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System-wide Strategies for Better Diabetes Care

Chapter 1: Evidence Approved Medicines

CHAired BY PROFESSOR PARTHA KAR





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Foreword



PROFESSOR PARTHA KAR, NATIONAL SPECIALTY ADVISOR, DIABETES, NHS ENGLAND

We now have over five million people living with diabetes in the UK and this number is expected to continue to grow.¹ The increasing prevalence is largely for those with type 2 diabetes and driven by rising rates of obesity. This comes at a huge cost to patients as well as for the NHS. As we now have significant data from national healthcare records to demonstrate the intricate relationships between comorbidities in diabetes care, as well as the NICE guidelines that demonstrate the efficacy of treatments, we can act preventatively to reduce the cost of diabetes and boost patient outcomes. Yet, there are challenges in uptake and implementation of best practice which we need to address if we are going to improve diabetes care across the UK.

This Diabetes Care Programme, '*System-Wide Strategies for Better Diabetes Care*', seeks to identify the gaps and inefficiencies and improve outcomes for patients. In this first roundtable event, we explored '*Evidence Approved Medicines*' within diabetes care. This refers to the numerous effective treatments recommended by NICE for diabetes treatment. The roundtable brought together key stakeholders from across the diabetes treatment pathway to better understand the challenges and potential solutions to adopt evidence approved medicines.

This report is the first in a series looking at specific areas of diabetes care in the UK. We have no shortage of examples of best practice seen in pockets across the UK and a wealth of quality improvement projects that show improvement is possible. We now need an overarching process to scale best practice into every corner of the NHS and implement it effectively and efficiently.

In just the last couple of years, we have seen significant progress in our ability to treat and manage the disease, particularly type 1 diabetes. With good leadership and uptake of the recommendations highlighted in this report, I am optimistic that we can make further progress in diabetes care, particularly for those with type 2 diabetes.

ABOUT PUBLIC POLICY PROJECTS

Public Policy Projects (PPP) is an organisation operating at the heart of health and life sciences policy delivery. We bring together senior leaders and practitioners in the public and private health and life sciences sectors to find realistic solutions to the most pressing issues relating to health and care delivery. We facilitate effective collaboration between

public and private sector organisations. We help businesses to grow their profile within the NHS and wider public sector. In turn, we support public sector leaders and organisations with practical recommendations on implementing policy to improve health and wellbeing outcomes for local populations.

Key Information

ACKNOWLEDGEMENTS

System-wide Strategies for Better Diabetes Care is a Public Policy Projects (PPP) programme designed to identify opportunities for improvements and transformation in diabetes care. The programme convenes key stakeholders from primary and secondary care, pharmacy and integrated care boards (ICBs) and other key stakeholders for key discussions across a series of roundtables and events. In 2024, PPP hosted the first of four roundtables, which was chaired by Professor Partha Kar, National Speciality Advisor for Diabetes, NHS England.

The session was attended by more than 20 sector leaders and key stakeholders, including: integrated care system (ICS) leadership, primary care diabetes leads, secondary care consultants, researchers, pharmacists, charities, patient representatives, and key industry representatives. The findings of this paper are based on these discussions, which have been supplemented with additional research by PPP. As such, it is not an exhaustive account of Evidence Approved Medicines within

diabetes care, but rather a succinct reflection from a key group of stakeholders.

We are extremely grateful to all of those who have given up their time to contribute to this series. We would like to thank Professor Partha Kar, whose insight and leadership has provided vital steer in this complex landscape. We would also like to thank the speakers; Professor Stephen Wheatcroft, Dr Waqas Tahir and Hannah Beba and the delegates who gave their time to contribute to the discussions. Finally, we thank Boehringer Ingelheim for being our industry partner on this roundtable as well as Diabetes UK for their support across the series.

This programme has been sponsored by Boehringer Ingelheim. Boehringer Ingelheim has had no influence over the agenda, programme development, content or selection of faculty. Editorial and content decisions were made solely by PPP, with the faculty chosen by PPP with the exception of the Boehringer Ingelheim case study.

NEXT STEPS

This is the first in a series of four roundtable insights reports in the 'System-wide Strategies for Better Diabetes Care' programme, which will be followed by webinars, a large-scale conference and a final report which will synthesise the recommendations from the series.

