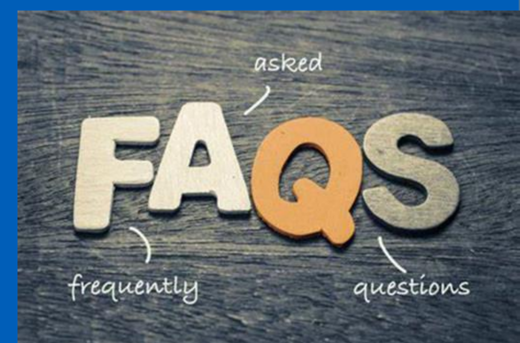
Diabetes Level 2 PCN MDTs 2024/25: FAQs & Mobilisation Guidance:

Redesigning a fit for purpose pathway

V5. – Updates in green.



Change history

Version	Issue Date	Summary of changes
v1	23-Oct-23	v1 of MDT FAQs issued as combined FAQs with the EOT2D/T2DAY FAQs.
v2	31-Oct-23	v2 of MDT FAQs issued as combined FAQs with the EOT2D/T2DAY FAQs. Updated with some questions from webinars national lead Shivani delivered on 4th & 19th October 23.
v3	16-Nov-23	v3 of FAQs issued as combined FAQs with the EOT2D/T2DAY FAQs. Updated with answers from remaining questions from webinars national lead Dr Shivani Misra delivered on 4th and 19th October 23.
v4	12-Jun-24	v4 of L2 MDT FAQs issued as a standalone document. Updated with questions from webinars national lead Dr Shivani Misra did on Feb & March 2024
v5	25-Oct-24	- Table of contents slide added - Mobilisation Guidance which was previously a standalone document added in through the document. - Clarification included on consultant requirements for the MDT. - FAQs segmented into people, processes and contracts to support easier navigation of the FAQs.

Contents

Section	Slide no
Background, Aims & Objectives	4
Model	5 - 9
MDT Process Overview	10 - 12
People FAQs	13 - 15
Processes FAQs	16 - 17
Contracts FAQs	18 - 20
Training & Support	21 - 25

Background, Aims & Objectives

Background
The NWL Diabetes Transformation Programme team was asked at the beginning of June 2023 to update the tier 2 diabetes specification, focussed on injectable initiation and optimisation. The scope was then broadened to allow a wider remit which includes establishing Multi-Disciplinary Team(MDT) meetings in each PCN.

The L2 MDT ES was introduced part year 23/24 dependent on available in year funding, with the intention to introduce it in a small number of PCNs who had the capacity to deliver it during the year as 'early adopters' to allow for a review before adding it for all PCNs from April 2024. The ES remains unchanged for 2024-25 and is within the North West London Single Offer Enhanced Services for 24/25.

Aims & Objectives
The objective of the service is to provide more intensive and integrated support for high risk groups of patients. This which will facilitate/enable:

- **A population health focus, allowing proactive, data-driven intervention** - not just injectable initiation and optimisation.
- **A more streamlined pathway to mental health support**
- **Addressing wider social concerns.** Social and mental factors are frequent barriers to effective self-management and engagement in health interventions
- **Closer collaboration with specialist diabetes teams** consisting of members of primary care, community specialist providers, mental health and other professionals such as social prescribers. We want to work with the community provider collaborative and acute provider collaborative to ensure that these are well resourced.

Model

Primary Care Team

Specialist Diabetes Team

Mental Health Team

Other INT Organisations (link workers, etc)

MDT is comprised of clinicians from primary care, specialist diabetes team, mental health team and team members from other organisations who can address wider health and wellbeing issues

Not all of these team members will need to be present at every MDT meeting

MDT Level 2 Service

Insulin/ GLP-1 Initiation / Optimisation

MDT Review

EOT2D/T2DAY Review

Patients identified for review by direct referral and/or clinical system searches/WSIC Dashboard

