solely focussed at patient level. It also helps your practice make more informed decisions on use of resources, prioritisation, and new models of care. Finally, it can help a practice understand how well it is doing – both in terms of outcomes and process metrics.

Using data this way makes these key outcome and process metrics visible. They move from being something you look at once a year (or less!) to something central to the rhythm of the practice that you update monthly. You’re then in a better position to be agile and react quickly.

In addition to plotting the three treatment targets and eight core care processes over time (as described in section e on *page 47*), the following metrics are helpful to measure and make visible. The data collection interval and format for each is detailed in Table 3 on *page 23*.

Gap between current and expected diabetes prevalence
This data tells a practice the effectiveness of its engagement, health check and diagnosis processes. The age-old argument is that a practice cannot afford to diagnose more patients as they are so stretched. But this short-term view will compound future pressures, as patients will be more likely to present later with more complex needs.

Number of patients with a completed care plan
This tells you about the basic reliability of your core care planning systems. It can offer a good proxy for wider reliability, helping you answer the basic question – are we doing what we say we do? If patients don’t have care plans – what else might be being missed?

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Rate of fully completed personalised care review cycles
We will centre on personalised care planning in the Mature stage of the Consulting Approach domain (see page 59). It marks a dramatic shift in the consulting and review model that challenges not only back office, diagnostic and patient engagement systems, but also clinicians. Due to its complexity, it is vital that you track the rate of adoption.

Rate of personalised care adjustment
As discussed in section e under Established in the Organisation and Process domain (see page 40), practices need to avoid personalised care adjustment where possible. Instead they should work on new, innovative ways of engaging patients. Tracking this rate over time is the first step to reducing it.

Number of people who have completed structured education
Referring patients for structured education is one thing. But to benefit, a patient needs to complete it. Tracking the rate of completion over time allows you to understand if there is a pattern in attendance and completion.

In some cases, obtaining the completion rates is harder than it should be. If the training provider doesn't make this information readily available, ask your commissioner to work with them to supply it.

j) We have designed junior clinical or non-clinical roles to use Eclipse, or similar, to organise our case finding and annual review activities[3]. In doing so, we remove the administrative burden from senior clinicians.
Junior staff can use these systems to report, prioritise, trigger engagement and provide data to senior clinicians a scheduled basis. This leaves clinicians more patient facing time. To work effectively, senior clinicians will need to put in work to prepare the process and operating framework and provide oversight.

Getting this setup right can transform a practice. It provides the engine room to type 2 diabetes care and puts the practice on a much more proactive footing.

Consistency

How consistent are we in our approach and how do we ensure we use the most effective models?

Maintaining consistency requires using the best available guidance and creating supporting documentation. It takes systems and regular discussion aimed at reducing unwarranted variation of approach. The focus here is on the timing and form of general intensification, handover and signposting for treatments. It may include the use of medicines, diagnostics, and referrals to specialists. It could incorporate health education, promotion, and prevention programmes. And it will likely need wider multi-disciplinary team working, involving healthcare assistants, nurses, pharmacists, social prescribers, wellbeing coaches, dieticians, physician associates, and administration professionals.

Intermediate

a) Clinicians have access to NICE guidance, or local equivalent, on the appropriate intensification of treatments and referrals to specialist services.
Any guidelines need to be readily available. Easy steps, ensuring shortcuts are on all desktops, can make a big difference. To limit variation, this accessibility is an institutional rather than an individual responsibility.

Established

b) We have discussed as a team the appropriate general intensification and handover points for treatment, diagnostics, referrals and involvement of non-GP professionals. These include the wider MDT, such as physician's associates, HCAs, nurses, pharmacists[10], social prescribers, wellbeing coaches, dietitians and admin.
Type 2 diabetes care and management continues to become more complex. It's driven by advances in, and wider availability of, treatment and support options. It's also down to the expansion of professional roles within practices. This evolution brings with it a challenge: how do you make use of these opportunities in a consistent manner? The first step to this is to discuss the intensification and handover points as a diabetes working group within your practice. Set aside protected time for these conversations, and agree who you will use for what, and when.

Mature

c) We have defined, in the form of a written practice protocol and/or pathway, the timing and form of general intensification and handover points for treatment [1] [12] [14]. Included here are medicines, diagnostics, referral to primary and secondary care specialists [2], use of health promotion, prevention programmes such as NDPP [26], MDT reviews [4] and the involvement of non-GP HCPs such as physician's associates, HCAs, nurses, pharmacists [10], social prescribers, wellbeing coaches, dietitians and admin.
Building on point b *(see page 54)*, the next step is to document the agreed way of working in a pathway or protocol document. Without writing down your practice approach to type 2 diabetes, there is no way you can understand whether you're doing we you say you're doing.

Documenting your practice approach takes time. The discussion it generates will reveal variation in belief, method, knowledge, and treatment. You might even find variation in the use of junior and additional roles, and belief in their competencies. You will need to work through all this, so that everyone in your team understands each other and the pathway as a whole. In doing so, you'll shift each team member's mindset from 'concentrating on my bit' to 'seeing how everything fits together'.

Involve those who are part of the new practice pathway in its creation and documentation. You want people to take ownership over the document, not just leave it sitting in a filing cabinet or computer folder. Remember: you're not starting from scratch. Guidance, such as that from NICE, will form part of your practice pathway.

Lastly, your discussion should consider the merits of standardisation. Will, or indeed should, your pathway fit all patients? It is important to stress that no pathway can fit all patients. But if you use an effective, evidence-based standard pathway, it will work for most . The times where it operates like clockwork will then free up more of your time to concentrate on cases that do not fit the standard pathway. Your team will use their professional expertise to distinguish between warranted and unwarranted variation from your pathway.

Without writing down your practice approach to type 2 diabetes, there is no way you can understand whether you're doing what you say you're doing.

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d) We have reviewed our pathway for efficiency and reliability gains, using quality improvement (QI) and/or lean-thinking as prompts.
In creating your practice approach pathway, you have the opportunity to make it as efficient and effective as possible. Principles of quality improvement principles and lean-thinking can help you and your team question and examine your pathway.