This is an evolving programme, and PPP has planned a host of events and engagement activities for across 2024. We plan to use the platform provided by this report and delve into the intricacies of population health management

strategy, of training and supporting the workforce to drive transformation and harnessing vital innovation to connect the sector together in a time of unprecedented pressure.

We invite all stakeholders who wish to facilitate a diabetes led transformation of health and care services or those likeminded industry partners who wish to contribute to this debate to write to: Ameneh Saatchi, Director of Market Access and Policy for Diabetes and Wound Care: Ameneh.Saatchi@publicpolicyprojects.com

Key Insights

- There are now various effective medicines in diabetes care, however, adoption of these medicines is slow among healthcare professionals, often due to clinical inertia.² This is particularly prevalent in paediatrics, geriatrics and primary care. Overcoming this inertia is crucial for improving diabetes care outcomes, so patients can be given the right medication at the right time to prevent disease progression and associated complications.
- Including new evidence approved medicines in the Quality and Outcomes Framework (QOF) would boost uptake of effective medications. Furthermore, the addition of a 'CRM bundled outcomes' indicator in the QOF could encourage more holistic comorbidity treatments and use of preventative medicines. This could look at prescribing of evidence-based preventative therapies like SGLT2i across a wider co-morbid population of type 2 diabetes, heart failure and chronic kidney disease (multiple long-term conditions).
- Integrated care systems (ICSs) support population health management techniques and within diabetes this can be used to identify those at risk and act to intervene and prevent disease progression. Interventions such as lifestyle changes and introducing preventative medicines can boost outcomes.
- Within care for type 1 (TD1) diabetes the patient voice has had a significant impact on promoting funding availability for treatments.

The stigma surrounding type 2 diabetes has meant that patient voice has not had the same strength and mobilising this 'patient power' would have a significant impact on treatment funding for this patient population.

- System level quality leadership is key to good service delivery. It is important to learn from quality leadership and examples of best practice to standardise care across the country.
- Harnessing AI algorithms such as for identifying patients at risk of developing diabetes or those whose diabetes is not well managed, could allow less highly trained staff to carry out tasks to support the population health needs.
- There is a need to reconsider traditional healthcare models to reach underserved communities. For diabetes care using those embedded in communities such as community pharmacists and 'Experts by Experience' could break through some socio-economic barriers' that prevent access to healthcare within communities impacted by diabetes could address health inequalities.
- Community pharmacists hold huge potential to improve access to diabetes care, due to their location within local communities across the country. With development of frameworks and protocols, pharmacists could build confidence in delivering diabetes care, particularly helping to support patients with prescribing and deprescribing effective medicines.

Recommendations

For integrated care boards (ICBs)

- Think beyond standard care delivery models when commissioning services – look at how Experts by Experience and those embedded in the community can be used to support adherence to diabetes treatment plans.
- Use population health management (PHM) algorithms to identify people at risk of diabetes earlier and intervene where possible.

For primary care leadership

- Look both within and outside ICSs for examples of best practice in care delivery and learn from these. Implement processes that support change, to make best practice a reality.
- Ensure that primary care professionals are aware of the latest NICE guidelines and the evidence for medicines. Where knowledge is lacking, provide training to ensure that healthcare professionals feel empowered to intensify treatments when appropriate and deprescribe when appropriate. Challenge staff where prescription of new, effective medicines is not taking place.

- Mobilise all primary care staff to help reduce the stigma surrounding type 2 diabetes by promoting the patient voice and having positive conversations around management and treatment of diabetes.

For NHS England and central government

- Revise the QOF to include an outcomes bundle that take multiple co-morbidities into account when devising incentives for general practice.
- Use a 'polluter pays' funding model to generate revenue to develop processes to support the growth of (PHM) across ICSs in the UK. This would enable earlier identification of individuals at risk of disease and allow earlier interventions which would be cost saving in the long term.
- Consider how to increase the role of community pharmacists for prescribing and deprescribing diabetes treatments. This should be considered (via a consultation process) in the next iteration of the 'Pharmacy First' plan.

