

Report on the National Diabetes Audit (NDA) Quality Improvement Collaboratives

Strengthening the quality improvement skills of audit recipients may increase improvement from national audit (Brown et al, 2019). The National Diabetes Audit Quality Improvement programme (2021-22) aimed to improve care and outcomes for people with diabetes across two national audit workstreams by collaborative support of QI initiatives:

- Type 1 diabetes – To increase the percentage achieving HbA1c within target
- Type 2 diabetes – To reduce cardiovascular risk

In addition, there was a network-level workstream, the report for which will be published [on our webpage](#) in early Autumn 2022.

The type 1 and type 2 diabetes improvement work was supported by creating Quality Improvement Collaboratives (QICs), as a co-intervention to support organisation-level improvement.

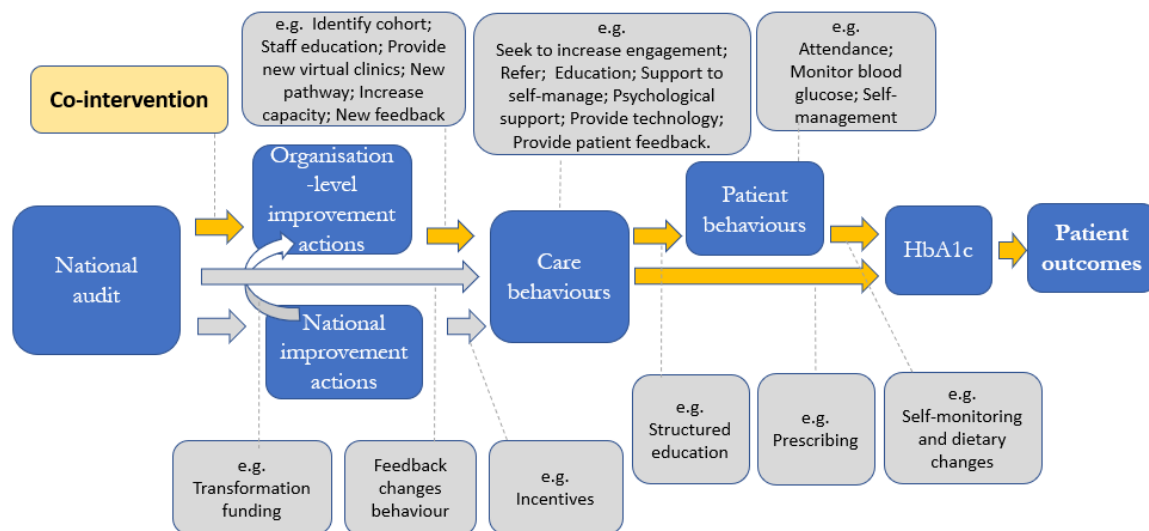
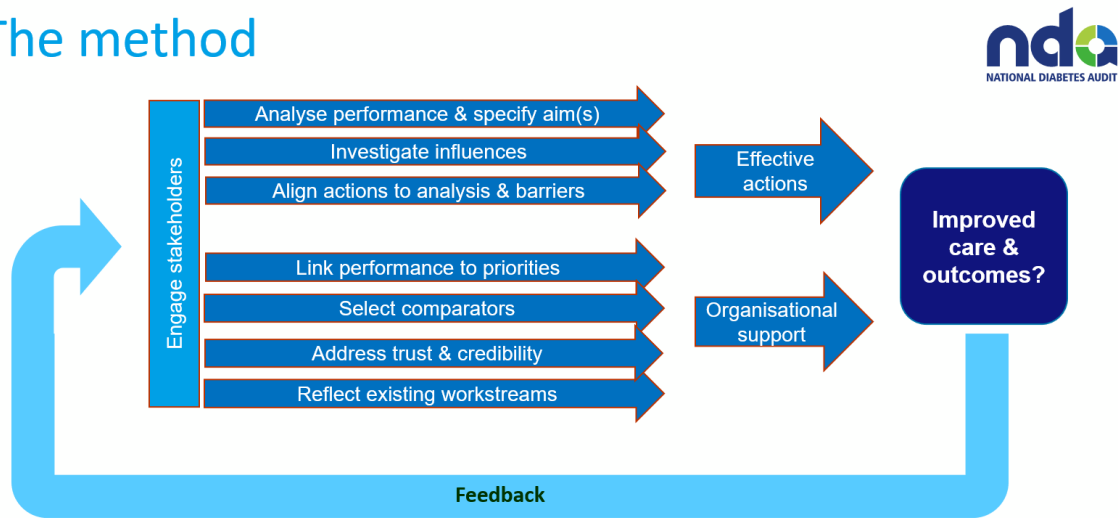


