Cambridgeshire & Peterborough
Integrated Care System

Diabetes LES Meeting 1

29th June 2023
1.00pm – 3.00pm

Dr Jessica Randall-Carrick
ICS Clinical Lead, Diabetes & Obesity;
& Co-Clinical Lead CVD Prevention

Housekeeping

To make the most of our time, we'll be using our 5 house rules:

1. **We will be using chat to hear from you today**. We are really keen to hear your views & queries.
2. **We're asking everyone to stay on mute**. If we have a chance for verbal contributions, please let us know via chat & we will let you know when it's time to unmute.
3. **We still want your views after the meeting!** If you have further comments to make, please contact cpicb.communityltc@nhs.net
4. **Whenever possible, please do have your video on** – although virtual sessions are often convenient, we miss out on making connections with you & would be great to 'meet you' here!
5. **Please let us know who you are via chat -** eg Full name, Practice or PCN that you are representing, & role.

Agenda

No	Item	Time	Lead
1.	Welcome and introductions	1.00pm – 1.05pm	Dr Jessica Randall-Carrick
2.	Medicines update • Diabetes Technology • GLP-1 and Obesity • Medication shortages • Blood glucose strips • Breakout rooms North vs South	1.05pm – 1.5pm	Stephanie Ransom/ Ellie Gurnell
3.	Diabetes LES Summary & Implications for Practices • Weight Management • Dietary Sheets • Very Low Calorie Diet • Eclipse • Metformin & B12 • Virtual Clinic Reviews (VCRs)	2.05pm – 2.35pm	Dr Jessica Randall-Carrick
4.	T2DR (formally LCD) Programme - OVIVA	2.35pm – 2.45pm	Karen Miller
5.			
6.	Close • Date of next meeting: Wednesday 13th September 2023, 1.00pm – 3.00pm	2.55pm – 3.00pm	Dr Jessica Randall-Carrick

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Eclipse

- *Data*

Eclipse Summary June - 23

Home | Overview | My Patients | NHS Performance | Medications | Action Plan | Alerts: 32 red 213 amber

All Practices

All Diabetes

53,267 (5.2%) with Diabetes

45% with all 8 care processes completed in rolling 12M — Rank 34/78

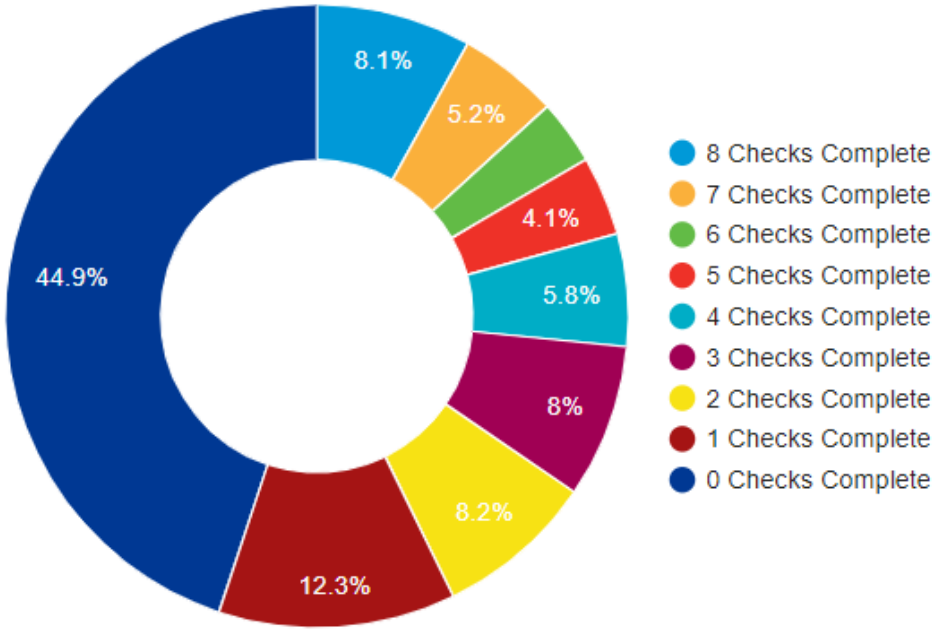
8% with all 8 care processes completed in current QOF Year — Rank 33/78

27% in range for all 3 treatment standards — Rank 40/78

115,915 / 426,136 (27.2%) Total Tests Completed in current QOF Year — Rank 27/78

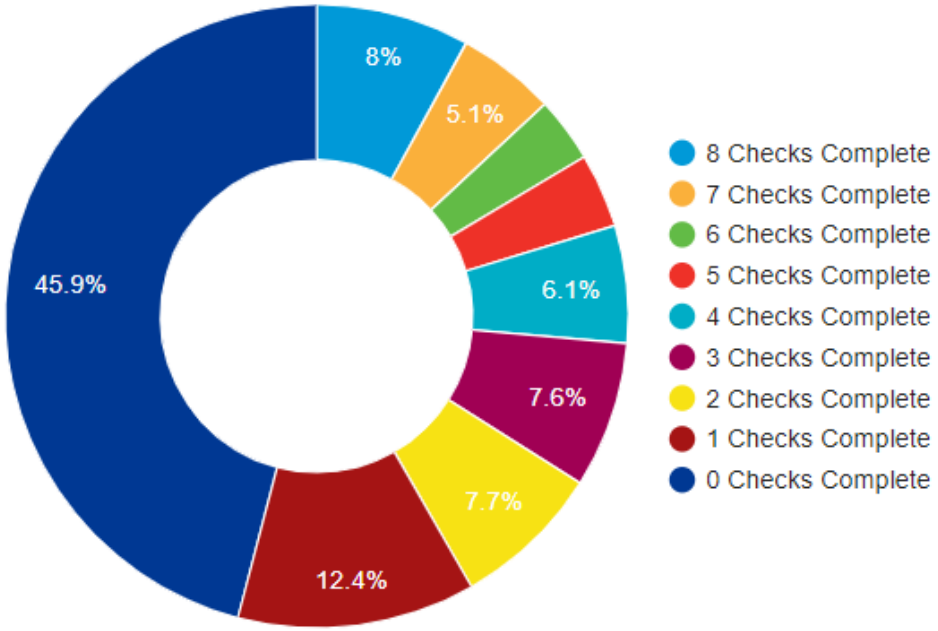
CCG

8 Care Processes (2023/24)



National

8 Care Processes (2023/24)



8CPs in QoF Year
June 2023

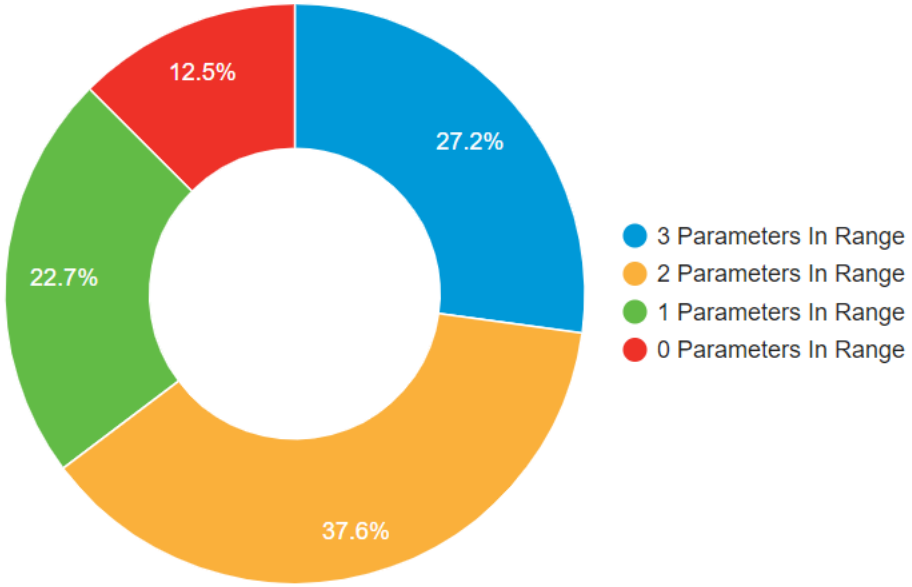
Name	Pop	Cond Count	Screen Count	Screen %	Rank
NATIONAL	27196300	1502183	119797	8.0%	
NHS Cambridgeshire and Peterborough CCG	1004509	53267	4291	8.1%	33 /78
Cantab PCN	55302	1182	133	11.3%	80 /541
A1 Network PCN	45615	2504	266	10.6%	99 /541
Ely South PCN	39032	2180	227	10.4%	108 /541
Peterborough & East PCN	60643	4006	387	9.7%	137 /541
Cambridge City PCN	49665	2437	231	9.5%	146 /541
South Peterborough PCN	69259	3969	373	9.4%	152 /541
BMC Paston PCN	43076	3196	290	9.1%	169 /541
Meridian PCN	37457	1864	168	9.0%	170 /541
Central and Thistlemoor PCN	52666	2322	204	8.8%	185 /541
South Fenland PCN	27264	1984	168	8.5%	206 /541
Ely North PCN	38869	2428	202	8.3%	218 /541
Granta PCN	54860	2807	221	7.9%	245 /541
Cambridge Northern Villages PCN	49024	2200	172	7.8%	247 /541
St Neots PCN	44811	2176	168	7.7%	254 /541
Huntingdon PCN	44459	2548	185	7.3%	277 /541
Cambridge City 4 PCN	57047	2072	150	7.2%	279 /541
Fenland PCN	29418	2516	167	6.6%	313 /541
St Ives PCN	45874	2693	167	6.2%	349 /541
Bretton Park and Hampton	31392	1781	101	5.7%	383 /541
Peterborough Partnerships PCN	31270	1882	106	5.6%	387 /541
CAM Medical PCN	48728	883	42	4.8%	447 /541
Wisbech PCN	48778	3637	163	4.5%	459 /541

Quick Action Plans	Total Patients	Total Patients needing tests	% Patients needing test
Phase 1: Patients for review to maximise 8 key processes and 3 treatment targets where 1 test is required and previous test was normal	53179	1657	3.12%
Phase 2: Patients for review to maximise 8 key processes and 3 treatment targets where 2 tests are required and previous tests were normal	53179	2555	4.8%
Phase 3: Patients for review to maximise 8 key processes and 3 treatment targets where 3 tests are required and previous tests were normal	53179	9867	18.55%
Phase 4: Patients for review to maximise 8 key processes and 3 treatment targets where 3 tests are required and 2 previous tests were normal	53179	11950	22.47%
Phase 5: Patients for review to maximise 8 key processes and 3 treatment targets where 3 tests are required and 1 previous test was normal	53179	6361	11.96%
Patients with HbA1c >= 59	53179	22143	41.64%
Patients with BP >= 140/80	53179	19574	36.81%
Patients with Cholesterol >= 5	53179	12408	23.33%
Patients with only smoking status required as 8th key care process	53179	241	0.45%
Patients with only weight required as 8th key care process	53179	132	0.25%
Patients with only ACR required as 8th key care process	53179	1464	2.75%
Patients with only blood pressure required as 8th key care process	53179	76	0.14%

3TT's as of June - 2023

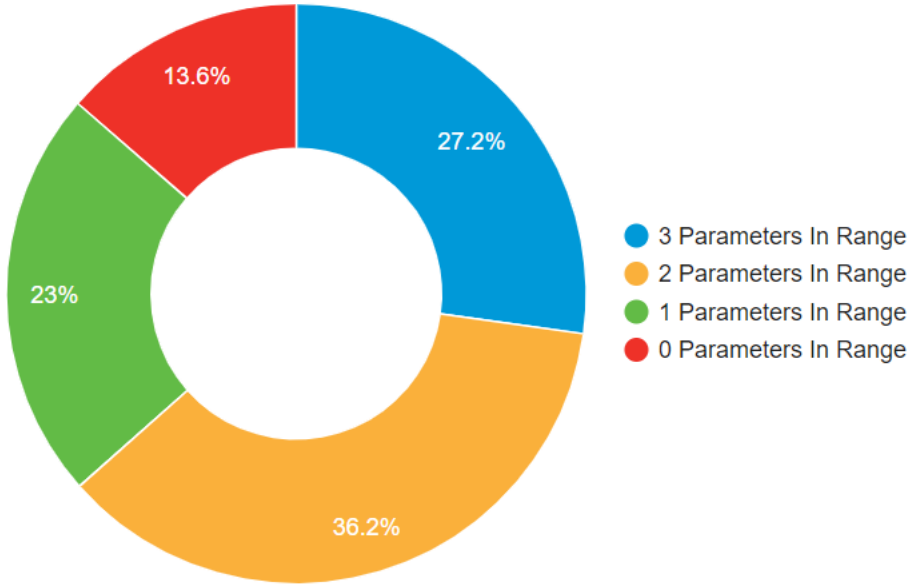
CCG

3 Treatment Standards (2023/24)



National

3 Treatment Standards (2023/24)



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A1 Network PCN	45615	2504	735	29.4%	151 /541
Cambridge City PCN	49665	2437	701	28.8%	169 /541
Huntingdon PCN	44459	2548	728	28.6%	179 /541
Cantab PCN	55302	1182	332	28.1%	208 /541
St Neots PCN	44811	2176	610	28.0%	211 /541
Wisbech PCN	48778	3637	1015	27.9%	220 /541
Ely South PCN	39032	2180	604	27.7%	231 /541
Fenland PCN	29418	2516	690	27.4%	246 /541
Cambridge City 4 PCN	57047	2072	566	27.3%	256 /541
Peterborough Partnerships PCN	31270	1882	512	27.2%	265 /541
South Peterborough PCN	69259	3969	1077	27.1%	268 /541
Granta PCN	54860	2807	758	27.0%	274 /541
Meridian PCN	37457	1864	494	26.5%	311 /541
St Ives PCN	45874	2693	706	26.2%	324 /541
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Medicines update & Learning

- Diabetes Technology
- GLP-1 and Obesity
- Medication shortages
- Blood glucose strips

Stephanie Ransom/ Dr Ellie Gurnell

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Insulin Biosimilars

✓ Trurapi

A biosimilar product is considered to be **interchangeable** with their Reference Product, which means a prescriber can choose the biosimilar medicine over the Reference Product (or vice versa) and expect to achieve the same therapeutic effect.

Likewise, a biosimilar product is considered to be interchangeable with another biosimilar to the same Reference Product.

All biological medicines, including biosimilars, should be **prescribed by brand name.**

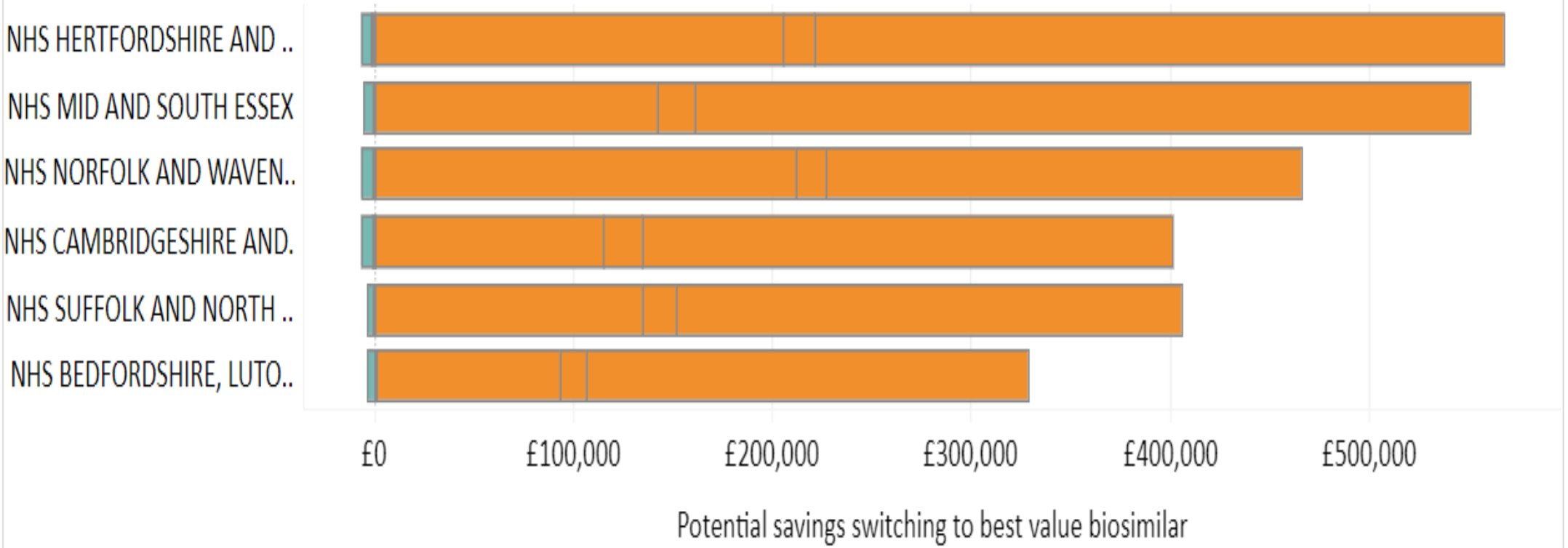
Trurapi is a biosimilar of NovoRapid (Insulin Aspart 100units/mL

- ✓ Interchangeable
- ✓ Must be prescribed by brand
- ✓ Cost effective to the NHS
- ❖ Not interchangeable with Fiasp
- ✓ System implementation
  - ✓ Patients advised of the change and the new packaging
  - ✓ Patient materials available
- ✓ Sufficient stock of Trurapi available to meet local

Insulin aspart potential savings per ICS across primary and secondary care

This chart shows potential maximum savings per ICS if current use of insulin aspart was switched to the best value biosimilar.

To sort, click in the axis at the bottom to reveal the stacked sort icons.



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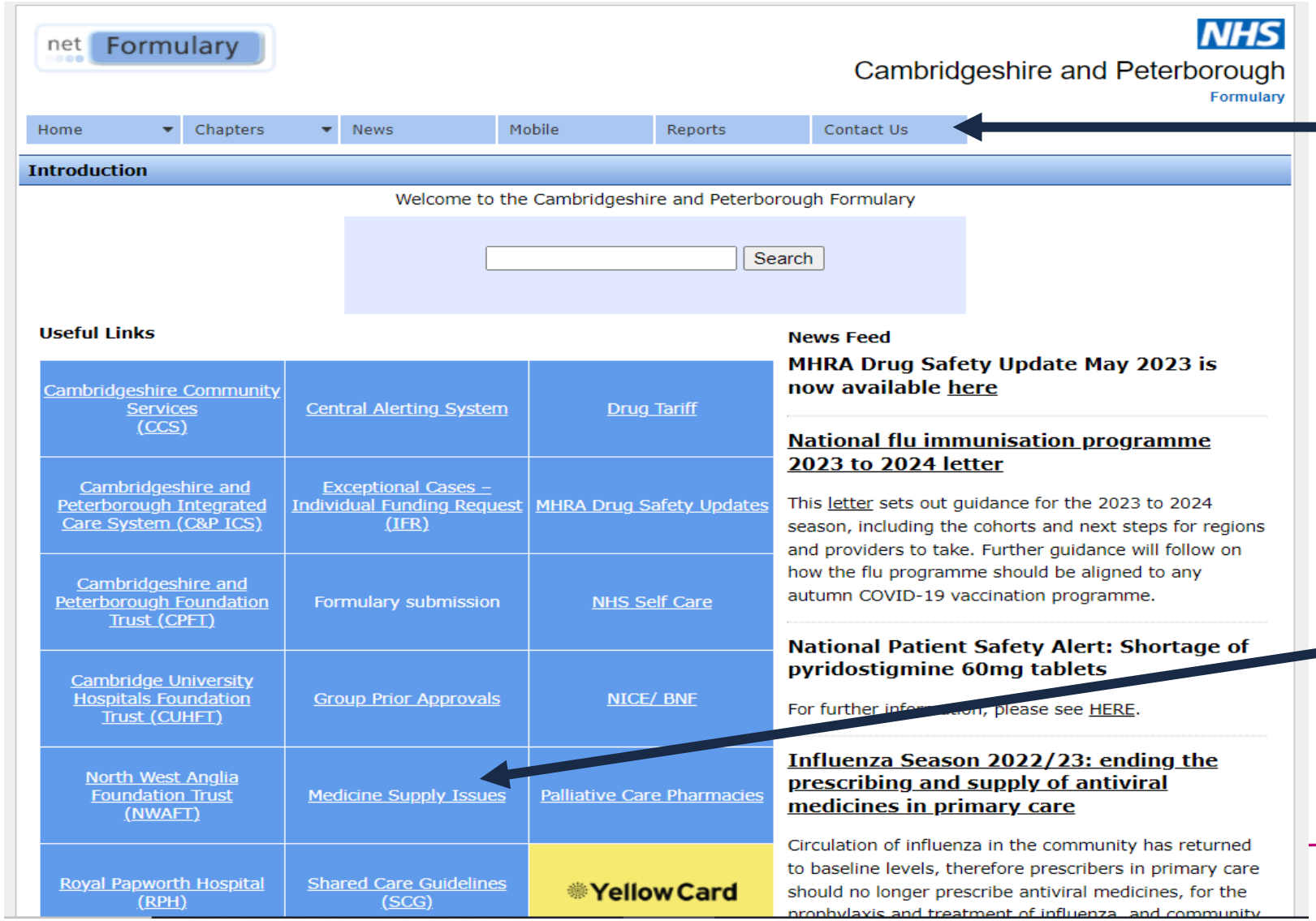
How to report and find information on Medication Shortages

Cambridgeshire and Peterborough Formulary
cambridgeshireandpeterboroughformulary.nhs.uk



Contact the system wide shortage group, when you become aware of a possible medicine shortage

Current shortage information and advice on alternatives can be found here

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Blood Glucose and Ketone Meter Testing Strips & Lancets

Blood glucose and ketone meters, testing strips

National commissioning recommendations

- ✓ Manufacturers available to support practices with a review and switch programme
- ✓ Optimise quantity of strips
- ✓ Optimise choice of meter
- ✓ Dispensing discounts available

Summary of recommended devices

Category	Patient Cohort	Meter	Recommendations
1a	Type 1 diabetes or ketosis prone Type 2 diabetes	Meters and strips which are suitable for the majority of people that also require a ketone testing meter.	A. Menarini Diagnostics - **GlucoFix Tech GK** Gluco Rx **– GlucoRx HCT,** Gluco Rx - **KEYA Smart** Nipro Diagnostics - **4SURE Smart Duo** Spirit Health **- CareSens Dual**
1b		As per 1a, plus require additional functionality.	A. Menarini Diagnostics - **GlucoFix Tech GK** Nipro Diagnostics - **4SURE Smart Duo**
2	Type 2 diabetes	Meters and strips which are suitable for the majority of people with Type 2 diabetes.	AgaMatrix – AgaMatrix **Agile** A. Menarini Diagnostics – **GlucoFix Tech GK** Ascensia – **Contour Plus Blue** Connect2Pharma – **On Call Extra Mobile** GlucoRX – **GlucoRx Q** Neon Diagnostics – **Finetest lite** Spirit Health – **CareSens S Fit** Trivida – **TRUE Metrix Air**
3	Type 2 diabetes (additional functionality)	Meters and strips which are suitable for people with Type 2 diabetes that require additional functionality.	Type 2 diabetes (enhanced functionality) First Line: AgaMatrix – **AgaMatrix Agile** Second Line: AgaMatrix – **WaveSense JAZZ**; AgaMatrix – **WaveSense JAZZ Wireless**; GlucoRx – **GlucoRx Nexus Blue** Type 2 diabetes Paediatrics First Line: Connect 2 Pharma – **On Call Extra Mobile and On Call Extra Voice** Second Line: GlucoRx – **GlucoRx Nexus Blue** Type 2 diabetes (Gestational diabetes - GDm-Health™) First Line: AgaMatrix – **AgaMatrix Agile**; Connect 2 Pharma – **On Call Extra Mobile** Second Line: AgaMatrix – **WaveSense JAZZ wireless**

Lancets

National commissioning recommendations

- ✓ Lancets which are suitable for the majority of people, and which are suitable for people that require additional functionality.

The following lancets are suitable for people with Type 1 and Type 2 diabetes including people who require additional functionality.

Category	Supplier	Lancet Name	Size	Lancet (£)	Pack size
4	A. Menarini Diagnostics	Glucoject Plus	0.22/33G	£3.77	100
	AgaMatrix	Comfort Twist	30G	£2.69	100
	AgaMatrix	AgaMatrix Ultra-thin	0.2mm/33G & 0.35mm/28G	£5.43	200
	Ascensia	Microlet	0.5mm/28G	£2.99	100
	Connect 2 Pharma	On Call	30G	£2.75	100
	GlucoRx	GlucoRx	30G	£4.50	200
	GlucoRx	GlucoRx Safety	23G, 26G, 28G, & 30G	£5.50	100
	Glucoze	Glucozen	0.35mm/28G	£8.49	200
	Neon Diagnostics	Neon Verifine safety	28G x 1.8mm & 30G x 1.8mm	£2.99	100
	Neon Diagnostics	Greenlan	28G	£3.00	100
	Nipro Diagnostics	4SURE	0.32mm/30G & 0.195mm/33G	£2.90	100
	Spirit Health	CareSens	0.36mm/28G & 0.31mm/30G	£2.95	100
	Trividia	TRUEplus	0.36mm/28G, 0.32mm/30G & 0.195mm/33G	£2.90	100

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Continuous Glucose Monitoring – offer to all Type 1's and some Type 2's.

CGM Local Position November 22

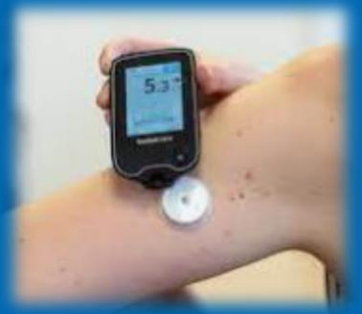
Individuals with Type 1 diabetes: Suitable for initiation in Primary or Secondary Care and can be prescribed to all patients with Type 1 diabetes. Please note additional information below:

- Children living with diabetes may need a CGM which allows a parent or guardian to monitor the patient's glucose levels in real time. Where this is required, this will be provided by the Specialist Paediatric Diabetes Team directly.
- There may be individual patients with type 1 diabetes who have complex clinical needs where a CGM with additional functions may be required. Secondary care will be responsible for prescribing these systems.

Individuals with Type 2 diabetes: Restricted to pregnant patients (with type 2 or gestational diabetes) and patients with type 2 diabetes who are on multiple daily insulin injections with any of the following:

- Severe hypoglycaemia or impaired hypoglycaemic awareness (Score ≥4 on the Gold hypoglycaemia unawareness Likert scale)
- Condition or disability that means they are unable to self-monitor but can act upon glycaemic changes
- Is living with a learning disability
- Renal failure on dialysis
- Cystic fibrosis
- Where they require help from a care worker or health care professional to monitor their blood glucose.