Introduction

Diabetes is a global issue. Predictions suggest 1.3 billion adults will have diabetes globally by 2050, with increased prevalence in every country and across every age group.³ In the UK, the NHS spends approximately 10 per cent of its overall budget on diabetes care and with the projected trends in diabetes (more than 5.5 million patients by 2030) this is set to rise, putting further pressure on an already strained health system.^{4,5} Furthermore, almost 80 per cent of the money the NHS spends on diabetes is on treating complications arising from diabetes, highlighting the need for a better long term diabetes care strategy to reduce a wider disease burden. In some hospitals more than a quarter of the beds are used by people with diabetes.⁶ The toll of diabetes on individuals, healthcare systems and society is immense, and presents one of the foremost challenges facing public health in the 21st century.

This rise in prevalence is primarily due to type 2 diabetes (T2D); more than 90 per cent of people with diabetes in the UK have T2D.⁷ This is largely driven by obesity and disproportionately affects ethnic ethnicities and those living in areas of deprivation.^{8,9} Other risk factors include smoking and having an immediate family member with type 2

diabetes and age.¹⁰ Type 2 diabetes (T2D) is 40 per cent more prevalent in the most deprived quintile and disproportionately affects Black and Asian ethnic groups.^{11,12} In the recent Core20PLUS5 NHS England approach to reducing inequalities for children and young people, diabetes is one of the five key areas for ICBs to focus on in order to address inequalities.¹³ England's ICSs must now prioritise diabetes care as a central component of their brief to improve outcomes for patient outcomes and service delivery.

NICE is currently updating the overarching guideline 'Management of Type 2 Diabetes in Adults'. Within T1D, guidance of hybrid closed loop systems for managing blood glucose levels presents a step change in the treatment and outcomes for T1 patients.¹⁴ Furthermore, since 2021 there have been two technology appraisals recommending new medications for T2D.^{15,16} These recommendations represent important progress in diabetes care. However, previous studies have found that across four common conditions, only 40 per cent of patients were receiving care in line with best practice guidelines. As such there remains a need to implement these guidelines effectively and efficiently.¹⁷

FUNDING AND INCENTIVES

In recent years, there has been an expansion in the number of medicines available to help treat and manage diabetes.^{18, 19} New guidelines from NICE have demonstrated the effectiveness of these medications, both as treatments and as effective at preventing or delaying longer term comorbidities.²⁰ Despite their availability, there is a reluctance from clinicians to adopt many of these treatments, partly due to clinical inertia, a common phenomenon in healthcare in which healthcare professions do not adopt or intensify treatments for patients despite evidence showing the efficacy for it.²¹ Various factors contribute to clinical inertia including a lack of awareness or poor understanding of new medication guidelines.²² This can lead to poorer outcomes for patients and therefore overcoming such inertia and promoting effective treatments is crucial to improve diabetes care.

One roundtable contributor, a clinical leader said: *“Effective medicines are something we have got a professional responsibility to make sure patients have.”*

The Quality and Outcomes Framework (QOF) is an annual reward and incentive programme for all GP practices across England.²³ It provides resources, financially rewards good practice and aims to improve outcomes in key target health areas (for instance, cardiovascular disease). Roundtable delegates argued that, as an established mechanism, the QOF could be used to increase uptake of certain medications. Historically, medications added into the QOF incentive scheme have seen an accelerated uptake across primary care and therefore, delegates felt that if new diabetes medicines were included in the QOF, this would positively impact uptake.²⁴

One senior geriatrician said, *“In order to kickstart the process, in order to make people think, ‘this equals this’, that’s where the rewards for practice, remembering that you’re talking to a really experienced and knowledgeable team here, and the average GP is balancing the chicken pox*

and the pregnancy, as well as everything that we’re doing as well. And therefore, knowing that this is something that comes with a reward might be the trigger to make them think as a second nature.”

However, delegates also went on to discuss the legitimacy of QOF (there is currently a national consultation open on the scheme), and whether the incentives should be based on outcomes, rather than processes. It was argued that a bundled outcomes approach, looking beyond single diseases and more holistically across comorbidities, such as across cardio-renal-metabolic (CRM) conditions, would be most effective at promoting population health and prevention. It was also mentioned that for diabetes, the UK is doing well against other Organisation for Economic Co-operation and Development (OECD) countries. Given the high mortality rate of cardiovascular disease, a combined or ‘bundled’ CRM optimisation QOF might therefore support the case for people living with multiple CRM long term conditions getting the funding needed to help accelerate the uptake of these medicines.²⁵

One roundtable contributor, a senior clinical diabetes lead proposed a model that would: *“pay people a significant amount for the process (prescribing medicines), but then leverage other increments based on outcomes. That would be a clever way of doing it, because then you have your prevention element intertwined with the strategy.”*

Delegates also argued that the incentive scheme should be more dynamic than the current QOF which, year-on-year, tends to incentivise the same metrics. One primary care lead suggested that a scheme that used an incremental build, progressing each year to bring in preventative, outcomes-based treatments would be a beneficial systematic approach for QOF and the wider NHS.