Figure 1: Quality Improvement Collaboratives as a co-intervention to enhance the national audit

As illustrated in Figure 1, the QICs seek to support the work of local teams to influence care and patient behaviours in order to improve patient outcomes. QICs can support healthcare improvement (Schouten et al, 2008). The content of the Quality Improvement Collaborative was informed by learning from the earlier 2017-2020 NDA QIC programme, in particular by developing organisational commitment for organisation and system level changes (Sykes et al, 2022).

The Collaborative involved teams attending interactive workshops that sought to support them in engaging stakeholders, analysing service performance, investigating influences upon this performance, selecting actions and using different techniques to increase organisational commitment for change (Figure 2). Each team was asked to set up mechanisms to monitor progress and provide feedback to their local teams and to the collaborative.

The method



Adapted from: Sykes, M. Thomson, R. Kolehmainen, N. Allan, L. Finch, T. (2021) Describing and enhancing audit and feedback in dementia care: An intervention development study. Newcastle University. Funded by NIHR DRF-2016-09-028

DIABETES UK
KNOW DIABETES. FIGHT DIABETES.

Figure 2: A logic model of the intervention

The cohort was split into two waves (Table 1), with a plan to bring both waves together in the Autumn to form two larger groups with greater opportunity to share learning and resources. Appendix 1 provides a map of participating QIC sites across all four audit workstreams. Appendix 2 summarises the work and current plans of each team.

Type 1		Type 2	
Wave A	Wave B	Wave A	Wave B
(10 teams)	(4 teams)	(7 teams)	(5 teams)

Table 1: The number of teams per collaborative

In addition to team-level actions, the collaborative has led to additional workstreams:

To work with NHS Digital to produce a dashboard providing quarterly data to specialist teams to enable the teams to monitor median HbA1c over time.

To pair teams recording high NDA performance on the three treatment targets (HbA1c, cholesterol and blood pressure) with collaborative teams. The plan was for them to discuss how they each deliver care, for the collaborative team leads to bring back to the group key messages, for example, about care processes, structures and contexts.

Appendix 1:

National Diabetes Audit
Quality Improvement Collaborative 2021-2022 sites



Appendix 2: A summary of the work of selected teams

Type 1 NDA QIC

Barking, Havering and Redbridge University Hospitals NHS Trust

Background: The existing secondary care diabetes service did not provide any specific care for young adults with T1DM. The transition service did not have enough appointments for the number of paediatric patients who needed to transition. Secondary care currently had no diabetes database and they had not submitted to the NDA as we are unable to quantify our patient cohort and delivery of care.

The team aimed to:

- Understand our population in terms of cohorts of T1DM and T2DM patients and to develop a database to look at HBA1c and delivery of care (3Ts).
- Develop a specialist service for young adults with T1DM aged > 16 and up to 25.
- Build and improve on the current transition service.
- Work with our community colleagues in a more integrated way to provide a better service overall.

To do this they:

- Setup an e-referral for young adult T1DM patients so they could be cohorted into a monthly clinic. Allocated DSN support for this clinic along with consultant review.
- Identified patients in our current diabetes clinics and reallocated them to T1 clinics and T2 clinics.
- Agreed funding for an extra DSN to support early discharge of patients with diabetes - in particular to allow telephone follow ups and to support Freestyle libre starts from the T1 clinic as well.
- Worked with pathology colleagues and our IT specialists to build a database that helped us identify T1DM patients using antibody tests, then linking these patients with HBA1c, Lipid and UACR data.
- Sought to allocate extra resources for those aged 16 -18 who are diagnosed with T1DM diabetes, recognising they need more support and access to technology.
- Developed a business case for an improved transition service along with a defined young adult service aged 16-25.

The monthly T1DM clinic started last August 2021 and we introduced another T1DM clinic fortnightly in Nov 2021, by April 2022, 116 patient appointments in these new clinics. This clinic has DSN support and has allowed them to start freestyle libre with DSN follow up.