Which CGM can be prescribed on a FP10



Freestyle Libre 2
scan or
'flash' the sensor
with smartphone
or receiver

Dexcom One
Automatically
every five minutes to
smartphone or receiver

- ✓ Both devices consist of a subcutaneous glucose-sensing electrode which sends interstitial glucose levels to a paired receiver and/or insulin pump via a transmitter.

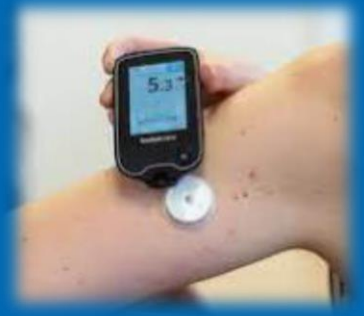
- ✓ All systems provide:
  - ✓ current interstitial fluid glucose
  - ✓ glucose history over the preceding hours, days and weeks

How to use Dexcom One and Freestyle Libre 2?

Freestyle Libre 2 – YouTube

Getting Started with the FreeStyle Libre 2 system – YouTube

Freestyle UK & Ireland - YouTube



Freestyle Libre 2
scan or
'flash' the sensor
with smartphone
or receiver

Dexcom One - YouTube

Dexcom One Getting Started mmol – YouTube

Dexcom One Receiver Video - YouTube

Dexcom UK and Ireland – YouTube

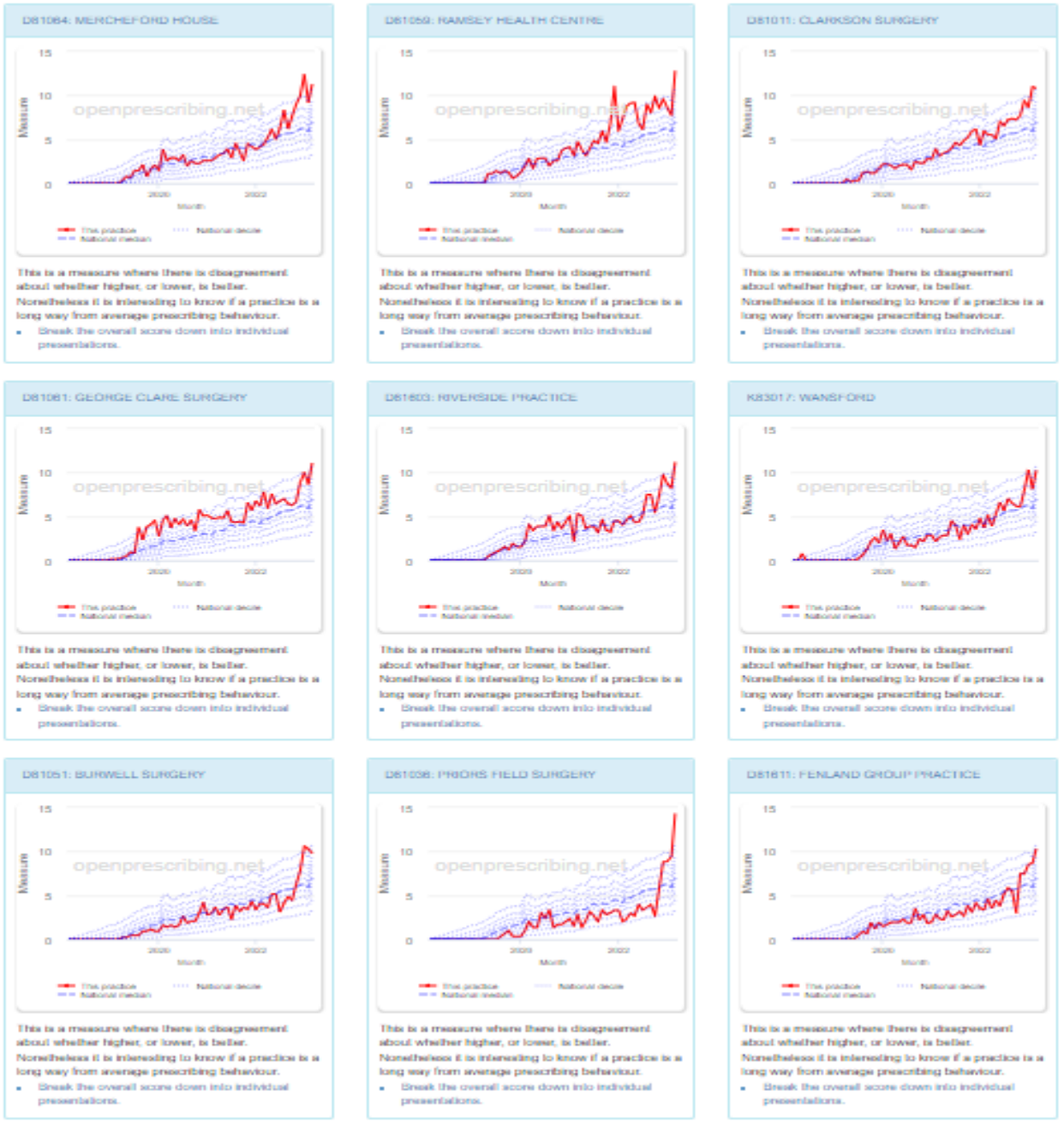
Dexcom One
Automatically
every five minutes to
smartphone or receiver

Association of British Clinical Diabetologist resources: https://abcd.care/dtn/resources

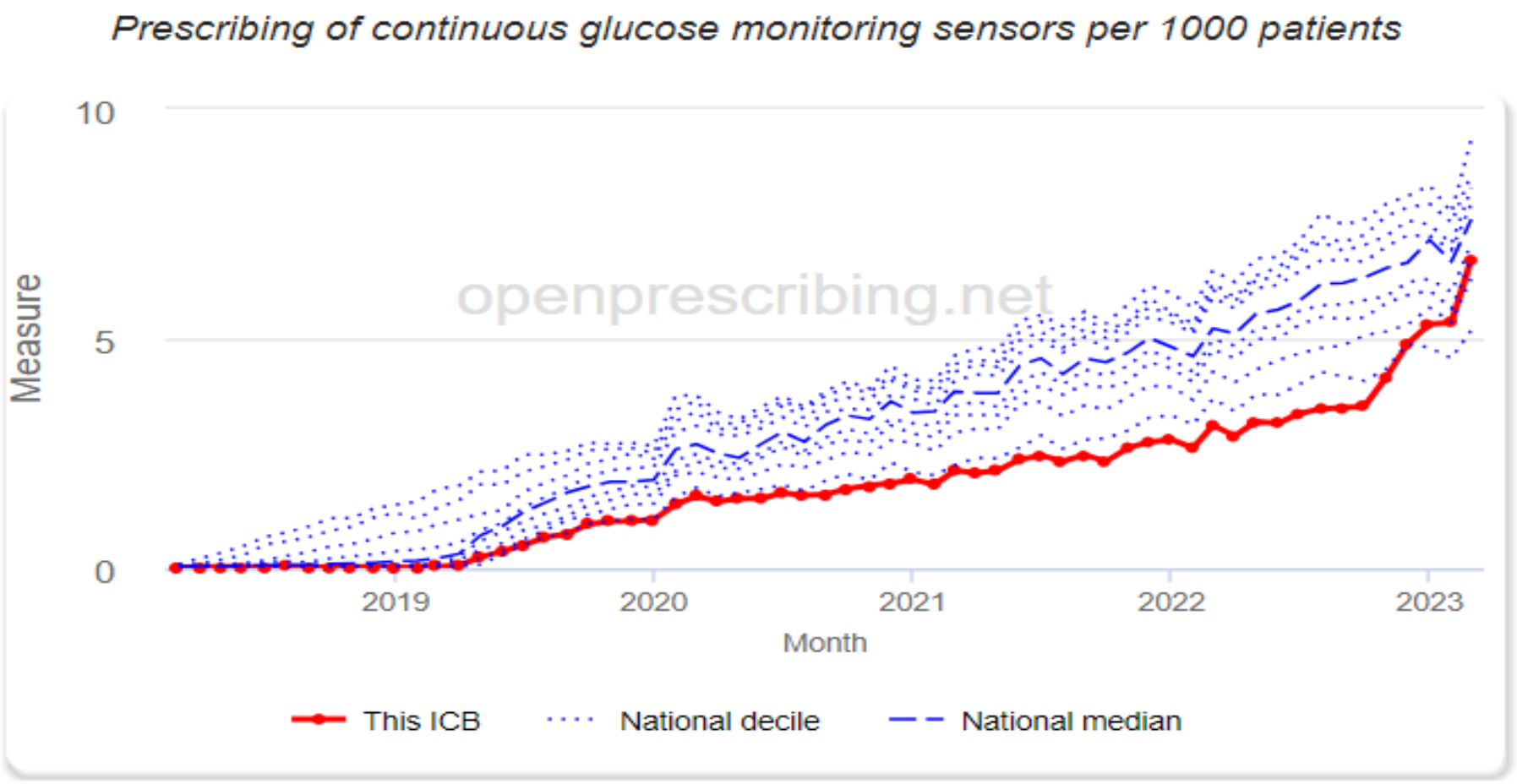
Thank you!

- ✓ All practices have increased their prescribing of Freestyle Libre 2 sensors or Dexcom One sensors

[Prescribing of continuous glucose monitoring sensors by practices in NHS CAMBRIDGESHIRE AND PETERBOROUGH | OpenPrescribing]



Prescribing of continuous glucose monitoring sensors



March 23 (29th percentile) 6949 sensors prescribed

October 22 (2nd percentile) 3602 sensors prescribed

Implementation Tips

- ✓ Appointment not always needed, many patients in other areas have self-started once they have collected the starter kit

- ✓ Links to patient resources from manufacturers can be sent by the practice to the patient via AccuRx messages.

- ✓ Helplines available to support patients (Dexcom 0800 031 5761 ; FreeStyle Libre 0800 170 1177)

- ✓ Patient Resources are available for both Freestyle Libre 2 and Dexcom One:
  - ✓ Freestyle Libre: Tutorials & Downloads | Freestyle Libre | Abbott
  - ✓ Dexcom One: UK Dexcom ONE Glucose Monitor for Type 1 - Type 2 Diabetes | Dexcom

- ✓ Remember to adjust their blood glucose test strip quantities

- ✓ Some patients will require specific CGM via their diabetes team – remember to stop the CGM on FP10. This will be in the specialist communication to the practice.

Cambridge University Hospitals
NHS Foundation Trust

Diabetes: LES

Quick Update

CUH, 2023

Together
Safe
Kind
Excellent

Ellie Gurnell
Consultant diabetologist

DM LES

Update:

Planning to Cover:

Shortages/ Biosimilars

What is coming?

DM LES Shortages:

GLP-1

Ozempic (Semaglutide) – resupply Jan 2024

Existing Patients

Counselling & Switch

Medicine	Frequency of administration	Equivalent Dose[3]			
Injectable Semaglutide (Ozempic®)	Once weekly	N/A	0.25mg	0.5mg	1mg
First option: Oral Semaglutide (Rybelsus®)	**Once daily**	3mg	7mg	14mg	14mg**
Second option: Injectable Liraglutide (Victoza®)	**Once daily**	0.6mg	1.2mg	1.8mg	1.8mg**

***Please note this is the highest licensed dose but is less potent than the maximum dose of Ozempic ® 1mg weekly*

DM LES Shortages:

Association of British Clinical Diabetologists

Home | About | Become a Member | Events | Grants | Research & Audit | Journal | Lifelong Learning

Home » Announcements » Joint ABCD and PCDS guidance: GLP-1 receptor agonist national shortage

Joint ABCD and PCDS guidance: GLP-1 receptor agonist national shortage

Author: Ketan Dhatariya, Chair ABCD

Date of the announcement: Wednesday, 28 June, 2023

We are aware that clinicians and people with type 2 diabetes will be concerned by the ongoing supply chain issues affecting the availability of GLP-1 Receptor Analogues. Many people with diabetes will find the current situation difficult and will not be able to access their GLP-1 RA medication. The need to consider switching or starting alternative therapies may have a significant impact on workload for primary care, community, and specialist diabetes teams. Unfortunately, we are informed that this limited availability is likely to continue until mid-2024.

The Association of British Clinical Diabetologists (ABCD) and Primary Care Diabetes Society (PCDS) have collaborated to produce guidance to support clinical decision making during this period, when GLP-1 RAs may be unavailable.

Where GLP-1 RAs are available, their use should be prioritised for people with clinical need, and they should only be prescribed within their licenced indication(s), in accordance with NICE guidance.

Clare Hambling, Chair, PCDS

Ketan Dhatariya, Chair, ABCD

DM LES

Shortages:

Department of Health & Social Care

NHS England

Medicine Supply Notification

MSN/2023/061

GLP-1 receptor agonists* used in the management of type 2 diabetes

*Annex 4 lists individual medicines affected

Tier 3 – high impact*
Date of issue: 27/06/2023
Link: Medicines Supply Tool

DM LES Shortages:

Actions Required

Actions for clinicians until supply issues have resolved:

- GLP-1 RAs should only be prescribed for their licensed indication
- Avoid initiating people with type 2 diabetes on GLP-1 RAs for the duration of the GLP1-RA national shortage.
- Review the need for prescribing a GLP-1 RA agent and stop treatment if no longer required due to not achieving desired clinical effect as per NICE CG28.
- Avoid switching between brands of GLP-1 RAs, including between injectable and oral forms.
- Where a higher dose preparation of GLP-1 RA is not available, do not substitute by doubling up a lower dose preparation.
- Where GLP-1 RA therapy is not available, proactively identify patients established on the affected preparation and consider prioritising for review based on the criteria below.
- Where an alternative glucose lowering therapy needs to be considered, use the principles of shared decision making as per NICE guidelines in conjunction with the **Supporting Information** below.
- Where there is reduced access to GLP-1 RAs, support people with type 2 diabetes to access to structured education and weight management programmes where available.
- Order stocks sensibly in line with demand during this time, limiting prescribing to minimise risk to the supply chain whilst acknowledging the needs of the patient.

DM LES Shortages:

Actions Required

GLP-1's should only be prescribed for their licensed indication

Avoid initiating people with type 2 diabetes on GLP-1 for the duration of the GLP1 national shortage

When is a GLP-1 normally recommended?

Failure of triple therapy which includes metformin

With caveats:
• a BMI of 35 kg/m2 or above (adjusted for ethnicity) and who also have specific psychological or medical problems associated with obesity;

• a BMI lower than 35 kg/m2 and for whom insulin therapy would have significant occupational implications or if the weight loss associated with GLP-1 would benefit other significant obesity-related comorbidities.

DM LES Shortages:

Actions Required

Review the need for prescribing a GLP-1and stop treatment if no longer required due to not achieving desired clinical effect as per NICE CG28.

When should a GLP-1 normally be withdrawn?

6 month review, only continue if there has been a beneficial metabolic response ie HbA1c reduction (a reduction of at least 11 mmol/mol [1.0%]
plus weight loss of at least 3% of initial body-weight

DM LES Shortages:

Actions Required

Avoid switching between brands of GLP-1 RAs, including between injectable and oral forms.

Where a higher dose preparation of GLP-1 RA is not available, do not substitute by doubling up a lower dose preparation.

Ok?

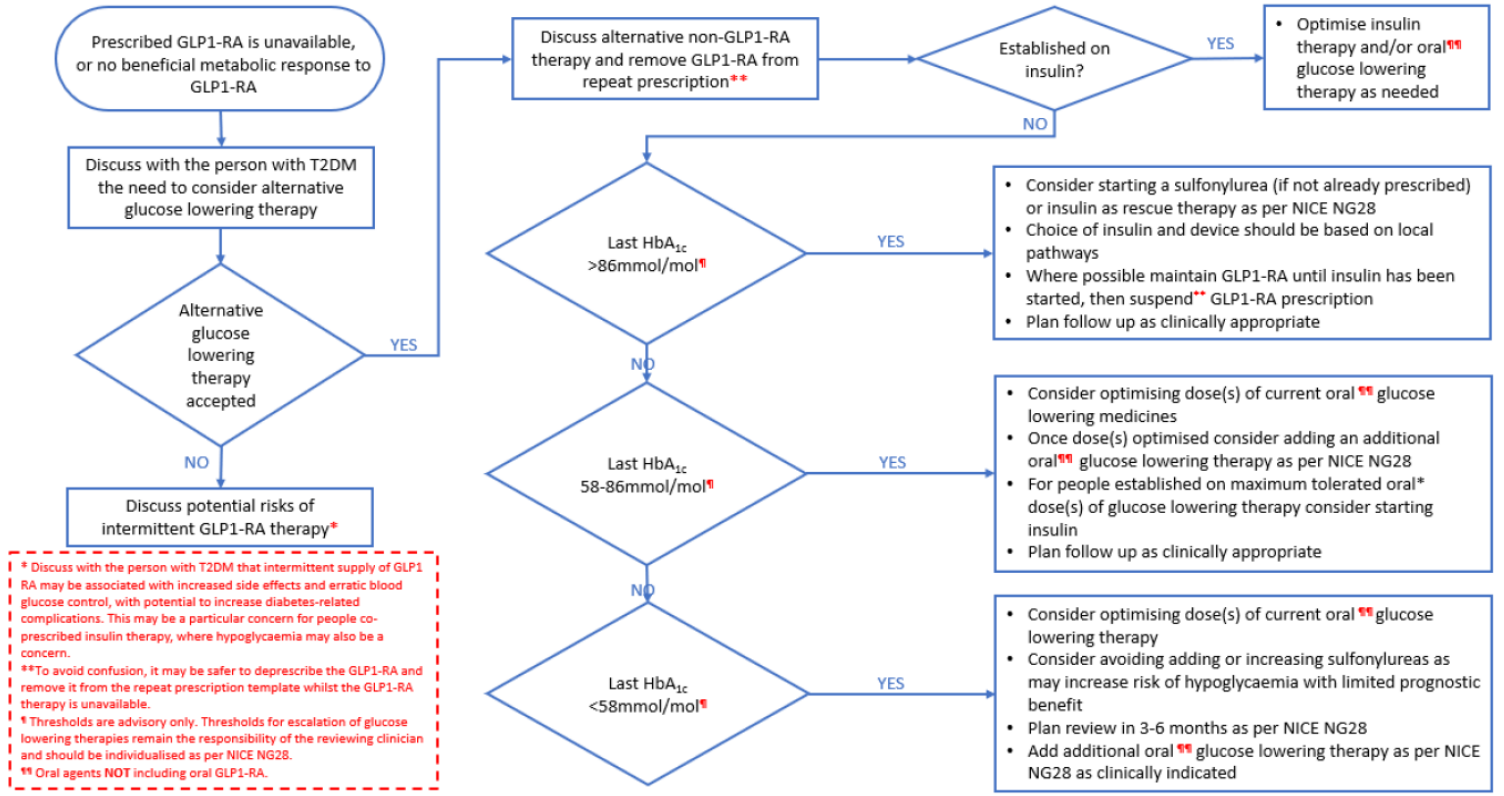
But what do I do with the patient in front of me?

DM LES Shortages:

Actions Required

Where GLP-1 therapy is not available, proactively identify patients established on the affected preparation and consider prioritising for review based on the criteria below.

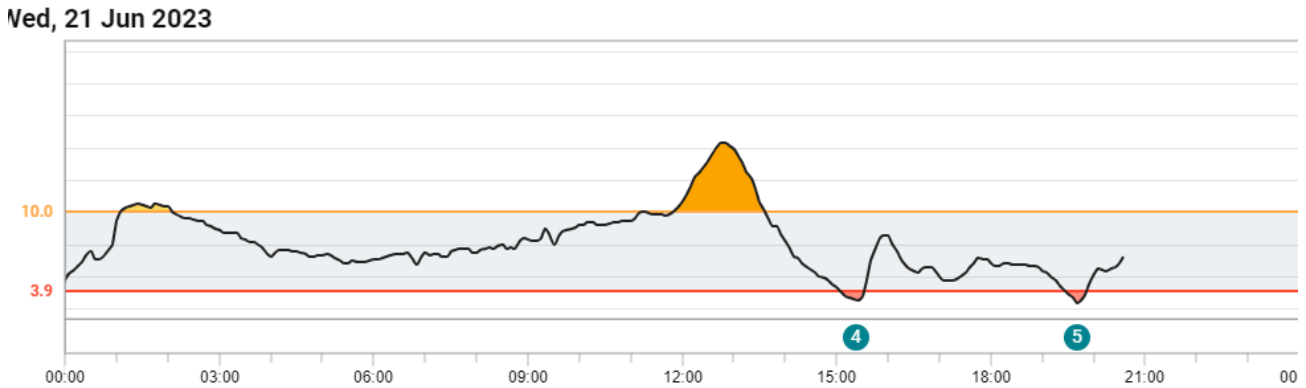
Annex 1: Selecting Alternative Glucose Lowering Therapy for People with T2DM when GLP1-RAs are unavailable

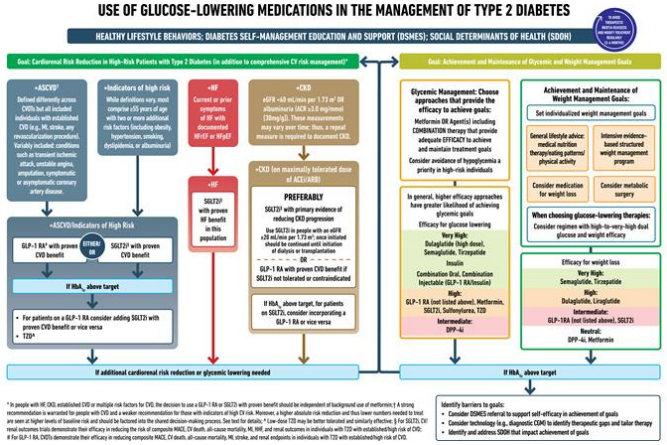


DM LES Shortages:

Actions Required – insulin for all

Problems: Insulin is not the right drug for some





Desmond
Diabetes Education and Self Management for Ongoing and Newly Diagnosed

Diabetes Care. 2022;45(11):2753-2786. doi:10.2337/dci22-0034

DM LES Shortages:

Actions Required

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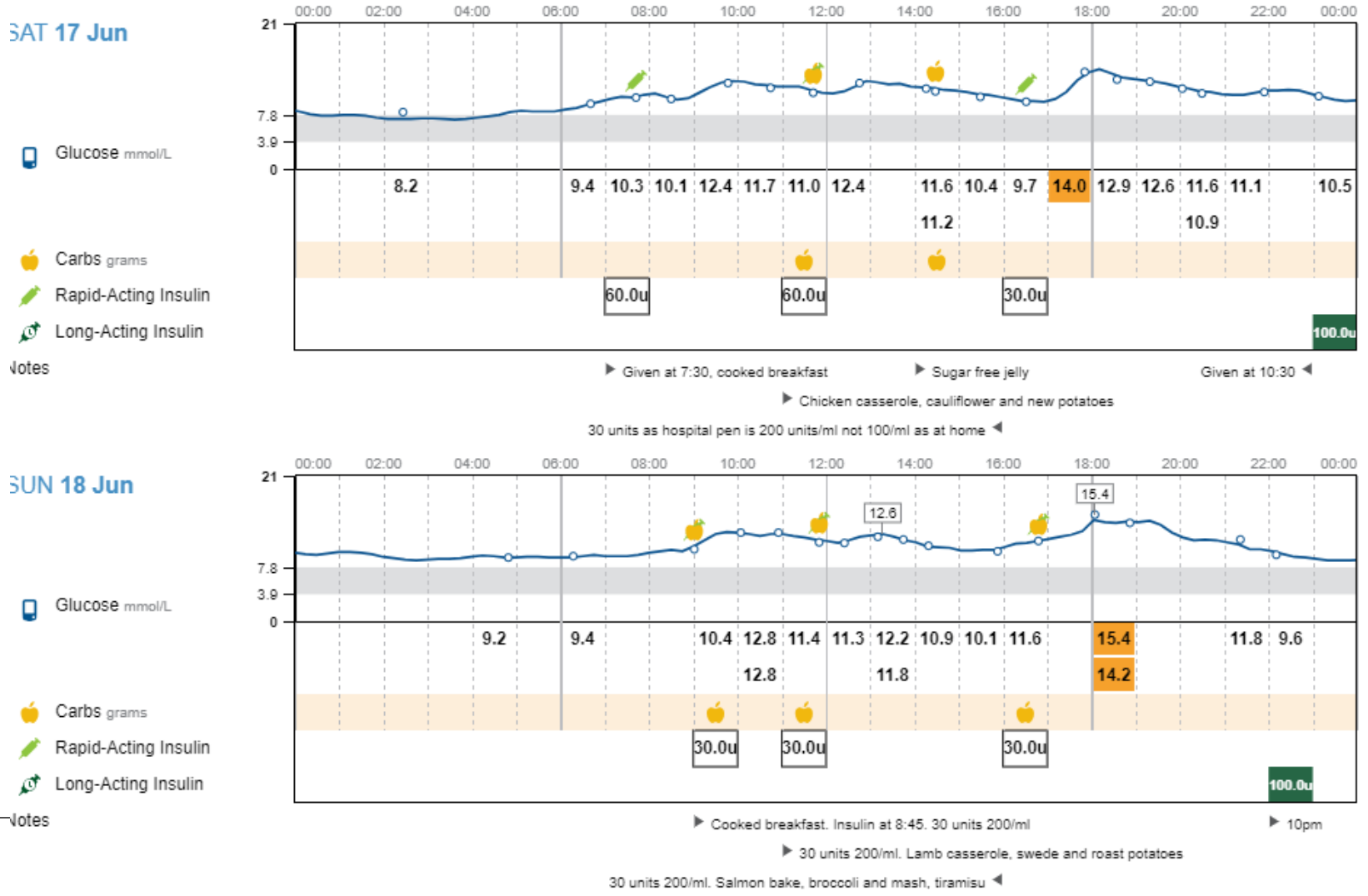
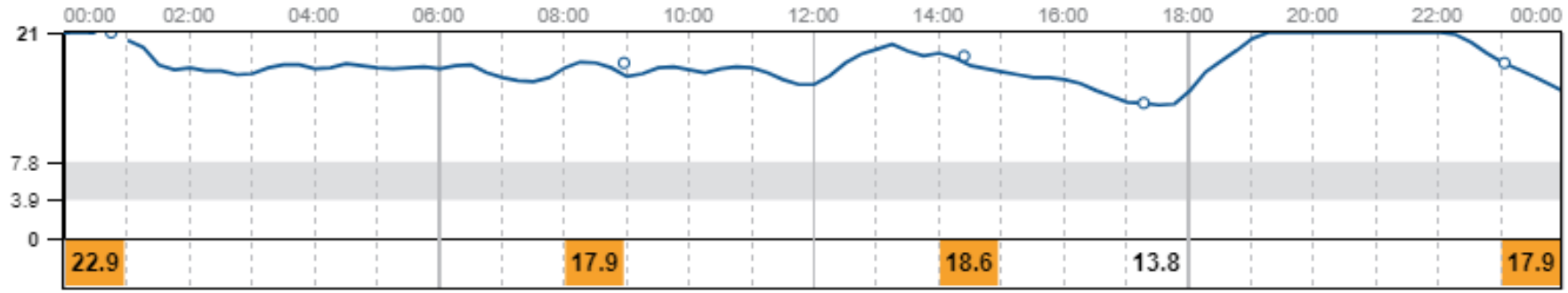


DM LES Shortages:

Actions Required

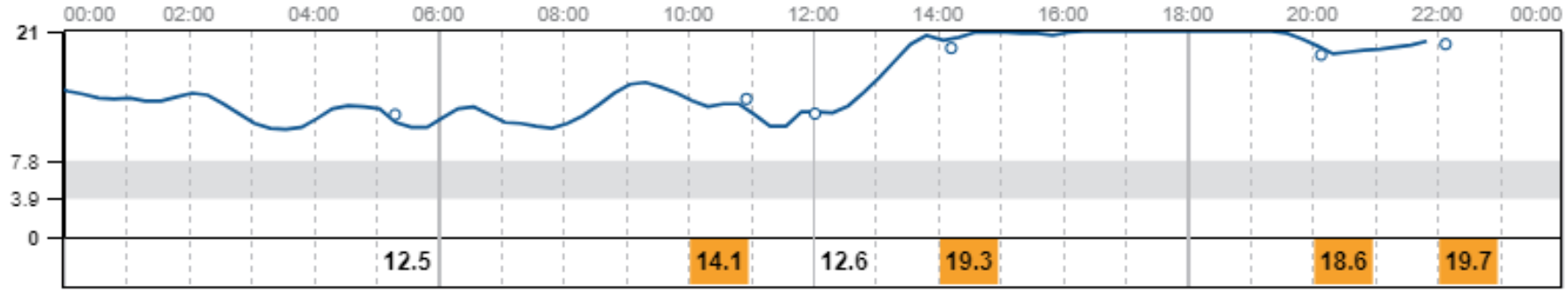
SAT **24 Jun**

Glucose mmol/L



SUN **25 Jun**

Glucose mmol/L



DM LES Shortages:

Actions Required

Problems: Insulin and GLP-1 is deemed to require secondary care

Insulin should only be prescribed in combination with a GLP-1 under specialist care advice and with ongoing support from a consultant-led multidisciplinary team.