Overall, roundtable contributors highlighted the need for innovative payment models that combine process-based incentives with outcome-based incentives to promote preventive care and boost patient outcomes.

There was also an acknowledgement of the finite resources available, particularly in the current economic climate. The prioritisation of prevention was raised, and it was expressed that there are potential savings to be made by deprescribing medicines and treatments based on anticipated life expectancy – currently there are still doctors prescribing treatments that won't work in the predicted life expectancy and therefore these are ineffective, and these resources could be diverted towards prevention. With the availability of data increasing, clinicians can make more effective decisions on prescribing to ensure that a particular treatment is worthwhile in a given timeframe for every patient.

MOBILISING THE PATIENT VOICE

When seeking funding, one commissioner pointed to the need to include both the evidence for the therapy (return on investment data), but also the emotion, or patient voice. The patient voice has been harnessed to great effect from the TD1 community and has resulted in some step changes, such as continuous glucose monitoring and insulin pumps becoming available for many patients.²⁶

The picture is different for T2D sufferers, who do not have the same ability to exert influence or promote reform into diabetes care. This is in part due to longstanding stigma surrounding T2D which stems from misinformation and beliefs that patients with T2D have 'caused' their diabetes through poor lifestyle choices such as overeating and poor diets.²⁷ All delegates felt this stigma has limited the 'patient power' of the T2D population and needs addressing in order to advocate for greater access to treatments for those with T2D.

One patient representative said that education was key in reducing stigma: *"showing real life examples of what type 2 diabetes looks and feels like. It's also important to share the challenges of*

living with diabetes day to day to try and reduce the preconceptions about the condition and the people who live with it as well. Building awareness and empathy around diabetes and the people who live with it is crucial to reduce the burden of stigma we face". Mobilisation of the T2D patient population would lead to significant funding advances. *"It's very difficult to deny the lived experience. As a commissioner."*

Ideas for mobilisation included more peer-to-peer support which is accepted as being successful at empowering patients.²⁸ Beyond the patients themselves, efforts need to be made to mobilise others affected by T2D, particularly people that are in remission (lower stigma) and the family and loved ones of someone with T2D.

"If you've got somebody who's a loved one, with type 2 diabetes, you've got to ask: 'why are they not on this drug which would prevent them from going into a kidney failure? This is all about improving health. We need to activate the type 2 patient group'" stated one senior clinical leader.

Using healthcare professionals that work most closely with patients could also be a route to harnessing the patient voice - these are often the regular point of contact for T2D patients and therefore with training and development such healthcare professionals can empower patients and 'Make Every Contact Count'.²⁹ The primary goal of the approach is to encourage healthcare professionals to take advantage of routine interactions to engage individuals in conversations about their health and deliver consistent and regular messages about health and wellbeing.³⁰ Roundtable contributors suggested that within T2D this can be very effective, as lifestyle factors are key drivers of the disease.

Finally, a point was raised about the NICE Technology Appraisal (TA) process. As with medicines, there has been a number of NICE TAs that have been relevant to diabetes

patients over the last couple of years.³¹ These TAs have shown the efficacy of HealthTech for diabetes, such as the closed hybrid loop systems which hold huge potential for transforming lives.³² Delegates discussed the positive role industry has had on ensuring diabetes technology has entered the NHS market and felt medicines adoption could learn from that blueprint. While commissioners are obliged to make NICE recommendations accessible to patients, there is not necessarily a budgetary increase associated with guidelines.³³ It was felt that lack of associated funding is a limiting factor to uptake, and that updates to the NICE guidelines should be done in conjunction with the Treasury to ensure that the necessary funding is allocated to boost uptake of new technologies.