Look out for:

- **areas of unwarranted variation (clinical, staff availability, equipment availability, etc.);**
- **diagnostic requests and procedures – optimising consultations by collecting and making diagnostics available in advance;**
- **collecting excess information that is not actually of use to the current process step;**
- **information flow – and delays caused by missing information;**
- **unnecessary complexity;**
- **duplication – for example, not considering other scheduled interventions the patient might be brought in for; and**
- **fragmentation – ask yourself: where can fewer people be involved, in fewer interventions?**
- **referrals – for example number of failed referrals and the reasoning behind them.**

e) The pharmacist role (if applicable) is expanded so that they attend MDT meetings, conduct reviews on diabetes and cardiovascular related drugs, and undertake signposting[10].
In many practices, the pharmacist role is still new and developing. Given the role drug treatments have in diabetes management, there is great opportunity for this role to contribute to improving type 2 diabetes care. Some practices integrate pharmacists into their multidisciplinary team approach, meetings and annual reviews.

f) We have systems for ensuring practice pathway and protocols are accessible to clinicians.
Digital clinical decision support tools, such as Patient Leaf, are becoming available. They help reduce increase the consistency of approach to conditions such as type 2 diabetes.

g) The PCN has discussed and agreed how to best use the ARRS roles to help the network of practices be more proactive with LTC management, including T2DM.
Additional Role Re-imbursement Scheme (ARRS) roles have opened up huge opportunities for practices. A lot of effort has gone into easing the contractual and fair distribution issues that come with these new primary care network roles. The bigger challenge is in effectively integrating these roles into each member practice. Each practice has its own, embedded, model of care. An ARRS professional, such as a social prescriber, will then have the challenge of working within four or five different models. Their success depends on the effort and commitment of member practices, as well as the primary care network team.

Advanced

h) We work to improve the quality of our referrals to specialist services[26].
The higher the quality of referral, the greater the probability it will be accepted. Lower quality referrals risk re-work or rejection. Look to understand any patterns in referral feedback from specialist services. Is there a problem with a particular clinician, for example, or a specialist, or a referral type?

i) We have a process for auditing our working against our pathway or protocols. This means that we do what we say we do in relation to intensification, MDT working, personalised care planning, etc.[10].
When you have a documented approach (see point e), you can then audit it. You can do this manually using small, regular samples, such as 10 per month or quarter. Or you can create an audit search using the practice data system. These audits will give you a picture of the reliability of the pathway. If you do it at various levels of detail, you'll be able to identify if any of the pathway steps are more difficult to adhere to than others. From there, you can put corrective measures in place.

Regular auditing creates a continuous improvement cycle, as illustrated in Figure 17.

Improvement Cycle
Co-produce the practice approach pathway. Define measurement and implementation
Plan
Do
Study
Act
Use the pathway over a defined period
Audit the pathway. Did we do what we said we do? Understand warranted and unwarrented variation
Iterate and improve the pathway and support staff in adoption

Figure 17: Audit approach

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j) We have developed new models of care to engage difficult-to-reach segments. We have systems that support clinicians in following agreed pathways, such as decision support tools and group consults.
Population health data allows practices to identify and understand inequalities in outcomes and access. In some cases, small changes will make improvements. In others, you'll need a different model of care. Frameworks such as the NHS Core 20+5* can help. It lists deprived populations by geography, population groups, inclusion health groups, and people with learning disabilities and/or neurodiversity. It records coastal communities with pockets of deprivation hidden amongst relative affluence, and it shows people with multi-morbidities, protected characteristic groups , and five clinical areas of focus.

The limitations of the current model of care are systemic. To be more successful, the model of care has to change – and primary care networks can be part of the solution. See domain 5: Engaging Patients and the Community (on page 67).

k) We use MDT consultations[(4)], which on occasion also include community and secondary care specialists.
As mentioned earlier, professional roles are proliferating in general practice and beyond in the NHS and community care. As a result, multidisciplinary teams are widening. And advances in remote working technology are making them more efficient.

For some patients, like those who are clinically and/or socially complex, it's helpful to involve the multidisciplinary team. This is why the Fuller Stocktake led to the introduction of neighbourhood teams. If a practice or primary care network wants to avoid micro lists (queues to see individual team members), multidisciplinary team consultations can help. These consultations can take a number of formats:

1. **A multidisciplinary team meets to discuss a patient or, in newer formats, invites the patient to contribute.**
2. **Multidisciplinary team members support the core clinician by consulting in real-time, either in person or remotely.**
3. **A senior clinician supports a multidisciplinary team of junior level professionals to manage the patient. The GP advises and enables the team to 'hold' the patient, reducing the need to refer them on.**

l) The PCN has integrated ARRS roles into the microsystems of each practice. They help the network be more proactive with LTC management, including T2DM.
Truly integrating these roles requires deliberate and considered planning. Practices need to consider exactly what work each role is best placed to take on. When is a social prescriber better placed to meet social needs than a GP? When might referring to a social prescriber actually make things worse and further fragment care? How do you know things are working well? How do you create an effective feedback loop? How do Additional Roles Reimbursement Scheme professionals check in with GPs about their work with complex patients?

*Source: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

Consulting approach

Are we making the most of our consultations?

Touch points with patients with type 2 diabetes must be as effective as possible. Clinicians, therefore, need to have consistent, evidence-based knowledge of care. This way, they'll be able to identify and discuss clinical variation. The practice should use care plans as standard. And they should optimise patient contact points for opportunities for preparation, data gathering, goal setting and joint action planning. An effective practice will have clear expectations for documentation, coordination of care and the use of alternative consultation formats.

Intermediate

a) Clinicians discuss complex PWD together in structured meetings at least once per month.
Many practices have clinical meetings to discuss complex cases. Take the time to hold meetings specially on type 2 diabetes with the wider group of consulting clinicians. Doing so is an investment in reducing variation of approach and ensuring the use of best practice.

To keep these meetings efficient, structure them and gather data in advance. See the Data Foundations domain *on page 45* for more on using real-time data systems to risk stratify and prioritise patients.

b) We have access to social prescribers or wellbeing coaches and other ARRS roles through our PCN.
Access to additional roles is generally enabled through primary care network working and can vary considerably. Be proactive with your network to make the most of support available for your long-term condition management.

c) We use HCAs and pharmacists in our diabetes care.
In some practices, healthcare assistants completely manage the eight core care processes annual review. In others, they play a more marginal, task-focused role. The same can be said about pharmacists. Their use in diabetes care varies massively from practice to practice. Ways of working evolve over time. Consider how you can integrate these roles as effectively as possible in your type 2 diabetes model.

d) We reliably refer PWD to diabetes structured education (such as DESMOND) through Book and Learn[19].
Structured education is a pillar of type 2 diabetes care. Don't just state that your practice is reliable in referring patients; know that it is, based on data. Achieve this through periodic audits and/or coding and resulting searches.

e) Where appropriate, we refer people at risk of diabetes (including non-hyperglycaemic diabetes) to the NDPP.
The National Diabetes Prevention Programme (NDPP), sometimes called the Healthier You Programme, is available nationwide both face-to-face and digitally. Build this programme into your diabetes pathway discussed in domain 3, Consistency *(see page 53)*.