Institutional Memory – when GLP-1 back in supply.

No cavalry is coming.

DM LES Shortages:

Insulin Degludec (Tresiba)

Insulin Degludec (Tresiba®)– resupply Jan 2024

Shortage of
Tresiba (insulin degludec) FlexTouch 100units/ml solution for injection 3ml pre-filled pens

NO Shortage of
Tresiba (insulin degludec) FlexTouch 200units/ml solution for injection 3ml pre-filled pens
Tresiba Penfill® 3ml cartridges

Actions
Do not initiate any new patients on Tresiba (insulin degludec) FlexTouch

Alternatives

Insulin Degludec (Tresiba)

Insulin Degludec (Tresiba®)– resupply Jan 2024

Existing Patients
Counselling & Switch

Tresiba Penfill® 3ml cartridges
PLUS NovoPen®6 (£26.86)

(NovoPen Echo Plus – 0.5 units)

NovoPen® 6

NovoPen Echo® Plus

Tresiba (insulin degludec) FlexTouch 200units/ml solution for injection 3ml pre-filled pens??

DM LES Shortages:

GlucGen Hypokit (Glucagon)

GlucaGen® 1mg powder for injection kit will be unavailable from mid-June 2023 until to mid-July

Alternative: Ogluo® 0.5mg and 1mg pre-filled auto-injector pens
(£73 vs £11.52)

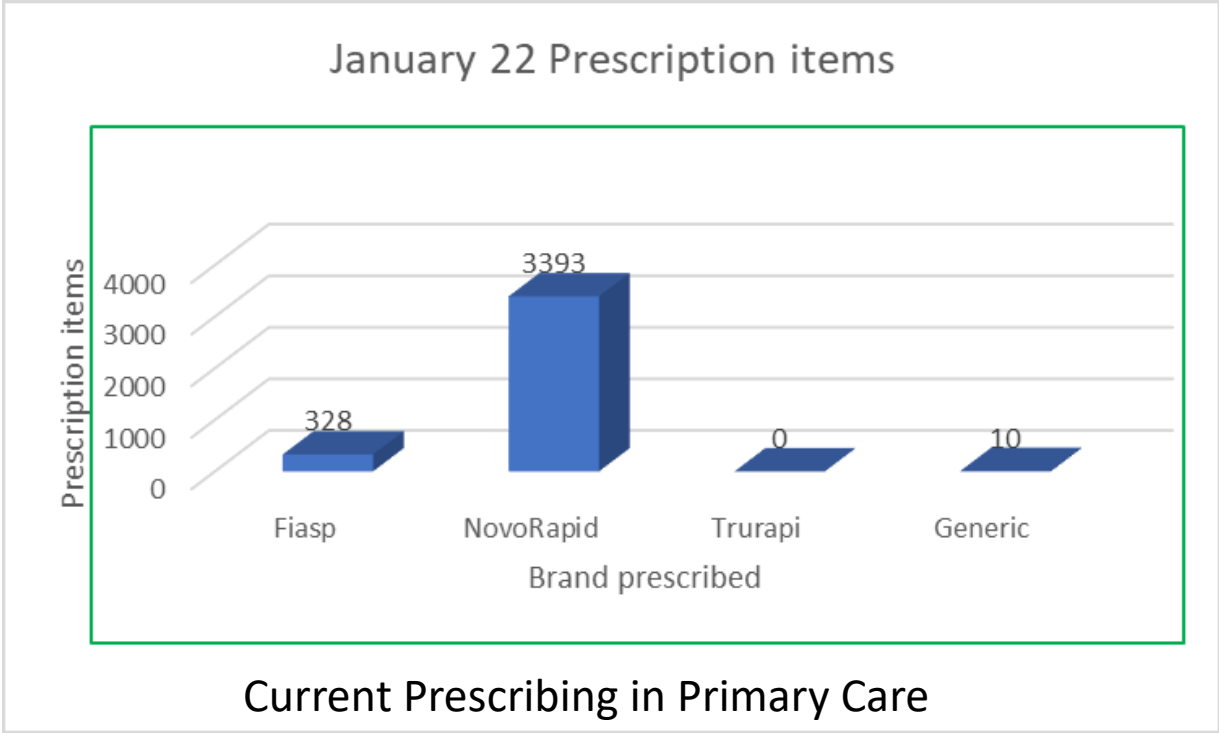
999 response times

DM LES Biosimilars:

TruRapi

Insulin Novorapid ® Flexpen– resupply Nov 22

Insulin Aspart Trurapi, Sanofi – Solostar device



Current Prescribing in Primary Care

DM LES Biosimilars:

TruRapi - Cost Comparison

Brand of Insulin Aspart (100units/ml formulations)	Formulation	Size	Price (March 22)	Saving compared to NovoRapid (per pack)
Fiasp	solution for injection 10ml vials	1	£14.08	N/A
	Penfill: solution for injection 3ml cartridges	5	£28.31	
	FlexTouch: solution for injection 3ml pre-filled pens	5	£30.60	
NovoRapid	solution for injection 10ml vials	1	£14.08	
	FlexPen: solution for injection 3ml pre-filled pens	5	£30.60	
	Penfill: solution for injection 3ml cartridges	5	£28.31	
	PumpCart: solution for injection 1.6ml cartridges	5	£15.10	
	FlexTouch: solution for injection 3ml pre-filled pens	5	£32.13	
Trurapi	solution for injection 3ml cartridges	5	£19.82	**£8.49**
	solution for injection 10ml vials	1	£11.97	**£2.11**
	solution for injection 3ml pre-filled Solostar pens	5	£21.42	**£9.18**

Implementation

(Not Fiasp®)

DM LES

Libre 2 conversion to rtCGM

On the horizon:

Libre 3 exists
Abbott launching App in UK

Omnipod 5 (Insulet)

NICE TA: Hybrid closed loop systems for managing blood glucose levels in type 1 diabetes

Young type 2, aged 18-40

DM LES Your CUH Team:

Ellie Gurnell
eleanor.gurnell1@nhs.net
Prepregnancy, Pregnancy, Young adults
Advice and Guidance, Choose and Book

Vishakha Bansiya
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Type 1 clinic, pregnancy
In patient work

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Type 1 and Type 2
Foot clinic
Virtual Clinic

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Foot clinic
Clinical Lead

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Lead Dietician

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Type 2

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General diabetes Clinic
Papworth Cystic Fibrosis

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Type 1

Kyla Lavender
makylah.lavender1@nhs.net
Lead DSN

Cambridgeshire & Peterborough
Integrated Care System

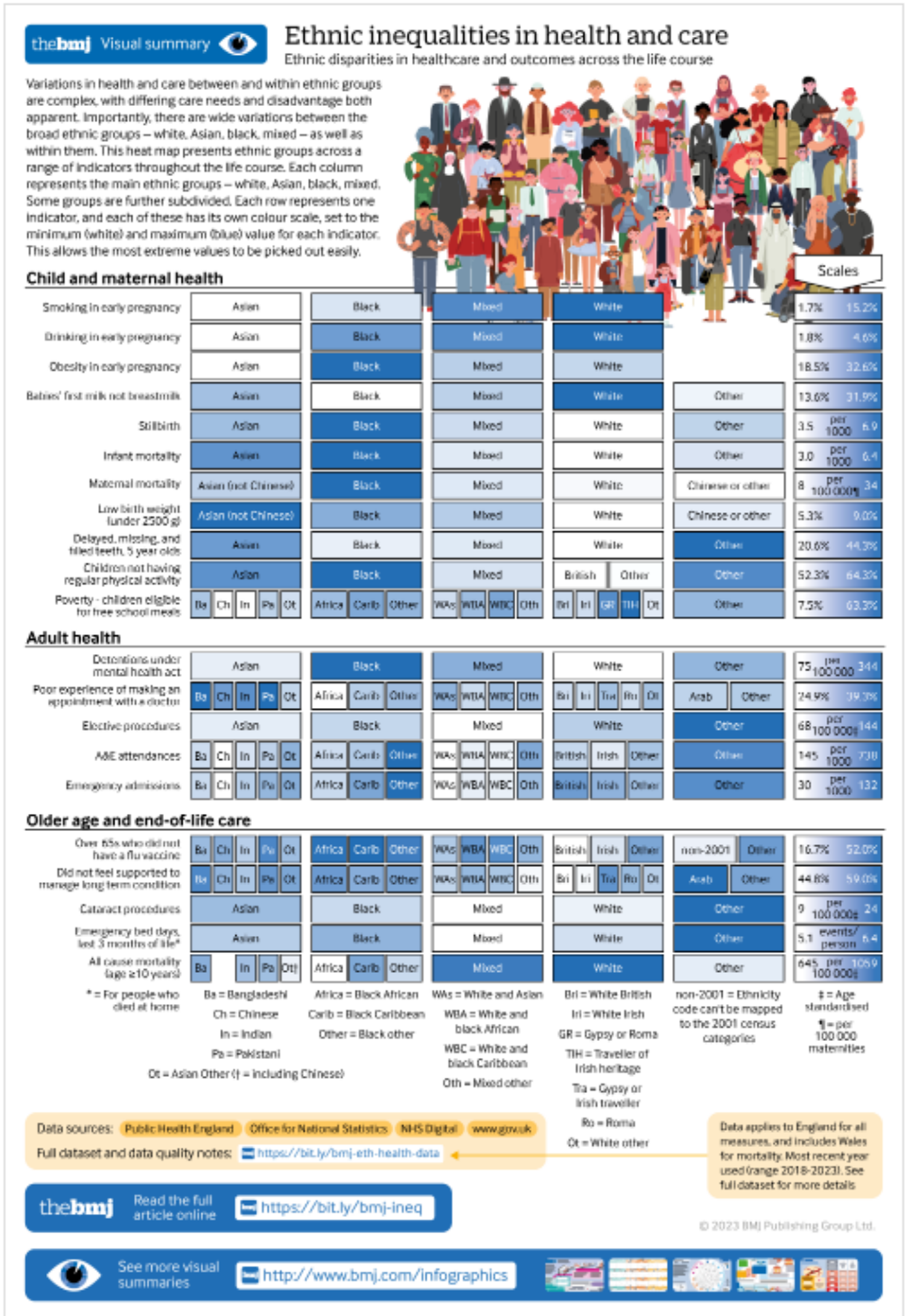
Diabetes LES Summary & Implications for Practices

Dr Jessica Randall-Carrick

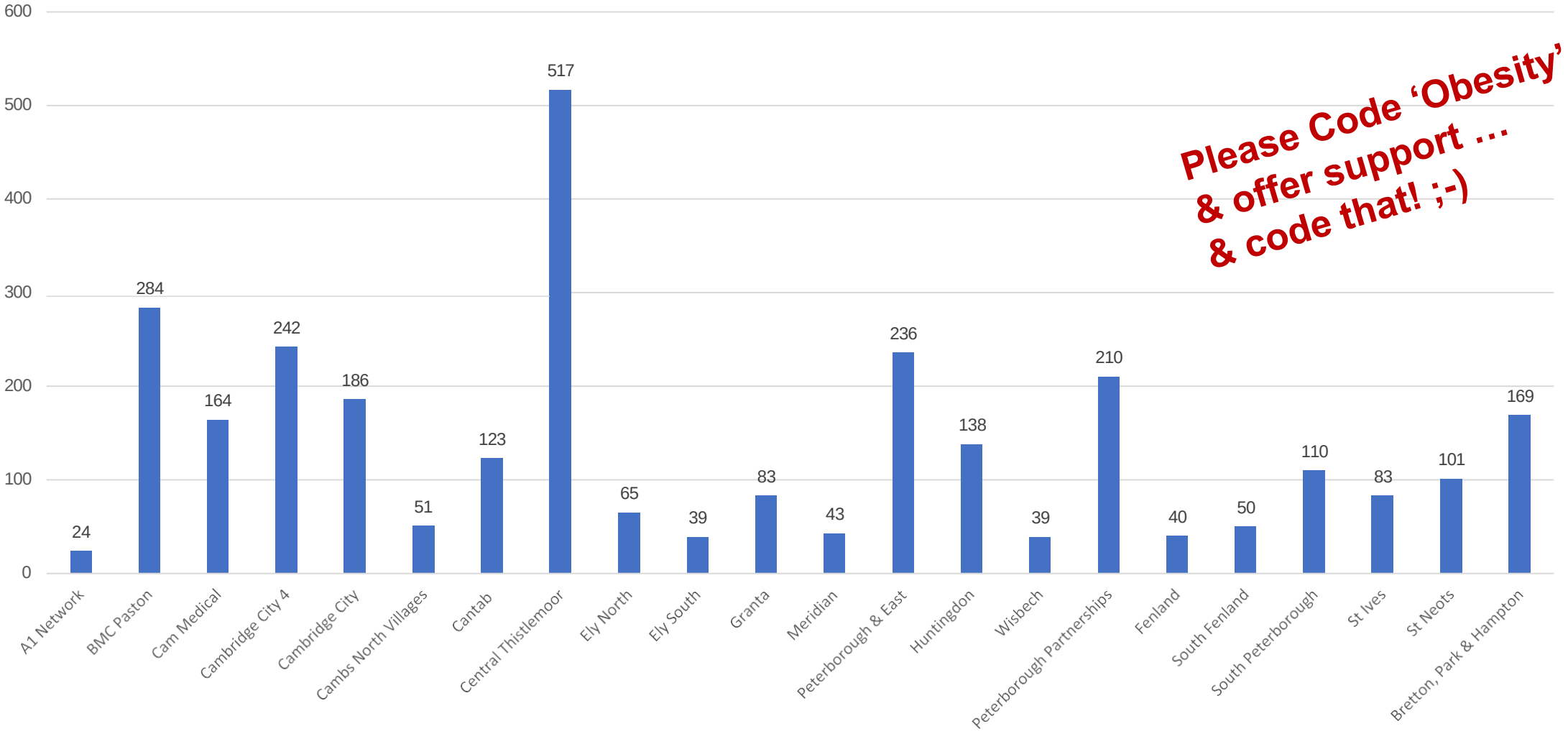
Across Practice Population:

Patients who are Overweight or Obese	1. If BMI recorded within the last 3 years and is raised (ethnic-specific) offer weight management services. 2. For those patients from a **Black or Asian ethnicity – a BMI of 23+ = overweight; a BMI of 25+ = obese** If no BMI recorded, then ensure that within the last three years there is a weight measurement and aspire to establish the BMI of at least 75% of practice population & if overweight or living with obesity, please offer Weight Management information 3. For those patients from a **White background: a BMI of 25+ = overweight; a BMI of 30+ = Obese** If no BMI recorded, then ensure that within the last three years there is a weight measurement and aspire to establish the BMI of at least 50% of practice population & if overweight or living with obesity, please record and offer Weight Management information. 4. For those patients with **no ethnicity recorded**, for example 'ethnicity unspecified' or 'ethnicity not recorded' practices should **contact patients** (eg using AccuRX florey or alternative) to aspire **to establish accurate ethnicity reporting** for at least 98% of practice population.
Eclipse	1. Practices are reminded that Eclipse is now updated automatically and is an excellent tool to support and facilitate the improvement of the care of their DM patients

[Ethnic inequalities in health and care: Ethnic disparities in healthcare and outcomes across the life course | The BMJ]

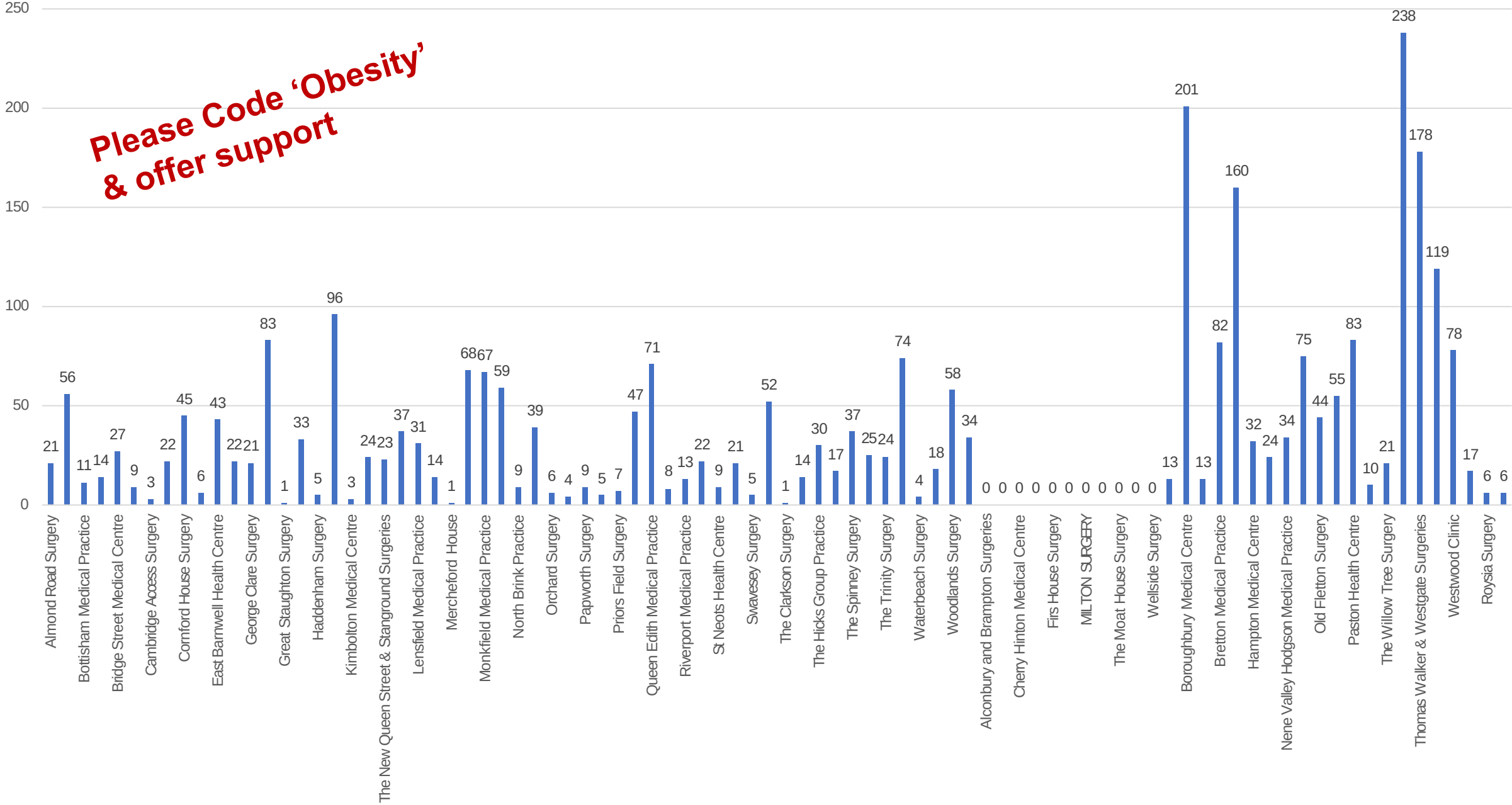


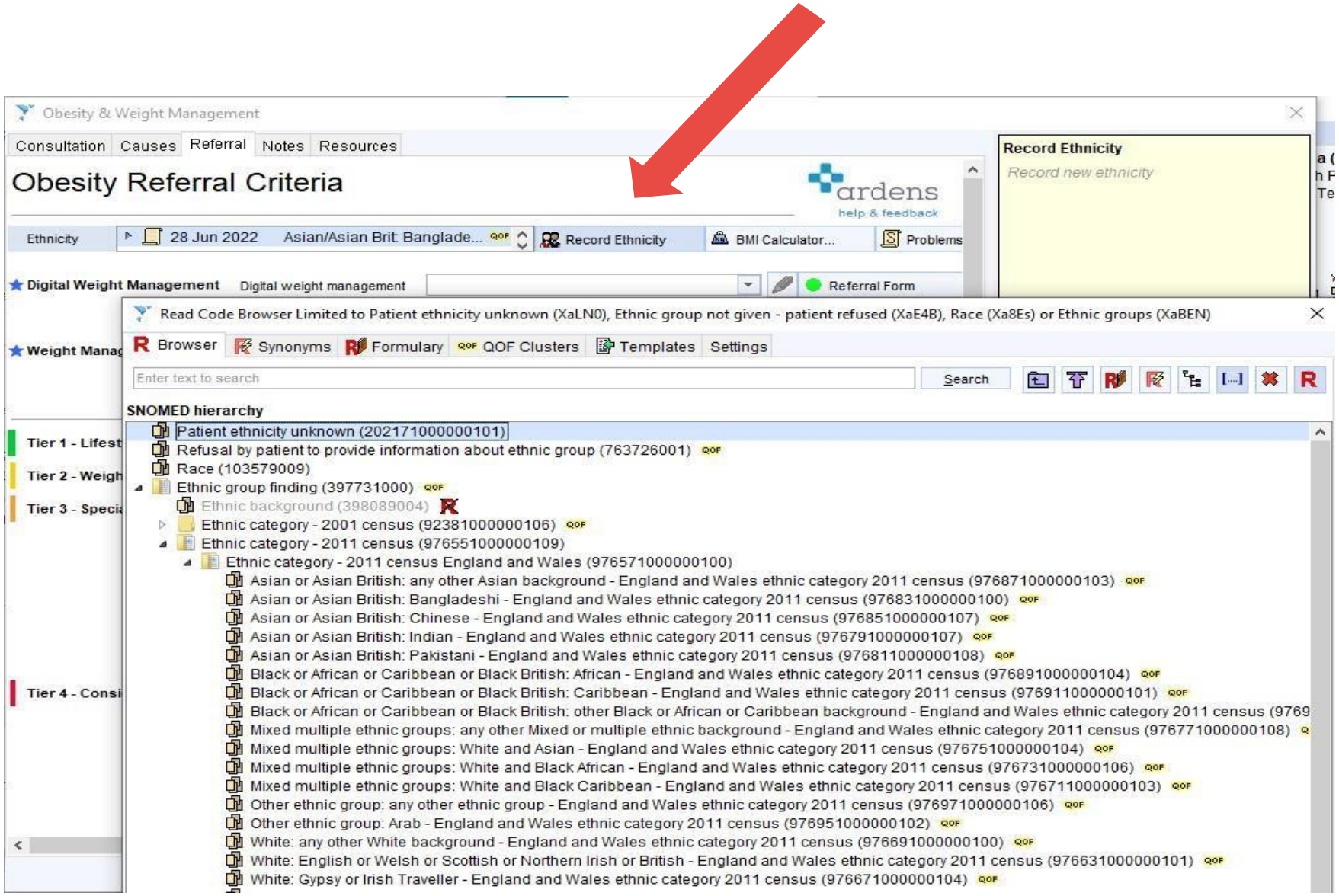
BAME Adults with BMI between 27.5-29.99 Not on the QOF OBTY REG: Patient Count



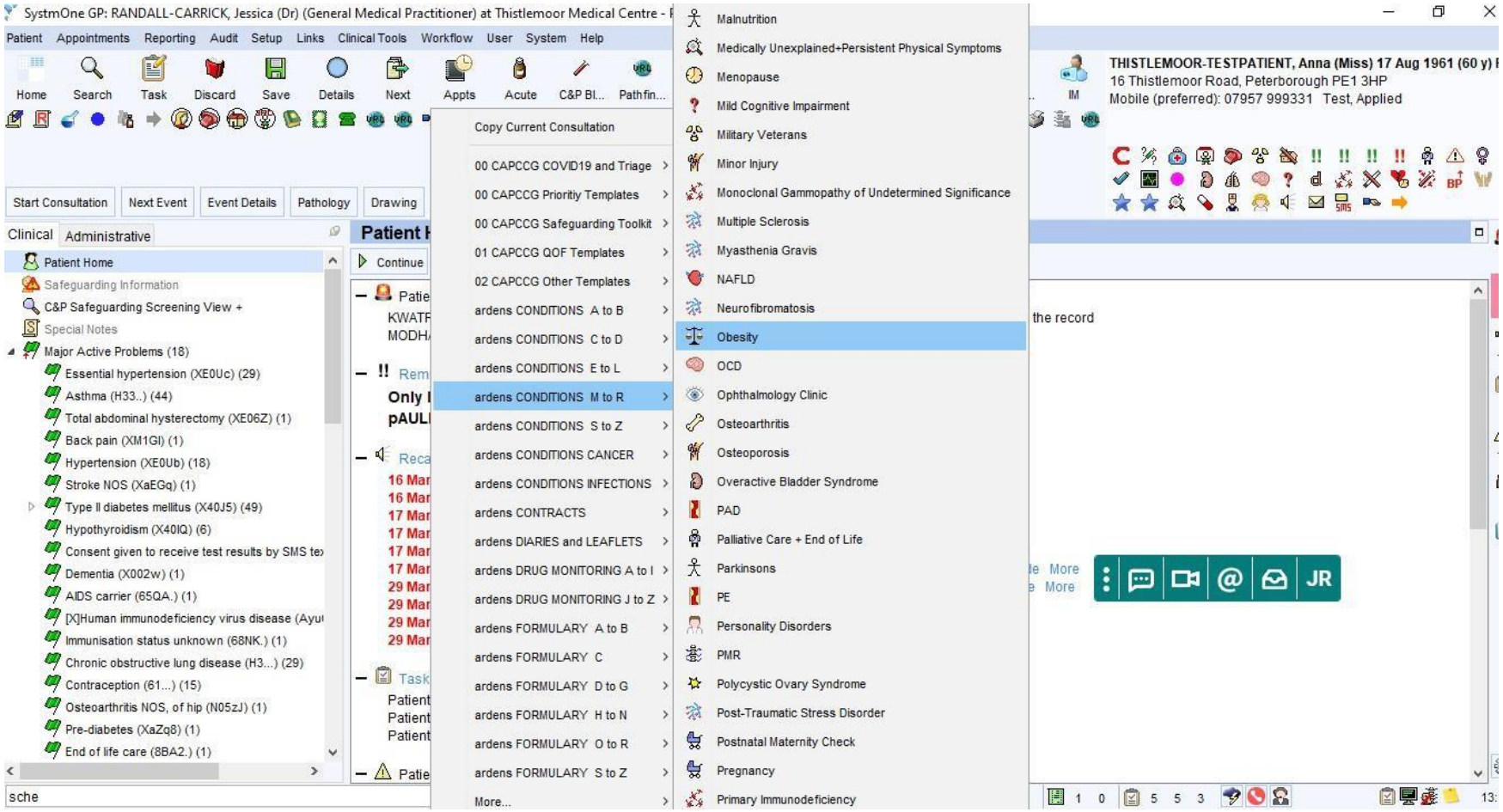
Please Code 'Obesity' & offer support … & code that! ;-)

