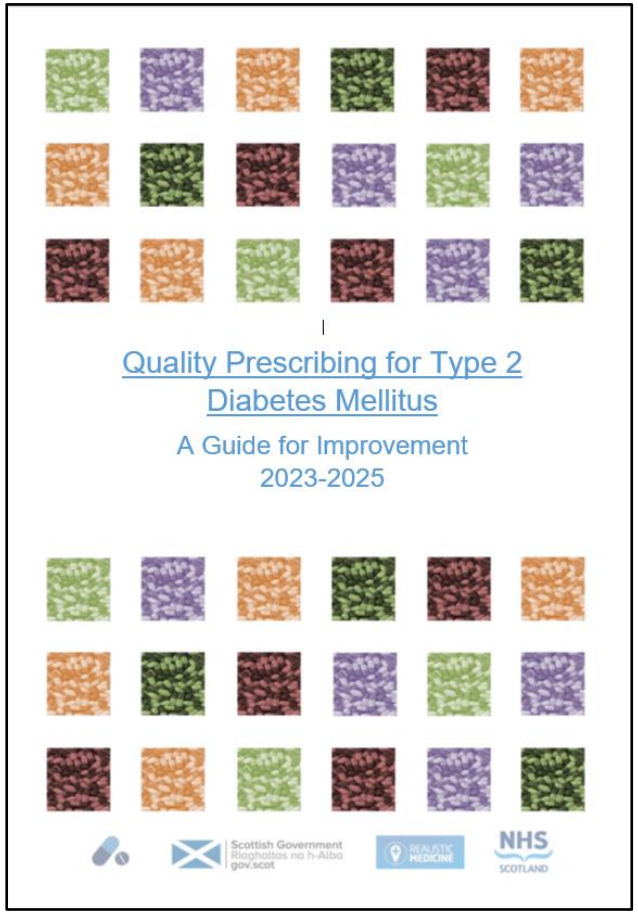
Quality Prescribing for Type 2 Diabetes Mellitus 2023-2025

A toolkit to support improvements in prescribing



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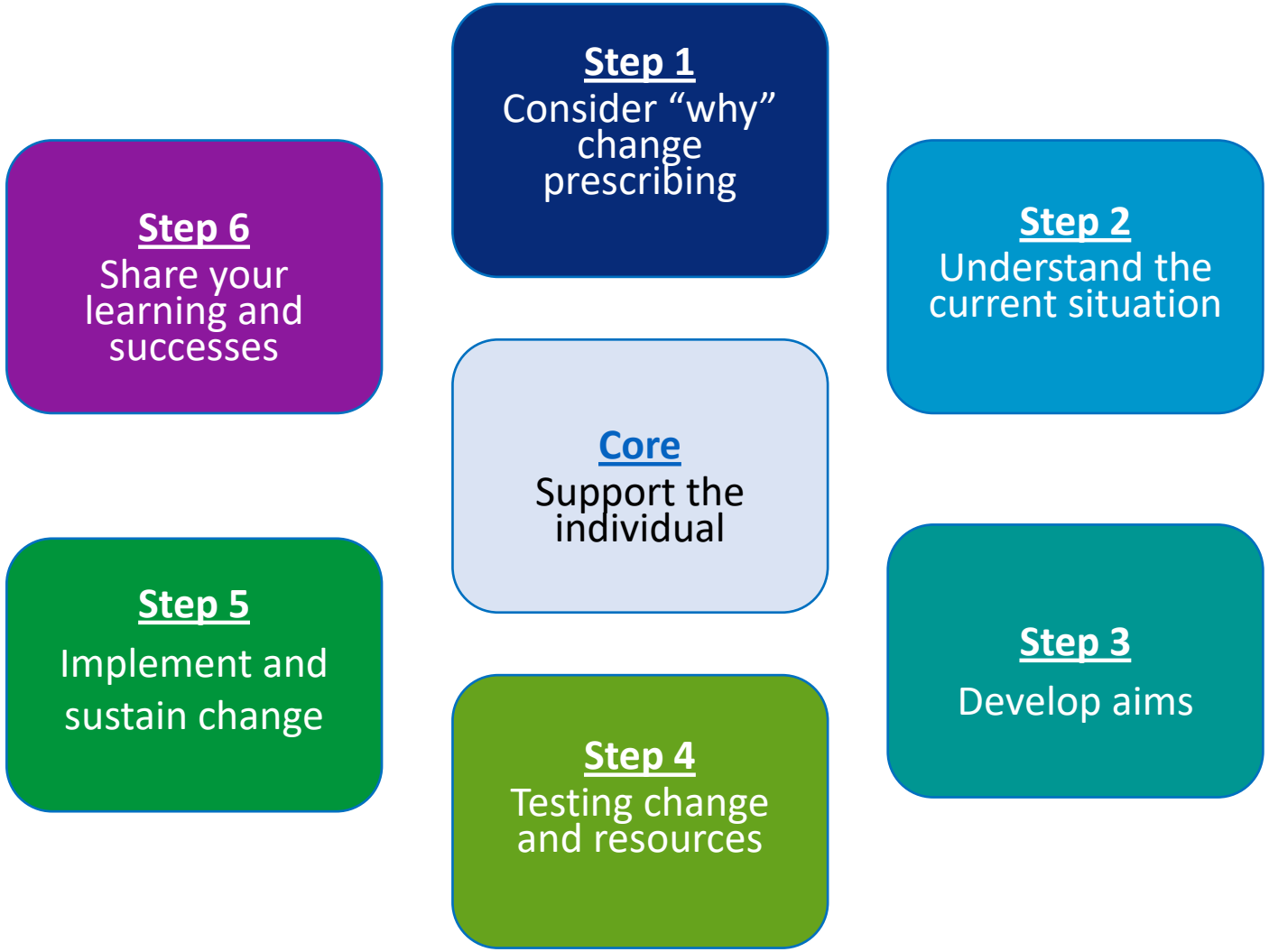
Introduction