Read more on the NDPP:
https://www.england.nhs.uk/diabetes/diabetes-prevention/

Established

f) Clinicians are consistent in the view that diabetes can often be put into remission[9].
Clinicians' core beliefs about the extent to which type 2 diabetes can be put into remission shape the clinical approach. If you think there may be variation in beliefs, taking time to explore them will be an important foundation for your improvement work.

g) PWD are given a copy of their care plan[14]. There is a single care plan for PWDs with multiple conditions[6].
A valuable step for patient ownership of their condition is access to their care plan. It acts as a reminder of their current position and agreed plan, and also provides transparency.

Producing a care plan in a sharable format can require system change. Ideally each patient will have a single, shared plan, based on a coordinated review of all their long-term conditions.

h) We reliably inform PWD of the choice and functionality within Book and Learn as part of our process for diabetes structured education [3].
Systems like Book and Learn give patients options in how they engage with structured education. Make sure that your practice team know how the system works. They will then be able improve their quality and credibility of referrals. As a result, there's a better chance that patients will complete the education.

A valuable step for patient ownership of their condition is access to their care plan. It acts as a reminder of their current position and agreed plan, and also provides transparency.

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i) PWD are offered emotional and psychological support on diagnosis and referral to self-management education[10]. We assess MH and/or diabetes distress[27] annually.
Mental health support is increasingly recognised as essential to holistic care for people with type 2 diabetes. A diagnosis can be distressing in itself. Current mental health status can also impact a patient's engagement with self-management support, advice and methods.

j) We have access to in-house or local group consultations[26].
Group consultations have two benefits. The first is harnessing the power of peer dialogue and influence. They help people with diabetes understand the experiences of others like them. The second benefit is productivity, as consulting one-to-many can be more efficient than one-to-one.

While not suitable for all, group consultations can be an important part of the mix in designing new, more effective care pathways. In many places, primary care networks enable their provision.

Whether you provide group consults in-house or by others, there are some success points to consider.

1. **Group consultations don't follow the one-to-one, professional-to-patient pattern. They're all about the collective power and support of peers – which can be harder to achieve than many think. Choose your facilitator carefully and make sure they have high quality training. Are they a good listener? Can they manage a group? Do they give others 'airtime'?**
2. **Ensure booking processes, including appointment types, are in place, to avoid getting tripped up by issues there.**
3. **Consider how well integrated group consultations are in your model of care. Do all your clinical colleagues believe in and understand them?**

Read more on group consultations:
https://www.england.nhs.uk/atlas_case_study/introducing-group-consultations-for-adults-with-type-2-diabetes/

and

https://www.nice.org.uk/guidance/ng56

k) A PWD's wider self-management knowledge and skills (nutrition, exercise, self-monitoring[15], etc.) are assessed annually.
A patient's context and skills are not static, and may not be linear in their development. As such, periodic re-assessment is useful to adjusting and optimising support.

l) We use longer appts where beneficial[9].
Flexible appointment lengths and formats can break the cycle of repeated, 10-minute consultations. A longer appointment may better meet the expectations of both the patient and the clinician.

m) We also suggest structured education to family members[19].
For many patients, their context is defined by their family unit (see Figure 19). They might not be the one doing the cooking in their household, for example. Opening structured education to family members as well as the patient increases the chances of the messages landing. Check with your provider or commissioner of structured education whether family members can attend. If not, push them to make it possible, perhaps using the collective voice of your primary care network.

n) We hold high quality conversations with PWD about the benefits of structured education including expert patient programmes[26]
Most clinicians will, of course, have a good idea of what is covered in structured education. But do they know the detail – the content, how it is taught? Your practice clinicians should know enough to answer questions from patients, for the referral to have the best chance of success.

Advanced

o) We use a full personalised care planning approach. It includes preparation, goal setting, joint action planning, documenting, coordinating[6] [7].
Personalised care and support planning involves a series of facilitated conversations. It sees the patient actively explore the management of their health and wellbeing, in the context of their whole life and family situation*. It's about enabling what matters to the patient and maximising the quality of the precious consultation.

Personalised care and support planning has been widely recommended by a range of influential stakeholders:

- **The NHS Long Term Plan, 2019**
- **NHS RightCare Pathway: Diabetes, 2018**
- **Making it happen: Personalised care and support planning – NHS, 2018**
- **Realising the value NHSE/Health Foundation/Nesta, 2016**
- **Personalised care planning for adults with chronic or long term health conditions – Cochrane Library, 2015**
- **Building the House of Care – The Health Foundation, 2015**
- **Delivering person centred care in long-term conditions – BMJ, 2015**
- **Personalised care and support planning handbook: The journey to person-centred care NHSE & Coalition for collaborative care – Action for Long-term conditions, 2015**
- **Five Year Forward View – NHSE, 2014**
- **King's Fund delivering better services for people with long-term conditions ,2013**
- **Strengthening the NHS Constitution – National Voices and its members, 2013**
- **Care planning – Improving the lives of people with LTCs; encouraging partnership; increasing the quality of Care – RCGP, 2011**
- **Improving Care for people with longterm conditions – DoH, 2011**

*Source: NHS England, Accessed July 2022: https://www.england.nhs.uk/ourwork/patient-participation/patient-centred/planning/

Most clinicians will, of course, have a good idea of what is covered in structured education. But do they know the detail – the content, how it is taught?

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The centrepiece of this approach is a new style of holistic consultation. It allows the patient to be an equal participant in decision making, rather than a recipient of advice. Much of its success is down to the pre- and post-consultation processes and preparation. It relies on you collecting and communicating diagnostic information before the consultation. It also requires new planning documents and mechanisms for capturing conversation and sharing the plan.

One big challenge is the need for clinicians to understand the approach across practice. The differences between traditional consults and personalised care and support planning are subtle but significant.

Clinicians will already consider a patient's context in their reviews. But to understand the differences with this planning concept, begin with training.

As discussed in point f in the Organisation and Process domain (*see page 40)*, there are digital solutions that bring personalised care and support planning to life. Automated systems can now let your practice send personalised videos that communicate a patient's results in an accessible manner. This way, the patient is better prepared in advance of their review, and the review can concentrate on what matters.

p) We use a scoring instrument, such as PAMS, to track a PWD's knowledge, skills and confidence[6] [5].
Patient activation describes the knowledge, skills and confidence a person has in managing their own health and care. The concept is important when it comes to long-term conditions. Its scoring instruments can offer a repeatable, standardised method of assessing a patient's level of activation. PAMS (Patient Activation Measure), for instance, are patient self-reported measures. They help you understand if the support you're putting in for a patient is having an effect on their ability to self-manage. From there, you can personalise your approach to each patient.