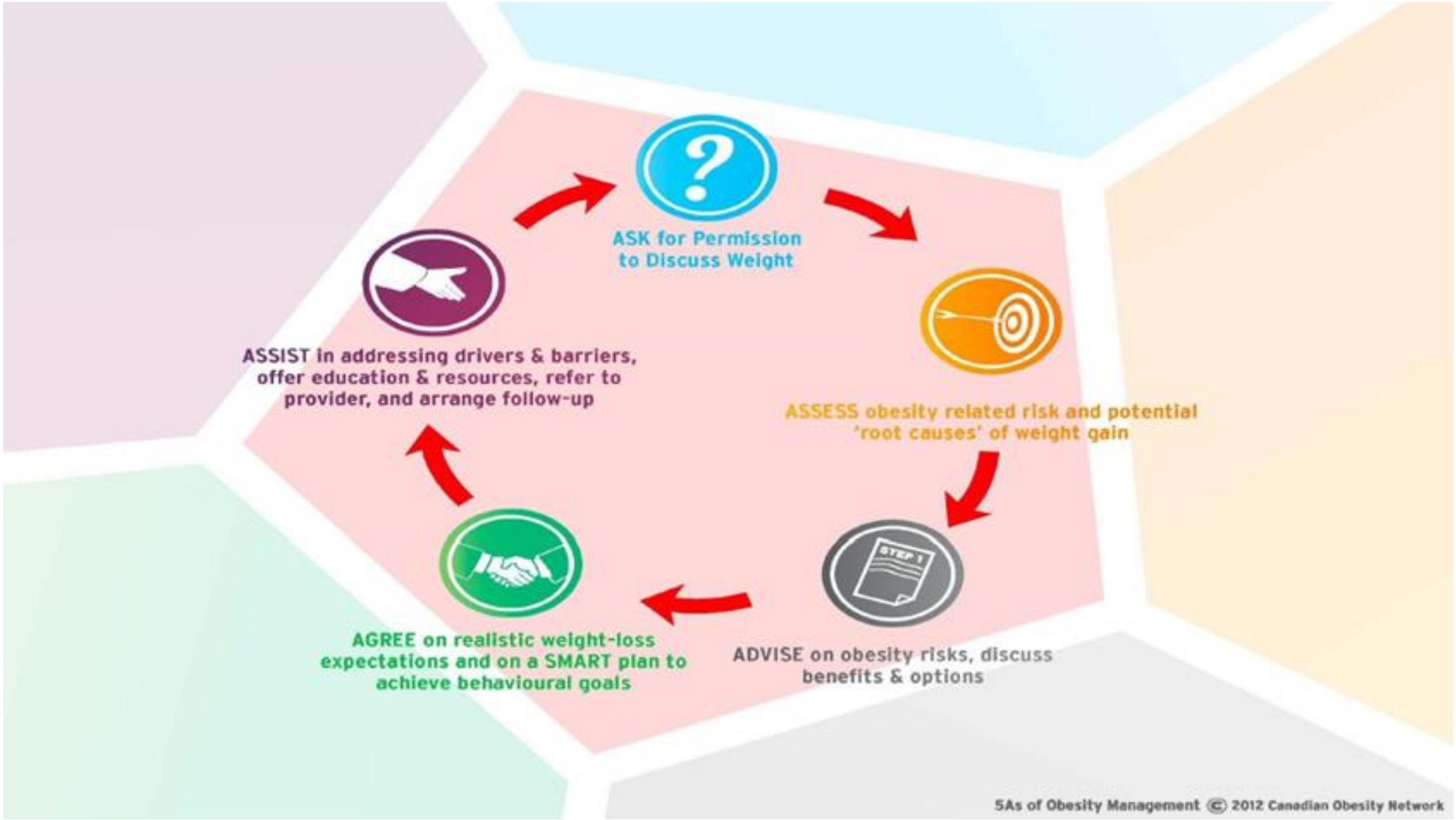
BAME Adults with BMI between 27.5-29.99 Not on the QOF OBTY REG: Patient Count




Obesity & Weight Management
Consultation
Causes
Referral
Notes
Resources
Obesity Referral Criteria
ardens
help & feedback
Ethnicity
28 Jun 2022
Asian/Asian Brit: Banglade...
Record Ethnicity
BMI Calculator...
Problems
Digital Weight Management
Digital weight management
Referral Form
Record Ethnicity
Record new ethnicity
Weight Manag
Tier 1 - Lifest
Tier 2 - Weigh
Tier 3 - Speci
Tier 4 - Consi
Read Code Browser Limited to Patient ethnicity unknown (XaLN0), Ethnic group not given - patient refused (XaE4B), Race (Xa8Es) or Ethnic groups (XaBEN)
Browser
Synonyms
Formulary
QOF Clusters
Templates
Settings
Enter text to search
Search
SNOMED hierarchy
Patient ethnicity unknown (202171000000101)
Refusal by patient to provide information about ethnic group (763726001)
Race (103579009)
Ethnic group finding (397731000)
Ethnic background (398089004)
Ethnic category - 2001 census (92381000000106)
Ethnic category - 2011 census (976551000000109)
Ethnic category - 2011 census England and Wales (976571000000100)
Asian or Asian British: any other Asian background - England and Wales ethnic category 2011 census (976871000000103)
Asian or Asian British: Bangladeshi - England and Wales ethnic category 2011 census (976831000000100)
Asian or Asian British: Chinese - England and Wales ethnic category 2011 census (976851000000107)
Asian or Asian British: Indian - England and Wales ethnic category 2011 census (976791000000107)
Asian or Asian British: Pakistani - England and Wales ethnic category 2011 census (976811000000108)
Black or African or Caribbean or Black British: African - England and Wales ethnic category 2011 census (976891000000104)
Black or African or Caribbean or Black British: Caribbean - England and Wales ethnic category 2011 census (976911000000101)
Black or African or Caribbean or Black British: other Black or African or Caribbean background - England and Wales ethnic category 2011 census (9769
Mixed multiple ethnic groups: any other Mixed or multiple ethnic background - England and Wales ethnic category 2011 census (976771000000108)
Mixed multiple ethnic groups: White and Asian - England and Wales ethnic category 2011 census (976751000000104)
Mixed multiple ethnic groups: White and Black African - England and Wales ethnic category 2011 census (976731000000106)
Mixed multiple ethnic groups: White and Black Caribbean - England and Wales ethnic category 2011 census (976711000000103)
Other ethnic group: any other ethnic group - England and Wales ethnic category 2011 census (976971000000106)
Other ethnic group: Arab - England and Wales ethnic category 2011 census (976951000000102)
White: any other White background - England and Wales ethnic category 2011 census (976691000000100)
White: English or Welsh or Scottish or Northern Irish or British - England and Wales ethnic category 2011 census (976631000000101)
White: Gypsy or Irish Traveller - England and Wales ethnic category 2011 census (976671000000104)

Obesity Referral Criteria

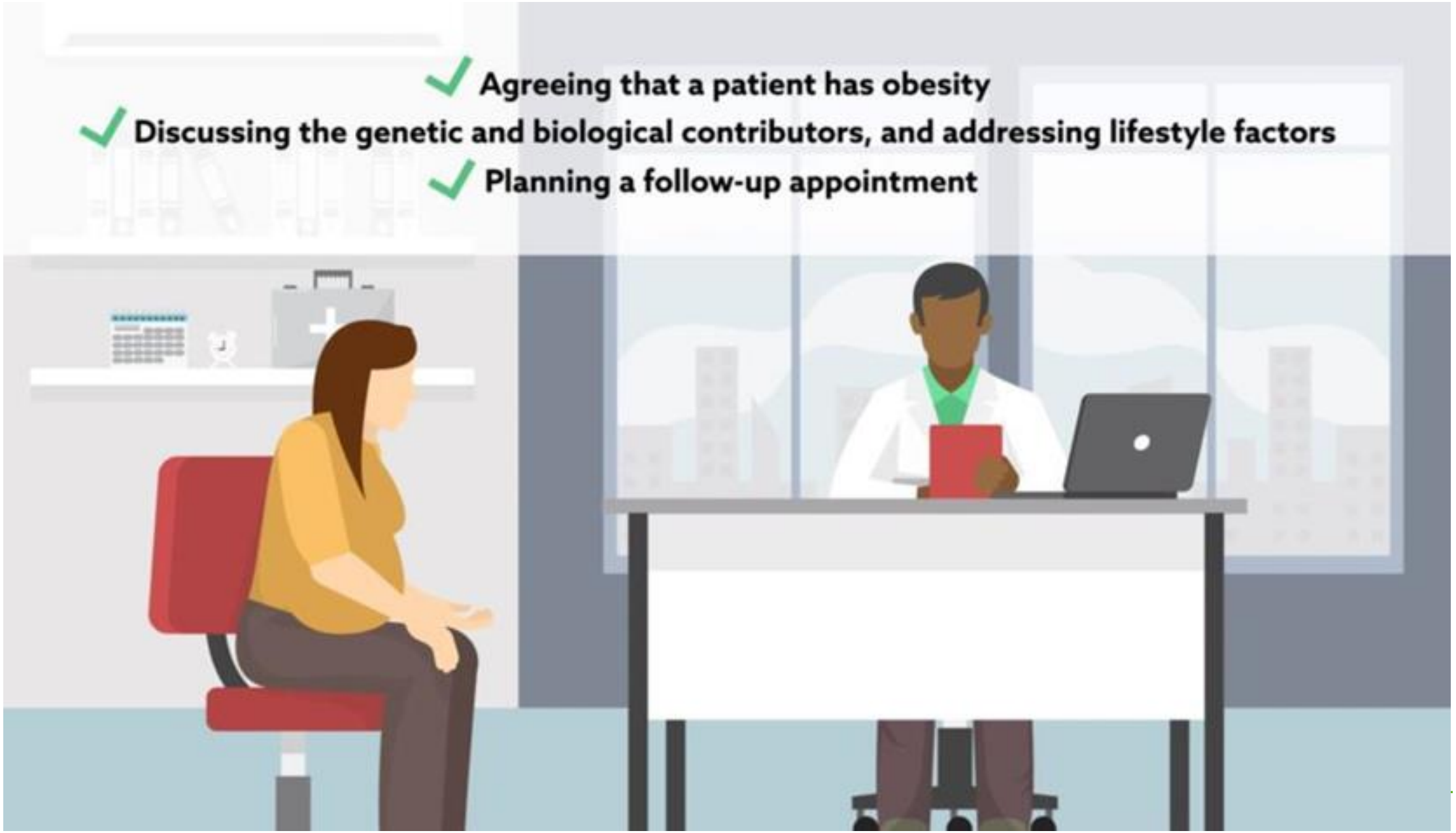



ASK for Permission to Discuss Weight
ASSESS obesity related risk and potential 'root causes' of weight gain
ADVISE on obesity risks, discuss benefits & options
AGREE on realistic weight-loss expectations and on a SMART plan to achieve behavioural goals
ASSIST in addressing drivers & barriers, offer education & resources, refer to provider, and arrange follow-up
5As of Obesity Management © 2012 Canadian Obesity Network

ASK

Sample Questions on How to Begin a Conversation About Weight:

- "Would it be alright if we discussed your weight?"
- "Are you concerned about your weight?"
- "Would you be interested in addressing your weight at this time?"
- "On a scale of 0 to 10, how important is it for you to lose weight at this time?"
- "On a scale of 0 to 10, how confident are you that you can lose weight at this time?"


✓ Agreeing that a patient has obesity
✓ Discussing the genetic and biological contributors, and addressing lifestyle factors
✓ Planning a follow-up appointment

Weight Management

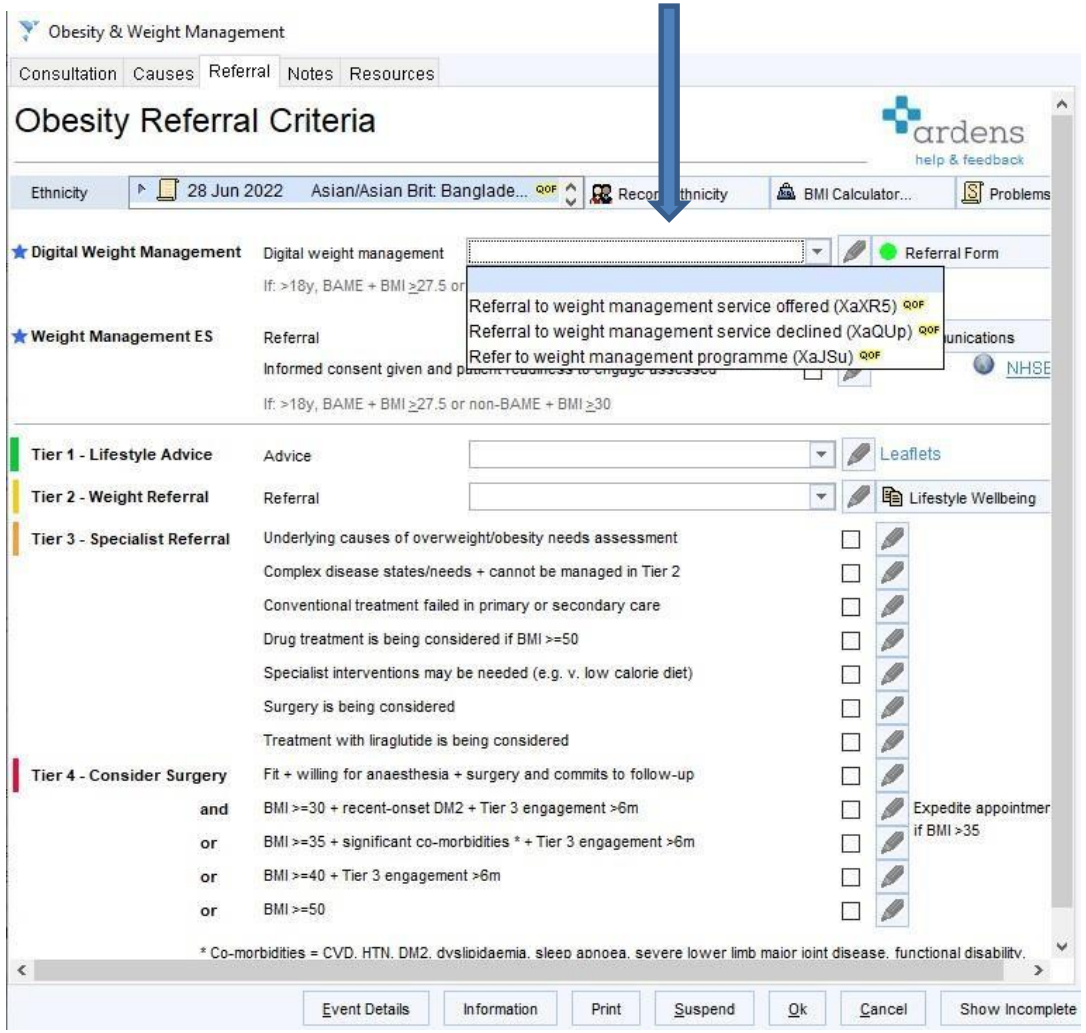
Referrals:

- Tier 2 – patients can self-refer OR practice can refer
- Tier3 & Tier 4 - MUST be practice referrals
- DWMP - MUST be practice referrals

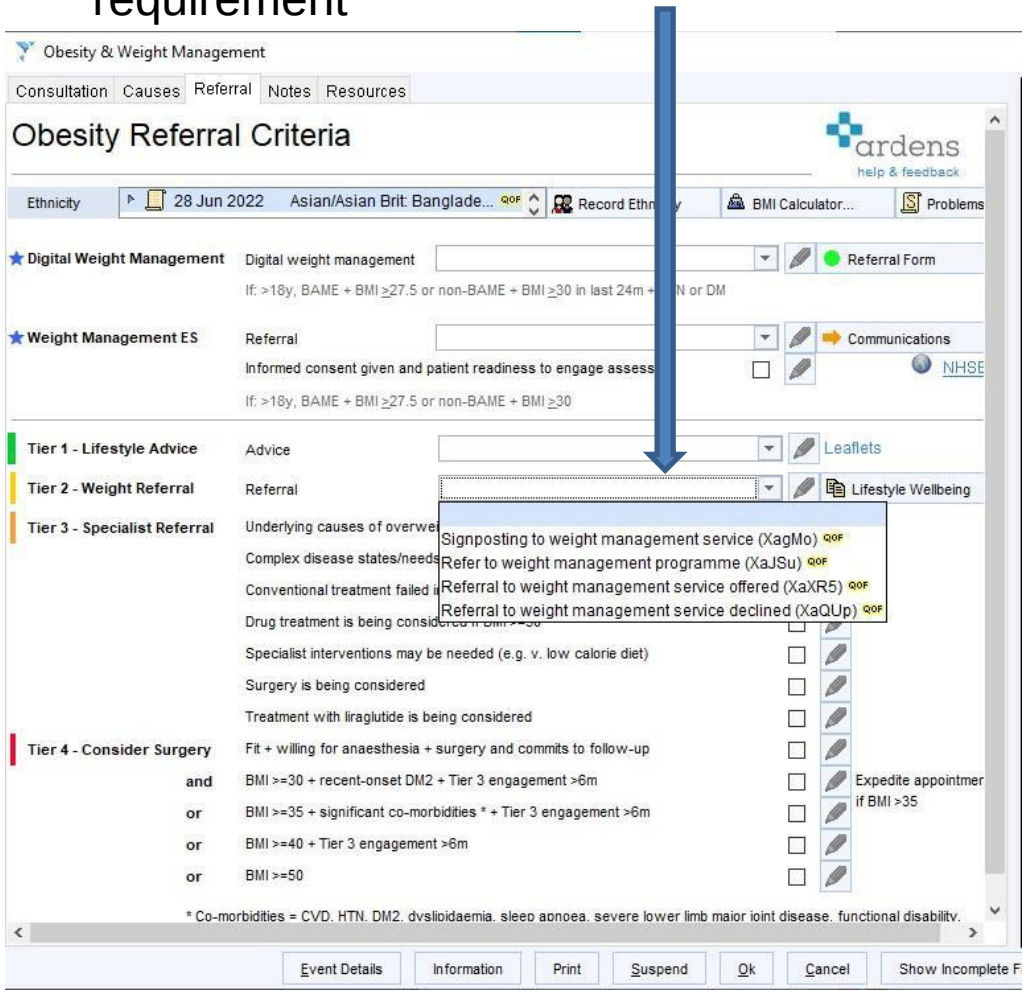
- **NB: Tier 4**
- Approx. 30-35% of T3 patients are referred to T4 Bariatric Services
- T4 patients currently referred to Luton & Dunstable, UCL and more complex to Portsmouth
- CUH & NWAFT are preparing a proposal for a local T4 Bariatric Surgery service, to commence 1 April 2023
- In 21/22, 41 patients had bariatric surgery. The average cost per patient is £8,441 (including outpatient pre & post op appointments)
- 85% were female, age range 25 – 69 years.

- **Future:** (10-15yrs) Possibly GLP-1s & other pharmaceuticals, rather than surgery?

Digital Wt Mx code (DWMP) = £11.50



Tier 1, 2,3 & 4 codes – national monies £11.50 if eligible; LES requirement



NHS Digital Weight Management (DWMP)

- Referral Criteria:
  - Age 18+, BMI >30 or more (adjusted to ≥27.5 for people from black, Asian and ethnic minority backgrounds)
  - **AND** have a diagnosis of diabetes (type 1 or type 2), **and/or** hypertension

- Exclusions:
  - Recorded as having moderate or severe frailty
  - Is pregnant
  - Has an active eating disorder
  - Has had bariatric surgery in the last two years

For people aged over 80 years old, the referrer will need to confirm on the referral form that a weight management programme is considered likely to pose greater benefit than harm

NHS Digital Weight Management (DWMP)

Next Steps:

- Recommendation to run patient eligibility report rather than rely on opportunistic referrals
- ERS referral: search for postcode ST4 4LX (over 100 miles radius)

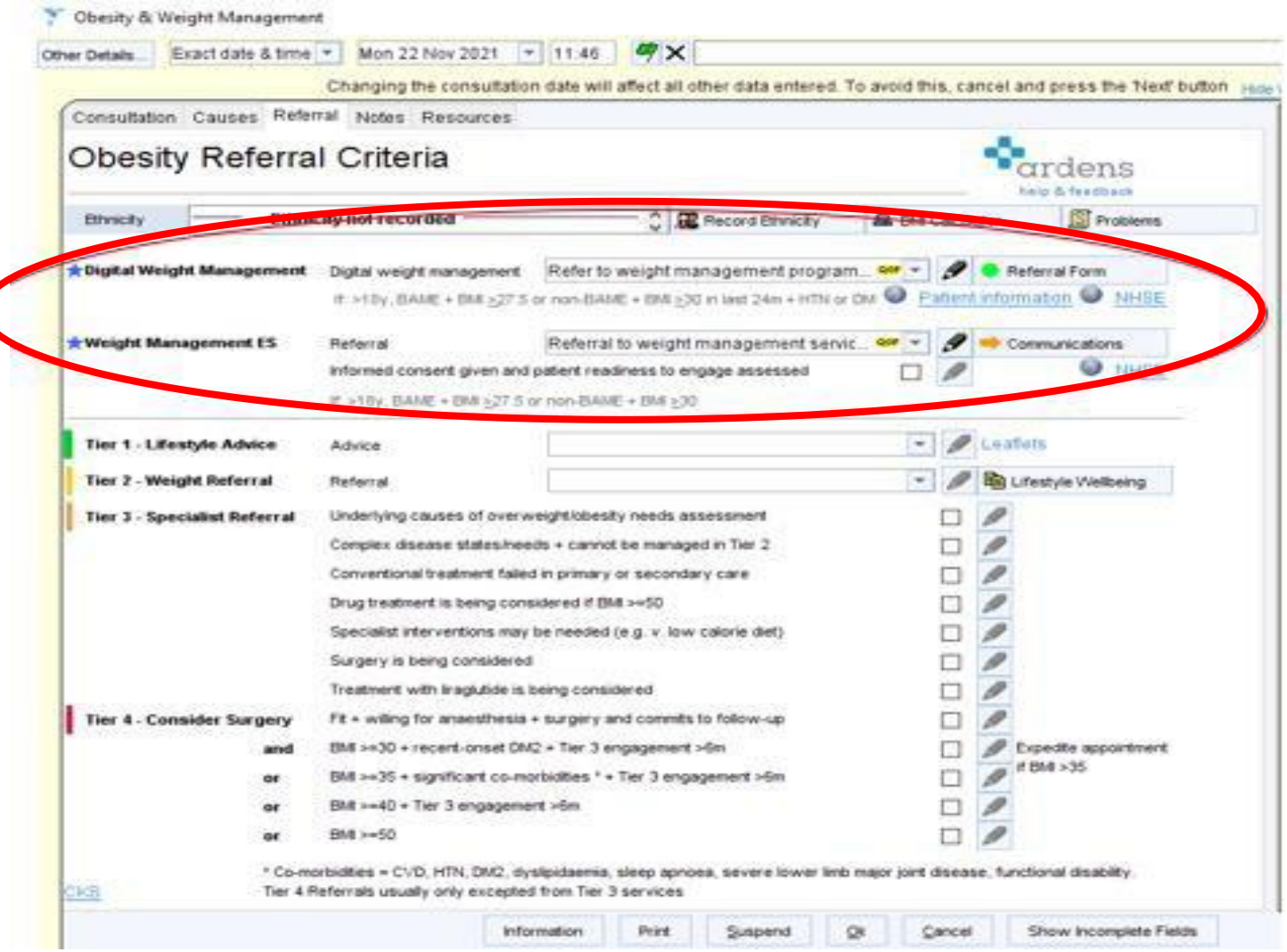
  Service Name: **NHS Digital Weight Management Programme –NHS England Version 2**

Resource:

- Template reports, letters and referral forms on GP system
- Webinar – provides overview of the Digital Weight Management Programme (DWMP) and details improvement actions in the East of England Region

- For more information on referring into the Digital Weight Management Programme please visit: https://www.england.nhs.uk/digital-weight-management/

Weight Management & Enhanced Services Codes



Coding

Digital Weight Management

There are 3 codes you can use from the template –

- Referral to weight management service offered XaXR5
- Referral to weight management service declined XaQUp
- Referral to weight management programme XaJSu

Weight Management ES

The specification only lists one code that should be used for this service to qualify for payment.