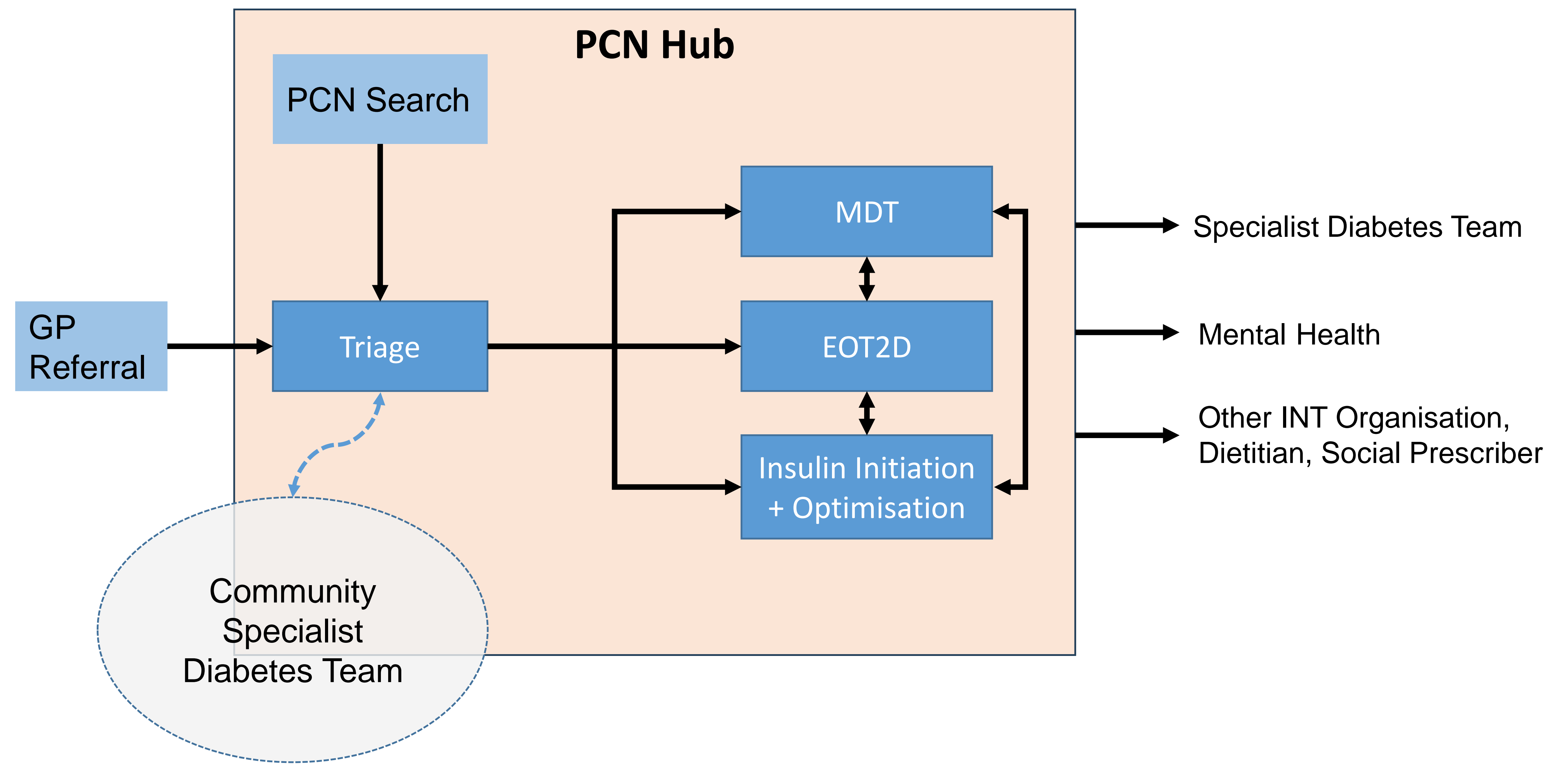
GP Practice

GP Practice

GP Practice

GP Practice

Diabetes Level 2 MDT Flow Diagram



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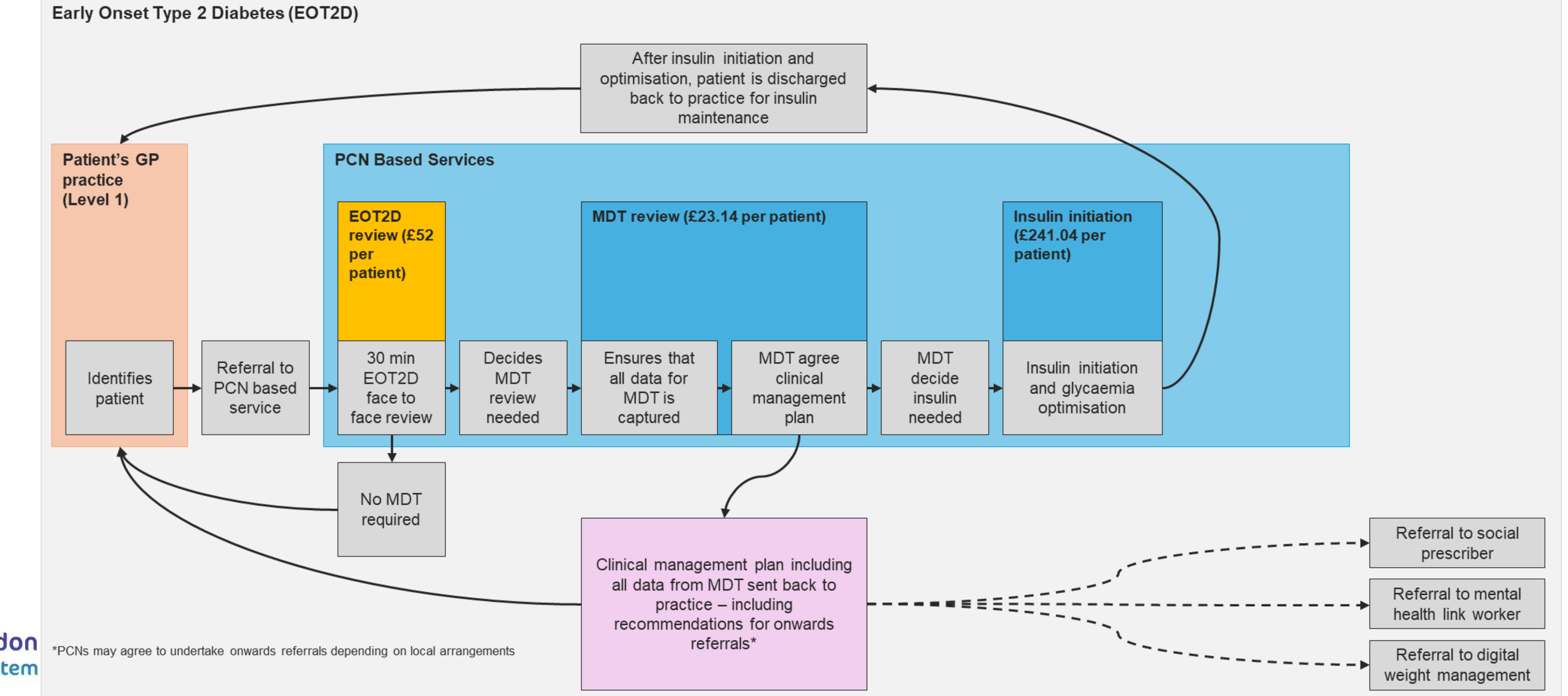
Example pathway for a patient with Early Onset Type 2 Diabetes

- Illustrating that one patient may attract payments for more than one service.