- This new toolkit has been developed as a resource to support the recommendations within the Quality Prescribing Guidance for the Management of Type 2 Diabetes Mellitus 2023-2025
- Watch the 90 second video summarising the guidance
- This toolkit allows you to select the key areas for action that are most relevant to you, your practice and health board
- Each Actions for improvement step card links to a range of actions and resources that will help you make improvements
- This is the first edition of this resource and it will evolve and grow over time. We would welcome feedback at EPandT@gov.scot

Actions for improvement



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Step 1

Consider “why” change prescribing

Create a sense of urgency - consider the impact of Type 2 diabetes locally, using local and national data, related to new guidance. Both long and short term outcomes need to be managed and reduced.

Suggested actions	Complete
New guidance available • Quality Prescribing for Type 2 Diabetes Mellitus 2023-2025 • SIGN 154 Pharmacological management of glycaemic control in people with type 2 diabetes • NICE Guidance Type 2 diabetes in adults: management (NG28) • MyDiabetesMyWay – Scotland’s interactive diabetes website	
Incidence of T2DM Consider the incidence and prevalence locally, at board, cluster and practice level. Does this vary with national and other local data? • Scottish Diabetes Data Group: Scottish Diabetes Survey 2020 • General practice - demographics data visualisation - Public Health Scotland • https://web.scidc.scot.nhs.uk/Site/user-how-to-guides/#dashboard	
Cost of managing T2DM The population is aging and living longer, with earlier onset T2DM Consider the cost of diabetes to the individual and the board in managing these – personally, financially and resource involved? • https://sci-diabetes1.mhs.scot.nhs.uk/sci-diabetes1/Auth/Login.aspx • Phase 5 Primary Care Dashboard | Tableau Public	
Target glycaemic control (HbA1c) Review current management strategies and population treated to target HbA1c range.	
Reducing/preventing long-term complications/co-morbidities Newer therapies reduce adverse clinical outcomes such as cardiovascular disease and kidney disease. Consider if these therapies are being prescribed where appropriate.	

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Step 1

Consider "who" can support prescribing change

Suggested actions -			Complete
Think about who should be included in your Guiding Coalition and your Improvement/implementation Team			
Specialism • Diabetologists • Endocrinologists • Managed Care Network • MCN manager • Diabetes specialist nurses • Clinic managers	**Hospital/acute location:** • Care of Elderly/Medicine for Elderly wards and staff • Renal • Acute admissions • Pharmacy department • Dietetics	**Primary care/GP practice:** • Cluster/practice quality leads • Clinical lead (in GP practice for diabetes) • ANPs, long-term condition nurses • Healthcare assistants • Reception staff/Practice/office manager • Pharmacist/technician	
Create and communicate a clear vision • Explain the benefits of changing prescribing in T2DM – better type 2 diabetes control, less complications and co-morbidities, potentially less medication usage, lower environmental impact • Acknowledge the challenges – resistance to change, polypharmacy should be appropriate, patient/clinician perception of 'good control' • Developing a communication and engagement plan will help ensure stakeholders across your service are kept informed and involved as you make changes			
Consider how you will engage with wider stakeholder networks Patient groups, Council and community groups (e.g. physical activity groups), Community link workers and third sector agencies, Local Formulary Groups, wider MDT (Opticians, Podiatry teams etc).			
Change leadership resources Kotter 8 steps towards change Health Improvement Scotland improvement programmes Creating the conditions			

Step 2

Understand the current situation

Understand your system - the processes, people and how they interact with each other. This helps identify the changes required and the impact they might have elsewhere in the system.

