

Diabetes Risk Stratification and Support tool guide

A Primary Care Review

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Background

This guide is to offer recommendations to support practices and the Primary Care Networks to prioritise, risk stratify and manage diabetes patients following the impact of COVID19. The reintroduction of QOF measurements in April 2022 will therefore require further intervention for people living with diabetes within primary care.

COVID19 impact led to a significant decrease in diabetes 8 care process delivery and in the number of people with diabetes meeting NICE recommended treatment targets in 2020/21 when compared with 2019/20. The latest available data (September 2021) shows that there is still a significant gap. Care process delivery is associated with reduced mortality, emergency admissions amputations and diabetic retinopathy. The ONS has reported significant increases in non-COVID19 related deaths in England since July 2021. This data shows a significant excess in those living with diabetes.

Given this potential for significant impact on population health outcomes, and as set out in national planning guidance for 2022/23, systems are asked to restore the identification, monitoring and management of diabetes to pre-pandemic levels, prioritising those at greatest risk of deterioration or complications. Systems should refer to National Diabetes Audit data and explain what action will be taken and how they will aim to ensure equitable recovery, given that the greatest decreases in routine reviews were in areas of greatest deprivation. Data Hub which includes a recovery dashboard, shows the extent of the decline of care process delivery during COVID19 and risk stratification dashboard which shows the extent to which those that did not previously meet the treatment targets are being prioritised for care process delivery.

Following the reintroduction of the QOF measurement in April 2022, systems should aim to restore diabetes identification and routine management to pre-pandemic levels, to support more people to meet NICE recommended treatment targets. This means increasing the number of people with diabetes receiving the 8 care processes - HbA1C, blood pressure, cholesterol, serum creatinine, urine albumin, foot surveillance, BMI and smoking.

This guide will outline the benefits and challenges of the use of suggested Risk Stratification search tools and support primary care in optimising Diabetes care delivery resulting in improved patient outcomes.

Risk Stratification Tools – Quick Reference Guide

Tool Description	Feature	Primary Care (Practice or PCN)	Free	Compatible with SystemOne	Compatible with EMIS	Compatible with Vision	Suitable for virtual MDT Clinics	Achieve 3 Treatment Targets	Support
Affinity Partnership 'Risk Searches'	'Low risk' cohort stratification	Practice & PCN	✓	✓			✓		User guide coming soon
GRASP – DM	Visual dashboard – ASCVD medication Pw	Practice	✓	✓	✓			✓	IT installation support
PARM Diabetes	Therapeutics focused stratification	Practice and PCN (partially)	✓	✓	✓	✓	✓	✓	Installation user guide with examples
RDCP	Multi-device connectivity and AGPs	Practice & PCN	✓	✓	✓		Partially		User manual
UCL	Focus on 'high risk' cohort (Covid 19 deterioration)	Practice & PCN	✓	✓	✓				User guide

Affinity partnership 'risk searches'

This search stratifies patients into simplified cohorts based on HbA1c levels, type of treatment therapies (oral vs GLP-1RAs vs insulin) and number of medications. It particularly focuses on the 'low risk' grouping and allows practices and PCNs to utilise the wider primary care workforce and additional roles to support and manage this cohort, thus creating much needed capacity within the primary care diabetes teams. Locally, it is integrated with simple, easy to follow diabetes treatment pathways.

Key features

- Stratification search focuses on the 'low risk' cohort to identify areas of sub-optimal diabetes management
- Guidance and suggestions on matching patient care to the expanded primary care workforce (pharmacists, physician associates, practice nurses and skilled diabetes HCPs)
- Quick and easy searches that run on the primary care clinical system(SystemOne)
- Searches can be ran by DQ teams and blended into bespoke clinical processes and pathways for primary care
- Conceptual similarity and overlap with PARM Diabetes tool
- A separate search works as a case finder – Helping to identify patients with a missing diagnosis of diabetes and allows the practice to determine a more accurate prevalence rate

Challenges

- Limited functionality - doesn't focus on 'high risk' cohorts, complex co-morbidities or risk of progression of diabetes complications
- Not suitable for virtual MDT clinic reviews

Integration with clinical systems

Searches can be easily run on SystemOne and take a few minutes
No patient data needs to leave the practice for you to use the tool

Highlights

Free, simple and easy to use searches on SystemOne
Support guide in development for the 'actionable cohorts' - exploring roles and expertise of primary care team and matching this to patient needs/complexity

Contact

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<https://affinitycare.nhs.uk/>

GRASP-DM

GRASP-DM has been designed to help practices to optimise the management and care of patients with diabetes and reduce the risk of developing associated complications. The tool assists case finding activity, encouraging practices to establish a more accurate prevalence rate, as well as assisting them to interrogate their clinical data and optimise care in keeping with novel therapeutic agents (SGLT2i and GLP-1RAs).