- Note that the EOT2D review is a separate but linked service specification.
- All onwards referrals are examples only, but are illustrative of the kind of support which may be required.



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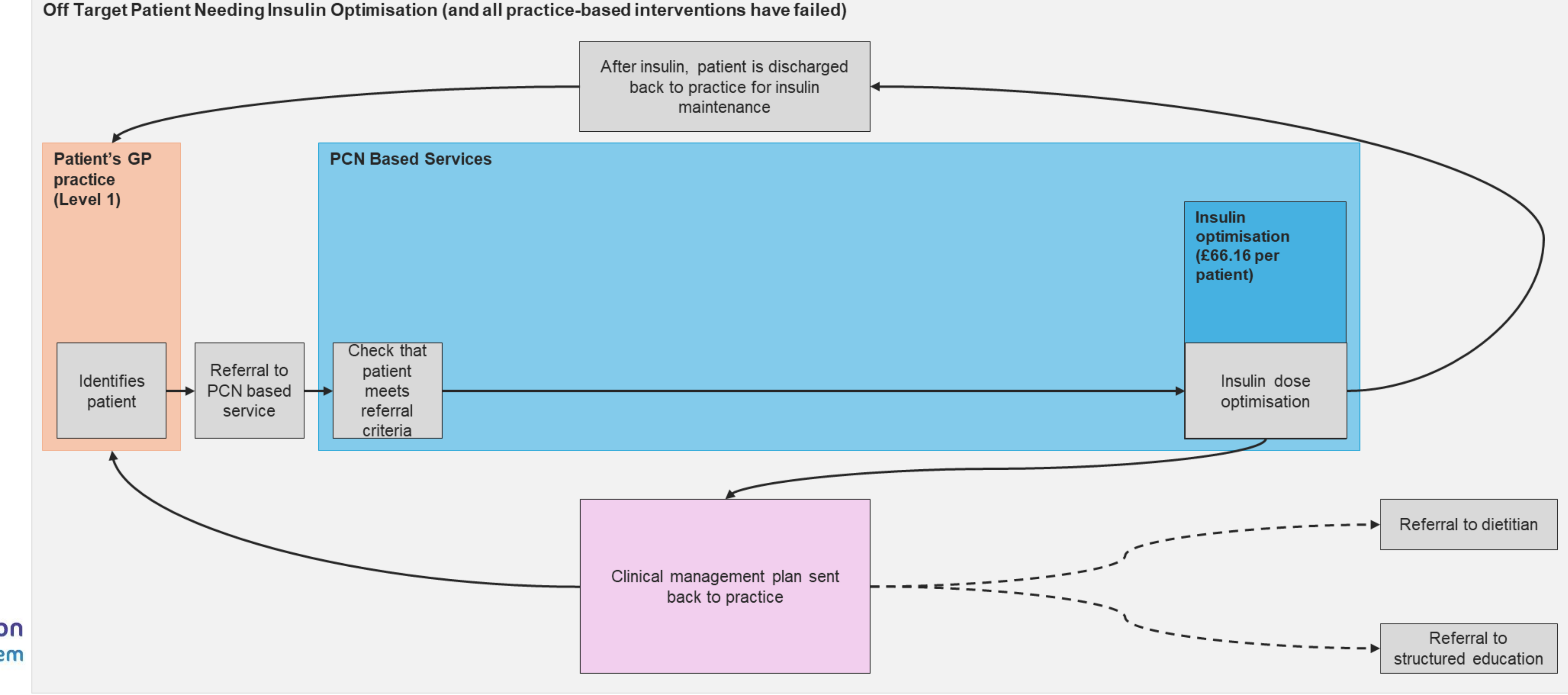
Example pathway for a patient referred by their GP practice requiring insulin optimisation but not MDT review