- **For a good overview of Patient Activation Measures, read this paper from the Kings Fund: *https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/supporting-people-manage-health-patient-activation-may14.pdf***

q) We have systems of pt follow-up to check a pt's understanding of annual review actions and outcomes[25] [6].
Considering the 8,760 hours a year a patient with diabetes lives with their condition, the time they spend with a practice is a tiny proportion. Annual reviews, and other interventions, tend to follow a cyclical pattern, often with many months between interactions. If a patient takes in your advice and is managing their condition well, this is fine. But it can become a problem if they didn't understand the plans and outcomes of their annual review.

A long-term condition is a marathon not a sprint. People with a long-term condition are on a long journey – they need help to stay in the race. The role of the healthcare professional is therefore more of a helper, supporter and facilitator than it is an advisor, care giver or expert consultant.

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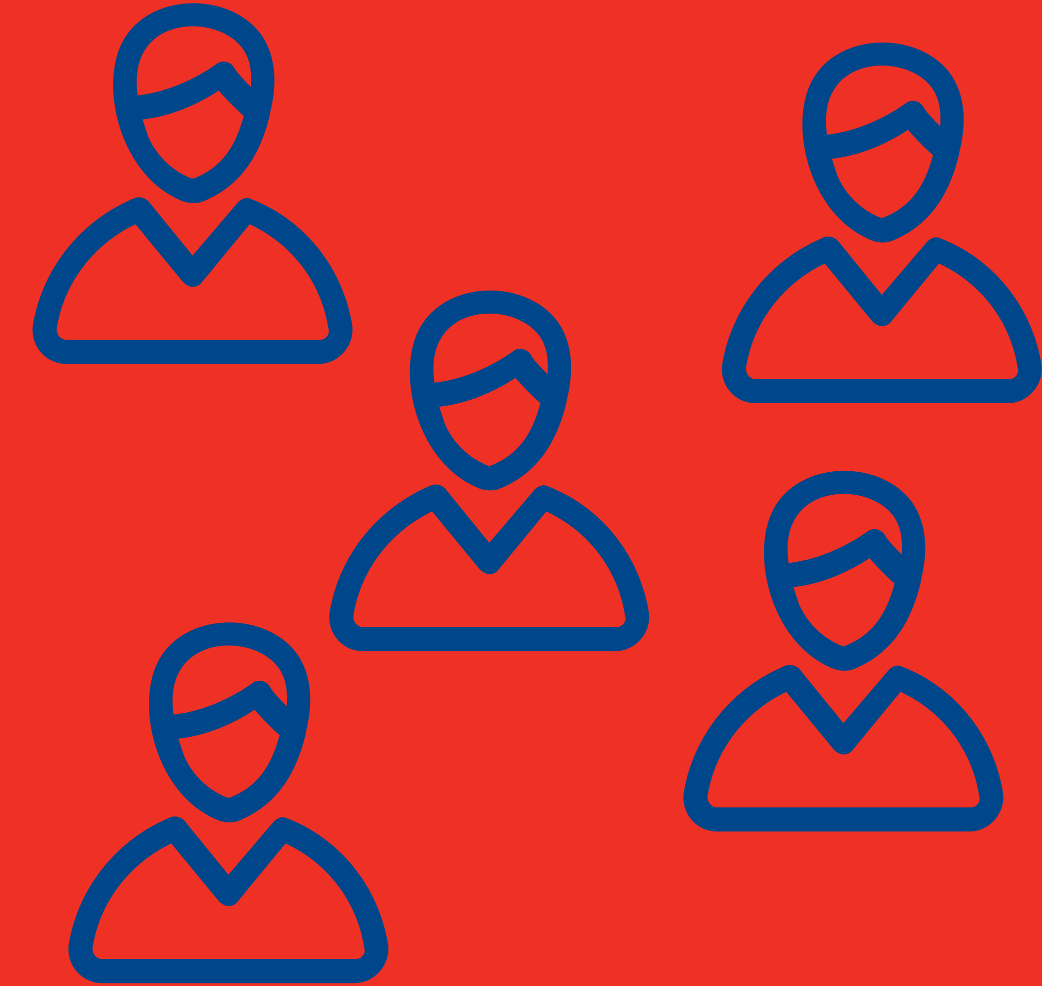
By following up at intervals after the annual review, your practice can know if its actions and advice landed, until the next review.

r) Clinicians meet quarterly to discuss diabetes care (beyond problem-solving complex cases) and check each other's approach and understanding.
Practices are generally good at discussing and sharing experiences on complex and difficult cases. Often, their forums for discussion focus on solving a particular problem and imparting advice.
To complement these discussions and increase consistency of approach, you need to be systemic too.

Arrange a meeting to discuss diabetes care overall. In doing so, your practice will understand consulting patterns as well as specific cases.

s) We conduct multi-morbidity annual reviews.
Many of your patients will have more than one long-term condition. Moving to one multi-morbidity review can help to ensure a holistic, integrated approach. Doing so will require multidisciplinary team work, coordinated diagnostics and careful preparation. This may seem challenging, but consider the time it takes against the total time and cost of managing the patient in a fragmented, individual way.

Engaging Patients and the Community



Is our community viewed as an asset in our model of care?
All practices should acknowledge that the time they spend with a patient is a tiny fraction of the time the patient spends living with diabetes. Investing in building links with the wider health and social care system and with communities can help you respond in a more effective way. It develops greater community wellbeing. Primary care networks can be effective in identifying and reducing inequalities with hard-to-reach, and easy-to-ignore, groups.

Intermediate

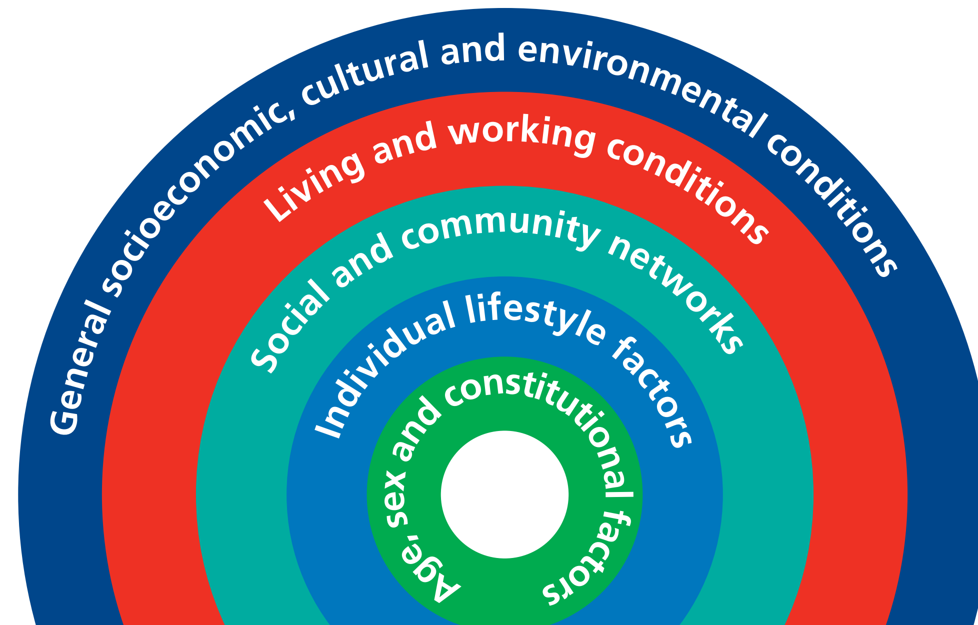
a) We have a PPG group, which has discussed diabetes care specifically or more generally care for those with LTCs.
Due to the pandemic, many patient participation groups have been paused. Even before this, the groups varied in their focus. Consider using your group to discuss specific disease topics such as type 2 diabetes, to build proactive collaboration.