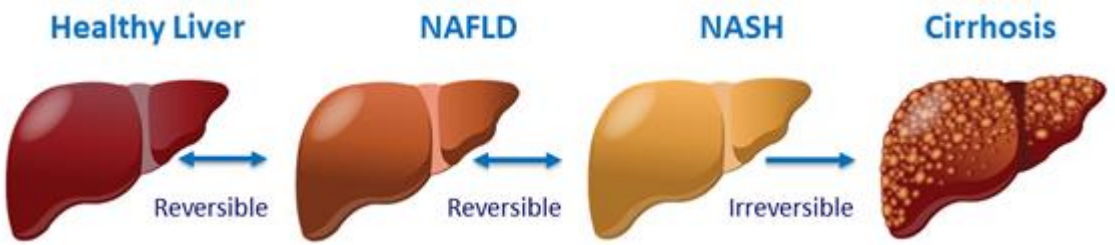
- Referral to weight management service Y2e63 which is now mapped to SNOMED code **1326201000000101**

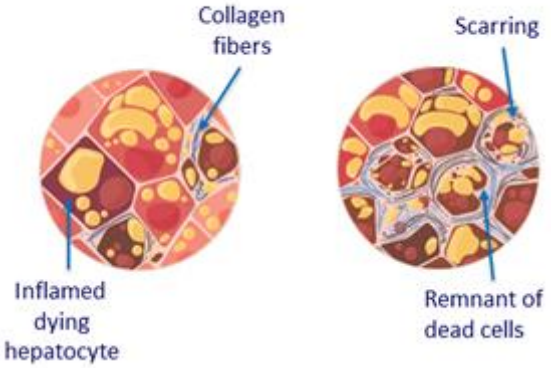
NDPP

For those with non-diabetic hyperglycaemia

- **1025321000000109** Referral to National Health Service Diabetes Prevention Programme (procedure)

NAFLD





- Please code ‘Fatty liver’ until consult
- Consultation:
  - Alcohol (in which case code ‘alcoholic liver disease’
  - Consent for BBV screening (Hepatitis C causes fatty liver)

- Ensure & calculate LFTs & FIB-4 score (?NASH; ?fibrosis – needs referral)
- Advise weight loss

- *NICE says:* Annual review – weight; LFTs; FIB-4 score …

Pragmatic approach – if you see it coded & doing routine / annual / additional bloods – add on LFT + FBC + AST & DEFG (HbA1c) ☺

Healthy You

Drink less

Alcohol Awareness Week

3-9 July 2023

The true cost of alcohol

alcoholchange.org.uk

ALCOHOL CHANGE UK

#AlcoholAwarenessWeek

it's time to think about 'drink'

Cutting down on how much you drink isn't always easy, but you won't be alone.

If you feel like you would need some support stopping or cutting down how much alcohol you drink, Healthy You can support you 1:1 with our Alcohol Health Trainer Team.

Healthy You

Drink less

Healthy You

Cambridgeshire County Council

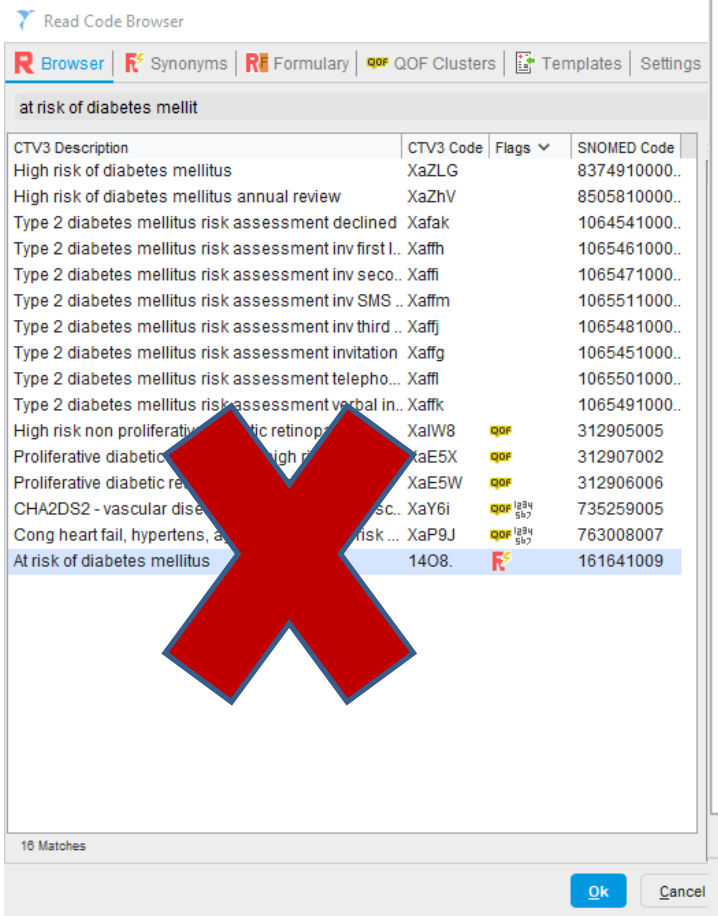
PETERBOROUGH CITY COUNCIL

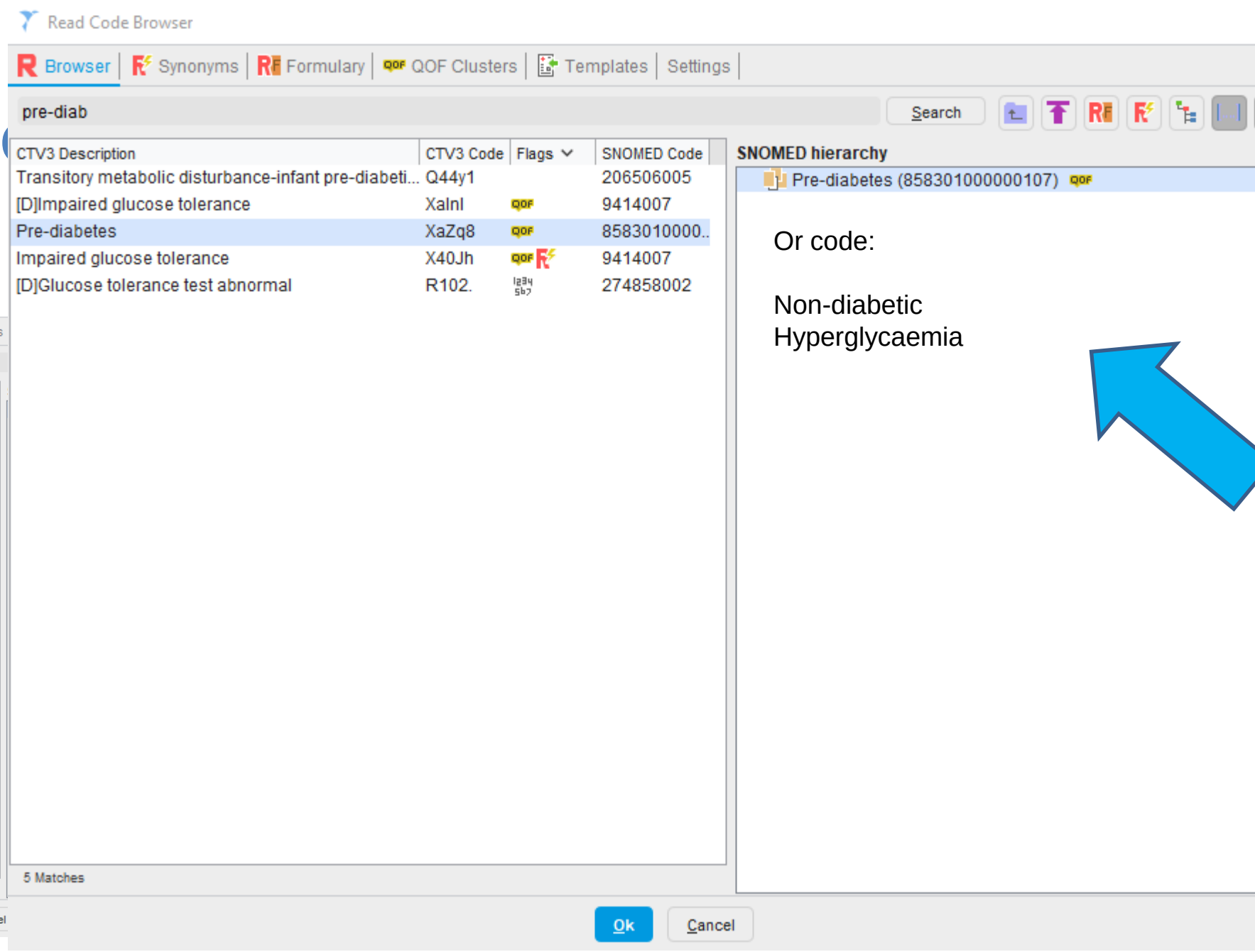
Funded by Cambridgeshire County Council and Peterborough City Council

Diagnosed Disease

Non-Diabetic Hyperglycaemia (NDH, or Pre-diabetes or borderline diabetes)	1. Ensure all **ALL patients who have had a raised HbA1c of 42-47mmol/mol** (but who are not pregnant nor with a diagnosis of diabetes) in the last 24 months are coded as 'pre-diabetes' *Other coding is inadequate & causes challenges for those taking a population-health approach* 2. **Offer annually patients with pre-diabetes (NDH) or those with a history of gestational diabetes HbA1c blood test & referral** to National Diabetes Prevention Programme (NDPP) 3. **Record** when a patient has been invited/ attended / declined/non-responder to complete NDPP structured education

Pre-Diabetes





Pre-Diabetes (Non-Diabetic Hyperglycaemia)

Talk about their weight (BMI; ethnicity; previous weight Hx; waist circumference)
Offer NDPP – sell it! Avg is almost 5kg weight loss!
Pt needs: a) NHS no. (b) HbA1c result & date (c) NDPP phone no.
(don't know enough about NDPP – we can ask the Provider Reed Wellbeing to come to one of Clinical Meetings?)
Encourage weight loss (5-10kg)
Plan follow-up appt

Referring patients into the NDPP

An eligible patient knows their:
NHS number,
HbA1c result and date
and can self refer to Reed Wellbeing by calling 0800 092 1191

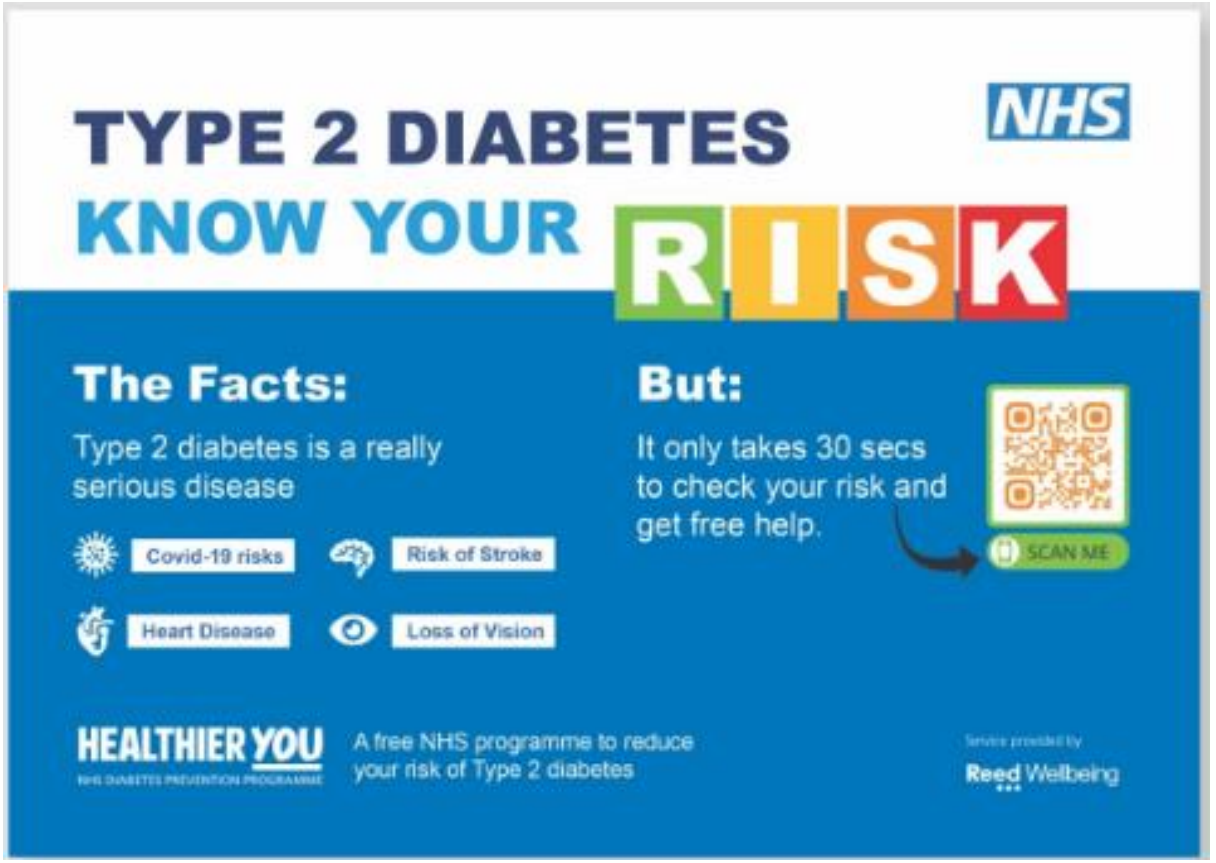
The Diabetes UK Know Your Risk score: individuals with a risk score of 'moderate' (between 16 – 24) or 'high' (between 25 – 47) will continue to be signposted to their GP surgery for HbA1c blood test & assessment of eligibility into the programme.
All completers of the tool will have access to supporting resources from Diabetes UK and the NHS.

Referral Options

GP referral cards

Know your risk poster

Displayed across the venues we deliver and we have started bringing them into surgeries across Cambridge and Peterborough.



Gestational Diabetes

Affects 10 - 20% of pregnancies → the most common medical condition to affect pregnant women.
If untreated during pregnancy it can led to poor maternal and neonatal outcomes.

In 2021: a feasibility study was undertaken by the audit team at NHS England to see if it was possible to collect data on women with GDM relating to the care and outcomes for mothers and babies.
This has led to the development of a new (June 2023) GDM Audit - National Gestational Diabetes Audit - NHS Digital
→ enable NHSE to collect data; understand the performance of maternity services; and develop recommendations that will serve this group of patients more effectively.

Hospital Maternity Services: will now mandatory log all incidents of GDM through the Maternity Services Data Set (MSDS). To do this use SNOMED code **11687002 (Gestational diabetes mellitus (disorder)** and put it in the **MSD106 Diagnosis (Pregnancy)** table.

GP Practices: Need to ensure robust coding of such letters/ information on patient record 'Major Active Problem'

GDM Mailshot campaign 2023

Mailshot Campaign

Mailshot Letters Sent

Month	PCN
April - 23	Huntingdon, St Ives, St Neots, Fenland, South Fenland
May - 23	Bretton Park & Hampton, A1 Network, Peterborough & East, Peterborough Partnerships, South Peterborough
June - 23	Central Thistlemoor & Thorpe, BMC Paston, Granta, Cambridge North Villages, Cantab, Meridian, Cam Medical, Cambridge City 4, Cambridge City, Ely North, Ely South, Wisbech

NB >6000 patients already coded with Hx of GDM

Only 3000 have had a HbA1c in last 12 months.

Participant Outcomes

- 2023: received **2809** referrals, **298** of those are GDM patients = **~562 a month** ☹
- **1368** patients from Cambridgeshire and Peterborough have attended a programme since Jan 2023.
- Since Dec 2020 (the start of the contract): **1,959** participants have **completed** the 9 month programme.

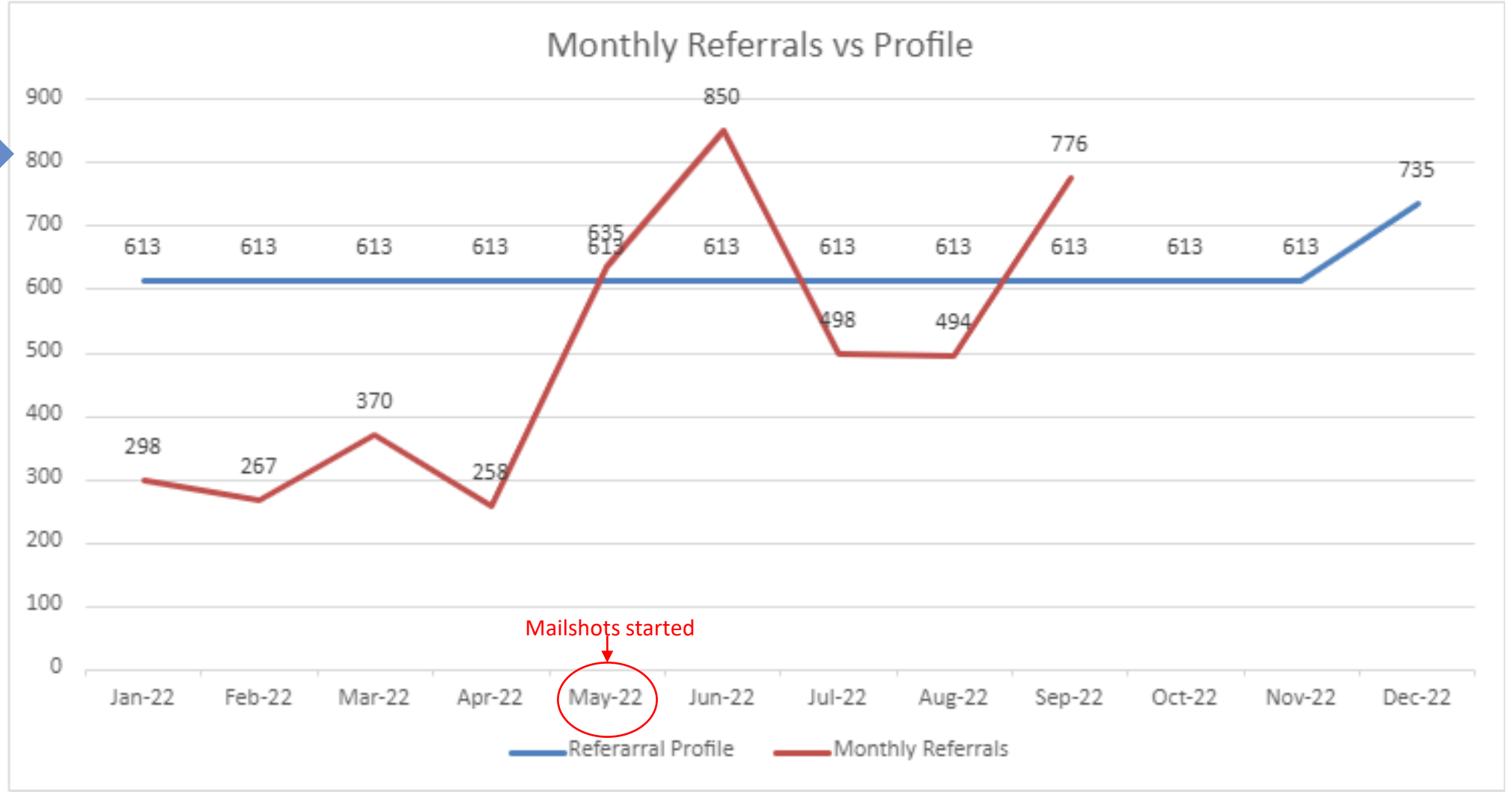
Reported outcomes

- Increased physical activity
- More energy
- Sleeping better
- Reduced other health problems such as blood pressure , joint problems
- Improved mental health
- Normal HbA1c Reading

Please take pre-diabetes seriously;
code it, even historic HbAc1 as Pre-DM or NDH & offer patients advice & referral.
T2DM is a significant condition, associated with premature morbidity & mortality.

National Diabetes Prevention Programme

Jan 2024: profile goes >800!



2023: referral profile is 735 a month

Updates

GDM Mailout

- 2757 letters have now been sent to patients with previous GDM. As a result, 298 people have called in and booked onto either our tailored remote course, a face to face programme or the digital option.

Physical Activity Pilot

- Working with the living sport team to provide physical activity within two of our programmes.

- Participants will have the option to opt-in to these programmes and the health benefits of incorporating physical activity will be monitored throughout.

- **Engagement Events.**

As always, we would love to come to any team meetings/engagement events online or in the local area where we can promote NDPP and answer any questions about the service.

One of our current groups enjoying their session 8 of the course. The are displaying their, thoughts about the programme, on the flip chart.

Email: hayley.cottam@reedwellbeing.org.uk
Website: https://reedwellbeing.com

Proposed Mailshot Campaign: Pre-DM – Jan 2024

Mailshot Letters – **Proposed** 2024

In Jan 2024 National referral target increases to: >800 / month (!)

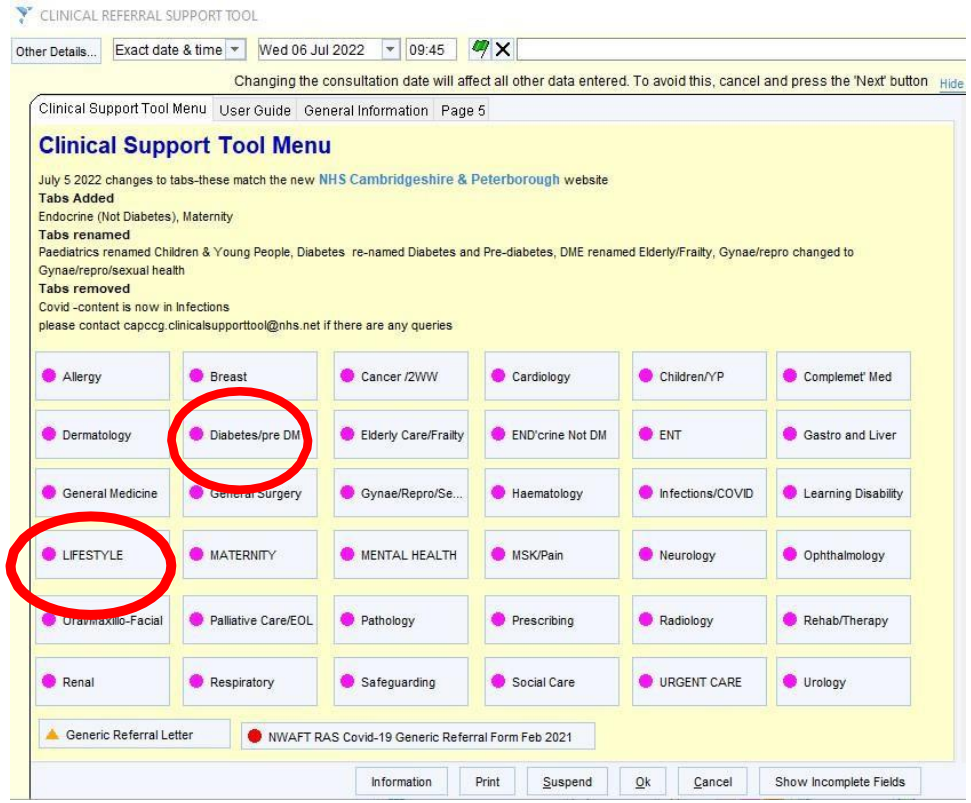
Month	PCN
Jan/Feb	Huntingdon, St Ives, St Neots, South Fenland, Fenland, Bretton Park & Hampton, Peterborough & East, A1 Network, Peterborough Partnerships, South Peterborough
March	Central Thistlemoor & Thorpe
April	BMC Paston
May	Granta
June	Cambridge North Villages Cantab, Meridian
July	Cam Medical Cambridge City 4 Cambridge City
Sept/Oct	Ely North, Ely South Wisbech

NB: This will go to all patients coded with Pre-Diabetes or NDH
AND
Have a HbA1c in past 12 months

ACTION for Practices: please can you consider QIP & achieve this?

Diagnosed Disease

Type 2 Diabetes	1. Continue to offer **structured education & weight management advice** 2. For those patients given a foot examination, **please inform patient of their risk of foot disease**. There are Patient Information leaflets embedded Clinical Support Tool (CST) (or use equivalent) 3. Using Eclipse, aspire towards **achieving at least the national average (41.7%) of 8 Care Processes (CP) level** 4. Using Eclipse to identify and **prioritise care to those patients with 'Red' level indicators**: BP >160/100 mmHg, HbA1c >86 mmol/mol, total cholesterol >7 mmol/l 5. Using Eclipse, aspire towards **achieving at least national average (27.9%) of the 3 Treatment Targets**. 6. **Record** when a patient has been invited/ attended / declined/non-responder to complete structured education 7. Use CST (or equivalent) embedded **dietary sheets**
Type 1 Diabetes	1. For those patients given a foot examination, please inform patient of their **risk of foot disease** and give patient embedded CST (or equivalent) leaflets (via SMS or printed) 2. Utilising Eclipse work to aspire towards achieving the **national average 8 Care Processes (CP) level** 3. Using Eclipse to identify and **prioritise care to those patients with 'Red' level indicators:** BP >160/100 mmHg, HbA1c>86mmol/l, total cholesterol > 7mmol/l. 4. Using Eclipse work to aspire towards achieving at **least national average of the 3 Treatment Targets**. Offer urgent clinical review, to include foot examination due to CVD risk. 5. **Record** when a patient has been invited/ attended / declined/non responder to complete structured education.


