The Set Up and Mobilise, Accelerate, Resources and Tools Multi-disciplinary (SMART MDT) Collaborative Working Project
Final Report

Project title	SMART MDT in Type 2 Diabetes
Project Partners	Nottingham City General Practice Alliance (NCGPA) Ltd Soar Beyond Ltd Novo Nordisk Ltd
Project timeline	January 2022 – December 2023
The Challenge	The Set up and Mobilise, Accelerate, Resources and Tools Multi-disciplinary team (SMART MDT) in Type 2 Diabetes (T2DM) project aimed to transform the capacity, capability and confidence of the entire primary care workforce in Nottingham City to deliver better patient outcomes in T2DM care. When the project commenced, Nottingham City had a population need for improving current T2DM management: • 5.4% of the population aged 15+ have been diagnosed with T2DM[1] Of these: • 34% have a family history of T2DM[1] • 49% of people with T2DM have 2 or more comorbidities[1] • 84% of people with T2DM are living with obesity or are overweight[1] • 17% of people with T2DM smoke[1] Nottingham City had not been achieving key parameters and outcome measures for T2DM management: • **40% of people living with T2DM received the 8 care processes (8CPs)** healthcare checks at least once a year as recommended by the National Institute for Health and Care Excellence (NICE). This compared with 51% for the whole Nottingham & Nottinghamshire Integrated Care System (ICS), 50% for Mid Notts Integrated Care Partnership (ICP) and 62% for South Notts ICP. Nottingham & Nottinghamshire ICS is made up of Mid Notts, South Notts and Nottingham City ICPs[1]

	• **31% of people living with T2DM achieved all three treatment targets (3TTs).** This compared with 35% of people living with T2DM for the whole ICS, 34% for Mid Notts ICP and 40% for South Notts ICP[1]
The Objectives	The objectives of this Collaborative Working project were to: • support Nottingham City GP Alliance (NCGPA) to improve the treatment of people living with T2DM utilising the whole primary care MDT skillset • utilise the web-based Soar Beyond SMART platform to assess workforce capability to manage and treat people living with T2DM • deliver role specific diabetes training and upskilling to free up clinical capacity, better utilisation of the workforce and support the delivery of T2DM healthcare to patients The outcome measures were: • increase in competence and confidence of the workforce via surveys and capability mapping • to develop an improved T2DM pathway which utilises the whole primary care MDT skillset • increase in number of patients achieving all 8 care processes from baseline of 40% • increase in number of patients achieving all three treatment targets from baseline of 32%
What we did	Novo Nordisk collaborated with Soar Beyond and NCGPA throughout the duration of this project to improve the treatment of people living with T2DM in Nottingham City. The contribution of each organisation can be found as follows: Novo Nordisk: • Co-funded the SMART MDT platform • Provided an NHS Partnerships Manager resource who supported the project management and co-facilitated workshops • Supported the identification and delivery of workforce training NCGPA: • Co-funded the SMART MDT platform • Provided a project champion/lead for implementation of the project • Led the formation of the project steering group to consult and direct project

	• Led the communications sent out to NCGPA staff and GP practices in Nottingham City Soar Beyond: • Provided Director & Associate Director support for the project management and co-facilitated workshops • Developed a T2DM competency framework based on Trend Diabetes competencies which was uploaded onto the SMART platform and used to identify competency gaps • Provided the SMART platform at a subsidised rate for an unlimited number of users. The platform was used for HCP self-assessment

Activities	• Facilitated stakeholder meetings to:
	  ○ Establish current state of T2DM care
	  ○ Present baseline competency assessment and identify areas to focus the training curriculum on
	  ○ Engage Primary Care Network (PCN) leads
	• Conducted onboarding onto the SMART platform with healthcare professionals (HCPs) so they could establish their baseline competencies in managing people living with T2DM
	• Mapped out the current T2DM patient journey based upon discussions with multiple General Practice (GP) practices (creation of process map)
	• Utilised pharmacy champions to onboard additional HCPs onto the SMART platform
	• Designed and delivered training curriculum based upon needs identified
	• Facilitated sessions with a GP practice to understand the T2DM patient journey in their practice, compared this to the process map from a previous workshop and worked with the practice to identify efficiencies and opportunities to utilise additional roles reimbursement scheme (ARRS) workforce
	• Data collection and analysis
	  ○ National Diabetes Audit (NDA) data:
	  ▪ Three Treatment Targets (3TT)
	  ▪ Eight Care Processes (8CP)
	  ○ HCP confidence pre & post training
	  ○ Qualitative feedback on how training has impacted practice