Established

b) We reliably use digital platforms (such as You & Type 2) for PWD communication. We have worked as a practice to create a set of tailored messages for different PWD groups.
For some patients, face-to-face communication remains the most suitable approach. For others, there are real benefits in digital asynchronous and real-time channels, like the diabetes-specific You & Type 2.

c) Some senior team members have allocated time in their portfolio to connect with their communities [14].
It's widely accepted that social determinants have a huge impact on health outcomes. As detailed in figure 18, social determinants are wide-ranging. It's important to discuss them in your practice care pathway planning and strategy.

Figure 18: Dahlgreen and Whitehead Rainbow (simplified)



Source: Dahlgren G & Whitehead M. (1991) European Strategies for Tackling Social Inequalities in Health, World Health Organisation, Copenhagen / Department of Health 2022 https://www.gov.uk/government/publications/health-profile-for-england/chapter-6-social-determinants-of-health

The social determinants of health overshadow the healthcare determinants of health*. To reduce demand in a sustainable, long-term way, your practice needs, then, to help communities proactively manage their own health. This way, you can prevent, reduce and delay the onset of long-term conditions for families and people in your communities.

Figure 19 below shows that, in the majority of cases, until a patient become complex, it is not the practice that controls outcomes.

Practices have a role as a trusted institution within a community. The first step is knowing your community and those within it. Once your community knows and trusts you, it becomes easier for you to influence other groups. You can then collaborate to support better wellbeing.

*Source: The Kings Fund, Accessed July 2022: https://www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health

Who controls outcomes in Type 2 Diabetes?

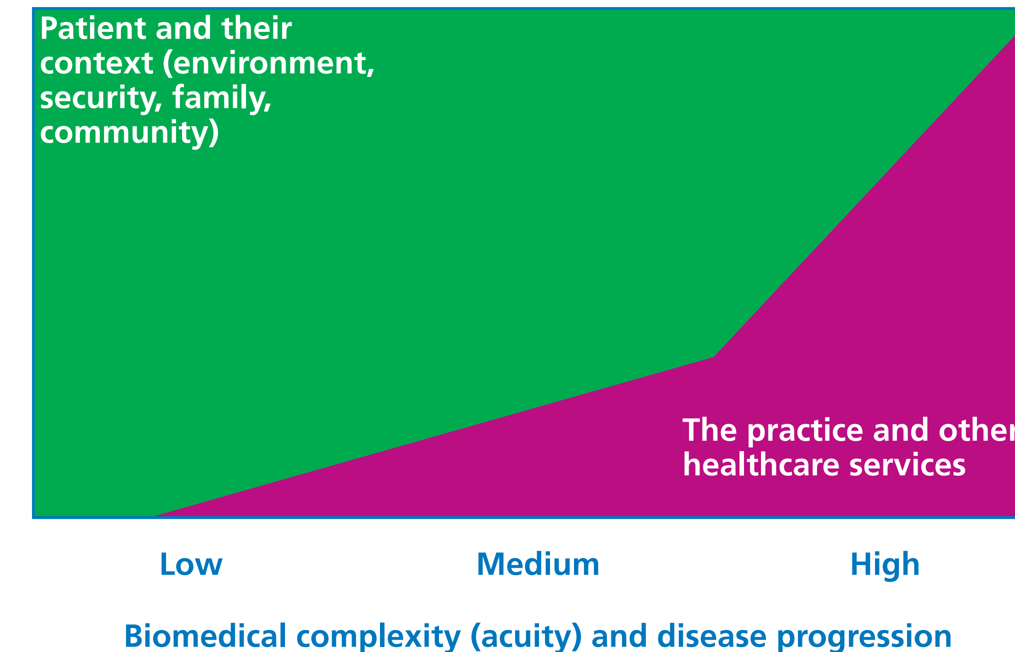


Figure 19: Who controls outcomes in Type 2 Diabetes?
Inspired by the work and similar model from the South Central Foundation (Nuka) system of care

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This is obviously long-term work. It requires investment from a practice, giving lead individuals regular time to make and maintain links with community groups.

d) We have mapped out links to community groups and services that can help PWDs with the wider determinants of health.
Spend an hour as a practice mapping out who knows who in the community. It can be as simple as sketching out relationships, networks and contacts on a flipchart. Consider community groups, retailers, local authority, schools, religious groups, sports teams, and leisure groups. This exercise will tell you what connections you can use now, and where you need to develop relationships.

Mature

e) The practice works to improve the health literacy of PWD[4].
Beliefs and knowledge about what keeps you healthy underpin the prevention and effective management of type 2 diabetes. Some of your patients might need basic health literacy before the core structured education. If there is currently no provision in your area, try working with your primary care network to get this support in place.

f) We signpost device manufacturer helplines[10] both verbally and in written guidance.
Device technical queries are frequent and can take up precious appointments. Aim to reduce some of these by clearly signposting manufacturer helplines on your website and other information given to patients using these devices.

g) We strategically view our community as an asset in the health of the population we service. This view is written and agreed in our long-term plans.
Referring back to point c in this domain, communities play a major role in increasing wellness*, and thus reducing demand. Being proactive in seeking out and working with community assets is key, rather than reacting to demand at a distance. This has to come from practice leadership. Consider whether the role of your practice is to react to illness or to enable wellness. If it's the latter, what does the relationship with your community need to look like?

h) We work with the community to address the issue of food security, if applicable[14].
Availability, affordability and quality of food is a core determinant of health. It is in a practice's best interest, then, to serve a community that has food security. While practices cannot provide food security, as a trusted institution they can link people to others who work towards it. They can use their position to bring together people, networks, charities and community groups to work on this problem.