PREVENTION

Last year the government published its interim Major Conditions Strategy report.³⁴ This report highlighted the need both for a more holistic understanding of health and comorbidities, but also the need for preventative health models. One in four adults has at least two health conditions and the five major conditions that formed the focus of the report (including diabetes) account for more than 60 per cent of ill health and early death in England.

Many diabetic medicines have been shown to be effective preventative drugs for CRM complications that often arise from diabetes (and poorly controlled blood sugar).^{35, 36} Delegates discussed the challenge of uptake particularly in certain demographics, for instance, in paediatrics and older adults. T2D now affects over 1500 children in England and this figure is predicted to rise, driven largely by rising obesity.³⁷ Medications are also now available for under 18s, yet there is a broad reluctance to prescribe such medications despite the condition being

more aggressive in children than in adults.³⁸ As this population will increase, and as the longer a person lives with diabetes, the higher the risks of complications, strategies to boost preventative treatments being prescribed must be considered by the NHS.

"We need to shift thinking in medicines for prevention; these drugs are not seen as preventative and that needs to change" stated a diabetes clinical leader.

Roundtable participants also recognised the importance of using PHM tools to identify those at risk and deploy the treatments and/or lifestyle support to boost outcomes. Over the last decade there has been a proliferation of healthcare data which can be used to support the NHS in looking for gaps in provision; one senior clinician said *"we can look at health care, resource strains and healthcare resource utilisation. We can look at delivery of these evidence-based medications and get greater clarity on where the gaps are, where the health inequalities lie"*. This data was discussed in terms of supporting PHM and allowing healthcare professionals to identify people at risk and intervene; *"so not waiting for people to develop complications of diabetes or end stage CVD, but actually identifying them early in life so that we can prevent these conditions developing. I think one thing that is important is whether we can look at more complex data modelling."*

There was also optimism around how the new ICS model promotes PHM. These new systems have the potential to promote joined up care and more effective co-ordination in tackling the needs of the population. Given the increasing prevalence of T2D across the country, tackling obesity (which is driving disease pathways both across diabetes and CRM conditions) as well as other risk factors such as smoking is crucial.³⁹ However, funding was again mooted as having a large impact on ICSs' ability to act on prevention. One delegate pointed out: *"I'm always blown away with quality improvement*

projects... People have set up cardiometabolic, cardio, renal, and metabolic pathways of care, often spanning primary and secondary care. But these are often funded by short term monies... there isn't that money there to invest in them to continue them".

Finally, delegates discussed the 'polluter pays strategy' as a potential source of income for prevention - top slicing tobacco and alcohol company revenues and reinvesting funds into healthcare delivery and prevention.⁴⁰

STAFFING

There are significant challenges with staffing across health. These include a shortage of trained staff, difficulty retaining staff, variation in quality of care and a need to move towards less specialist silos, enabling health professionals to work across multiple morbidities.

Across the UK, there are significant variations in diabetes care delivery and outcomes. Data shows that while the Index of Multiple Deprivation is strongly correlated to outcomes, in some areas, outcomes are better than expected, which demonstrates that the model of care being used is important.⁴¹

Delegates argued that leadership is a key factor in care delivery and outcomes. Quality leadership is often cited as an important factor in care quality improvement. The discipline of improvement in health and social care says '*every single person is enabled, encouraged and capable to work with others to improve their part of the service*' - this can only happen with quality leaders.⁴² The culture of competition that used to be prevalent across the NHS is gradually changing with the introduction of ICSs, and as new leadership has emerged. Learning from best practice and sharing insights will help standardise care and reduce inequalities in outcomes.

Beyond England, within the devolved nations there is also an emphasis on sharing best practice and standardising care across the nations.

There was a strong focus within the roundtable discussion on how to better reach underserved communities. Standardising and improving processes and protocols that would allow less highly trained staff to deliver care was discussed as a route to both cost saving and addressing some of the barriers to engagement. Several case studies were mentioned in which health engagement came from people within the community. For instance, a randomised controlled trial in Salford trained lay people (people with the same background and living in the same areas as the target population) on a telephone support service for those prescribed complex T2D medication.⁴³ These were people in the most deprived section of the population and the telephone service followed up on care plans and supported patients in the pursuit of the care plan goals. This trial proved effective in improving patient outcomes (the study saw improvements in HbA1c levels and with patient satisfaction within the test group).^{44, 45}

