HIN 2024 Cardiometabolic Fellowship Diabetes QI Project Ideas and Information

Diabetes - sample project aims

- Detect undiagnosed diabetes, non-diabetic hyperglycaemia or gestational diabetes
  - SMART aim: : Review 100 patients with a history of elevated blood glucose levels who are not coded for T1DM, T2DM or non-diabetic hyperglycaemia and send them for HbA1C, BP, BMI cholesterol, Urine ACR by September 2024.
- 8 Care Processes data capturing, patient tracking, and reporting improvement
  - SMART aim: To search patients coded for T2DM and review the medical records of 60% to send for testing or re-code appropriately for 8CP before September 2024.
- 3 Treatment Targets: Hypertension outcome improvements
  - SMART aim: Review 40% of patients with T2DM and identify patients who are not reaching targets for cholesterol or hypertension. Review for optimisation of medication or initiation of statin therapy by September 2024.

A SMART Aim is Specific, Measurable, Achievable, Relevant, & Timebound

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8 Care Processes and 3 Treatment Targets

8 Care Processes achieved every 12 months for T2DM patients

1. HbA1C
2. Blood pressure
3. BMI
4. Cholesterol
5. Creatine
6. Urine Albumin
7. Foot examination
8. Smoking Assessment

3 Treatment Targets

- Treatment Target One – HbA1C ≤ 58 mmol/mol
- Treatment Target Two – BP ≤ 140/80
- Treatment Target Three – Statin prescribed to those with high heart risk

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UCLPartners Proactive Care Framework: Type 2 Diabetes Risk Stratification

These patients are then stratified into priority groups based on HbA1c levels, complications, co-morbidity, social factors and ethnicity.

High risk		Medium risk		Low risk
Priority One **Hba1c >90 OR** **Hba1c >75 WITH any of the following:** • BAME • Social complexity** • Severe frailty • Insulin or other injectables • Heart failure ** Social complexity includes Learning disability, homeless, housebound, alcohol or drug misuse	**Priority Two** **Hba1c >75 OR** **Any HbA1c WITH any of the following:** • Foot ulcer in last 3 years • MI or stroke/TIA in last 12 months • Community diabetes team codes • eGFR < 45 • Metabolic syndrome (Except patients included in Priority 1 group)	**Priority Three** **Hba1c 58-75 WITH any of the following:** • BAME • Mild to moderate frailty • Previous coronary heart disease or stroke/TIA >12 months previously • BP≥140/90 • Proteinuria or Albuminuria (Except patients included in Priority 1 and 2 groups)	**Priority Four** **Hba1c 58-75 OR** **Any HbA1c WITH any of the following:** • eGFR 45-60 • BP≥140/90 • Higher risk foot disease or PAD or neuropathy • Erectile Dysfunction • Diabetic retinopathy • BMI >35 • Social complexity • Severe frailty • insulin or other injectables • Heart failure (Except patients included in Priority 1, 2 or 3 groups)	**Priority Five** **All others** (Except patients included in Priority 1-4 groups)

Diabetes Projects – Ideas for Delivery

Following are ideas for delivery to get you started in planning your project. Your project will need to reflect ways of working in your practice, staff and patient need, and any other factors – but this can help you get started.

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3 Treatment Target outcome improvements

To implement 3TT outcome improvement project you might:

1. Engage with relevant staff (administrative and clinical) as well as patient representatives to co-design a process map and look at the user journey.
2. Run search to identify T2DM patients who have been coded for hypertension in the last 6 months.
3. Invite a set number of these patients for review based upon what is achievable in the time frame
4. Review most current BP, HbA1c results and identify whether patient has been offered a statin.
5. Initiate statin if eligible or start on.
6. Review blood glucose interventions. If eligible, start on metformin or flozin.
7. Use intolerance pathway and shared decision-making tools to support adherence.
8. Arrange follow-up bloods and review if needed.
9. Support patients with self-management advice and resources.
10. Track patients to assess impact.
11. Compare progress to aim - look at what is working well and what could be further improved.
12. Rerun the cycle (PDSA cycle) with the next set of patients.

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8 Care Processes data capturing, patient tracking, and reporting improvement

1. Identify who needs to be involved and invite them to co-design the process with you. This may include administration staff and other clinicians.
2. Construct a process map of how you would proceed with searching for the patients, call and recall, sending them for consultations and then discussing treatment options with them. Refer to local and national guidelines and consider patient experience.
3. Engage patient representatives to help you co-design the patient facing aspects, ie communications and the process.
4. Use a search to identify how many patients are coded for T2DM to create your baseline group. Consider UCLP priority 1 group, a hard to reach, or vulnerable target population.
5. Chose a manageable amount of this group to focus on for the first PDSA cycle.
6. Review their healthcare records. Re-code any patients who appear to have been coded incorrectly.
7. Identify and pull codes, patients records, or care plans submitted by secondary or external care teams and include them in patient records
8. Invite any patients who are coded for T2DM within the target population and need further tests and checks under the 8CPs. Prepare patient information leaflets and FAQs prior to these appointments.
9. Organise follow-up with patient for repeat testing, foot checks, Urine ACRs, discussions etc..
10. Track patients to assess impact.
11. Compare progress to aim - look at what is working well and what could be further improved.
12. Rerun the cycle (PDSA cycle) with the next group of patients.

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Detect undiagnosed diabetes, non-diabetic hyperglycaemia or gestational diabetes

1. Draft a process map, engaging others who may be involved in the process, such as administration staff and other clinicians. Refer to local and national guidelines.
2. Engage patient representatives to create communication materials and develop a patient journey, including required support and education information.
3. Undertake a search for patients who have previously been coded for elevated blood glucose levels 7.8mmol/L and are not coded for T1DM, T2DM, or non-diabetic hyperglycemia. Consider patients who have uncontrolled hypertension or are/have recently been pregnant.
4. Select a set number of these patients based upon what is achievable in the time frame and review their notes and refer appropriately for review or testing. These reviews could coincide with their regular reviews.
5. Communicate with patients regarding their results and manage appropriately, refer to shared decision-making tools, and local guidelines.
6. Review this cycle, what worked well, what didn’t?
7. Start another cycle, with any changes that were required, with the next group of patients.

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Diabetes- Other things to consider

- Who do you need to involve in your project? (Stakeholders – This could include practice and / or PCN staff, patients, carers etc)
- Who else could help project delivery? Would they need training to support?
- Who can run searches in the practice? Can anyone be trained to help?
- Do you need training to help with delivery?
- Are staff confident with coding? With escalation procedures? Local pathways and guidance?
- Is there already a call and recall system to bring in patients for regular checks? How well is this working?
- What information on self-management do you have for patients? Does it reflect your patients' diets and culture? How are they sent information?

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Diabetes resources to support your project

- SWL ICB: SWL Diabetes Clinical Guidance
- SEL ICS: Type 2 Glycaemic Control Pathway for Adults
- UCLP: Proactive Care Framework for Diabetes and CVD Risk
- NICE: Clinical guidelines for treating T2DM
- NICE: Clinical guidelines for treating hypertension
- Clinical Effectiveness South East London (CESEL) : Guides
- Fellowship Data Dashboard
- HIN Protected Characteristics Dashboard

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