Key features

- Highly visual practice-level summary in the form of a dashboard as well as allowing practices to drill down to examine detailed patient care at an individual level
- Audits patient care against current best practice guidelines for diabetes management (NG28, 2015)
- Reports on achievements of care processes and 3TTs identifying 'work to do'
- Multiple data views - ASCVD dashboard, medication pathway and tabular summaries
- Highlights areas of sub-optimal care delivery and safety point of view with advice and actions included from the BNF. This is a really useful feature
- Helps to identify patients with a missing diagnosis of diabetes and allows practices to determine a more accurate prevalence rate
- Case finder function - identify missing diagnosis, sub-optimal management, CVD risk or safety point of view (metformin and low eGFR)
- Focus on key co-morbidities - patients with diabetes and ASCVD

Challenges

- Time consuming to set-up and run on SystmOne and often requires remote IT support for installation of the CHART software tool. It often takes up to 30mins to re-load or refresh the CHART tool with current data so feels slow to navigate the dashboard
- The visual practice-level summary dashboard is excellent but the other tabular summaries (medication pathways, ASCVD, care processes etc) are clunky and not the best user experience
- Needs updating and alignment to new NICE guidance (NG17,18 and 28)
- Not suitable for virtual MDT clinic reviews

[grasp-dm-quickguide-2022-v-1.3-.pdf \(nottingham.ac.uk\)](#)

Integration with clinical systems

Tool is compatible with the EMIS and SystmOne clinical systems
No patient data needs to leave the practice for you to use the tool

Highlights

Free, easy to use tool with multiple functions to support QI in diabetes care - identifying missing diagnosis, auditing patient care journey, medication pathway and ASCVD tab summary (EASD/ADA)

Contact

PRIMIS Web [PRIMIS: making clinical data work \(nottingham.ac.uk\)](#)
enquiries@primis.Nottingham.ac.uk

ProActive Register Management (PARM) Diabetes

PARM Diabetes dashboard is a population health management tool which helps you understand specific cohorts across your T2D population by stratifying the risk based on simple measures like HbA1c and BP profiles, NDA (3TTs) achievements, care processes and treatment therapies.

Key features

- Practice-level patient data shows achievement of 3TTs and supports understanding of local National Diabetes Audit(NDA) data and how well patients are managing their condition - useful for diabetes reset and recovery plans
- Additional stratification based on care process measures like foot surveillance, BMI and eGFR, among others
- Supports understanding variation in local QoF data
- Identify which patients require a review or intervention by risk-stratifying large patient lists into actionable cohorts
- Helps select patients appropriate for escalation to their specialist diabetes services
- Excellent for virtual case-based reviews or MDT discussions with community diabetes teams. The practice's own PARM Diabetes tool can be saved in a shared space for the MDT diabetes team to begin identifying patients whose treatments may be optimised and working together on smaller, more manageable patient cohorts
- 'Time since last HbA1c' feature is useful for tracking when patients have last had this test done and escalating or prompting a sooner review
- Key prescribing and safety alerts - identifying patients on SU or insulin with HbA1c
- <48mmol/mol and highlighting 'hypo risks'

Challenges

- Needs a user guides and SOP to support matching and integrating actionable cohorts into primary care pathways and diabetes teams - workforce and LTC workload sustainability
- Not applicable for T1D cohort

Integration with clinical systems

Tool is compatible with the EMIS, SytmOne and Vision clinical systems
No patient data needs to leave the practice for you to use the tool

Highlights

Free, easy to use tool with clever 'bite-size' manageable cohorts to support quality improvement in diabetes care management.

Excellent tool to support virtual MDT reviews by specialist diabetes team across PCNs OR integrated care partnerships(ICPs) given the limited resources at place

Contact

Your local account manager or email PARM@lilly.com

Roche Diabetes Care Platform (RDCP)

The Roche Diabetes Care Platform (RDCP) is an innovative cloud-based diabetes management software that seamlessly connects healthcare professionals to people with diabetes, creating actionable insights to help deliver more efficient personalised care.