Similarly, other ICSs are looking at an engagement model from Brazil (*The Family Health Strategy - Estratégia de Saúde da Família, ESF*) which sees local people within a community, trained and paid to become community health workers, and then regularly 'call in' on a case load of people, whether requested to or not.⁴⁶ Again, this model has shown promising results, including evidence of community health workers picking signs and symptoms up early and breaking through some of the socio-economic barriers that impact access to healthcare. It has also been effective in challenging some of the assumptions that healthcare professionals have about why people behave in the way they do. Delegates also discussed 'Experts by Experience' (people who have

experience of using or caring for someone who uses health, mental health and/or social care services) and the co-production of services in the context of effective patient engagement. This group of people possess a huge amount of knowledge, as well as the patient perspective which can be invaluable in engaging others.

Models such as these that go beyond the traditional medical model might be effective in promoting medicines uptake in particular populations.

"I think we do have to think beyond the standard medical model to overcome a lot of these difficulties." - diabetes clinical leader.

ROLE OF PHARMACISTS

The government and NHS England have recently launched the 'Pharmacy First' scheme.⁴⁷ Under this scheme, community pharmacists can supply prescription-only medicines, including antibiotics and antivirals, in order to treat seven common health conditions, without patients needing to first visit their GP. This model of pharmacy-led care is aimed at alleviating some of the burden currently experienced by primary care. This is the first in a series of steps towards empowering community pharmacists to deliver more care to patients.

"Pharmacists have huge workforce potential if we can educate and build confidence for them to act up to these roles." – commissioner.

However, there was also some trepidation at the roundtable as delegates raised fears around diabetes. One delegate said: *"I think traditionally pharmacists haven't been involved in diabetes care. And so, pharmacists have lent themselves to some of the more protocol-driven things in the past. I think sometimes it's the nuances of care that start to worry people in their clinical practice"*. There appeared to be a lack of awareness amongst clinicians who

were not pharmacists that there are multiple frameworks which can help with training and supporting pharmacists from early career, into advanced and consultant practice. The Royal Pharmaceutical Society has supported a robust process of assessment for advanced and consultant portfolios.⁴⁸ In the case of consultant pharmacists, this process involves credentialling both a post and a person before full functionality in the role would be supported. This portfolio approach to building confidence and confidence lends itself to help pharmacists move past education and start putting diabetes care into practice. One commissioner at the roundtable highlighted that *"as a result of this portfolio approach we are seeing a developing interest and expansion of the pharmacist workforce in diabetes care. In some areas we are seeing senior pharmacist roles in diabetes care in primary care networks, consultant pharmacist posts in integrated care systems and community pharmacies offering a wider range of services to serve their communities at risk and living with diabetes"*.

Delegates felt this doesn't have to end with pharmacists; dieticians and other professionals can also be trained to deliver care with the right processes in place. It was also argued that industry is well placed to help with this.

"I think there's also a role for industry to prove models of care and new models of care. We've been doing some work with different stakeholders from pharmacy backgrounds advanced nurse practitioner backgrounds as well. Once industry can prove the model of care, the next step is scaling these models in the NHS and this is difficult bit" said an industry partner.

Pharmacists sit across silos and therefore support connectivity across disciplines – a fact that helps to optimise pathways of care. Better understanding of pharmacy networks and how they overlap ICS networks, can optimise implementation of new medicines and guidelines.⁴⁹

PROJECT USING MULTIDISCIPLINARY COLLABORATION TO DRIVE IMPROVEMENTS IN TYPE 2 DIABETES OUTCOMES IN BIRMINGHAM AND SOLIHULL ICS

Moor Green Lane Medical Centre is in the Birmingham and Solihull Integrated Care System (ICS) in the West Midlands. The ICS has one of the highest rates of type 2 diabetes in the country and diabetes related complications have a significant impact on the population and the health system¹. In 2021, Moor Green and Boehringer Ingelheim began a joint project to align diabetes care with the wider strategic objectives of the ICS.

Boehringer Ingelheim is a global, research driven company that works to improve the health of humans and animals. They have expertise in Quality Improvement (QI), which is why they were key partners for this project.