- All onwards referrals are examples only, but are illustrative of the kind of support which may be required.



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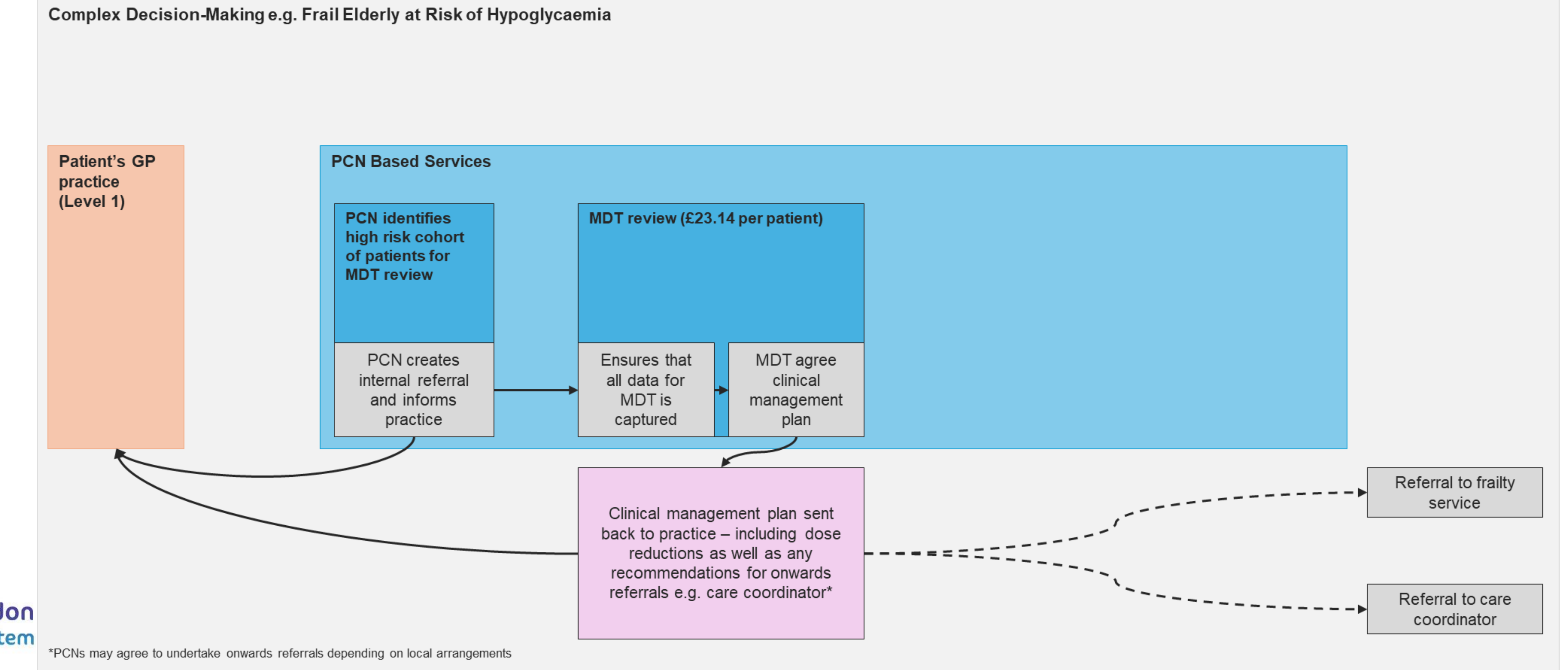
Example pathway for a patient identified through PCN-based clinical system or WSIC searches

- In this case the MDT recommendation back to the patient's practice is for de-intensification of diabetes medication and onwards referral to a frailty service and care coordinator.