Source: South Central Foundation (Nuka) System of Care

Advanced

i) We review PWD information for format and language. We use colour and display information visually[4].
As we explored in section e of this domain, using the suitable format and channels for your type 2 diabetes population is vital for effective communication. It goes beyond making things available in different languages and sticking to brand guidelines. Reach out to communications professionals within your integrated care system for help.

j) We have a diabetes PWD reference group and use their feedback to improve system and process.
Going beyond using a patient participation group, a diabetes-specific reference group can be vital to your practice. It can act as a periodic feedback and co-design group. If it seems like a lot of effort and investment, consider it against the resources you already use in the care and management of type 2 diabetes (see page 13). Be clear from the outset on the group's intentions. Is it a consultation group? A feedback group? A co-design group? For the latter, public representatives will need to have equal voice and influence as the clinicians and other practice professionals.

Read more on co-design:
https://beckymalby.wordpress.com/2015/11/08/17/

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j) We have a diabetes communication strategy[3] detailing formats and content that fit the needs of the local population – not only for the management of existing PWD but also for proactive activities.
To maintain momentum and keep development progressive rather than reactive, write down your plans. A communications strategy is even more important as practices and primary care networks try to be more proactive with patients and communities. It can help as you become a convenor of groups tackling thorny issues, like health inequalities or obesity.

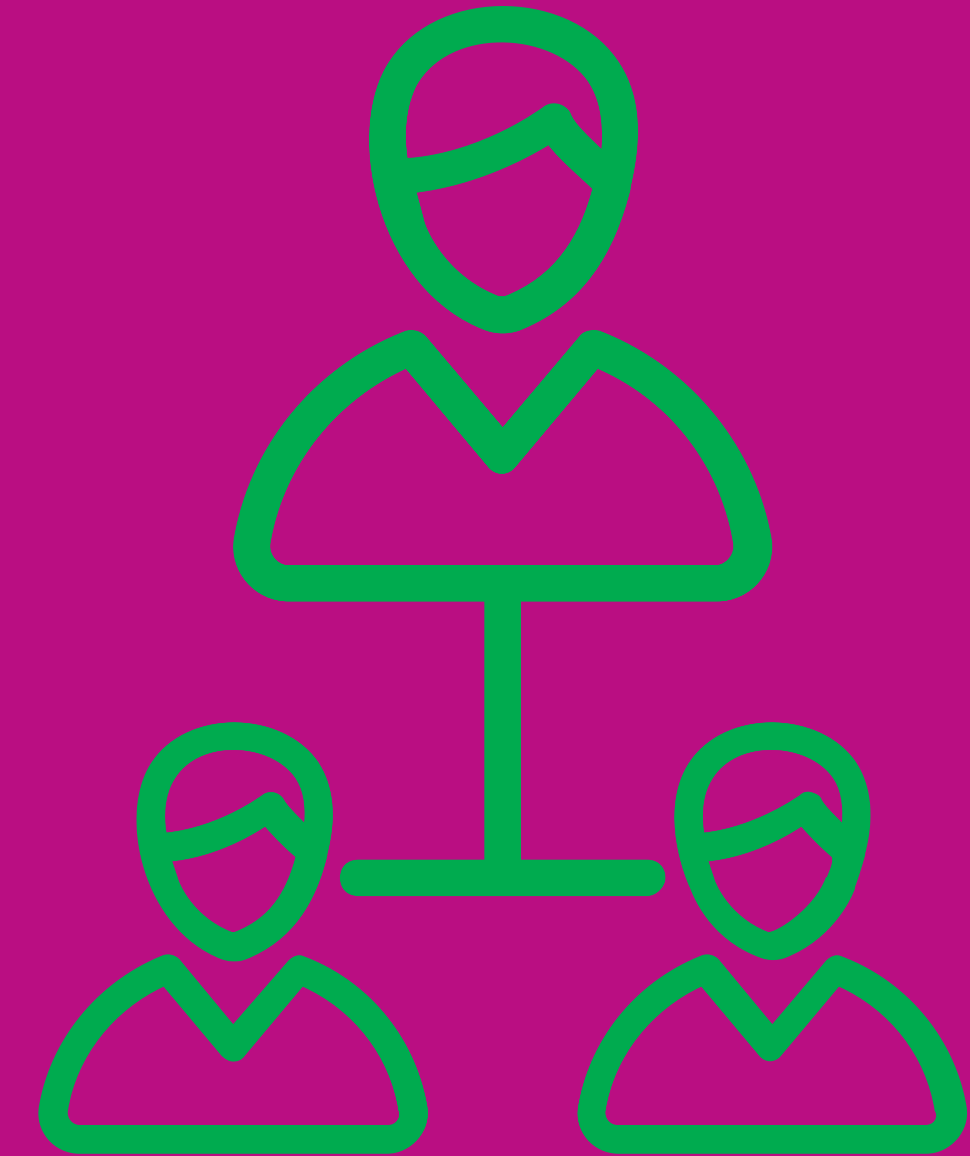
k) We use online platforms, such as GPdoc, to facilitate networks between PWD[10].
Network working is not just for those seeking to help patients. Digital platforms can also connect patients and enable them to create peer support groups.

l) We actively engage and support the community, including schools and community groups, to contribute to the wider determinants of health. This engagement and support can take the form of the use of facilities, greater practice links, and practice-based groups (such as gardening or walking). It may also include community and practice champion programmes.
Building on much of the discussion in this domain, the practice has moved beyond planning and creating relationships, to actively working with groups within the community. This builds on the foundations previously discussed of strategic intent, data driven view, PCN plans, time in portfolio and understanding of existing and required relationships.

m) We invest time in working with providers of specialist services (such as an inpatient stay) on the transition of diabetes services between them and primary care.
Transitions are sources of miscommunication and confusion. Time invested in developing care boundaries to avoid such issues can help to avoid this. When starting this work it can sometimes feel out of reach – but with the evolving role of primary care networks, and integrated care systems, it is easier for primary care to have an effective voice.

To maintain momentum and keep development progressive rather than reactive, write down your plans.

Leadership



Is our leadership as supportive as possible?

Clarity of leadership roles and responsibilities is essential in the type 2 diabetes system and process. You'll have a diabetes specialist lead. Practice leaders will formally support the development of an improved model of care. This will include investment in training, use of data and protected time for improvement. You will document it all in strategy or meeting records.

Intermediate

a) There is a senior clinician with responsibility for diabetes[6].
True shared responsibility is difficult to achieve. particularly considering questions of accountability. In its absence, a clear line of responsibility is important. The clinician with responsbility for diabetes does not necessarily do all the work. Rather, they ensure that the work is done, whether improvement or clinical.

Established

b) We have an identified lead for recalls and annual reviews.
Expanding on point a, you may establish clear lines of responsibility for these core processes. A junior staff member may be operationally responsible. If this is the case, nominate a senior team member for ultimate responsibility and oversight.

c) We have short-, medium- and long-term plans of diabetes improvements[23] that fit the needs of our local population.
Most practices have plans and aspirations for their Long-Term Condition system and process. The next step is to write them down and refer to them regularly in improvement decisions. Planning for the future can help stop circular discussions, focus the whole team, and avoid just reacting to process problems.