CLINICAL REFERRAL SUPPORT TOOL
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Wed 06 Jul 2022
09:45
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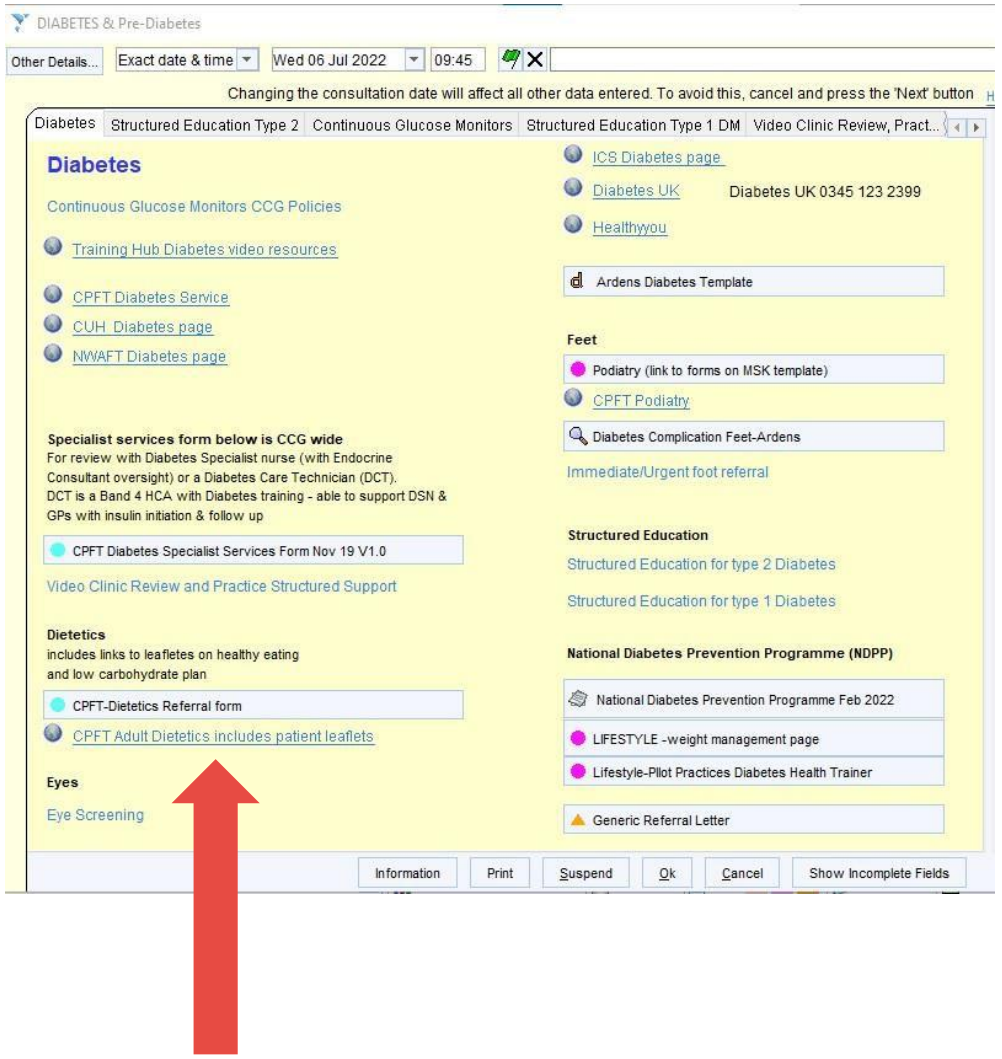
Hide
Clinical Support Tool Menu
User Guide
General Information
Page 5
Clinical Support Tool Menu
July 5 2022 changes to tabs-these match the new NHS Cambridgeshire & Peterborough website
Tabs Added
Endocrine (Not Diabetes), Maternity
Tabs renamed
Paediatrics renamed Children & Young People, Diabetes re-named Diabetes and Pre-diabetes, DME renamed Elderly/Frailty, Gynae/repro changed to Gynae/repro/sexual health
Tabs removed
Covid -content is now in Infections
please contact capccg.clinicalsupporttool@nhs.net if there are any queries
Allergy
Breast
Cancer /2WW
Cardiology
Children/YP
Complemet' Med
Dermatology
Diabetes/pre DM
Elderly Care/Frailty
END'crine Not DM
ENT
Gastro and Liver
General Medicine
General Surgery
Gynae/Repro/Se...
Haematology
Infections/COVID
Learning Disability
LIFESTYLE
MATERNITY
MENTAL HEALTH
MSK/Pain
Neurology
Ophthalmology
Oral/maxillo-Facial
Palliative Care/EOL
Pathology
Prescribing
Radiology
Rehab/Therapy
Renal
Respiratory
Safeguarding
Social Care
URGENT CARE
Urology
Generic Referral Letter
NWAFT RAS Covid-19 Generic Referral Form Feb 2021
Information
Print
Suspend
Ok
Cancel
Show Incomplete Fields


DIABETES & Pre-Diabetes
Other Details...
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Diabetes
Structured Education Type 2
Continuous Glucose Monitors
Structured Education Type 1 DM
Video Clinic Review, Pract...
Diabetes
Continuous Glucose Monitors CCG Policies
Training Hub Diabetes video resources
CPFT Diabetes Service
CUH Diabetes page
NWAFT Diabetes page
Specialist services form below is CCG wide
For review with Diabetes Specialist nurse (with Endocrine Consultant oversight) or a Diabetes Care Technician (DCT).
DCT is a Band 4 HCA with Diabetes training - able to support DSN & GPs with insulin initiation & follow up
CPFT Diabetes Specialist Services Form Nov 19 V1.0
Video Clinic Review and Practice Structured Support
Dietetics
includes links to leafletes on healthy eating and low carbohydrate plan
CPFT-Dietetics Referral form
CPFT Adult Dietetics includes patient leaflets
Eyes
Eye Screening
ICS Diabetes page
Diabetes UK
Diabetes UK 0345 123 2399
Healthyyou
Ardens Diabetes Template
Feet
Podiatry (link to forms on MSK template)
CPFT Podiatry
Diabetes Complication Feet-Ardens
Immediate/Urgent foot referral
Structured Education
Structured Education for type 2 Diabetes
Structured Education for type 1 Diabetes
National Diabetes Prevention Programme (NDPP)
National Diabetes Prevention Programme Feb 2022
LIFESTYLE -weight management page
Lifestyle-Pilot Practices Diabetes Health Trainer
Generic Referral Letter
Information
Print
Suspend
Ok
Cancel
Show Incomplete Fields

Dietary Sheets

Other useful resources

General

High fibre diet- March 2019.pdf [pdf] 519KB

Up-to-date and easy-to-read guidance on a number of topics on nutrition can be found at the **British Dietetic Associations web page.**

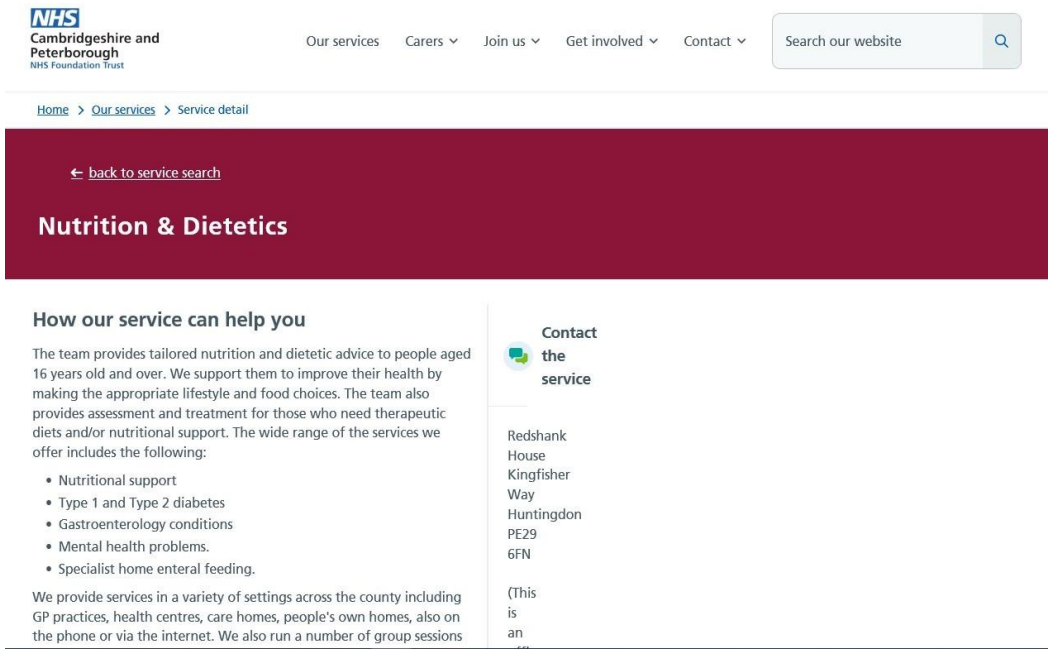
Diabetes

An intro to healthy eating for people with T2 diabetes Jan 21.pdf [pdf] 3MB
Low Carbohydrate Diet Plan for Type 2 Diabetes 07.02.2020.pdf [pdf] 470KB
Eating styles and strategies.pdf [pdf] 954KB
1800kcal eating plan.pdf [pdf] 2MB
Carbohydrates.pdf [pdf] 2MB
1500kcal eating plan.pdf [pdf] 2MB
Snack ideas 2020 complete.pdf [pdf] 413KB
Starting a GLP-1.pdf [pdf] 3MB
An Easy Guide for Your Main Meal (with meal ideas).pdf [pdf] 7MB
Education and Support of the Newly Diagnosed Type 2 Patient (training for healthcare professionals) 01.07.2021.pptx [pptx] 11MB
Education and Support of the Newly Diagnosed Type 2 Patient (training for healthcare professionals) 01.07.2021.pptx [pptx] 11MB

Other useful information on diabetes can be found at **Diabetes UK**

us on Twitter Like us on Facebook

Business Hours/Visiting Hours: Monday-Friday, 8am-5pm, excluding Bank Holidays


NHS Cambridgeshire and Peterborough NHS Foundation Trust

Our services | Carers | Join us | Get involved | Contact | Search our website

Home > Our services > Service detail

← back to service search

Nutrition & Dietetics

How our service can help you

The team provides tailored nutrition and dietetic advice to people aged 16 years old and over. We support them to improve their health by making the appropriate lifestyle and food choices. The team also provides assessment and treatment for those who need therapeutic diets and/or nutritional support. The wide range of the services we offer includes the following:

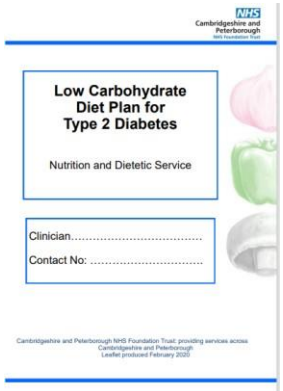
- Nutritional support
- Type 1 and Type 2 diabetes
- Gastroenterology conditions
- Mental health problems.
- Specialist home enteral feeding.

We provide services in a variety of settings across the county including GP practices, health centres, care homes, people's own homes, also on the phone or via the internet. We also run a number of group sessions

Contact the service

Redshank House Kingfisher Way Huntingdon PE29 6FN

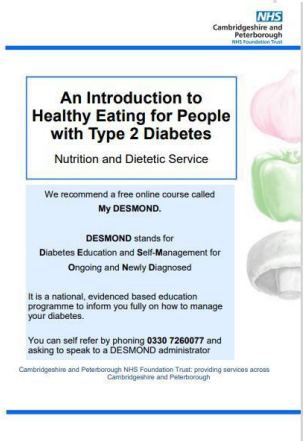
(This is an


Low Carbohydrate Diet Plan for Type 2 Diabetes

Nutrition and Dietetic Service

Clinician.....

Contact No: .....


An Introduction to Healthy Eating for People with Type 2 Diabetes

Nutrition and Dietetic Service

We recommend a free online course called **My DESMOND.**

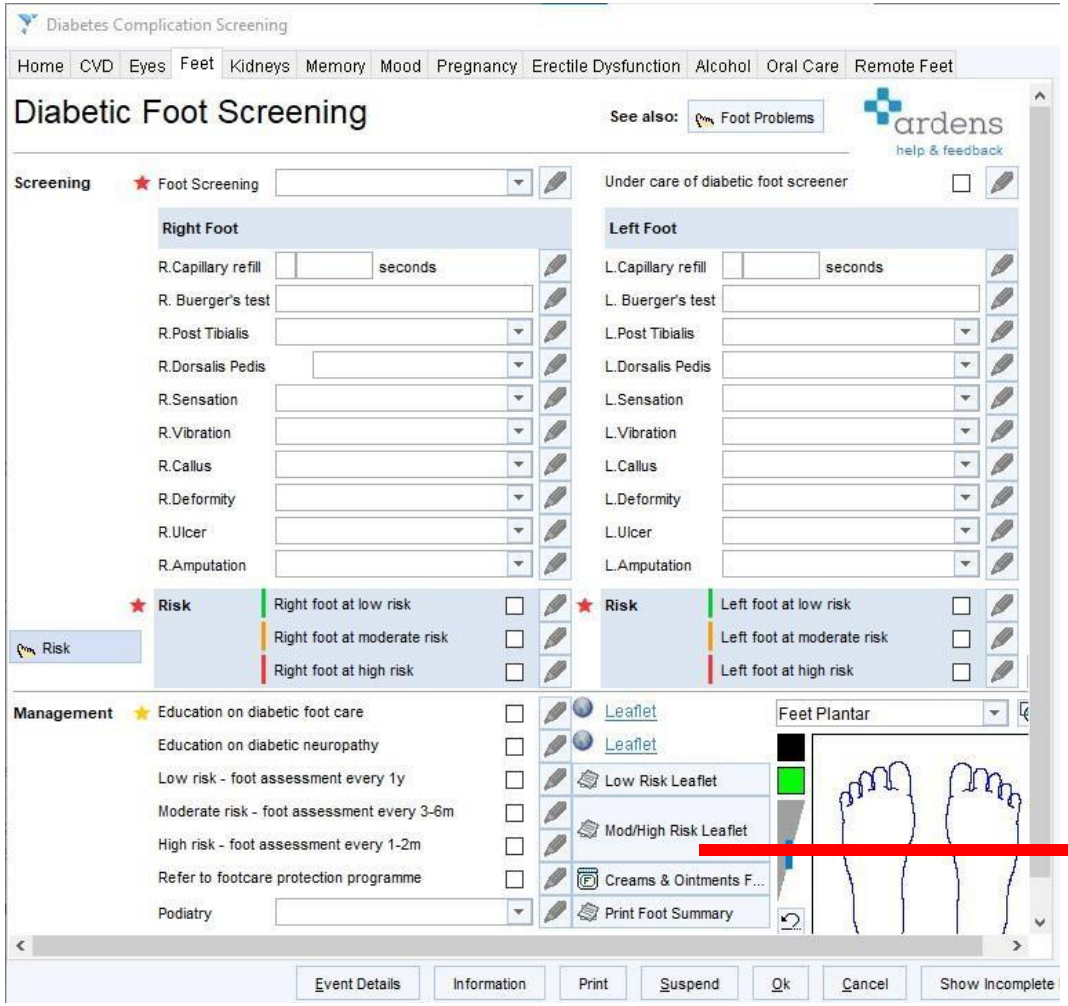
DESMOND stands for **D**iabetes **E**ducation and **S**elf-**M**anagement for **O**ngoing and **N**ewly **D**iagnosed

It is a national, evidenced based education programme to inform you fully on how to manage your diabetes.

You can self refer by phoning **0330 7260077** and asking to speak to a DESMOND administrator

https://www.cpft.nhs.uk/search/service/nutrition-dietetics-89

Ardens Diabetic Foot Screening



Name: Anna Thistlemoor-TestPatient Date: 06 Jul 2022
Name of Doctor/Nurse or Podiatrist:

DiABETES UK
KNOW DIABETES. FIGHT DIABETES.

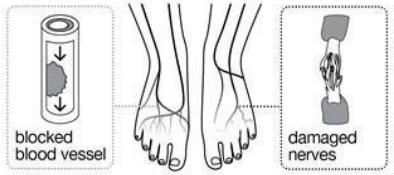
Diabetes and your feet
Information Prescription

Your foot risk is ☐ **Moderate** ☐ **High**

People with diabetes are at higher risk of developing serious foot problems, including ulcers and infections. These could lead to amputations and increase your risk of a heart attack and stroke. By managing your diabetes and looking after your feet you can reduce your risk of foot problems.

What you should know about your feet and diabetes

- Diabetes can damage the blood flow to your feet.
- Diabetes can damage the nerves in your feet, changing the way you feel things.
- High blood glucose (sugar) also increases the risk that any wounds or ulcers could become infected.



When do you have a foot problem?

The damage to nerves or blood flow can cause numbness, burning, dull ache or changes in the skin. If this happens, see your GP or podiatrist. However if you develop changes in the shape, colour or temperature or notice a wound you didn't know was there, see your local foot team urgently.

How do you keep your feet healthy?

Get to know what's normal for your feet. Remember, if you lose feeling in your feet you might not be able to feel damage – no pain isn't a sign that it's not serious.

Smoking

☐ Get advice to stop smoking. Smoking makes it harder for blood to flow around your body.

Look after your diabetes

☐ Keep your blood sugar, cholesterol, and blood pressure at safe levels. Talk to your doctor or nurse about your latest results and what your personal targets should be.

☐ Ask about local diabetes courses.

Eat a healthy balanced diet and stay active

☐ Lifestyle changes could help manage your diabetes. Some activities can increase the risk to your feet, so discuss new ways to get active with your clinician.

Look after your feet

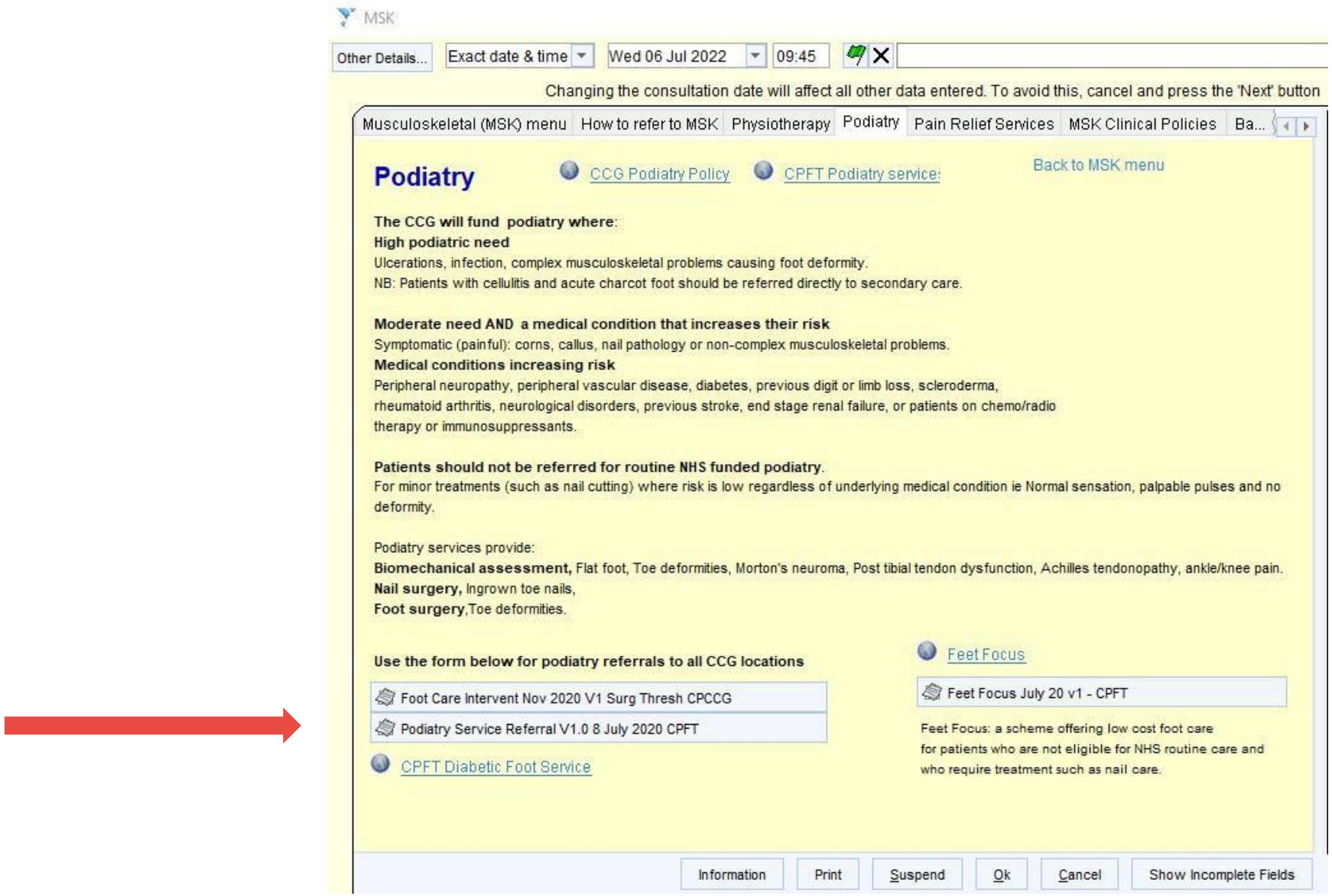
☐ Check your feet daily or ask for help if you can't.
☐ Look after toe nails – not too short or long.
☐ Wear shoes and socks that don't rub – get your feet measured to check the fit of shoes.

Safety note

Check your feet every day for:

- broken skin, cuts or blisters that don't heal
- red, hot, swollen foot or toe
- colour changes
- new pain.

If you notice any of these changes contact your local foot team within 24 hours as these can become


MSK
Other Details...
Exact date & time
Wed 06 Jul 2022
09:45
Changing the consultation date will affect all other data entered. To avoid this, cancel and press the 'Next' button
Musculoskeletal (MSK) menu
How to refer to MSK
Physiotherapy
Podiatry
Pain Relief Services
MSK Clinical Policies
Ba...
Podiatry
CCG Podiatry Policy
CPFT Podiatry service:
Back to MSK menu
The CCG will fund podiatry where:
High podiatric need
Ulcerations, infection, complex musculoskeletal problems causing foot deformity.
NB: Patients with cellulitis and acute charcot foot should be referred directly to secondary care.
Moderate need AND a medical condition that increases their risk
Symptomatic (painful): corns, callus, nail pathology or non-complex musculoskeletal problems.
Medical conditions increasing risk
Peripheral neuropathy, peripheral vascular disease, diabetes, previous digit or limb loss, scleroderma, rheumatoid arthritis, neurological disorders, previous stroke, end stage renal failure, or patients on chemo/radio therapy or immunosuppressants.
Patients should not be referred for routine NHS funded podiatry.
For minor treatments (such as nail cutting) where risk is low regardless of underlying medical condition ie Normal sensation, palpable pulses and no deformity.
Podiatry services provide:
Biomechanical assessment, Flat foot, Toe deformities, Morton's neuroma, Post tibial tendon dysfunction, Achilles tendonopathy, ankle/knee pain.
Nail surgery, Ingrown toe nails,
Foot surgery,Toe deformities.
Use the form below for podiatry referrals to all CCG locations
Foot Care Intervent Nov 2020 V1 Surg Thresh CPCCG
Podiatry Service Referral V1.0 8 July 2020 CPFT
CPFT Diabetic Foot Service
Feet Focus
Feet Focus July 20 v1 - CPFT
Feet Focus: a scheme offering low cost foot care for patients who are not eligible for NHS routine care and who require treatment such as nail care.
Information
Print
Suspend
Ok
Cancel
Show Incomplete Fields

Dopplers

Every Practice should have access to ABPI
Every Federation given equipment

Place/ICB Action: to establish current provision

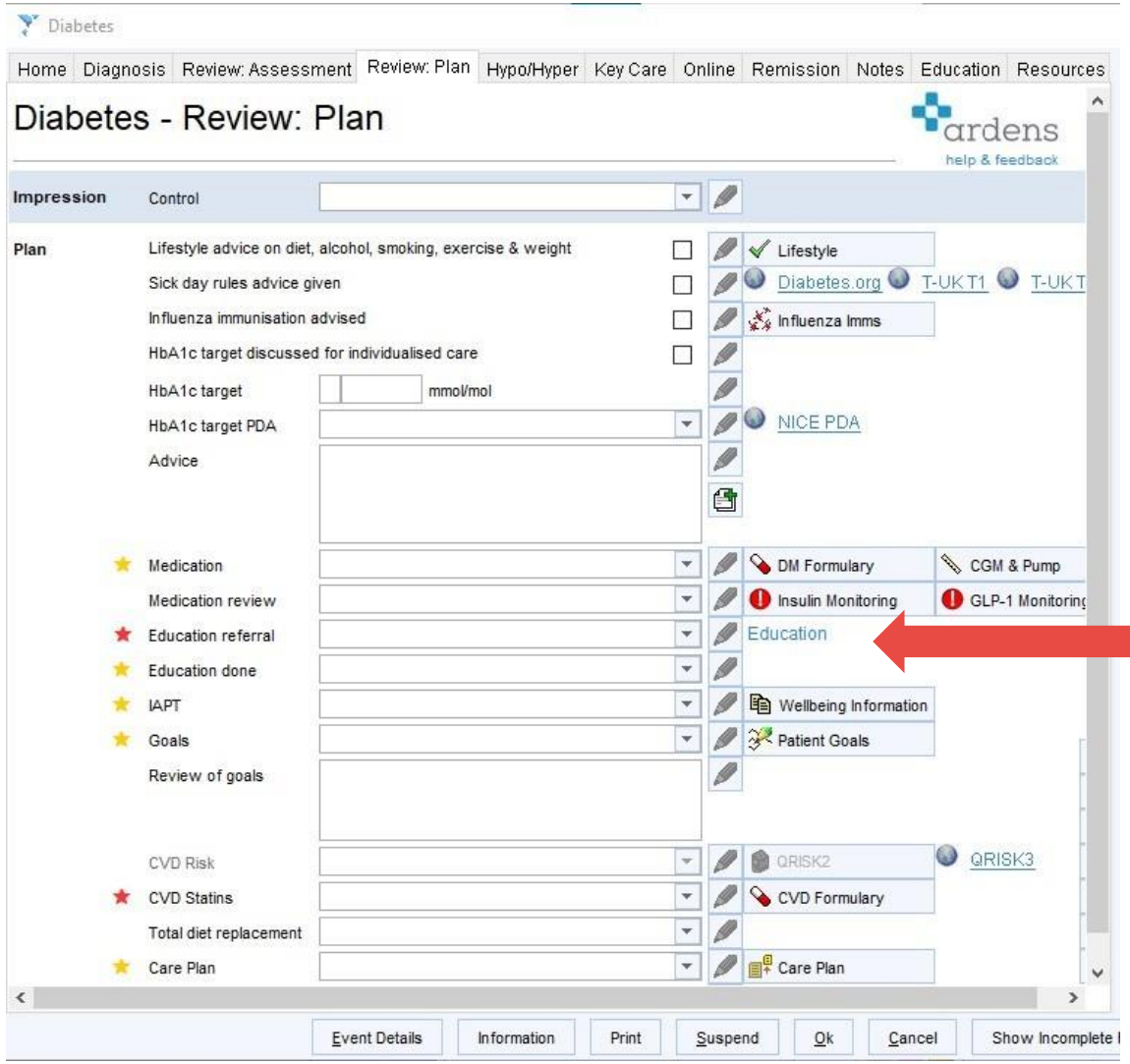
Greater Peterborough Network
Working Together for a Healthier Future

Following recent new NICE guidelines, The GP Hub has suspended bookings for APBI and Dopplers, due to advice regarding equipment being used.

Please see attached guidance for more information.

Can this please be circulated across your wider team, and that we are no longer able to accept bookings for Dopplers.

GPN has renamed the GP Hub Practice Nurse ‘slots’ to highlight that we are now unable to accept these type of appointments.