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Diabetes Level 2 MDT Specification

1) **Establish an MDT per PCN** consisting of a primary care team lead(s), diabetes specialist clinician, mental health practitioner, social prescriber / link worker and other MDT members as needed

2) **Hold regular (frequency TBD) MDT sessions**

3) **Accept referrals** for care optimisation from other practices within the PCN/Integrated Neighbourhood Team/Borough

4) **Use data driven approaches to identify patients from within the PCN/INT** in most need of additional clinical input. This will follow a prioritisation approach - this will require either
   a. Use of WSIC RADAR to identify cohorts of patients for discussion (at least one member of the team will require access to data from all practices in the locality
   b. Reports from SystmOne/EMIS reporting modules at PCN/INT level.

5) **Initiate / optimise injectable therapies**

6) Ideally the MDT would also **link in other specialists** e.g. CVD, CKD

PCNs may choose to just run with the MDT component this financial year while getting trained in injectable initiation

MDT PROCESS – Overview

Establish MDT

Leadership / membership

MDT should be jointly led by

- Lead GP
- Diabetes Consultant / Nurse Consultant

Recommended MDT membership includes:

- DSN with Diabetes Consultant support
- Practice Nurse
- Social Prescriber / Link Worker
- Health and Wellbeing Coach
- District Nurse (where housebound / residential home patients are being discussed)
- Psychologist / Mental Health Support Worker
- Clinical Pharmacist
- Dietitian
- Podiatrist

* This list is not intended to be exhaustive. Not all of these team members will need to be present at every MDT meeting

Purpose

- Support injectable initiation / optimisation where local skill mix requires this
- Support complex decision making

Baseline activities

Agree dates

Ensure that members have invitations

Ensure that all members have necessary IT configuration e.g. MS Teams access, access to WSIC

Clinical Systems configuration to support referral in to the PCN team, smart card configuration, training on use of clinical system templates and tasking

IT Tools

Referrals in configuration

WSIC accounts

Smart cards

Cohort Identification

Suggested approach is a proactive systematic, thematic review of PCN/INT patients as well as taking ad hoc referrals from practices in the PCN/Integrated Neighbourhood Team

High risk groups include:

- Mental health / social factors interfering with ability to self-manage effectively (e.g. SMI, needle phobia, social complexity)
- Young T2DM (note that HbA1c targets should be tighter - ideally 48 or less - for this group). This may include exclusion of other diagnoses, signposting and support to engage with dietary interventions and / or initiation of injectable therapies)
- Off target and on 3+ oral medications, needing intensification or other risk factors present)
- Off target and on 3+ oral medications (e.g. 2 HbA1c > 75)
- Patients with established CKD / CVD complications
- Frail elderly at risk of hypoglycaemia for de-intensification
- Others nominated by the patient's GP practice, particularly where there would otherwise be a secondary care referral – e.g. patients with CKD or Heart failure where a specialist opinion about medication would be helpful

Approaches to systematic cohort identification will include:

- Whole Systems Integrated Care (WSIC) diabetes RADAR (most of these cohorts are established)
- Clinical system searches

IT Tools

Clinical system searches

WSIC radar

Pre MDT Activities

Clinical Pharmacist / Nurse

Check 9 key care processes complete where possible

Mental health screening score

Medication review

Check patient adherence

Check health beliefs e.g. anti-injections

Check previous interventions:

- Lifestyle factors including diet and activity
- Structured education
- Engagement with REWIND / other weight management programmes

Ensure that all suitable patients with T2DM are encouraged to take up weight management interventions and create a Know Diabetes account

Offer Health and Wellbeing Coach / Psychology support where appropriate

Clinical Pharmacist / Nurse + GP

Identify key questions to resolve

Administrator

Review all relevant data entries completed

IT Tools

Pre-MDT template

Tasking / email for communication with patient's normal GP

MDT

- Screenshare clinical record or spreadsheet where needed
- Clinician from patient's own practice attends for discussion and to action outcomes
- Mental health worker to attend if patient is known to mental health service
- Scribe actions – ideally using Diabetes MDT template in shared clinical record (this will require a PCN instance of EMIS/SystmOne and either a referral in or an MDT appointment)