Our self-assessment tool (*see page 28*) provides the basis for short- to long-term planning for type 2 diabetes processes.

d) PCN members are consistent on the role that PCN plays in addressing inequalities and gaps in efficacy for pt segments less well served by traditional models – such as young adults, people from minority populations and people with learning difficulties[21].
Views on the purpose of primary care networks can vary widely, even between member practices. Are they just a mechanism to centralise funding and provide extra roles to members? Or are they a way for members to work together on local solutions to the thorny problems like health inequalities?

Agreement among member practices on the network's purpose is vital if it is to be effective in enabling them to work together.

Mature

e) We hold monthly or bi-monthly diabetes working group meetings to review our progress against improvement plans. The group also review key diabetes team metrics, such as 8CCP rolling %, 3TT figures, AR within birth month rates, etc.
As discussed earlier (*see page 16*), the diabetes working group provides the drum beat of improvement. The group reviews how well the diabetes system and process is going, and ensures improvement plans are implemented.

f) We have the skills to complete quality improvement projects and have a history of being able to follow through full PDSA cycles [16].
Quality improvement that uses a plan-do-study-act cycle is useful when it comes to improving system and process. It provides skills in problem solving. More importantly, it structures improvements, ensuring you understand the problem, engagement, measurement and feedback loops.

Many sources of quality improvement training are available for primary care. They range from private providers to professional bodies to NHS England both nationally and regionally. Reach out to your network for recommendations.

Read a useful overview of quality improvement: https://*www.england.nhs.uk/sustainableimprovement/improvement-fundamentals/*

g) There is consistent trust across all GPs in the competencies of non-GP colleagues [1].
Over time, the model of type 2 diabetes care in most practices has moved from being largely GP based to involving the multidisciplinary team. The extent to which your practice integrates nursing and other professionals depends on the beliefs and confidence of GPs. GPs need to believe in the role and competences of a professional group, to avoid variation of approach and maximise improvements. Hold open and honest discussions as a senior team to work towards consistency of beliefs across all GPs.

Practices often don't have the scale or resources to introduce new models of care alone. Primary care networks can help here, bringing members together to agree plans for reducing inequalities.

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h) Our PCN has detailed and agreed plans that address inequalities and gaps in efficacy in services for traditionally less well served segments. These plans may take the form of wider network DES plans for more proactive and anticipatory care for those with chronic conditions.
Practices often don't have the scale or resources to introduce new models of care alone. Primary care networks can help here, bringing members together to agree plans for reducing inequalities. These plans should include a view of the future and detail iterative process changes. Documenting these views and plans will help you to reduce cyclical discussions when revisiting previous decisions.

Advanced

i) We have set aside time for the senior leadership team to learn and reflect on our leadership[22]. Senior team members have received leadership training.
Practice leaders have one of the toughest leadership challenges in the NHS. They're often practicing clinicians with a substantial clinical workload. They have clinical, financial and legal responsibility for the practice. Add to that rising patient and social complexity and increasing patient expectations, and it gets even tougher. And on top of that can be complicated inter-partnership dynamics and funding or contracting arrangements. All this can undermine the appetite for change and flexibility.

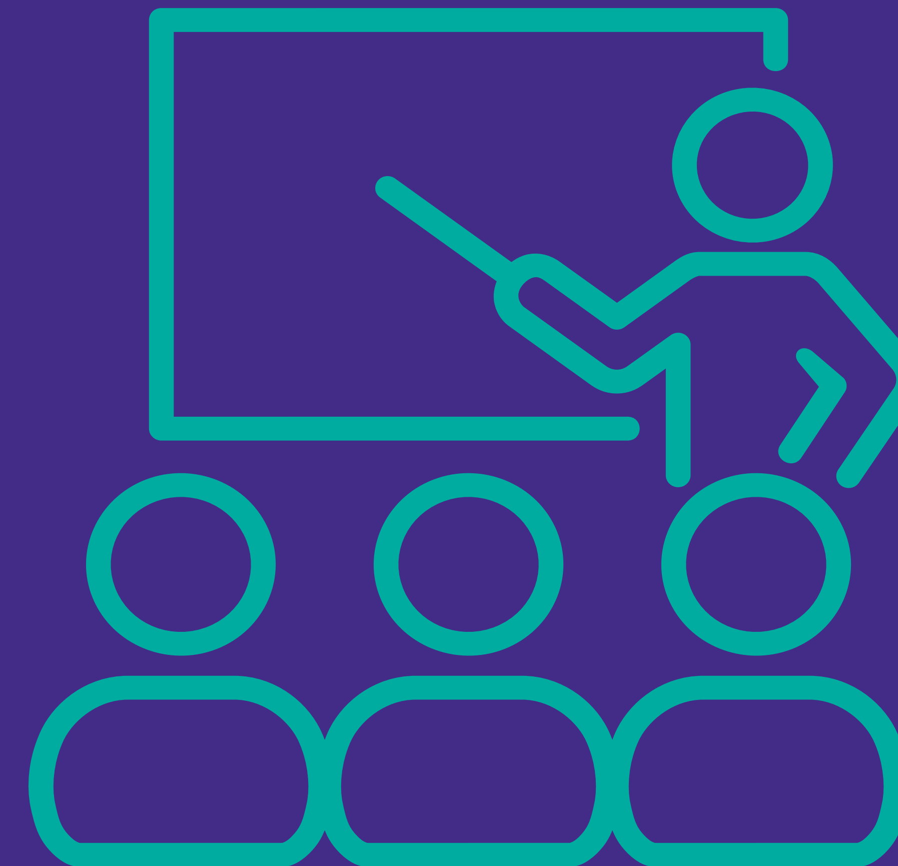
It is important, then, for your practice leadership team to take time, perhaps once a year, to reflect. They should ask themselves: how well are we leading our practice? Are we making good decisions? How would we know?

With all this in mind, *leadership training* can benefit your practice in two ways:

1. **It equips leaders with vital skills and theory to better to navigate complex leadership challenges.**
2. **It provides structured space for reflection – on their own leadership competencies and also on the practice as a whole.**

Figure 20: Practice Leadership Challenges – How Well are we Doing?

Training and Competencies



Do we have up-to-date knowledge?

It is easy to overestimate the knowledge and confidence of clinicians within your practice. During the development of this guide, a lead diabetes GP in a large practice surveyed GP colleagues asking about their level of knowledge and confidence regarding T2DM management and prescribing. Two thirds of the GPs responded stating they were not confident. Your clinicians should have up-to-date clinical knowledge and understanding of engagement and educational interventions. That includes the options available, their content and their booking methods. To achieve this, your clinical leads for type 2 diabetes will have regular training and access to specialists for support. You'll also have systems in place to train non-clinical patient-facing staff in communications techniques and the practice model of care.