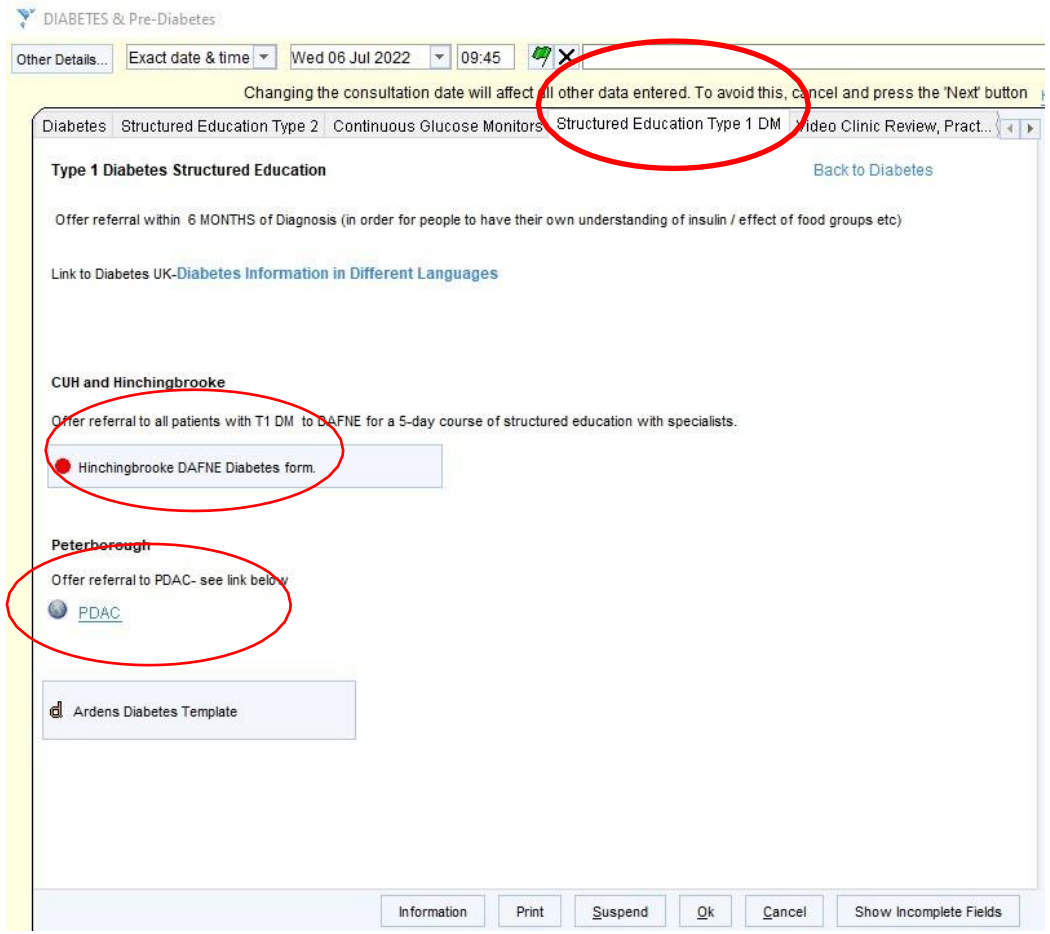

Diabetes
Home
Diagnosis
Review: Assessment
Review: Plan
Hypo/Hyper
Key Care
Online
Remission
Notes
Education
Resources
Diabetes - Review: Plan
ardens
help & feedback
Impression
Control
Plan
Lifestyle advice on diet, alcohol, smoking, exercise & weight
Lifestyle
Sick day rules advice given
Diabetes.org
T-UKT1
T-UKT
Influenza immunisation advised
Influenza Imms
HbA1c target discussed for individualised care
HbA1c target
mmol/mol
HbA1c target PDA
NICE PDA
Advice
Medication
DM Formulary
CGM & Pump
Medication review
Insulin Monitoring
GLP-1 Monitoring
Education referral
Education
Education done
IAPT
Wellbeing Information
Goals
Patient Goals
Review of goals
CVD Risk
QRISK2
QRISK3
CVD Statins
CVD Formulary
Total diet replacement
Care Plan
Care Plan
Event Details
Information
Print
Suspend
Ok
Cancel
Show Incomplete

Structured Education

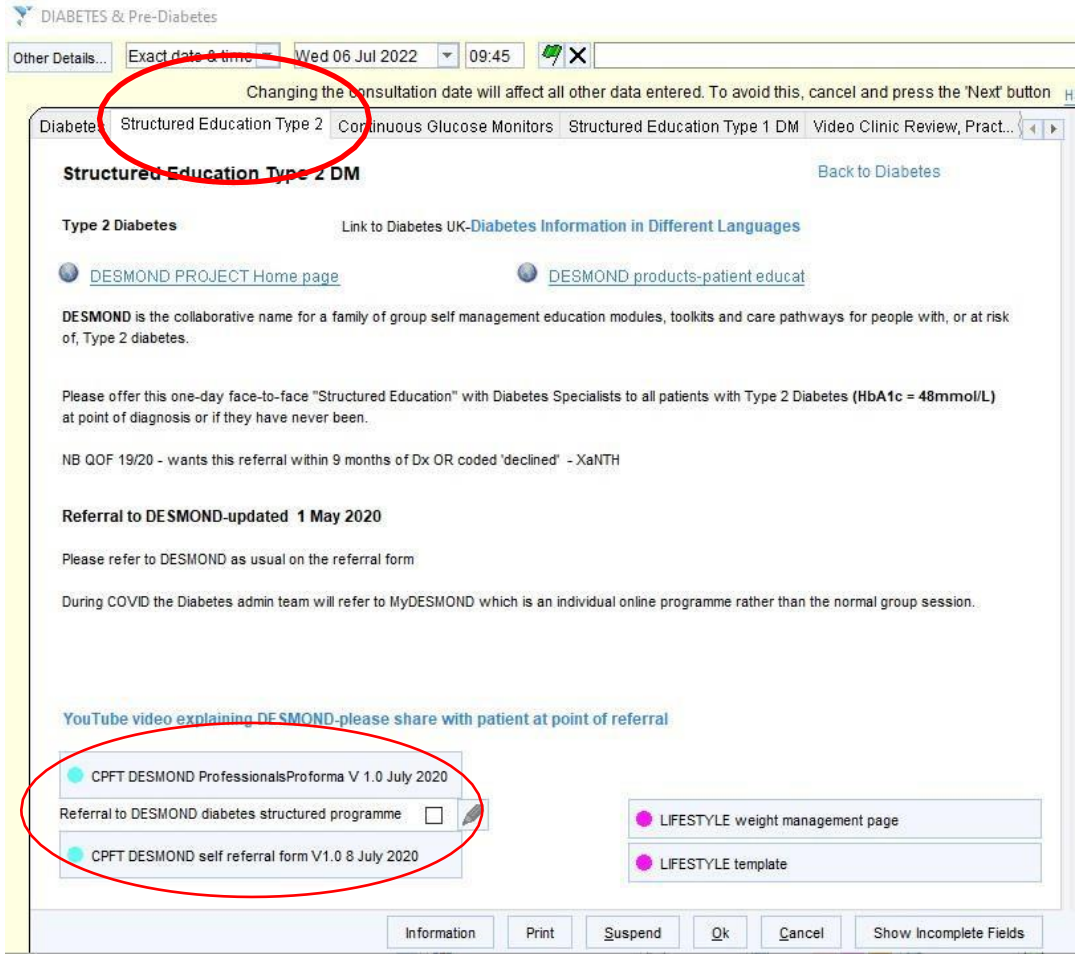
Structured Education Available		
Pre Diabetes	Type 1	Type 2
NDPP	DAFNE	DESMOND
	PDAC	myDESMOND
	BERTIE online	Healthy Living
	MyTYPE1 Diabetes	

Structured Education - CST

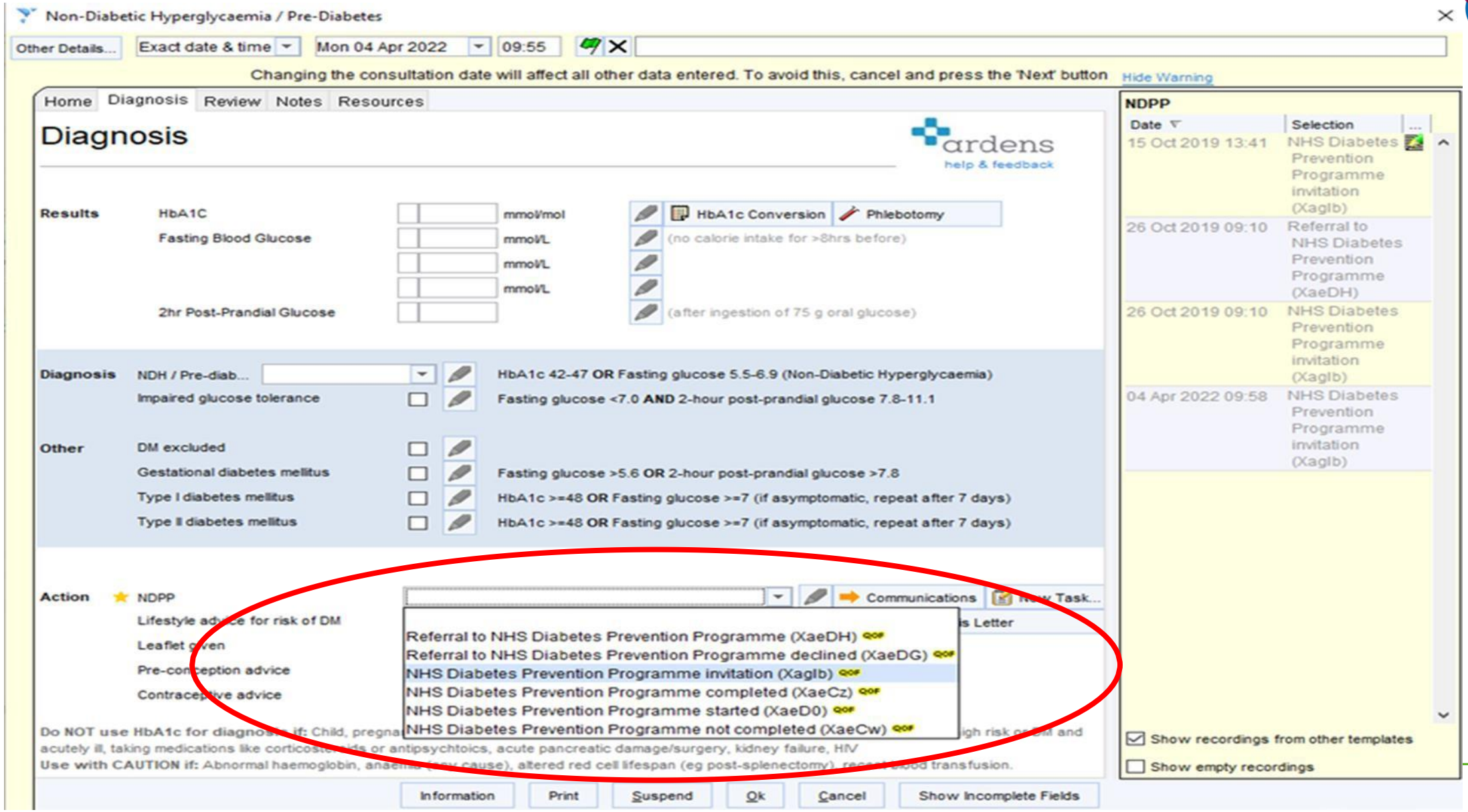
Type 1



Type 2



Pre-Diabetes Arden's Template



Cambridgeshire & Peterborough
Integrated Care System

Digital Diabetes Programme Evaluation

Early Adopter programmes requested a Patient-facing app for Structured Education.

Two Providers identified (Gro Health & MyDESMOND)

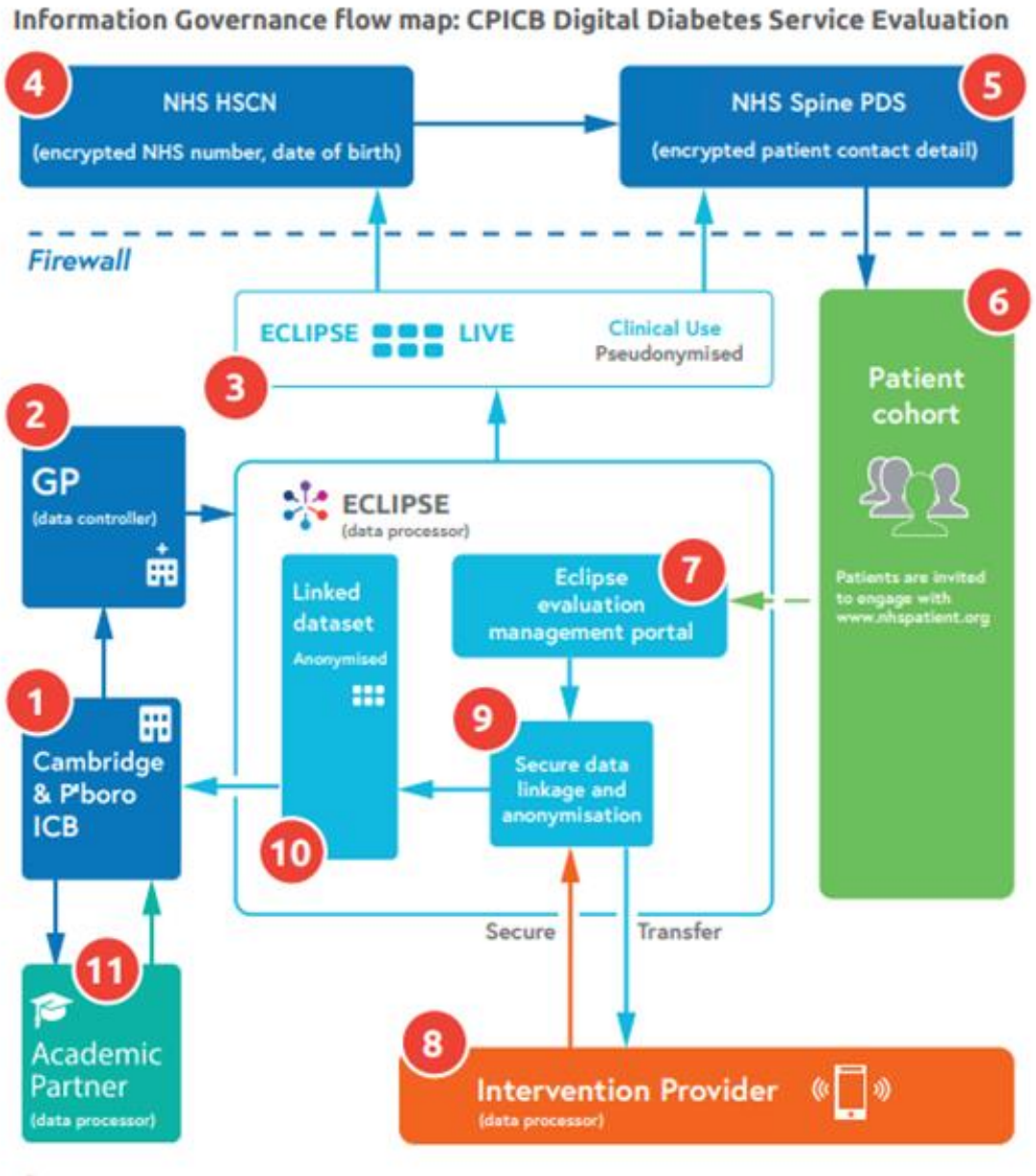
2000 ‘licences’ available.

>5000 patients have had their 1st SMS.

So far 14% of those offered & have signed up!

90% of these have completed the questionnaire assessing wellbeing, their knowledge, skills & attitude towards self-care and diabetes.

Formal review – Uni of Cambridge at 6m & 12m



8CP Achievement by Practice - <20% March 23

Those practices with 8CP lowest quartile as recorded on Eclipse in March 2023 and those who had 3TT achievement of <22% will have a virtual ‘visit’ to discuss any specific challenges they are experiencing and the options of support available.

These supportive visits are also available on request to all other practices.

The intention is that these visits are scheduled as soon as practically possible.

	Practices that appear on both lists
1	Botolph Bridge Community Health Centre
2	Great Staughton Surgery
3	Jenner Healthcare
4	Nene Valley and Hodgson Medical Practice
5	North Brink Practice
6	Orchard Surgery
7	Park Medical Centre
8	Parson Drove Surgery
9	Riverport Medical Practice
10	Roysia Surgery
11	Waterbeach Surgery
12	Willingham Medical Practice
13	Willow Tree Surgery

These are the practices we will be reaching out to – supportive visits to share learning from working with Early Adopters
&
Early Implementers

The highlighted practices are Malling Health & have already scheduled appointment.

PRACTICE STRUCTURES

National Diabetes Audit	1. Continue practice participation
Practice or PCN Diabetes Lead	1. Depending on size of Diabetes population, practices may decide to have individual named practice leads and/or PCN **Diabetes Lead** 2. Practice or PCN Diabetes Lead to attend **two 2-hour ICS-wide Diabetes meetings** and cascade key messages to their respective Practice Diabetes Leads. Meetings dates to be circulated in due course. These sessions will be available as a recording, however attendance at practice/PCN level is mandatory. 3. Practice or PCN Diabetes Lead is **responsible for disseminating information** from ICB to local clinicians 4. Practice or PCN Diabetes Lead to **support staff to be competent** to fulfil their particular role in Diabetes care and Management. 5. Practice or PCN Diabetes Lead will **inform ICB of their Diabetes - accredited staff at year end**.
Engage in Virtual Clinic Reviews with your named Endocrine Consultant	These are now ***optional*** and remain good opportunities to support the care and management of targeted patients. The aim is to bring a few patients, or themes, to discuss as an MDT with the Endocrinologist, Dietician & DSN – both for personal CPD and improved care of patients. Virtual Clinic Reviews - can be held at either Practice or PCN level depending on number of patients with diabetes. There should be practice representation at any PCN level meeting to ensure agreed clinical action is taken and learning disseminated.

VCR's

A VCR brings the benefits of a specialist Diabetes Multi-disciplinary team (MDT) to you via telephone or video conferencing.
The MDT consists of Consultant Diabetologist, Diabetes Specialist Nurse and a Diabetes Specialist Dietician.

The MDT can support you with the following –

- Management of specific individuals and complex cases from your Practice
- How to support your patients living with Diabetes to manage their own condition
- Upskilling and developing yourself and/or colleagues by discussing best practice and the various treatment options.
- Understanding the wide range of community and specialist services available to your patients
- A combination of the above.

We recommend booking VCR's on a regular basis to help you with the ongoing management of your caseload and to stay up to date with the latest treatments and best practice.

North - How do I book a VCR

1. Please send all VCR requests through to – cpicb.communityltc@nhs.net

The following information is required -

- GP Surgery
- Contact Name and Number
- Preferred date & time slot

2. Requests will be confirmed upon receipt of an MS Teams Invitation.

Should your preferred time slot be unavailable, the team will advise as to alternatives.

Current Availability

Diabetologist	Availability
Dr Ashwini Swamy	Tuesdays 1-3pm
Dr Sidrah Khan	Tuesdays 3-5pm

***Note** - Updated Consultant Availability will be sent out to all Practices on a quarterly basis.*

South - How do I book a VCR

VCR's with Dr Latika Sibal

Usually 1st and 2nd Tues PM Month
Or 1st and 2nd Weds AM Month

To organise please contact : DiabetesVCRs@cpft.nhs.uk

Any topic of your choice..

REPORTING

The following information will be monitored by the ICB:

Achievement for the majority of indicators will be monitored remotely via ECLIPSE. There is no requirement to submit information to the ICB.

The following information will be extracted remotely by our Primary Care Information Team:

1. The number of patients on the Non-Diabetic Hyperglycaemia (NDH) register – baseline & year end
2. The number of patients on the Obesity register - baseline & year end

Cambridgeshire & Peterborough
Integrated Care System

Metformin & B12

Metformin & B12

Metformin and reduced vitamin B12 levels: new advice for monitoring patients at risk

- Decreased vitamin B12 levels, or vitamin B12 deficiency, is now considered to be a common side effect in patients on metformin treatment, especially in those receiving a higher dose or longer treatment duration and in those with existing risk factors.

- Therefore the advise is to check vitamin B12 serum levels in patients being treated with metformin who have symptoms suggestive of vitamin B12 deficiency. It is also advised that periodic monitoring for patients with risk factors for vitamin B12 deficiency should be considered.

Metformin and reduced vitamin B12 levels: new advice for monitoring patients at risk - GOV.UK (www.gov.uk)

Cambridgeshire & Peterborough
Integrated Care System

Very Low Calorie Diet

Recruitment

Total number of patients invited to participate:

1020

- Patients were identified through SystmOne searches in the participating practices using the following criteria:
  - Type 2 Diabetes diagnosis within <6 years
  - BMI between 27-45 kg/m2
  - HbA1c>47 mmol/mol, or 43 mmol/mol if on oral diabetes medications.

Number of patients who responded to invitation:

213

- If patients registered an interest they were referred to the programme and contacted to provide further information and undertake screening if appropriate.

Number of patients who were eligible and agreed to participate:

72

- This represents 7.1% of the population who were identified as eligible.

Key Findings

- Diabetes Remission

	TDR (n=50)	FRI (n=35)	WM (n=10)
Remission achieved (n)	24 (48%)	18 (51%)	4 (40%)

- Reduced HbA1c

	TDR (n=50)	FRI (n=35)	WM (n=10)
Reduction in HbA1c mmol/mol	11.9	13.2	5.8

- Reduced weight

	TDR (n=50)	FRI (n=35)	WM (n=10)
Weight reduction (kg)	10.9	11.6	9.9

- Number of people who achieved 15kg weight loss

	TDR (n=50)	FRI (n=35)	WM (n=10)
Achieved 15 kg weight loss n	11 (22%)	8 (23%)	2 (20%)

I couldn’t be happier. The programme for me has been easy to follow and I feel better than I have for years. To be able to say that my diabetes is in remission is amazing and I feel optimistic that I can keep it this way.

Mr A: Lost 17 kg, reduced HbA1c by 58 mmol/mol and achieved diabetes remission

Thank you so much, I am now no longer on diabetes or blood pressure medications. I found the programme difficult at times, but the results just show that it is worth it.

Mrs B: Lost 26 kg, reduced HbA1c by 34 mmol/mol and achieved diabetes remission

- On an individual basis, for some the programme was life changing.
- But high drop out rate.
- A future programme would do well to identify patients most likely to succeed, and also have robust structure in place to aid patient engagement.

Cambridgeshire & Peterborough
Integrated Care System

T2DR (formally LCD) Programme - OVIVA

Karen Miller

Oviva

The NHS Type 2 Diabetes Pathway to Remision Programme (formally LCD) delivered by Oviva

May 2023

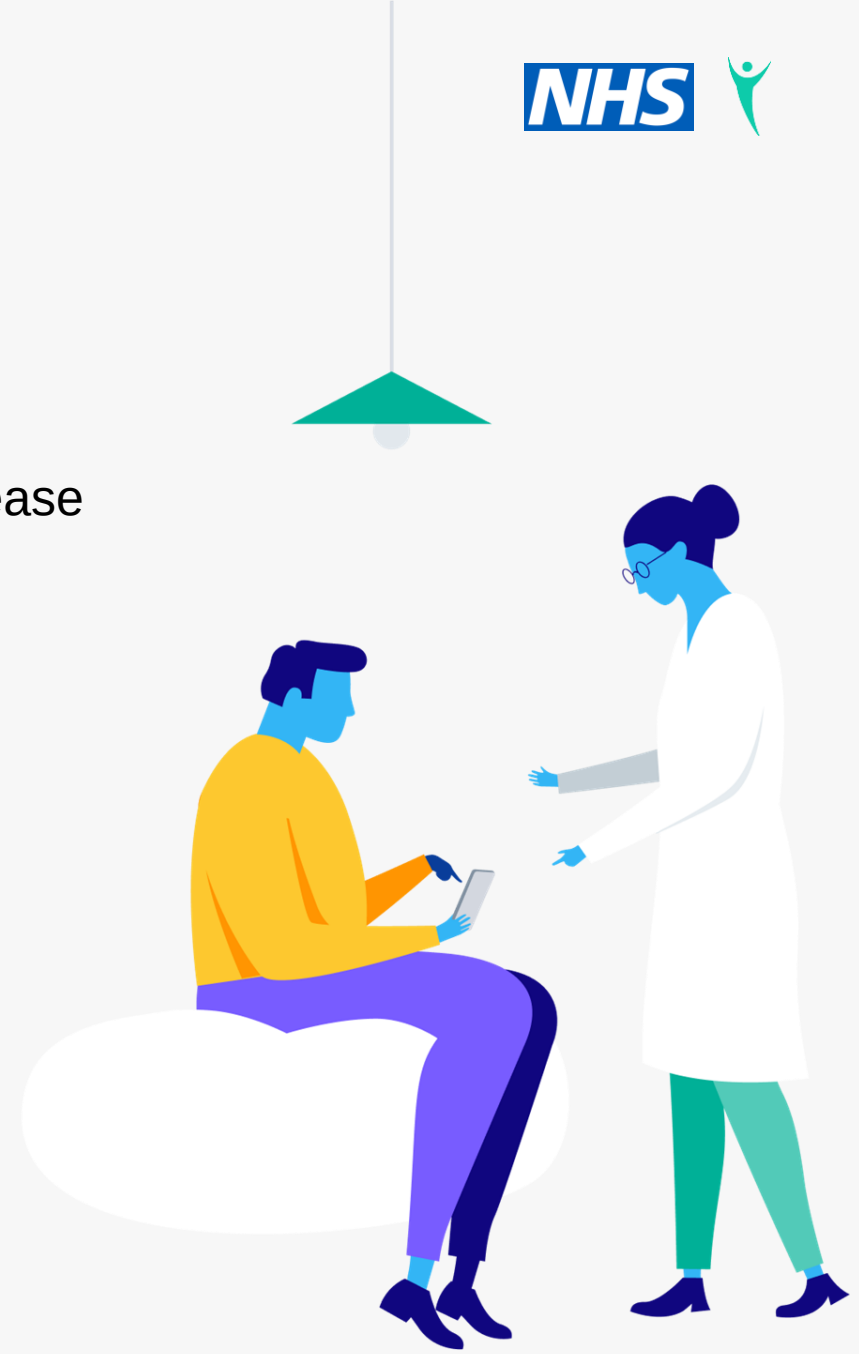
The NHS T2DR (formally LCD) Programme

The NHS T2DR provided by Oviva is a type 2 diabetes behaviour change programme.

Our diabetes clinicians help people with type 2 diabetes lose weight, increase physical activity and reduce their medication needs.

The programme aims for participants to achieve:

- Significant weight loss (15kg)
- Improvement in HbA1c
- Reduction in medication needs
- Potential for diabetes remission



"This programme has been life changing. I have lost 5 stone, and no longer am on any medication. I now have so much more energy and confidence!"

Larry, NHS Low Calorie Diet Programme participant

About Oviva

Oviva is a digitally-enabled behaviour change provider. Our team of specialist healthcare professionals combined with our unique digital tools support people to improve their health and better self-manage their conditions.

We partner with NHS to offer 7 proven digital behaviour change programmes covering prediabetes, type 2 diabetes, tier 2 and 3 obesity and adult and paediatric nutrition.

Oviva offer:

- ✓ Superior accessibility, patient engagement and retention compared to face-to-face care alone, especially in harder to reach groups such as ethnic minorities, men, working age.
- ✓ At least equivalent clinical outcomes at significantly lower per patient delivery costs compared to face-to-face services.
- ✓ 97% of our participants would recommend our services

The NHS Low Calorie Diet Participant Journey

Patient referral

Oviva receive the patient referral from GP.

Oviva Start

Oviva processes referral form and a Patient Pathway Coordinator will contact programme participant to complete their initial assessment.

Oviva Change

Participants receive support from a clinician during 12 weeks of a total diet replacement diet, followed by six weeks of gradual and tailored food reintroduction.

They will receive an extended first session to set goals and develop a personalised health care plan.

Oviva Sustain

Support from a clinician to establish new healthy habits to sustain weight loss and manage their diabetes. If participant gains weight, they can complete refocus with additional appointments with their clinician.

End of Programme

Final support with a clinician at 12 months. Participants can continue to self-track activities and use the Oviva Learn resources to embed new habits.