Key features

- Connectivity to multiple diabetes medical devices (Blood glucose meters, Insulin pumps, CGM and other apps)
- Patients can share real time diabetes data with HCPs via the the mySugr app or manual plugin via the user-friendly patient portal
- Converts key data(BGLs) into actionable insights to help HCPs identify patterns (hypo or hyperglycaemia, blood glucose fluctuations and variability) and areas that may need rapid intervention or treatment adjustment
- Less time spent by HCPs in data collection (BGLs)
- Supports analysis and decision making with easy to follow patient views/outcomes
- HCPs can share patient data easily and securely between sites offering interoperability between different areas of the healthcare system
- mySugr®; the diabetes management app for people with diabetes offers seamless connectivity to the RocheDiabetes Care Platform. It offers carb counting, glucose tracking, and bolus dose calculation estimates. It has a clean, intuitive, customisable dashboard interface and the ability to sync (Bluetooth) with your glucose monitor also set this app apart
- Dashboard allows practice, PCN or diabetes service-related population overview and risk stratification based on BG levels, hypo- and hyper-alerts and achievement of care processes

Challenges

- Less beneficial to patients on oral therapies / not requiring blood glucose testing
- Free during pilot/service evaluation but will attract a cost in future

Integration with clinical systems

Does not integrate directly with primary care clinical systems or e-HR. Patient data can be downloaded and attached to the patients e-HRs.

Highlights

Best utilised across a PCN / community / hospital service where there are sufficient number of patients on insulin therapy and you can share data securely between healthcare providers & specialist teams.

Contact

Roche key account manager (local) / Outcome specialist
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UCL Risk Stratification Tool

This search stratifies patients with T2D into priority groups based on HbA1c levels, complications, co-morbidity, social factors, and ethnicity. This grouping will allow practices to prioritise patients for follow up and to safely phase review appointments over time. Patients in the high-risk groups have greater degrees of complexity and are at higher risk of deterioration.

Key features

- Stratifies patients into 3 groupings: High, Medium and Low risk allowing HCPs to prioritise patients based on clinical needs/deterioration
- Guidance and suggestions on matching patient care to the workforce
- Quick and easy searches that are run on the primary care clinical systems. Helpful user guide also available
- Searches can be run by DQ teams and blended into bespoke clinical processes and pathways for primary care
- Brilliant at identifying patients with T2D who are at high risk of deterioration and complications of covid-19 infection

Challenges

- Limited use across an enriched CV cohort or prevalent BAME population as the tool stratifies almost ~90% of the diabetes population across a practice/PCN into high and medium risk groups
- Extremely difficult to integrate the risk tool searches into routine primary care clinical pathways and workflows especially for patients using insulin or other injectables

Integration with clinical systems

Searches can be easily run on both SystmOne and EMIS and take a few minutes
No patient data needs to leave the practice for you to use the tool

Highlights

Free, simple and easy to use searches on primary care clinical systems

Contact

UCL partners

[Search and risk stratification tools - UCLPartners](#)

UCL Risk stratification RAG Rating

High risk		Medium risk		Low risk
<p>Priority One</p> <p>Hba1c >90 OR</p> <p>Hba1c >75 WITH any of the following:</p> <ul style="list-style-type: none"> • BAME • Social complexity** • Severe frailty • Insulin or other injectables • Heart failure <p><small>** Social complexity includes Learning disability, homeless, housebound, alcohol or drug misuse</small></p>	<p>Priority Two</p> <p>Hba1c >75 OR</p> <p>Any HbA1c WITH any of the following:</p> <ul style="list-style-type: none"> • Foot ulcer in last 3 years • MI or stroke/TIA in last 12 months • Community diabetes team codes • eGFR < 45 • Metabolic syndrome <p><small>(Except patients included in Priority 1 group)</small></p>	<p>Priority Three</p> <p>Hba1c 58-75 WITH any of the following:</p> <ul style="list-style-type: none"> • BAME • Mild to moderate frailty • Previous coronary heart disease or stroke/TIA >12 months previously • BP≥140/90 • Proteinuria or Albuminuria <p><small>(Except patients included in Priority 1 and 2 groups)</small></p>	<p>Priority Four</p> <p>Hba1c 58-75 OR</p> <p>Any HbA1c WITH any of the following:</p> <ul style="list-style-type: none"> • eGFR 45-60 • BP≥140/90 • Higher risk foot disease or PAD or neuropathy • Erectile Dysfunction • Diabetic retinopathy • BMI >35 • Social complexity • Severe frailty • insulin or other injectables • Heart failure <p><small>(Except patients included in Priority 1, 2 or 3 groups)</small></p>	<p>Priority Five</p> <p>All others</p> <p><small>(Except patients included in Priority 1-4 groups)</small></p>

Further information:

If you require further information with regards to this document, please contact Yorkshire and the Humber Diabetes Clinical Network – england.yhdiabetescn@nhs.net