Working with the pathology team, we have pulled a data set of all patients with positive GAD and islet cell antibodies and are cross referencing with patients under our service to try and identify who is currently under our care and who is 'missing'. This search tool will also allow us to monitor HBA1c going forward and will form the basis of a more robust database.

The team have been able to submit data to the NDA for the first time.

They are working collaboratively with their commissioners to have funding approved to support the development of the T1DM service.

Liverpool University Hospitals NHS Foundation Trust

The team aimed for 25% of people with type 1 diabetes across Liverpool to achieve a HbA1c of <58mmol/mol by June 2022.

To do this they:

- Analysed data to identify variation between sites, and identify areas to work on and develop whole team engagement.
- Identified how many patients were on different insulin regimens, technology use, impact of postcode / social deprivation. Their goal here was to increase the use of insulin pumps.
- Discussed care processes with a high-performing team to identify lessons. They found that the team had: DAFNE team for 6 years, Type 1 Team, Type 1 weekly MDT, ABCD videos, more dietetic and DSNs, almost half patients on pumps, quarterly NDA data review.
- Sought to introduce HbA1c point of care testing.
- Surveyed patients about HbA1c understanding to identify educational needs, and sought to address these through new patient letters.
- Set up a new type 1 diabetes optimisation clinic.
- Reviewed specific T1 DM clinics, and the mix between face-to-face and virtual appointments. All patients with HbA1c >86 mmol/mol had a doctor led note review
- Provided a staff education day.
- Monthly type 1 improvement group set up in department to continue improvements.
- Quarterly NDA type data review set up internally to look for effects of process changes.

United Lincolnshire Hospitals NHS Trust

The team aimed to increase by 10% the number of patients in each patient group (age group as per NPDA) with HbA1c ≤ 58mmol until June 22.

To do this they:

- Created a database for recording HbA1c results.
- Clinic capacity to increase frequency of attendance.
- Staff grade doctor to join the Diabetes clinic.
- Point of care testing for HbA1c.
- High HbA1c clinic.

Their next steps are:

- To increase frequency of attendance.
- To increase the nursing and dietitian time.
- To introduce a high HbA1c clinic.
- To explore implementation of a drop-in clinic.
- To explore provision of clinics closer to patients' home.

Salford Royal NHS Foundation Trust

The team aimed that 90% of people with type 1 diabetes achieve a HbA1c <86mmol/mol by June 2022.

To do this they:

- Used NDA submission to identify full cohort of type 1 patients, and using a database to review HbA1c every 3 months.
- Undertook fact finding interviews and questionnaires to understand influences upon attendance.
- Reviewed patients with highest HbA1c to see where to intervene and proactively invite them in for review.
- Offered more choice for education - remote, face to face, day and evening DAFNE courses as well as the Roche carbohydrate counting course for those unable to commit to DAFNE.
- Increased access to technology (libre/CGMS/pumps/closed loop systems).
- Undertook formal 3-6 month trials for patients commencing freestyle libre with regular support to enable improved diabetes control.
- Changed DNA procedure to follow up email for patients who do not attend.
- Increased clinic capacity by +10%, provide virtual clinics and produce business case for additional consultant.
- Increased staff numbers able to provide education, to provide more capacity and increase access to support.
- Provide full weekday phone support for patients.
- Increased psychological support through 'living with long-term conditions' groups.
- Explored the case for DM technician role in implementation of technology.

The following has been achieved to date:

- More education sessions have been running in different formats including virtually. Evening courses have also been provided.
- Newer staff members have been trained to support patients with technology.
- Substantive funding was approved for 2 DSNs (initially funded on secondment through covid funds). This has allowed for increased clinic capacity.
- Formal libre trials continue with significant improvement in mean HbA1c
- Increased numbers of patients have improved HbA1c through use of technology in particular closed loop systems where eligible.
- Regular diabetes specific groups are being run by psychologists for people "living with long term conditions".
- A diabetes technician has been appointed to support the increasing use of technology.

The team have struggled with IT support and are currently awaiting data to enable full analysis to see if planned improved HbA1c targets have been met.

Berkshire Healthcare NHS Foundation Trust

The team aimed to increase the number of people with type 1 diabetes whose HbA1c is equal or less than 58 mmol/mol by 3% by the end of June 2022.