Suggested actions - understanding systems	Complete
Health boards Is this a clinical priority for the health board? If not, why not? Does the board have an identified clinical lead for this?	
Managed Clinical Network (MCN) Is the MCN aware of the guidelines and ready to lead by example in implementing these? Does the MCN link with local patient groups and can these be developed locally?	
Clusters and cluster quality leads (CQLs) Have the CQLs and clusters reviewed the recently published cluster reports? Are the clusters willing to work together to share experience and learning and work together to focus implementation on this area?	
GP Practices and Primary Care Team Is there a clinical lead within the practice for T2DM? Is this the sole practitioner managing these patients? How does the practice direct/support the prescribing of others in the practice for the benefit of those living with T2DM? How do patient groups link with this?	
Engage with key stakeholders How will you engage with patient groups, wider MDT, community link workers/third sector groups to co-design your approach?	

Step 2

Understand the current situation using data

Understand your system - the processes, people and how they interact with each other.
This helps identify the changes required and the impact they might have elsewhere in the system.

Suggested actions - understanding systems and available data	Complete
• Dashboard - National therapeutic indicators data visualisation - Public Health Scotland **National therapeutic indicators** available include • Metformin - percentage of people with T2DM prescribed an anti-diabetic medicines (aim for high percentage) • Polypharmacy - prescribed three or more categories of anti-diabetic medicines (aim for minimal medication to manage condition) • Sulfonylureas in individuals aged over 75 years (aim for lower percentage to reduce risks) • Individuals with diabetes and CVD treated with a SGLT-2 inhibitor and/or GLP-1RA (higher level of prescribing should reduce complications) • Glucose self-monitoring products prescribed in individuals (ensure valid rationale for prescribing) https://scotland.shinyapps.io/nhs-prescribing-nti/	
Scottish Therapeutic Utility (STU) in GP practices linking prescribing data with GP system read codes, values, etc Information and download instructions for practices STU installation	
Pareto chart Process map	
IT systems • GP systems – update drug dictionaries, highlight formulary choices, update prescribing synonyms, update ScriptSwitch messages for clinicians • Hospital prescribing systems – highlight new formulary choices and update dispensary stock systems	

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Step 3a

Develop aims – consider particular patient groups

Your aim to improve prescribing in T2DM in line with guidance, should be specific (e.g. all patients or limited to particular groups); timebound (e.g. in next quarter, at next medication review); aligned (e.g. to guidance and local formulary choices), numeric (e.g. target percentage change).

Suggested actions - developing aims	Complete
Those with T2DM often have other co-morbidities. Supporting particular at risk groups can help prioritise reviews, target resources and reduce adverse outcomes.	
Frailty There is greater risk of over-treatment with subsequent risk of hypoglycaemia, falls and hospitalisation. Less stringent HbA1c targets can reduce this risk, reduce medication and polypharmacy and improve medicine adherence. • National therapeutic indicator for Endocrine and falls (sulfonylureas older people %) • Frailty section in Diabetes guidance: section 9 • Rockwood Clinical Frailty Scale	
Co-morbidities Those with established atherosclerotic cardiovascular disease, heart failure and/or renal disease would benefit from SGLT-2i or GLP-1RA regardless of HbA1c. • Diabetes Quality Prescribing Guide: Section 6 - ASCVD, heart failure and renal disease • National therapeutic indicators data visualisation - Public Health Scotland ASCVD not treated with SGLT-2i/GLP-1RA • NICE Guidance: Chronic kidney disease: assessment and management (NG203)	
Use Scottish Therapeutic Utility (STU) to identify (groups of) individuals in GP practices Information and download instructions for practices STU installation	

Step 3 Develop aims – consider particular patient groups (continued)