The NHS T2DR Programme

Referral information

Inclusion criteria

- Minimum age of 18 and maximum age of 65 years old
- Minimum BMI of 27kg/m² (25kg/m2 in people of ethnic minority origin).
- Duration of Type 2 Diabetes: Diagnosed with within the last 6 years
- HbA1c eligibility, most recent value, which must be within 12 months:
  - Medication, HbA1c 43-87 mmol/mol
  - No medication, HbA1c 48-87 mmol/mol
- Patients must have attended for monitoring and diabetes review when last offered, including retinal screening, and must commit to continuing even if remission is achieved.

Exclusion criteria

- Current insulin use
- Pregnant, planning pregnancy within 6 months, breastfeeding
- Significant physical comorbidities such as active cancer, heart attack/stroke, severe heart failure
- Other less obvious exclusions are, active substance use disorder, active eating disorder, porphyria, untreated proliferative retinopathy
- The patient has been discharged from the programme in the last 12 months
- Health professional assessment that the person is unable to understand or meet the demands of the treatment programme and/or monitoring requirements.

How GP practices can refer patients onto the programme

Step 1

Identify eligible patients

Run the search or use the consultation checklist to check the patient is eligible

Step 2

Invite eligible patients to express interest in the programme and complete referral form

Give patients a copy of the flyer provided by Oviva

Step 3

Confirm the patient's suitability and motivation

Use the FAQs to answer questions about the programme

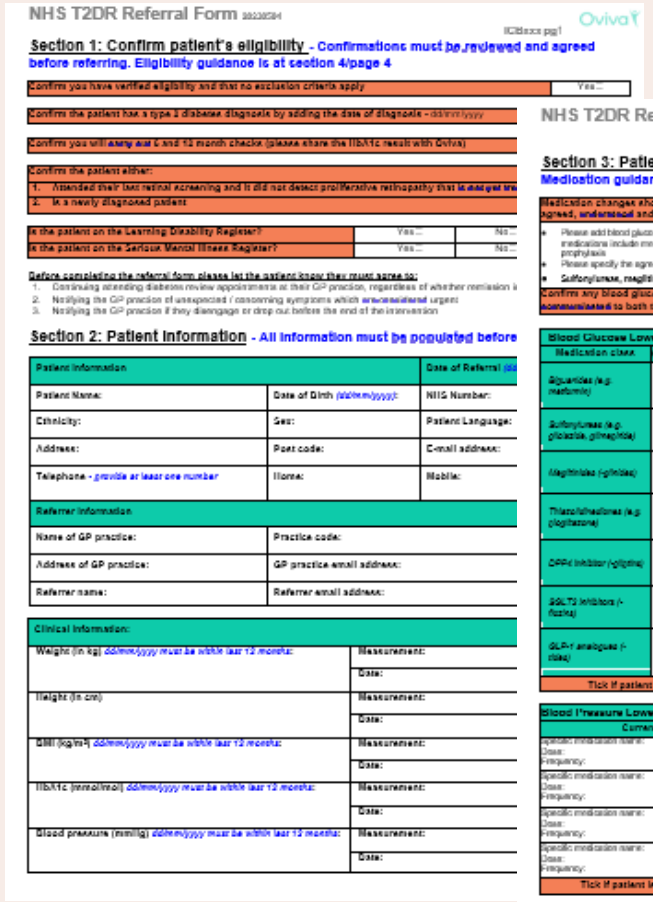
Step 4

Discuss and agree required medication adjustments with the patient

Read the 'Required Medication adjustments' section on the referral form

Ensure the referral form is fully complete before sending it to ovivauk.T2DR@nhs.net

Referral Form



NHS T2DR Referral Form

Section 1: Confirm patient's eligibility - Confirmations must be reviewed and agreed before referring. Eligibility guidance is at section 4/page 4

Confirm you have verified eligibility and that no exclusion criteria apply — Yes

Confirm the patient has a type 2 diabetes diagnosis by adding the date of diagnosis - dd/mm/yyyy

Confirm you will carry out 6 and 12 month checks (please share the HbA1c result with Oviva)

Confirm the patient either:

1. Attended their last retinal screening and it did not detect proliferative retinopathy that is managed via
2. Is a newly diagnosed patient

Is the patient on the Learning Disability Register?	Yes	No
Is the patient on the Serious Mental Illness Register?	Yes	No

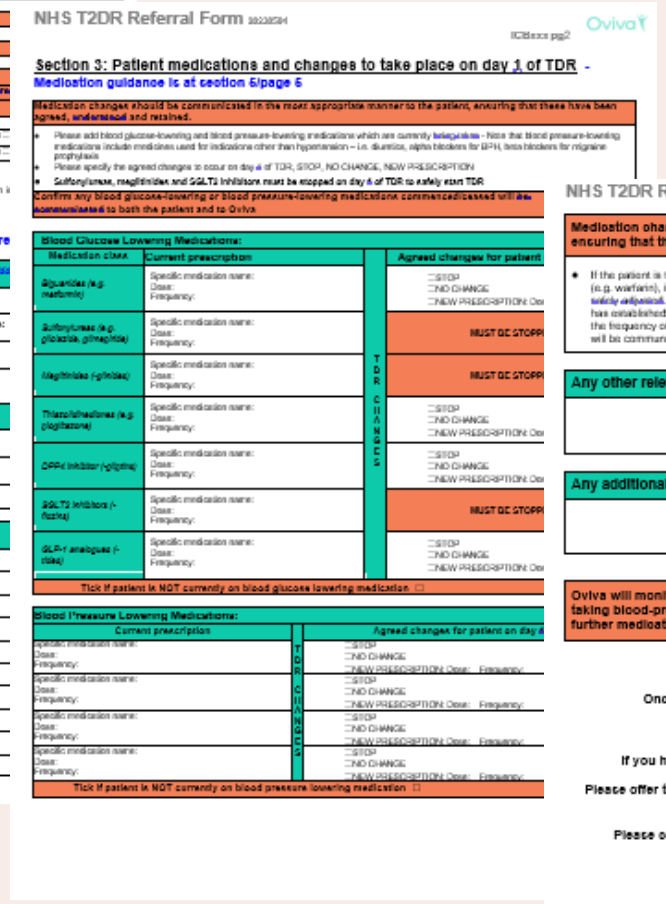
Before completing the referral form please let the patient know they must agree to:

1. Continuing attending diabetes review appointments at their GP practice, regardless of whether remission is
2. Notifying the GP practice of unexpected / concerning symptoms which are considered urgent
3. Notifying the GP practice if they disengage or drop out before the end of the intervention

Section 2: Patient Information - All information must be populated before

Patient Information		Date of Referral (dd/mm/yyyy):
Patient Name:	Date of Birth (dd/mm/yyyy):	NHS Number:
Ethnicity:	Sex:	Patient Language:
Address:	Post code:	E-mail address:
Telephone - provide at least one number	Home:	Mobile:
Referrer Information		
Name of GP practice:	Practice code:	
Address of GP practice:	GP practice email address:	
Referrer name:	Referrer email address:	

Clinical Information:	
Weight (in kg) dd/mm/yyyy must be within last 12 months:	Measurement: Date:
Height (in cm)	Measurement: Date:
BMI (kg/m²) dd/mm/yyyy must be within last 12 months:	Measurement: Date:
HbA1c (mmol/mol) dd/mm/yyyy must be within last 12 months:	Measurement: Date:
Blood pressure (mmHg) dd/mm/yyyy must be within last 12 months:	Measurement: Date:



NHS T2DR Referral Form

Section 3: Patient medications and changes to take place on day 1 of TDR - Medication guidance is at section 5/page 5

Medication changes should be communicated in the most appropriate manner to the patient, ensuring that these have been agreed, understood and retained.

- Please add blood glucose-lowering and blood pressure-lowering medications which are currently being taken - Note that blood pressure-lowering medications include medicines used for indications other than hypertension – i.e. diuretics, alpha blockers for BPH, beta blockers for migraine prophylaxis
- Please specify the agreed changes to occur on day 1 of TDR; STOP, NO CHANGE, NEW PRESCRIPTION
- Sulfonylureas, meglitinides and SGLT2 inhibitors must be stopped on day 1 of TDR to safely start TDR

Confirm any blood glucose-lowering or blood pressure-lowering medications commenced/ceased will be communicated to both the patient and to Oviva

Blood Glucose Lowering Medications:

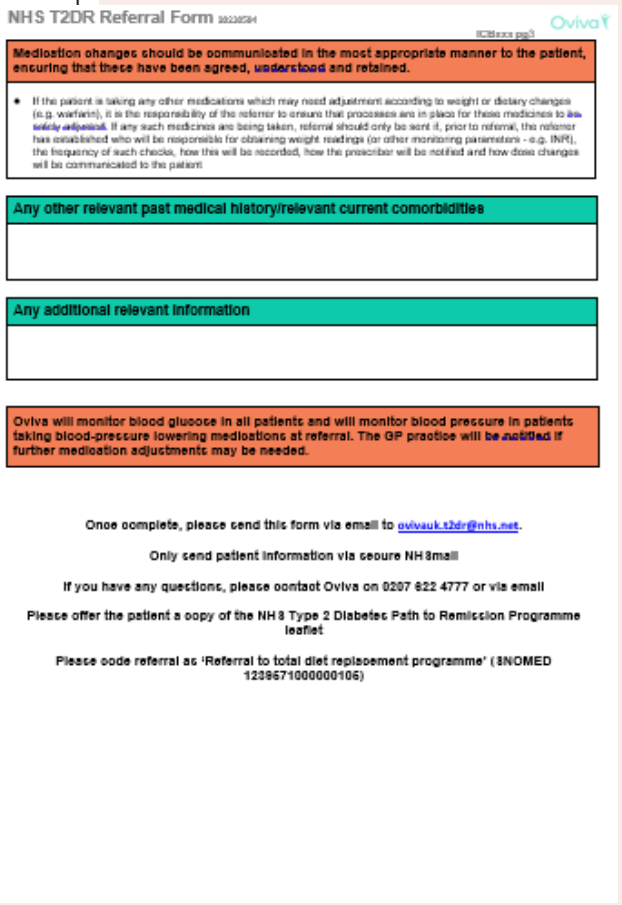
Medication class	Current prescription	TDR CHANGES	Agreed changes for patient
Biguanides (e.g. metformin)	Specific medication name: Dose: Frequency:		☐STOP ☐NO CHANGE ☐NEW PRESCRIPTION: Dose:
Sulfonylureas (e.g. gliclazide, glimepiride)	Specific medication name: Dose: Frequency:		MUST BE STOPPED
Meglitinides (-glinides)	Specific medication name: Dose: Frequency:		MUST BE STOPPED
Thiazolidinediones (e.g. pioglitazone)	Specific medication name: Dose: Frequency:		☐STOP ☐NO CHANGE ☐NEW PRESCRIPTION: Dose:
DPP4 inhibitor (-gliptins)	Specific medication name: Dose: Frequency:		☐STOP ☐NO CHANGE ☐NEW PRESCRIPTION: Dose:
SGLT2 inhibitors (-flozins)	Specific medication name: Dose: Frequency:		MUST BE STOPPED
GLP-1 analogues (-tides)	Specific medication name: Dose: Frequency:		☐STOP ☐NO CHANGE ☐NEW PRESCRIPTION: Dose:

Tick if patient is NOT currently on blood glucose lowering medication ☐

Blood Pressure Lowering Medications:

Current prescription	TDR CHANGES	Agreed changes for patient on day 1
Specific medication name: Dose: Frequency:		☐STOP ☐NO CHANGE ☐NEW PRESCRIPTION: Dose: Frequency:
Specific medication name: Dose: Frequency:		☐STOP ☐NO CHANGE ☐NEW PRESCRIPTION: Dose: Frequency:
Specific medication name: Dose: Frequency:		☐STOP ☐NO CHANGE ☐NEW PRESCRIPTION: Dose: Frequency:
Specific medication name: Dose: Frequency:		☐STOP ☐NO CHANGE ☐NEW PRESCRIPTION: Dose: Frequency:

Tick if patient is NOT currently on blood pressure lowering medication ☐



NHS T2DR Referral Form

Medication changes should be communicated in the most appropriate manner to the patient, ensuring that these have been agreed, understood and retained.

- If the patient is taking any other medications which may need adjustment according to weight or dietary changes (e.g. warfarin), it is the responsibility of the referrer to ensure that processes are in place for these medicines to be safely adjusted. If any such medicines are being taken, referral should only be sent if, prior to referral, the referrer has established who will be responsible for obtaining weight readings (or other monitoring parameters - e.g. INR), the frequency of such checks, how this will be recorded, how the prescriber will be notified and how dose changes will be communicated to the patient

Any other relevant past medical history/relevant current comorbidities

Any additional relevant information

Oviva will monitor blood glucose in all patients and will monitor blood pressure in patients taking blood-pressure lowering medications at referral. The GP practice will be notified if further medication adjustments may be needed.

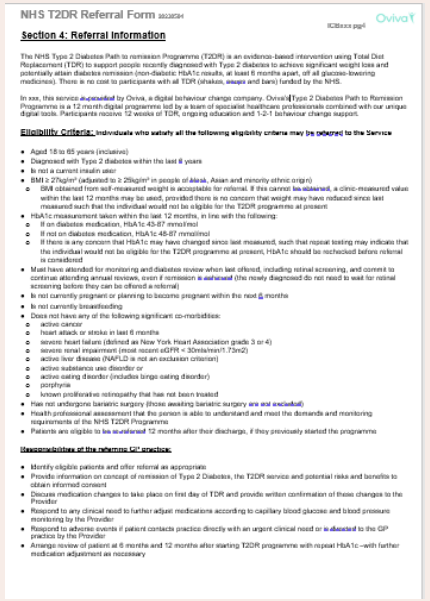
Once complete, please send this form via email to oviva.uk.t2dr@nhs.net.

Only send patient information via secure NHSmail

If you have any questions, please contact Oviva on 0207 822 4777 or via email

Please offer the patient a copy of the NHS Type 2 Diabetes Path to Remission Programme leaflet

Please code referral as 'Referral to total diet replacement programme' (SNOMED 1239671000000105)



NHS T2DR Referral Form

Section 4: Referral Information

The NHS Type 2 Diabetes Path to remission Programme (T2DR) is an evidence-based intervention using Total Diet Replacement (TDR) to support people recently diagnosed with Type 2 diabetes to achieve significant weight loss and potentially attain diabetes remission (non-diabetic HbA1c results, at least 6 months apart, off all glucose-lowering medicines). There is no cost to participants with all TDR (shakes, soups and bars) funded by the NHS.

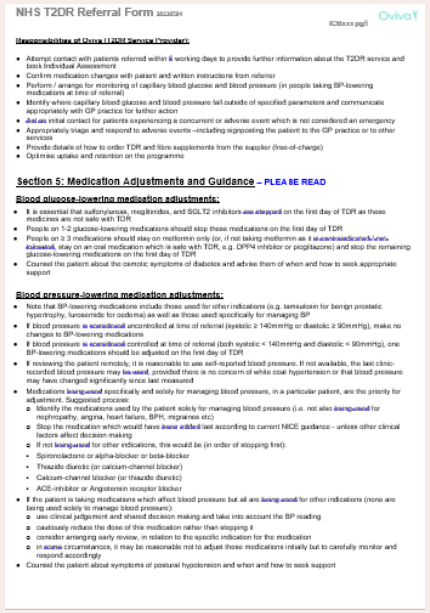
In xxx, this service is provided by Oviva, a digital behaviour change company. Oviva's Type 2 Diabetes Path to Remission Programme is a 12 month digital programme led by a team of specialist healthcare professionals combined with our unique digital tools. Participants receive 12 weeks of TDR, ongoing education and 1-2-1 behaviour change support.

Eligibility Criteria: Individuals who satisfy all the following eligibility criteria may be referred to the Service

- Aged 18 to 65 years (inclusive)
- Diagnosed with Type 2 diabetes within the last 6 years
- Is not a current insulin user
- BMI ≥ 27kg/m² (adjusted to ≥ 25kg/m² in people of Asian and minority ethnic origin)
  - BMI obtained from self-measured weight is acceptable for referral. If this cannot be obtained, a clinic-measured value within the last 12 months may be used, provided there is no concern that weight may have reduced since last measured such that the individual would not be eligible for the T2DR programme at present
- HbA1c measurement taken within the last 12 months, in line with the following:
  - If on diabetes medication, HbA1c 43-87 mmol/mol
  - If not on diabetes medication, HbA1c 48-87 mmol/mol
  - If there is any concern that HbA1c may have changed since last measured, such that repeat testing may indicate that the individual would not be eligible for the T2DR programme at present, HbA1c should be rechecked before referral is considered
- Must have attended for monitoring and diabetes review when last offered, including retinal screening, and commit to continue attending annual reviews, even if remission is achieved (the newly diagnosed do not need to wait for retinal screening before they can be offered a referral)
- Is not currently pregnant or planning to become pregnant within the next 6 months
- Is not currently breastfeeding
- Does not have any of the following significant co-morbidities:
  - active cancer
  - heart attack or stroke in last 6 months
  - severe heart failure (defined as New York Heart Association grade 3 or 4)
  - severe renal impairment (most recent eGFR < 30mL/min/1.73m2)
  - active liver disease (NAFLD is not an exclusion criterion)
  - active substance use disorder or
  - active eating disorder (includes binge eating disorder)
  - porphyria
  - known proliferative retinopathy that has not been treated
- Has not undergone bariatric surgery (those awaiting bariatric surgery are not excluded)
- Health professional assessment that the person is able to understand and meet the demands and monitoring requirements of the NHS T2DR Programme
- Patients are eligible to be re-referred 12 months after their discharge, if they previously started the programme

Responsibilities of the referring GP practice:

- Identify eligible patients and offer referral as appropriate
- Provide information on concept of remission of Type 2 Diabetes, the T2DR service and potential risks and benefits to obtain informed consent
- Discuss medication changes to take place on first day of TDR and provide written confirmation of these changes to the Provider
- Respond to any clinical need to further adjust medications according to capillary blood glucose and blood pressure monitoring by the Provider
- Respond to adverse events if patient contacts practice directly with an urgent clinical need or is directed to the GP practice by the Provider
- Arrange review of patient at 6 months and 12 months after starting T2DR programme with repeat HbA1c –with further medication adjustment as necessary



NHS T2DR Referral Form

Responsibilities of Oviva (T2DR Service Provider):

- Attempt contact with patients referred within 5 working days to provide further information about the T2DR service and book Individual Assessment
- Confirm medication changes with patient and written instructions from referrer
- Perform / arrange for monitoring of capillary blood glucose and blood pressure (in people taking BP-lowering medications at time of referral)
- Identify where capillary blood glucose and blood pressure fall outside of specified parameters and communicate appropriately with GP practice for further action
- Act as initial contact for patients experiencing a concurrent or adverse event which is not considered an emergency
- Appropriately triage and respond to adverse events –including signposting the patient to the GP practice or to other services
- Provide details of how to order TDR and fibre supplements from the supplier (free-of-charge)
- Optimise uptake and retention on the programme

Section 5: Medication Adjustments and Guidance – PLEA BE READ

Blood glucose-lowering medication adjustments:

- It is essential that sulfonylureas, meglitinides, and SGLT2 inhibitors are stopped on the first day of TDR as these medicines are not safe with TDR
- People on 1-2 glucose-lowering medications should stop these medications on the first day of TDR
- People on ≥ 3 medications should stay on metformin only (or, if not taking metformin as it is contraindicated/not tolerated, stay on an oral medication which is safe with TDR, e.g. DPP4 inhibitor or pioglitazone) and stop the remaining glucose-lowering medications on the first day of TDR
- Counsel the patient about the osmotic symptoms of diabetes and advise them of when and how to seek appropriate support

Blood pressure-lowering medication adjustments:

- Note that BP-lowering medications include those used for other indications (e.g. tamsulosin for benign prostatic hypertrophy, furosemide for oedema) as well as those used specifically for managing BP
- If blood pressure is occasional uncontrolled at time of referral (systolic ≥ 140mmHg or diastolic ≥ 90mmHg), make no changes to BP-lowering medications
- If blood pressure is occasional controlled at time of referral (both systolic < 140mmHg and diastolic < 90mmHg), one BP-lowering medications should be adjusted on the first day of TDR
- If reviewing the patient remotely, it is reasonable to use self-reported blood pressure. If not available, the last clinic-recorded blood pressure may be used, provided there is no concern of white coat hypertension or that blood pressure may have changed significantly since last measured
- Medications being used specifically and solely for managing blood pressure, in a particular patient, are the priority for adjustment. Suggested process:
  - Identify the medications used by the patient solely for managing blood pressure (i.e. not also being used for nephropathy, angina, heart failure, BPH, migraines etc)
  - Stop the medication which would have been added last according to current NICE guidance - unless other clinical factors affect decision making
  - If not being used for other indications, this would be (in order of stopping first):
    - Spironolactone or alpha-blocker or beta-blocker
    - Thiazide diuretic (or calcium-channel blocker)
    - Calcium-channel blocker (or thiazide diuretic)
    - ACE-inhibitor or Angiotensin receptor blocker
- If the patient is taking medications which affect blood pressure but all are being used for other indications (none are being used solely to manage blood pressure):
  - use clinical judgement and shared decision making and take into account the BP reading
  - cautiously reduce the dose of this medication rather than stopping it
  - consider arranging early review, in relation to the specific indication for the medication
  - in some circumstances, it may be reasonable not to adjust these medications initially but to carefully monitor and respond accordingly
- Counsel the patient about symptoms of postural hypotension and when and how to seek support

T2DR provider role supporting patients

- Attempt contact with patients referred within 5 working days to provide further information about the service and arrange an Individual Assessment
- Confirm medication changes with patient from the referrer instructions
- Perform/arrange for monitoring of capillary blood glucose and blood pressure and weight
- Identify where capillary blood glucose and blood pressure fall outside of specified parameters and communicate appropriately with GP practice for further action
- Initial contact for patients experiencing a concurrent or adverse event which is not considered an emergency
- Appropriate triage and respond to adverse events - including signposting the patient to the GP practice or to other services.
- Provide information on ordering the free fibre supplements and ongoing supply as necessary
- Optimise uptake and retention on the programme

GP role in supporting patients

The Oviva Medications and Monitoring protocol outlines the role, responsibilities and guidance for Oviva delivery staff and primary care colleagues.

Primary care responsibilities are as follows:

1. To ensure all relevant staff at the practice have **read and understood the protocol** before referring patients
2. To ensure patients who are referred are **eligible** (as per criteria) and informed (T2DR is not for everyone)
3. Carry out **6 and 12 month reviews** to measure HbA1c and review medications, and share the results with Oviva
4. To make telephone calls/**appointments available within 2 weeks** of request to review patient case and change medications in case of an adverse event
5. Establish a **clear channel of communication** via NHSmail

Thank you!

Please contact ovivauk.T2DR@nhs.net if you have any questions

Switzerland

Headquarter
Oviva AG
Zürcherstrasse 64
8852 Altendorf

Additional location
Oviva AG
Sihlstrasse 37
8001 Zürich

Germany

Headquarter
Oviva AG
Dortustrasse 48
14467 Potsdam

Additional location
Oviva AG
Büro Berlin
TBD

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Headquarter
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71 rue Desnouettes
75015 Paris

UK

Headquarter
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Runway East
20 St Thomas Street
London, SE1 9RS

Additional location
Oviva Ltd.
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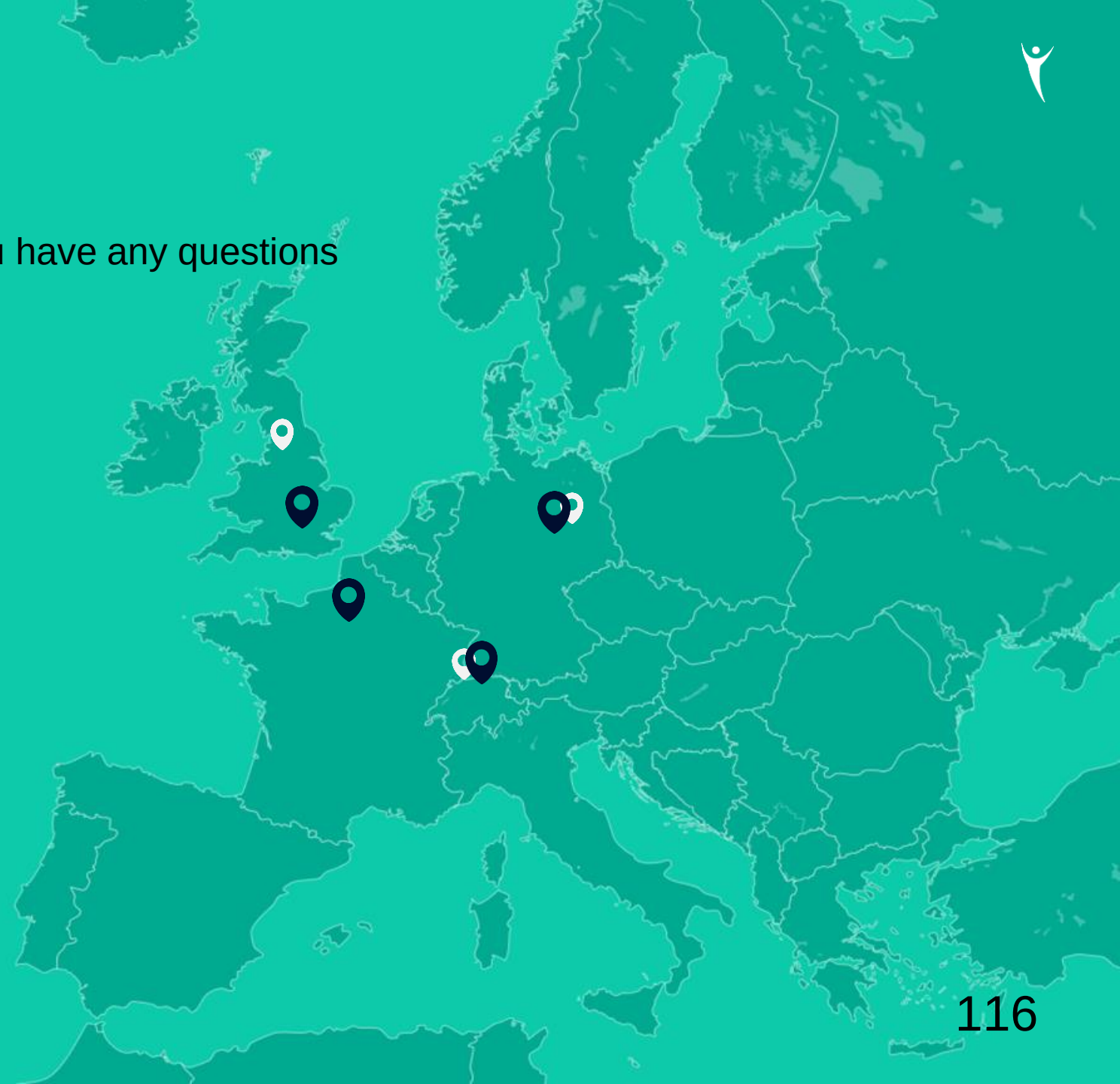
Leeds, LS1 2RY



Cambridgeshire & Peterborough
Integrated Care System

Close

Date of next meeting:

Wednesday 13th September 2023 - 1pm-3pm