To do this they:

- Used QMIS methodology and improvement in outcomes for people with type 1 diabetes became the Team Driver Metric. This metric was discussed at the Team 'Huddle' meeting held every 10 days. As part of this, a project planner was put in place to assign individual pieces of work associated with the metric to all team

members. This supported team ownership and responsibility and helped set realistic timelines to move the project forwards.

- Conducted a root cause analysis of patients not achieving HbA1c of < 58mmol/mol.
- Reviewed the frequency of appointments and
 - Increased frequency of appointments & allocated appropriate clinic time
 - Created dedicated Type 1 and Technology Clinics
 - Split Clinics according to need (eg Libre Clinic)
 - Explored influences on attendance and offered more telephone and virtual appointments.
- Identified the number of people with CGMs and Freestyle Libre and reviewed the pathway and
 - Developed virtual and face to face Freestyle education to ensure on-going support to aid self management
- Type 1 Education – CHOICE delivered virtually. Also obtained QISMET accreditation for virtual delivery.
- Developed a Diabetes Assessment on RIO to support improvements in recording and obtaining data for the National Diabetes Audit. Work still on-going.
- Tableau report produced to help support better identification of people with type 1 diabetes and their clinical outcomes so that the service could become more proactive in reviewing their audit data. This work is also supporting future development of an extract submission for the NDA which is currently being entered manually.
- Working with the ICS informatics team to find location of approximately 700 people with type 1 not under the care of the specialist service.
- Business case submitted and funding agreed to recruit to a dedicated 1.0 WTE Diabetes Consultant to support service development. New Consultant took up post in January 2022.
- Increased clinic capacity so that people with type 2 diabetes could be reviewed and discharged back to Primary Care as appropriate and therefore releasing more capacity for specialist type 1 clinics.
 - Upskilled Primary Care Healthcare Professionals by delivering virtual modular diabetes education to help support improvement in diabetes management.

Cardiff and Vale UHB

The team aimed to increase the TIR to maximise the potential of CGMs such that 80% of users are able to review their own data and 50% are achieving the recommended TIR, TAR and TBR by the end of the project.

To do this they:

- Changed their process for Libre, so that new starters get education that focusses on why & how to download.
- Encourage existing Libre users to download, and gave a card about the goal for time-in-range to people with diabetes.
- Provided additional resources from DTN guidelines for pregnant women to self-adjust.
- Hybrid-closed loops – Explored TIR improvement .
- Developed their initial assessment of needs and education programme (virtual).

Sheffield Teaching Hospitals NHS Foundation Trust

The team aimed to:

- Decrease the proportion of patients with HbA1cs >69 by 5% identified in NDA
- The initial aim was to decrease the mean HbA1c in Libre-naïve cohort by 10mmol/mol for those starting with an HbA1c of 70 mmol/mol or more.
- However, due to staffing issues this was amended to focus on people on pump therapy and libres as part of the NHS England Closed Loop pilot.

To do this they:

- Built on existing MDT relationships and success of the new type 1 clinic.
- Recognised the value of shared messages, intensive and responsive input, and the need to build processes around this culture.
- Provided individualised education.
- Identified all possible people eligible for the closed loop pilot.
- Wrote to individuals who might be eligible, n=43, asking them to have blood tests to ensure baseline HbA1c >69 mmol/mol.
- 35 people were eligible and offered the hybrid closed loop.
- Due to the very tight time scales imposed by NHS England, we made a team decision to only offer the Tandem Control IQ system as this is the one we have previous experience of using .
- 5/35 preferred to stay on their patch pump.
- 30/35 opted to join the pilot.
- 27/30 stayed on the closed loop system for at least 3 months.

Key Lessons:

- Mean HbA1c drop of 20 mmol/mol achieved within 3 months and maintained at 6 months.
- Switching everyone onto DEXCOM 7-10 days prior to switching the pump helped with the burden of learning something new.
- Compared to previous users of the system who had decided to self-fund, there were a lot more teething issues, therefore closer follow-up required. Probably a general reflection of their pump / diabetes skills – hence high HbA1cs to begin with.
- Of the 3 that discontinued, 2 disliked the tubing and moved back to patch pump. The third is older with significant hypoglycaemic episodes previously, and found the new pump to difficult to learn, he reverted back to his old pump.
- 27/30 highly rate the system, 25/27 very pleased with improvements in HbA1c, and describe the system as “life-changing”.