Suggested actions - developing aims, project planning	Complete
Under-treated and over-treated • HbA1c >58mmol/mol. Generally require additional treatment. Ensure that guidance is followed, as it may be more appropriate to substitute a more effective treatment than add an additional agent. • HbA1c <48mmol/mol. Increased risk of hypoglycaemia (especially if frail), therefore reduction of treatment may be appropriate, either stopping treatment or dose reduction.	
Polypharmacy National therapeutic indicator. Section in guidance Draft Diabetes Quality Prescribing Guide section 2 Polypharmacy Guidance 2018.	
Focus on disadvantaged groups This may include minority ethnic groups, those with English as an additional language, low literacy, mental health conditions. How are they supported – leaflets in additional languages, community outreach work? Mental health • Depression and anxiety patient health questionnaire (PHQ-9) • Scottish Government publication: Improving the Physical Health and Well Being of those Experiencing Mental Illness • Prime scholars articles: Cultural barriers impeding ethnic minority groups from accessing effective diabetes care services	
Patient identification • Use the National Therapeutic Indicators (NTIs) to identify variation between boards, clusters or practices. • Individuals within each group can be identified using the Scottish Therapeutics Utility (STU) in general practice.	

Step 3b

Develop aims – holistic patient care

Lifestyle management is a fundamental aspect of diabetes care.
Weight loss can delay the onset of T2DM and can lead to remission, and should be considered in the aim.

Suggested actions – consider the role of lifestyle management	Complete
Education Are there leaflets/electronic resources/links available to support everyone, not only those with T2DM, and encourage active lifestyle, physical activity, healthy diet, weight management and smoking cessation? Consider inclusion on practice website and refer to Polypharmacy: Manage Medicines (scot.nhs.uk) patient resource Type 2 diabetes: food fact sheet Diabetes Improvement Plan (2021-2026) The Scottish Government's Diet and Healthy Weight Delivery Plan The Scottish Government's T2DM prevention, early detection and early intervention framework MyDiabetesMyWay – Scotland's interactive diabetes website	
Lifestyle Do practitioners and local co-ordinators know and have lists available of local groups, e.g. walking groups, weight management groups, sports centres? ALISS - find services, groups and activities for health and wellbeing across Scotland	
Diet/weight management Are local arrangements known to all and referral pathways accessible?	
Additional support Be aware of local pathways available for smoking cessation and social prescribing support. Smoking cessation information NHS inform	

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Step 3c

Develop aims – what changes are needed in your practice

What is required for your practice to deliver improvements in prescribing in T2DM?
For example, embedding the 7-Step medication review, ensuring trained and competent team, empowering patients, using data (NTIs and STU).

Suggested actions - work with your team to develop your aim and change theory	Complete
Once you have taken some time to examine and understand your system, your team should have some good ideas about what changes may lead to improvement. A driver diagram is a useful tool to help visualise how you will achieve your goal. It can also be used to help communicate your aim. It will show what parts of the system should change, in which way, and includes your ideas about how to make this happen. As your project progresses and you gather more information, your aim and change theory may need to be updated to reflect new knowledge. Your driver diagram should be updated in line with your aim and change theory.	
Measurement Use data to monitor progress and tell other of the impact of your changes. Use a measurement plan to outline what types of data to collect, how and when to collect it and how it will be analysed and presented. These measures will be key to understanding the impacts – planned or unplanned – that your change ideas are having. Populate the measurement plan or other tracking device with details from: STU data NTIs Patient feedback	

Step 4

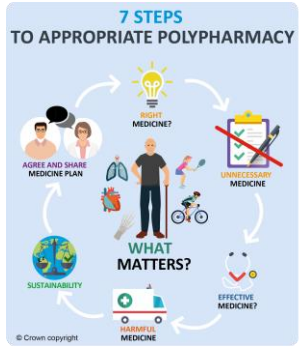
Testing changes

Making change is not limited to one person/role. Everyone involved in the care of those with T2DM has a role. However change ideas need to be tested to determine what works well and is sustainable.

Suggested actions testing changes	Complete
Before making changes/starting a new process: define your current process, what works well, what could be better? Always remembering that the aim of implementing the prescribing guidance is improving care of those with T2DM. Process map; Pareto chart; Cause and Effect Analysis; SWOT analysis There may be more than one change required.	
Consider the location The location of the review will determine the type of review (ad hoc or planned); staff involved; preparation required (e.g. bloods, measurements); single disease or polypharmacy. Define all the steps and people involved. **Planned – acute setting:** diabetic clinic – focus on diabetes including hypertension, cardiovascular risk. May not include other co-morbidities. **Planned – primary care:** Diabetic clinic or all chronic disease management. **Ad hoc – acute setting:** During acute admission for diabetes complication/adverse event or other, e.g. surgery. **Ad hoc - primary care:** When other change in medication occurring; acute condition/minor illness, e.g. osteoarthritis flare up.	