IT Tools

MDT template

Rego advice & guidance

Post MDT Activities

Agree communication back to referring practices (via tasking or email)

IT Tools

Tasking / emails

Consultant support in the Diabetes Level 2 MDT

The Specification gives some flexibility in the consultant's discharge of the anticipated functions under the ES specification (pages 3 & 4)

A Consultant Diabetologist has 3 main roles within the MDT:

1. Quality assurance - having an involvement at the early stages to ensure correct decision making and overseeing audit

2. Regular involvement in complex clinical care - at least quarterly MDTs with consultant and ability to see most complex patients whether in consultant clinics separately at Tier 3 or even better within the Tier 2 MDT

3. Training and importantly research - PCN level hubs should be encouraged to take on clinical trial work as this will deliver T2DM clinical research

The full L2 MDT service specification can be found here

Options for sourcing consultant support and advice:

PCNs currently have 3 options to gaining consultant level support for the L2 MDTs:

- Community Consultant Diabetologist
- Diabetes Nurse Consultant
- Acute diabetes consultant

asked
FAQS
frequently
questions

People
Process
Technology

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MDT – People FAQs

Question	Answer
There should be an option to amend the MDT model as not all of the roles specified in MDT are available in all boroughs?	We have agreed the roles through consultation across NW London and at the Diabetes (Clinical Reference Group (CRG). We have also agreed minimum co-standards for MDT as mentioned.
Who is leading and bringing borough-based teams for the formation of MDTs? It cannot be the lead GP/CD.	Its envisaged that the Diabetes Level 2 MDT will be run at a PCN Level. PCN leadership inc. Business Managers will be involved. Named leadership with be identified at a PCN level as appropriate. Named clinical leadership will be different from the delivery leadership for formation and delivery of MDTs.
How will borough teams work with PCNs to develop and agree local pathways and what is the time frame? Clinical Directors are overwhelmed.	Borough leads are involved directly with PCNs leadership to provide support. The ICB's programme teams are working to support borough leads/teams and borough leads are working together We are contacting borough leads and supporting them. We also recognise that not all PCNs will be working delivering at the same time. PCNs level of maturity on running MDTs is variable.
What is the core staffing for these MDT meetings?	Compared with 23/24 the specification for 24/25 has not changed, in specifying L2 MDTs: • That it should be led by a GP and Diabetes Consultant and also • The consultant should attend the MDT at least quarterly. However, this was read as a consultant or diabetes nurse consultant needing to be present at every MDT for the MDT to be quorate. Recommended MDT membership is included in service spec. There is an expectation that MDTs will be cross organisational and will be supported by community teams.
There is variability in available workforce, therefore MDT composition and oversight may vary. Please clarify the expectation around MDT membership and oversight?	MDT composition and oversight may vary but there will be a lead GP and specialist diabetes clinician for MDTs.

MDT People FAQs

Question	Answer
Is there an expectation that the referring practice or clinician should attend the MDT to present their patients to the MDT to support discussion?	Ideally yes as it will help extend learning and pass on new skills and learning.
Will there be transition support for setup and transformation?	There is support for the process, skills and learning. The ICB with support from NW London Training Hub and the national T2DAY team has offered training for practices. See the training and support section below.
Does a consultant need to be at every MDT	No. To confirm: • A consultant is **not required** to be present at every individual MDT discussion • It is essential that the MDT is composed of professionals with sufficient competencies to meet the needs of the specification, ensuring that the standards of care are maintained.

MDT Process FAQs

Question	Answer
Can MDTs be run virtually or must it be face to face?	Can be virtual, face-to-face or hybrid. It is envisaged these MDTs will be case discussions and patients will not be present at the case review. PCNs need to do the searches, identify cohorts & agree on a suitable management plan to run these and in fact might find it advantageous in terms of getting providers across the path to attend if virtual as would negate the need for travel and therefore reduce time commitment.
How will the patient be informed of the MDT outcome?	PCNs and Practices will have a process for communicating with patients. We will also have discussions with PCNs regarding this process.
How will the outcome of MDT be communicated to Practices?	Letter to Practice Practice can see the MDT data entry template as well.
How often does my PCN need to hold an MDT?	Its based on the PCN's forward planning individual patient's clinical need & availability of specialist capacity
In planning our diabetes MDT how long should we allocate per patient including the time it will take to outline the patient's case history?	It's estimated to be 9 minutes per patient.
Will all the referrals be generated/brought to the MDT by primary care or can our community and acute care partners also bring a patient for discussion?	Yes community and acute partners can also bring a patient for discussion.