Dartford and Gravesham NHS Trust

The team aimed to increase the number of patients in each patient group (divided by ages as per NPDA) with HbA1c <58mmol/mol

To do this they:

- Focussed on pre-post Libre data and then DSN and admin pulled together database of type 1 patients .
- Provided additional virtual clinics for DSN with people with high HbA1c.
- Developed a DIASEND business case to improve monitoring.
- Provided additional patient education: DAFNE refresher.

- Explored how to provide additional psychology support.
- Developing a database to support care for people with diabetes.
- Provided additional GP education to increase referrals.
- Successful in securing funding for 6 month pilot in setting up integrated diabetes care as there was no community diabetes care prior to this programme.

St George's University Hospitals NHS Foundation Trust

The team aimed to improve glycaemic control in patients >86mmol/mol and high levels of diabetes distress.

To do this they:

- Developed a business case for psychology, with a focus on reducing complications and DKA.
- Provided staff education.
- Sought to increase consistency of communication between healthcare workers and people with diabetes.
- Developed a new SOS clinic.

Their next steps are:

- To provide feedback to clinicians about their use of technology.
- Investigate how to provide more frequent follow-up and reduce waiting times.

Imperial College Healthcare NHS Trust

The team aimed to reduce HbA1c in a high-risk cohort

To do this they:

- Undertook initial work to review caseload to identify people with high HbA1c and to review care to identify themes and modifiable behaviours.
- Identified people with type 1 diabetes not on caseload with high HbA1c. Engaged with the group to understand rationale for primary care and to identify opportunities for specialist support (e.g. virtual care, specialist care provided in GP surgery).
- Created an educator role to increase capacity and reduce waits.
- Piloted virtual DAFNE and increased DAFNE capacity.
- Developed education around Freestyle Libre.
- Provided staff training for junior DSN and dieticians regarding technology e.g. patient self-management, provide DAFNE.
- Developed and implemented a technology pathway, including implementation of self-monitoring of downloads and an MDT pump clinic.

Royal United Hospital Bath NHS Foundation Trust

The team aimed to increase the delivery of 9 care processes.

To do this they:

- Set up a one-stop face to face clinic where an appointment included retinal screening, feet check, bloods, consultation with Diabetologist, DSN, Dietician, and Psychologist depending on patient's need.

The pilot clinics received very positive feedback from patients and will be re-run as a pilot.

Their next steps are:

To continue to work with CCG and the Trust to gain funding. To this end, they are currently developing the business case.

Kingston NHS Trust

The team aimed to identify high risk patients and identify areas to improve.

To do this, and with the support of junior doctors and M.Pharm students they:

- Identified all Libre users and reviewed data from before and a year after libre was initiated.

They found that:

- DAFNE education status was recorded for 62%, and had been completed for 21%.
- There was significant variation in education uptake between the least and most deprived areas.
- Lower HbA1c was associated with both increased scanning and reduced deprivation

Their next steps are:

- To increase DAFNE uptake rate by putting further emphasize in clinic and offering more DAFNE courses – both virtual/face to face – and to document reasons for non-attendance. For those unable to attend – provide focussed carb counting training.
- To secure more funding from CCG to increase our DAFNE capacity with this data.
- Set up complex type 1 diabetes multi-disciplinary clinics to manage people with the highest HbA1C tertile, persistently high DDS score and/or any other complex needs.
- Build on our database by adding any new referrals and identify missing people with type 1 diabetes in the community by working with local CCGs.
- Work towards reducing impact of Index of Multiple Deprivation on poor glucose control and continue to monitor performance of people from the most deprived background as a measure of service improvement.

Type 2 NDA QIC

Frimley Health NHS Foundation Trust and HCRG care group

Aimed to improve care and prescribing in general practice, more specifically to:

- Promote 3-monthly HbA1c check and feedback, towards a goal of <53mmol/mol in the first 12 months after diagnosis.
- Promote use of SGLT-2 / GLP-1 as first choice second line agents where indicated.
- Promote use of dual therapy at time of diagnosis if HbA1c >75mmol/mol.
- Promote statin use in those with a QRISK score >10% or raised ACR.
- Improve communication at diagnosis to include focus on uptitration of medication, referral to the LCD weight loss program and agents to reduce cardiovascular risk.