Step 4

Testing changes – resources to support



Regular medication review is essential to ensure all medication continues to be appropriate and any changes in clinical conditions are managed appropriately. The 7-Steps medication review process improves clinical outcomes and reduces harm. Medication review can be planned or ad hoc and will often depend on the setting and patient group.

Suggested actions testing changes

Consider the review process and the 7-Steps medication review.

Current guidance

Draft Diabetes Quality Prescribing Guide Manage Medicines app

Training and case studies

Case studies in guidance Draft Diabetes Quality Prescribing Guide
Polypharmacy guidance including 7-Steps medication review process, this includes a template for a 7-Steps medicine review
Evidence Based Polypharmacy Reviews and the 7-Steps Process (CPD accredited online training on Turas)
Turas Shared Decision Making
NES Diabetes modules (available via Turas)

Treatment summaries

Treatment algorithm and summary charts (full table, renal disease, frailty) in guidance Draft Diabetes Quality Prescribing Guide

Patient guide

Patient guide on Manage Meds app (in development)
MyDiabetesMyWay – Scotland's interactive diabetes website

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Step 4

Testing changes – resources to support

Regular medication review is essential to ensure all medication continues to be appropriate and any changes in clinical conditions are managed appropriately. The 7-Steps medication review process improves clinical outcomes and reduces harm. Medication review can be planned or ad hoc and will often depend on the setting and patient group.

Suggested actions

Ensure follow-up
Ideally after 3 months if changes made to medication HbA1c (scot.nhs.uk)

The House of Care Model - Health and Social Care Alliance Scotland (alliance-scotland.org.uk)
Medication sick day guidance postcard manual from the Manage Meds app
Quality improvement in diabetes care | Diabetes UK

Measurement
Use data to monitor progress and tell other of the impact of your changes.
Use a measurement plan to outline what types of data to collect, how and when to collect it and how it will be analysed and presented.
These measures will be key to understanding the impacts – planned or unplanned – that your change ideas are having.
Populate the measurement plan or other tracking device with details from:
STU data
NTIs
Patient feedback

Step 5

Implement and sustain change

Once your change ideas have been tested, determining what works and what can be improved, these changes can be expanded to others in the team and a wider population.

Suggested actions - approaches to implementation	Complete
Implementation supports making the change a routine part of practice and “business as usual”	
Implementation as a series of cycles Three implementation approaches: • Just do it • Parallel • Sequential Implementation checklist	
Remember to keep measuring and feeding back to all involved!	

Step 6

Share your learning and successes

Share with others in the cluster and throughout networks. Be honest about what worked and what didn't and what you learnt from this.

Suggested actions	Complete
Consider how to share the results • Cluster meetings • Practices meeting	
Regular progress reports and outcomes Use STU reports, SCI Diabetes, NTIs and dashboards to monitor (and celebrate) change.	
Consider organising an improvement event This could be board wide, across primary and secondary care, or multiple events tailored for each area, but with same common purpose. Have a senior manager or executive attend. They can be invaluable in leveraging necessary support and resolving bottlenecks especially if the action can be linked to wider organisational priorities.	
Regular follow-up and progress reports Establish regular meetings reporting action and progress. Remember to praise progress and, where applicable, share the team's success and innovative ways of working.	

Core

Support the individual

Having a diagnosis of Type 2 Diabetes Mellitus has many implications. Some will accept this and take positive steps to put the diabetes in remission. Others will have difficulty accepting this and therefore managing the condition, particularly if they have concurrent mental health conditions. Therefore, supporting the individual is essential.

Suggested actions	Complete
Prevention Does every team member support and encourage an active lifestyle, healthy diet, weight management and smoking cessation at every opportunity?	
Diagnosis What resources does the team have to support the person newly diagnosed? Diabetes UK	
Ongoing care Summary of anticipated review – medication, feet, eyes, height, weight, diet, bloods Frequency of review	
Patient version of guide Patient guide on Manage Meds app (in development)	

Core Resources

Resources
Polypharmacy Manage Medicines app
Lived experience of T2DM in Diabetes: my information, my support, produced by The Health and Social Care Alliance Scotland
My Diabetes My Way e-learning course
NHS Inform information
Type 2 Diabetes food fact sheet
Diabetes UK information on improving care for people with diabetes and a learning disability
Diabetes UK: information in different languages
DVLA information on assessing fitness to drive
ALISS - find services, groups and activities for health and wellbeing across Scotland