MDT – Process FAQs

Question	Answer
How can we identify patients who would benefit from/are suitable for MDT discussion? What is the criteria to a patient being presented at the MDT?	Clinical searches have been created in SystmOne and EMIS to support with this. But not all patients who fit within the searches would benefit from an MDT case discussion. This needs to be balanced with a level of clinical discretion and individual patient choice & circumstances. Clinical judgement based on glycaemic control &/or additional need for other specialist care (Markers like recent HbA1C, BP, lifestyle/MH needs assessed) The criteria is set out in the service specification. The report below provides patients in Enhanced Services DQ folder who can be seen under MDT.

08 Diabetes Level 2 MDT

Name

DL201------------------------------------PAYMENT------------------------------------

DL201-ES-Patients NOT discussed at MDT (in this Financial Year)

DL201b-Patients on Diabetes Register seen under MDT MISSING Enhanced Services Admin

DL203-ES-Patients who may benefit from Insulin Treatment Initiation

DL203a-ES-Patients presribed on Insulin WITHOUT Insulin Treatment Initiated recorded

DL206------------------------------------QUALITY METRICS MDT REVIEW------------------------------------

DL206f-Patients discussed at MDT NOT Referred for Weight Management Programmes

DL206g-Patients discussed at MDT NOT Referred for ARRS Team

DL208------------------------------------QUALITY METRICS INSULIN------------------------------------

DL208f-Patients initiated or optimised on Insulin NOT Referred for Weight Management Programmes

DL208g-Patients initiated or optimised on Insulin NOT Referred to ARRS Team

DL209------------------------------------QUALITY METRICS GLP-1------------------------------------

DL209f-Patients with GLP-1 Therapy Initiated NOT Referred for Weight Management Programmes

DL209g-Patients with GLP-1 Therapy Initiated NOT Referred to ARRS Team

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Contracts FAQs

Question	Answer
What services within the single offer can be sub-contracted? Is there a choice?	For the new services which were launched in-year, the services can be delivered individually or in any combination of them, depending on the affordability for the borough and PCNs readiness to mobilise the service. The contract should be delivered by PCNs (with GP practices subcontractors) to enable delivery of the full range of services covered by the contracts and full patient population coverage. If the PCN want to sub-contract outside the PCN, the Provider (PCN/Lead Practice Model) must agree the delivery model including locations of delivery for each service with North West London ICB.
GP practices will sign up to manage patients in line with agreed pathway- What about patient choice?	Patient choice will be respected.
What is the start date, end date and annual review date of service spec?	The service specification runs for the financial year. As such the specification in its current form is for 2023/23 and runs until 31 March 2024. Version control is being maintained. We will add the annual review date for service spec.
Is there any flexibility with regards to payments/constitution for 2023/24? For example: Can we give flexibility to PCNs for MDTs to do top slicing for admin costs?	PCNs will be paid based on achievement of meeting the specification requirements. It is up to PCN discretion on how to use the funding flexibly to deliver an appropriate model.

Contracts FAQs

Question	Answer
Can my Practice choose not to participate in any of the three components of the Level 2 service?	Participation is dependent on available in year funding. NHS England has allocated additional funding for an Early Onset Type 2 Diabetes Service (EOT2D). To avoid any risk of losing the additional NHS England funding, PCNs will be offered the opportunity to deliver the service specification in year (2023-24). Our intention is to introduce the Level 2 MDT Service in a small number of PCNs who confirm they have the capacity to deliver these during the remainder of 2023-24 as 'early adopters' to allow for a review before adding them for all PCNs from April 2024. These services can be delivered individually or in any combination of them, depending on the affordability for the borough and PCNs readiness to mobilise the service.
Does my practice have to sign up to all three components?	See above.
What's the remuneration for PCNs?	£23.14 per patient discussed at MDT capped to a maximum of 10% of patients on the diabetes register.
How do the payments work? Is it by MDT session or by patient?	Payment is by patient (£23.14 per patient)
Is funding PCN based or Practice based?	PCN based
What will be the impact of this NW London service on other Diabetes MDT running in the boroughs?	This service represents a minimum core MDT framework. It will have a positive impact and a good start of a structured MDT with a level of flexibility and learning until 31 Mar 25.