To achieve this, they:

- Provided baseline data describing HbA1c and drug use in first 12 months and breakdown of historical choice of second-line anti-diabetic agent.
- Delivered roadshows to practices within the Integrated Care System. This involved 45-min update on best-practice, laminated GP crib card, tips on how to improve care and save money, small group question and answer sessions for all practice staff and provided lunch. Key messages were that 'we cannot afford to wait' if we are to effect a reduction in accrued cardiovascular risk, fat is not inert and that raised ACR means raised cardiovascular risk. They also gave messages about hypoglycaemia, the importance of pre pregnancy preparation, include the HbA1c when referring for an operation and avoid delays in footcare, early referral is key for both patients and practitioners. They are in the process of developing bite-size patient education through animated presentation to be sent out via AccuRx.

To date they have delivered 19 roadshows to >200 healthcare professionals.

The next steps are to review prescribing practice and HbA1c trend (process and outcome) in first 12 months after diagnosis of type 2 diabetes in those aged between 18-65yrs in December 22 and June 23.

The Newcastle upon Tyne Hospitals NHS Foundation Trust & Newcastle Gateshead Clinical Commissioning Group

The presence of Chronic Kidney Disease (CKD) in individuals with diabetes is associated with higher rates of morbidity and mortality. It is estimated that over 40% of all patients with type 2 diabetes have Chronic Kidney Disease (CKD). Diabetes is also the most common cause of End-Stage Renal Disease (ESRD) requiring Renal Replacement Therapy (RRT) in the UK.

The team sought to achieve a reduction in CVD and ESRD through:

- Optimised clinical management of patients with diabetic kidney disease.
- Improvement in urine ACR recording rates.
- Improvement in 8 key care processes.
- Improvement in 3 care treatment targets.

To achieve this they:

- Introduced virtual weekly diabetic renal clinic in addition to existing weekly service. The clinic addressed directly to patient with action plan for GP and made long-term management recommendations for multiple risk factors.
- Developed a local collaborative group of Eight General Practices in Newcastle Area. This involved:
 - Targeted searches of practice patients to saturate referrals into virtual clinic.
 - Monthly meetings (via MS Teams) – education, case-based discussions, strategies to improve patient care and ACR recording.
 - Guidelines for management of patients with albuminuria.
 - ICS funding - targeted searches to identify patients who have not had uACR in the last year followed by automated text message reminders to provide sample.
 - Practice visits.

Their next steps are:

- Ongoing monthly meetings – education, case based discussions.
- Practice visits; building closer personal links.
- Addressing gaps in coding, repeat searches.
- Dashboard data analysis and generation of run charts.
- Working within new ICS structure.

Haivering North PCN

The team aimed to:

- Achieve a 20% reduction of BMI >35 by June 2023 through NHS Weight management.
- Reduce smoking by 20% from baseline by June 2023.
- Reduce cholesterol by 10% from baseline by June 2023.
- Refer 95% to National Diabetes Prevention Programme.

To achieve this they:

- Ran searches and developed digital resources, including an EMIS template and lifestyle intervention codes.
- Developed a pathway and protocols.
- Recruited pharmacy team members and provided feedback on prescribing.
- Virtual practical education re: understanding Q-risks, prescribe statin, new protocol and QI Staff (UCLP training hub monthly).
- uACR project working progress with healthy.io and CCG, particular focus on minority ethnic and learning difficulties populations to address identified inequalities.
- Sought long-term condition funding.
- Obesity strategy interventions: Group consultations; Patient education; Expert patient / patient champions; Health coaches using templates to guide support; LCD training; HCP education; Pharmacy training; PA training.
- Training and education and support for patients.
- Improve self-management via EIER Apps.
- Home BP monitoring implemented via CCG.
- Supported practices to develop their own QI plan.