The project had clear aims:

- Improve attainment of the three diabetes treatment targets, HbA1c, blood pressure and cholesterol by optimisation of medicines, lifestyle advice and/or referrals.
- Enable access to general practice education and QI skills and support.
- Improve patient experience and quality of life.
- Encourage patient empowerment and ownership over their own health.
- Reduce demand on secondary care services.

In collaboration with Boehringer Ingelheim, Moor Green piloted a community based 'holistic' diabetes multi-disciplinary team (MDT) across Moor Green and four other local medical practices. The pilot started in July 2021 and ran for over 18 months. The MDT consisted of a Diabetes lead GP, consultant, pharmacist, nurse, dietician, health coach and social prescriber. The team ran bi-monthly four-hour sessions including referring practice and GP teams. They used a tool (PRIMIS GRASP-DIABETES) to identify patients that would benefit most from the access to review by the MDT¹¹.

Over the 18-month pilot period, members of the MDT shared knowledge and expertise with each other. This enriched the skills of the staff involved, helping to improve the care of patients with Type 2 Diabetes. Staff were better able to empower patients to make healthier lifestyle choices which were reflected in improved attainment of diabetes treatment targets:

- **HbA1C:** this is a test that measures the amount of blood sugar (glucose) attached to haemoglobin in the bloodstream. It indicates how well diabetes is being controlled – a raised HbA1c is a risk factor for diabetes related complications. The MDT found that 179 patients had elevated HbA1c levels. The pilot led to a meaningful reduction for patients in all groups with an overall mean reduction of 7.5mmol/mol. Patients in the group with the highest

levels of HbA1c (>75mmol/mol) saw a mean reduction of 11mmol/mol. Evidence from the UK Prospective Diabetes Study that a lowering of HbA1c by 11mmol/mol was estimated to equate to a 37% lower risk for microvascular complicationsⁱⁱⁱ. Therefore the reduction in this trial was a significant improvement for patients.

- **Blood pressure:** 44 patients were identified with above target blood pressure. Following MDT review there was an average reduction in systolic blood pressure of 16mm/Hg. As blood pressure is another risk factor for complications, particularly of having a heart attack or stroke, this reduction is a positive step for patients.
- **Referrals and health resource use:** In a sample of 34 patients who attended the MDT clinic, it was found that onward referral to diabetic outpatients was prevented in 30 (88.24 per cent) patients. Assuming this rate is reflective of the entire pilot cohort (179 patients) 158 onward referrals to diabetic outpatients were prevented, with a total saving of £28,914 in referrals^{iv}.

Following this pilot's success, there are discussions between the NHS and Boehringer Ingelheim to roll out the MDT concept across the wider area.

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Conclusion

The range of medicines and treatments available to people with diabetes is better than it has ever been before. The data shows that these treatments are effective and hold huge potential for improving outcomes for people with diabetes. Boosting uptake using tools such as the QOF will have significant impact on diabetes care. As ICSs become more mature systems, they will support more joined up care that moves away from siloed, single disease treatment. Across the devolved nations, health boards are striving for more joined up care. Given the comorbidities associated with diabetes, this shift to more holistic care may reduce complications and act preventatively to improve patient outcomes.

PHM approaches are still in their infancy in the UK and again, but are gaining increasing traction, supported by growing health data and the ICS model. PHM, if funding permits, could allow step changes in prevention by identifying those at risk of certain disease pathways and intervening early, mitigating poor outcomes. Given the increasing prevalence of T2D combined with the understanding clinicians have of the drivers of the disease pathway,

PHM offers huge promise in stemming this increased prevalence.

However, none of these measures can happen without the people needed to make them happen. Quality leadership is essential for better diabetes care but isn't the only answer. Mobilising the T2D population, and overcoming the associated stigma, will profoundly impact care delivery and patient outcomes. Lived experience is key to driving change and demanding improvements and this is particularly important for the growing numbers of T2D sufferers.

Insulin was first used to treat diabetes just over 100 years ago. With the plethora of medications, treatments and technology now available, diabetes care has come a long way. The challenge is ensuring the best available treatments and interventions are delivered and that people are effectively engaged in their treatment plans. As the NHS evolves to adapt to the challenges of a population living longer than ever and often with comorbidities, such interventions must and will be a priority.

Attendees

The insights and recommendations of this report have been informed by a roundtable event which took place on the 5th February 2024. Thank you to all the participants of the roundtable, and those who supported and gave comment to the report.

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