Intermediate

a) Reception staff are trained in which appts to book for PWD[4] when considering the need and practice factors such as clinical skill mix and continuity.
Much of this domain builds on the ways of working suggested in the Organisation and Process domain (see page 37). Training for reception staff on the appointment types for type 2 diabetes patients should be part of their induction and reinforced periodically. Consider training the wider team, including all GPs and nurses, on what is being asked of reception too. This way you'll avoid any confusion resulting from clinicians questioning their decision-making.

Established

b) Reception staff have been trained in diabetes basics.
Most reception staff are not clinicians so should not be expected to make clinical decisions or give advice. That said, given the volume of type 2 diabetes patients and their queries, it is useful for these staff to have a basic familiarisation with the condition. They can then better empathise and understand the patient. They are also more able to direct patients to the most appropriate help, first time.

When delivering familiarisation training, take care to reinforce the boundaries of the use of this knowledge. Reception staff must not, for example, give clinical advice.

c) HCPs (GPs and nurses) working with PWD attend twice yearly educational training by secondary care diabetic specialists[17].
Maintaining type 2 diabetes competencies is an ongoing process for all clinicians. Given the volume of type 2 diabetes (see page 13), training here should be a high priority, scheduled at regular intervals. To reduce variation, arrange training for all GPs, not just the diabetes specialists.

Local diabetes specialists could deliver the training. This way, you'll maintain relationships with a useful network of local clinicians and teams. Or structured programmes such as the Cambridge Diabetes Education Programme (CDEP) could deliver it.

d) All PWD-facing staff are trained in process and aims of the Book and Learn system.
As mentioned in the Leadership domain (see page 73), successful referrals rely on the referrer having knowledge of the system themselves. Your patient-facing staff should, then, have training in the functionality and options of structured education booking systems like Book and Learn. This basic training could make the difference between a patient acting on a referral, or a referral failing.

Mature

e) All members of the diabetes healthcare team, including non-clinical, are familiar with content and format of structured education[19], such as DESMOND.
Continuing from point d, knowledge of the content of structured education enables the most effective and credible referrals. Build overviews of this content into your periodic type 2 diabetes training for clinicians.

f) Non-clinical pt-facing staff have been trained in the role (timing, scope and form) of all professionals involved in diabetes care.
For fully integrated working, all professionals need to understand each others' roles. This expands on point a in this domain (see page 78). It also builds on the documenting explored in Organisation and Process (see page 37) and the practice pathway in Consistency (see page 53). Don't assume that everyone knows this information. Consider including it in mandatory training cycles and new starter inductions.

g) At least one clinician and a member of key admin staff have received training in Eclipse (or similar).
As detailed in Data Foundations (see page 45), real-time data systems are important. They help you to focus, prioritise and understand the effectiveness of type 2 diabetes care. Whichever system you use, ensure at least one member of the team has received training.

This basic training could make the difference between a patient acting on a referral, or a referral failing.

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h) Community and secondary care diabetes specialists conduct reviews or participate in joint consultations at the practice at least twice a year.
Many local systems offer peer reviews. They support practices with community or secondary care diabetes specialists. Plan multidisciplinary representation into these reviews to get the most out of them.

Advanced

i) All clinicians involved in the care of PWD are trained in personalised care planning and are clear on their role within it[7].
Linked with the Consulting Approach domain (*see page 59*), embracing personalised care planning means committing to training. Your approach can have wide-ranging implications on consultations, on system and process, and on how your practice interacts with patients. It pays, then, to explore the method in considered training.

For good sources of information and training see:
https://www.yearofcare.co.uk/training-and-support

and

https://www.personalisedcareinstitute.org.uk/your-learning-options/

j) Reception, admin, HCAs and other PWD-facing staff are trained in communication techniques to increase engagement with PWD.
As you will know, communication techniques can make or break your interaction with a patient with diabetes. An assessment of communication skills and training can be a huge help.

Training can target use of language, tone and written communication. A practical start can be thinking through the exact words and method you use to invite people in for their annual reviews. Consider whether this approach needs changing.

k) Reception staff are trained in appropriate appointment types for multi-morbidity reviews.
If using multi-morbidity reviews, your practice's scheduling and allocation becomes more complex. Be sure to update your reception training and documentation to mirror these processes.

l) Clinicians are trained in conducting multi-morbidity annual reviews.
For good providers of multi-morbidity review guidance and training, see: *https://www.southwestlondonics.org.uk/our-work/diabetes/multimorbid-reviews/*

m) The lead diabetes clinicians have at least 10 hours training per year [2]. Locum cover is provided for those attending training [6].
Scheduling in regular training for lead clinicians is core to maintaining a high level of knowledge and competency. Key to enabling this training is building in locum cover. This way, your clinicians will be able to prioritise the training and have the headspace to reflect properly on the practice approach.

Appendices:

Appendix 1 – *Self Assessment Maturity Matrix*

Appendix 2 – *Working Group Agenda*

Appendix 3 – *Support Menu*

Appendix 4 – *Call & Recall Guidance*

Glossary:

- **3TT:** three treatment targets
- **8CCP:** eight core care processes
- **Appt:** appointment/consultation
- **ARRS:** Additional Roles Reimbursement Scheme. The funding streams for groups of practices, working within a PCN, to employ additional roles such as pharmacists, physiotherapists, wellbeing coaches, social prescribers, etc.
- **BP:** blood pressure
- **CDEP:** Cambridge Diabetes Education Programme
- **Diabetes:** type 2 diabetes mellitus, sometimes referred to as adult-onset diabetes
- **DBL:** Diabetes Book and Learn platform (a structured diabetes education booking service)
- **DES:** directed enhanced service
- **HCP:** healthcare professional
- **LTC:** long-term condition
- **MH:** mental health
- **NDA:** National Diabetes Audit
- **NDPP**: National Diabetes Prevention Programme
- **PAMS:** Patient Activation Measure
- **PCN:** primary care network
- **PDSA:** an improvement cycle created by Walter Shewhart and popularised by Edwards Deming. It features the elements: plan, do, study and act.
- **Personalised care planning:** sometimes referred to as collaborative care planning or the Year of Care approach. A holistic care planning approach for chronic conditions that features a reliable cycle of preparation, goal setting, action planning, documenting, coordination and supporting actions
- **PPG:** patient participation group
- **PTS:** patients
- **PWD:** person with diabetes
- **MDT:** multi-disciplinary team
- Reliably: the confidence something happens as intended. Do we think something happens, or do we actually know something happens? – perhaps supported by audit or other data-driven assurance approach
- **QOF:** quality and outcomes framework

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