Bradford District and Craven Clinical Commissioning Group

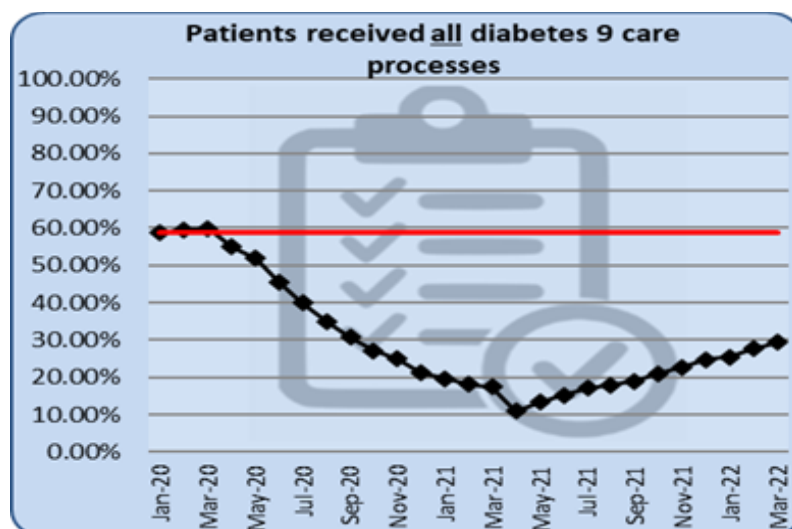
Bradford district and Craven has areas with the highest rates of deprivation nationally and a diverse multicultural population. There are significant variations in diabetes prevalence and health outcomes for those living with diabetes, particularly high rates of cardiovascular disease.

As a system, they wanted to be able to use data more effectively and look at innovative ways to use technology to help healthcare professionals but also improve their population 's health and wellbeing.

The team aimed to increase the achievement of the 9 care processes and improve the three treatment targets and quality of life for those living with diabetes.

To achieve this they:

- Designed and implemented AssistBCD decision making tool to help healthcare professionals efficiently and effectively direct individuals at high risk of developing or diagnosed with diabetes to the right care at the right time.
- Ensured clinical decision trees embedded in AssistBCD supported healthcare professionals in all clinical settings to implement evidence based treatment and care. To help identify, optimise and reduce complications.
- Designed and created a new diabetes dashboard showing primary, secondary and prescribing data on a monthly basis. It helped to focus on disparities across our PCNs both in terms of health inequalities and service delivery.
- Ensured that Structured Education and lifestyle support is offered at diagnosis and incorporated throughout the care pathways during care delivery (Essential).
- Increased utilisation of culturally appropriate patient educational material collaborating with nationally recognised diabetes sources through AssistBCD.
- Developed educational videos for colleagues to view any time.
- Developed and delivered educational training sessions using specialists from our system for primary care clinicians, administrators, health care assistants and social prescribers, etc.
- Re-established a multi-disciplinary specialist team to work within PCNs.
- Worked with Healthy.io to improve ACR testing and uptake as part of NHSE pilot.
- Worked with local communities to promote patient education, including in different languages.



Note: Results adversely affected by the pandemic

There next steps are to:

- Work with Renal and Cardiovascular consultants to link pathways across all 3 disease areas – building on our ‘CVRM and holistic’ approach in diabetes care delivery.
- Continue to build on improvement of 9 care processes and 3 treatment targets sharing best practice across the ICS.
- Continual review of new innovative treatments and technology to help with the delivery of diabetes care.

Kent and Medway Clinical Commissioning Group

The team aimed for 10% of patients in Primary Care, who haven't had their 8 Care Processes measured for the longest time, to be invited into the Practice to have referrals made and checks completed.

To achieve this they undertook multiple projects:

- Healthy.io – Second year funded
- My M Health – Rollout underway
- Advanced Diabetes Practitioners
- To increase use of low calorie diet
- Clinical Psychology
- Structured Education – Case Finding service to rollout

Their next steps are to:

- Meet with the HCP leads to discuss dissemination of the funding and other solutions to address the lack of 8 Care Process measurement.
- Conduct interviews for Advanced Diabetes Practitioners.
- Ensure communications are sent out for all complementary projects.
- Finalise the local Diabetes Dashboard.

Cardiff and Vale UHB

The team aimed to improve glycaemic control and optimise the use of newer agents.

To do this they:

- Are reviewing prescribing data
- Developed prescribing guidelines (cardiology, renal and diabetes guidance)
- Developed community health pathways
- Provided script-switch prescribing advice

Their next steps are:

- For cluster pharmacists to provide targeted input in relation to optimising use of newer agents.