Outcomes	Competence & Confidence of the workforce: • 56 HCPs completed the competency assessment • 21 of the 56 were clinical pharmacists (CPs), 10 of these engaged with at least one part of the curriculum and 3 of these completed the reassessment • 71 HCPs engaged with the training curriculum totalling 159 learning contacts (average 2.2 events per person) • Improvement in all confidence measures as assessed on a scale of 0-10 (0 being not confident and 10 being extremely

	confident) via a Microsoft Form questionnaire following one of the training sessions. Some examples are listed below: ○ Confidence in diagnosing T2DM increased from 6.9 to 8.5 ○ Knowledge of national guidelines increased from 5.9 to 7.8 ○ Choosing appropriate treatments increased from 4.9 to 7.3 ○ Knowing when to intensify therapy increased from 4.9 to 7.2 • 22 of the HCPs who engaged with the curriculum completed an evaluation form. This qualitative feedback showed a positive impact on their clinical practice when seeing patients with T2DM. Some examples are listed below: ○ "Increased confidence in the T2DM guidelines" – clinical pharmacist ○ "Improved understanding around carbohydrate portions" – social prescriber ○ "I now have great confidence in knowing when it is the right time to intensify treatment" – clinical pharmacist ○ "More confident in understanding carbohydrate counting and helping patients understand their insulin requirements and titration" – GP ○ "Focusing on diet and lifestyle. Providing practical tips to reduce carbohydrate portioning" – clinical pharmacist Improved T2DM pathway: During the facilitated session in a GP practice, their T2DM patient journey was compared to the baseline T2DM patient journey discussed at an earlier meeting. This identified opportunities to better utilise their ARRS workforce and create efficiencies in the T2DM patient journey. The following points are some examples: • Following a blood test taken at an annual review, the practice nurse would contact all patients with their results. It was suggested to consider sending a text to patients whose results were in range instead of them having a fifteen minute appointment with the nurse. This would allow more time to focus on patients whose blood results weren't at target. The practice also plans to use their two clinical pharmacists with an interest in diabetes for some consultations with people living with T2DM in the future • They are also utilising their Health & Wellbeing coach (another ARRS role) to support with lifestyle support for people living with T2DM • Foot checks were previously completed at a separate appointment to the patient's annual review. This is now done as part of the same appointment

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Letters to patients to include the need for them to bring a urine sample to annual review to avoid the need for a separate appointment
Receptionists were given training to ensure patients were given the correct duration for each consultation avoiding the need for multiple appointments

Data changes:

8CPs – the data showed a decline in 8CPs achievement in City ICP. However, the decline was smallest in City ICP vs the other 2 ICPs in the ICB
3TTs – the data showed a small increase in 3TT achievement for City ICP which was the only ICP to increase its achievements over this period

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<tr><th></th><th>8 CP – baseline[1]</th><th>8 CP – end</th><th>3TTs – baseline[1]</th><th>3TT – end</th></tr>
<tr><td>ICB</td><td>51%</td><td>36%</td><td>35%</td><td>36%</td></tr>
<tr><td>City ICP*</td><td>40%</td><td>31%</td><td>31%</td><td>32%</td></tr>
<tr><td>Mid Notts ICP*</td><td>50%</td><td>37%</td><td>34%</td><td>34%</td></tr>
<tr><td>South Notts ICP*</td><td>62%</td><td>41%</td><td>40%</td><td>39%</td></tr>
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Baseline data above refers to 2018/2019 NDA year
End data refers to 2023/2024 NDA year[2] but only includes Jan 2023-Sept 2023 data as the full years data is not available at the time of writing this report.

It is important to stress any improvements in the data above cannot be solely attributed to this project.
*Data for ICPs is calculated from the data for the respective PCNs that make up the ICP.
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<td>Lessons learned</td>
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Challenges:

Running the project across the whole of Nottingham City caused challenges due to the huge number of stakeholders needed to consult with. The project steering group felt on reflection, running the project over 1 or 2 Primary Care Networks (PCNs) to evaluate the concept would have been beneficial
Trying to incorporate all the ARRS roles was ambitious. A pilot with pharmacists (as the most established ARRS role) in NCGPA would have been beneficial

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	• Covid-19 remained an issue during the early stages of the project as it delayed some of the engagement with HCPs due to redeployment • Workload pressures led to a de-prioritisation of the project by some HCPs Successes: • Assessment of competence enabled development of a training programme suited to the needs of HCPs • The training programme held has shown a clear improvement in the competence and confidence of those HCPs involved to manage people living with T2DM in primary care • The process mapping session in a practice led to efficiencies in the T2DM patient journey and utilisation of some of their ARRS roles to support the management of their patients living with T2DM

References:

1. Integrated Care System Nottingham and Nottinghamshire. Population Health Management; 2020. Available from: https://healthandcarenotts.co.uk/wp-content/uploads/2020/01/PHM-Diabetes-Pack-Final.pdf [Accessed 23 September 2023]
2. NHS Digital. National Diabetes Audit (NDA) 2023-24 quarterly report for England, Integrated Care Boards (ICB), Primary Care Network (PCN) and GP practice, 2024. Available from National Diabetes Audit (NDA) 2023-24 quarterly report for England, Integrated Care Board (ICB), Primary Care Network (PCN) and GP practice - NHS England Digital [accessed 14 February 2024]