Durham and Tees CCG

The team's primary aim was to ensure detection, coding and appropriate management of diabetic microalbuminuria and albuminuria. To do this, systems were designed to:

- Improve uptake of uACR testing.

- Ensure patients with results confirming diabetic microalbuminuria/albuminuria are appropriately coded.
- Ensure patients with suspected diabetic microalbuminuria/albuminuria were targeted for repeated testing to confirm renal status.
- Ensure patients with diabetic microalbuminuria/albuminuria are offered appropriate RAAS blockade treatment.

To do this they:

- Developed and introduced searches by Derwentside Healthcare Ltd with the Clinical Digital Resources Collaborative to produce baseline and monitoring data for GP practices which included identifying those patients who hadn't had a uACR recorded in the last 13 months or after their annual review, those who need repeat testing, those who need more accurate coding and those who should be offered RAAS blockade.
- Produced a monthly report showing GP practices performance to support them to make improvements.
- Developed a protocol for SystmOne and EMIS to automatically prompt administration staff about patients who had had a diabetes review but had not submitted urine for ACR measurement, to allow prompting.
- Provided education for HCAs, PNs and GPs including a management flow chart, frequently asked questions and a video presentation.
- Provided additional funding to GP practices to support improvement.
 - Provided feedback from a local dashboard across 7 localities.

Their next steps are:

With already 100% sign up from County Durham GP Practices and Darlington GP Practice, next steps are to continue to roll out the programme across the Tees Valley area.

Norfolk and Waveney CCG

The team aimed to improve metrics in diabetes care and outcomes for CVD through the achievement of treatment targets for BP, cholesterol and glycaemic control.

To do this they:

- Created a report from Eclipse to capture relevant metrics to observe change in outcomes.
- Designed a Local Enhanced Service (LES) contract for primary care to address variation in statin prescribing.
- Establishment of a technology in diabetes forum.
- Improving close links with community pharmacists and the New Medicines Service.
- Developed a BP at home model of care, accompanied by a Standard Operating Protocol, which facilitates an individualised approach to BP management .
- Diabetes Programme has developed a Protect NoW Diabetes Prevention work-stream to increase the uptake of referrals into the NHS Diabetes Prevention Programme. This approach will be explored for improving the uptake of statin prescribing, using a population health management approach.
- Scoped and implemented Healthy.io, a smart phone-powered point of care Albumin:Creatinine Ratio (ACR) testing programme.

- Improved detection and management of hypertension through screening for hypertension (and Atrial Fibrillation) in Community Pharmacies and home self-monitoring of BP.
- Assisted self-referral to NHS Diabetes Prevention Programme .
- Access to technologies, such as Freestyle Libre, CGM and pump therapy.
- Identifying lessons from practice engagement.

Their next steps are:

- To work to prevent laboratories from leaving blank results if no protein present.

Sheffield CCG

The team aimed to identify areas in the city with high prevalence of young type 2 diabetes (<40years), poor CVD outcomes and risk factor treatment.

To do this they:

- Sought to increase the 9 care processes for diabetes care and the prescription of CVD risk lowering therapy.
- Developed a new SGLT2 guideline for pharmacotherapy and lipid guidance for young patients with type 2 diabetes.
- Increased the involvement of dietetic service for weight management .
- Raised awareness on the importance of young type 2 diabetes among primary care workforce, including Primary Care Network, to achieve engagement.
- Raised awareness on the importance of diabetes engagement among the young patients through practice nurses, health trainers and link workers, particularly for ethnic minority groups.
- Developed a new care pathway for young people with T2DM.
- Provided feedback about prevalence and outcomes and practice education.
- Specialist pharmacists outreach working with 6 practices with high levels of young people with T2DM, including work targeting inequalities (South Asian population).

On a final note



In my view, the NDA QIC programme 2017-22 has been successful on several fronts. Firstly, it generated enthusiasm and motivation among the almost 100 participating clinical teams which, remarkably, was sustained even throughout the Coronavirus pandemic. Secondly, there was lots of learning about how to deliver support without being too demanding of clinical staff time. And thirdly, it laid a foundation for properly evaluating the impact of a QIC programme linked to a National Audit. This will be taken forward over the next three years. Meanwhile, as this report documents, there are encouraging indications that this approach may indeed help NDA measurements to be better used for identification of improvement priorities.

Bob Young, NDA Clinical Lead