Contracts FAQs

Question	Answer
Are there any activity caps?	Activity is capped at 10% of PCNs' Diabetes population (5% for last 6 months of 2023/24 financial year).
Will anticipated funding per Borough be protected until they start?	Yes. For 2023/24, the decision to sign up to this NW London MDT and Insulin Service is with the Borough Teams is dependent on available in year funding. Our intention is to introduce the Level 2 MDT Service in a small number of PCNs who confirm they have the capacity to deliver these during the remainder of 2023-24 as 'early adopters' to allow for a review before adding them for all PCNs from April 2024. These services can be delivered individually or in any combination of them, depending on the affordability for the borough and PCNs readiness to mobilise the service. This will be the same for the insulin initiation and optimisation element of the service.
What is the rationale/costing breakdown for each element of Diabetes Level 2 Service?	Please see costing breakdown here: Diabetes Level 2 Service costing breakdown.docx.
How can I be an early adopter PCN?	PCN/INT can provide EOI to ICB primary care team. For the initial period from October 2023 to end of March 2024, the MDT component can be delivered independently of GLP-1 initiation.
When will the service start?	October 2023. PCNs/Practices will need to sign the contract in order to get paid.

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Training & Support

Training & Education – PITstop Foundation (PrePITstop) Diabetes Course

NWL Training Hub are funding ***THREE places per PCN from the ARRS roles of either Pharmacists, Paramedics or Physician Associates*** to complete the PITstop Foundation (PrePITstop) Diabetes Course

About the Training	Who is the Training for?	Registration Details
This 3-day multidisciplinary diabetes foundation course focuses on the core diabetes services and care provision for people with type 2 diabetes and prediabetes and emergency management for people with type 1 diabetes. It is aimed at healthcare professionals working in primary care who want to work as a team to improve diabetes services and patient outcomes using structured care pathways. **What will be covered?** • Classification and accurate diagnosis • Diabetes screening for at risk groups • Day to day living choices • Encouraging referrals to the Diabetes Prevention Programme and Structured Education • The oral diabetes medication pathway and related subjects (DVLA, hypoglycaemia, monitoring, concordance, individual target setting) • Managing illness • The provision of essential diabetes care using structured care pathways • Cardiovascular disease prevention, including blood pressure, lipid and kidney management • Eye screening and diabetes eye complications • Emotional and mental health • The foot assessment, foot advice and appropriate referral • Preconceptual counselling and family planning advice (self-directed learning) • Case studies: putting it into practice • Use of audit to improve outcomes	This training is for THREE places per PCN from the ARRS roles of either Pharmacists, Paramedics or Physician Associates working as part of a practice/PCN diabetes team.	Please email nomaan.omar@nhs.net with: • the three clinicians names, • NHS email addresses, • role • practice/employer; • PCN We will then send them instructions of how to register onto the course.

PITstop Advanced (Injectable Therapies) Diabetes Course

NWL Training Hub are funding **TWO clinicians per PCN** (this can either be Nurses, GPs or Pharmacists) to complete the PITstop Advanced (Injectable Therapies) Diabetes Course

About the Training	Who is the Training for?	Registration Details
This practical 2.5-day advanced course gives multi-disciplinary, practice teams the resources to work towards an enhanced diabetes service provision for injectable initiation (type 2 diabetes only). **What will be covered?** • Revision of diabetes oral medications • GLP-1 Agonists, including initiation using a structured care pathway • Insulin: building the profile • Injection technique • Device workshop • Detective work at review appointments focusing on injectables • Insulin safety (self-directed learning) • When is insulin indicated? • Working through the PITstop insulin pathway to assess for insulin, initiate an appropriate insulin regimen and support the patient for the first 6-months: a case study approach • Changing insulin regimens • Dietary considerations and insulin, including minimising weight gain • Decisions about injectable therapies: a case study approach • Embedding the learning and university accreditation	This training is for TWO clinicians (GP, Nurse Practitioner, Practice Nurse and Clinical Pharmacist) per PCN working as part of a practice/PCN diabetes team, that are already experienced in providing a diabetes service and have attended a foundation level diabetes course or can provide evidence of self-directed learning, focusing on the oral diabetes medication pathway. It is preferable that they have undertaken their Independent prescribing, but not essential.	Please email nomaan.omar@nhs.net with • the two clinicians names, • email addresses, • roles; • practice(s)/employer; • PCN • mentors name and role • along with the evidence that they have completed the foundation level diabetes course or equivalent. We will then send them instructions of how to register onto the course.

Training & Support

Recordings for primary care team inc nurses, clinical pharmacists and dieticians.

Course	About the Training	Links:
The NWL Diabetes Guidelines: Optimising therapy for patients with Type 2 Diabetes Webinar	Recording of interactive, informative and evidence walk-through the NW London diabetes guidelines and how to choose the right medication for the right patient at the right time. Delivered by Dr Marcus Martineau, Consultant Physician & Clinical Research Fellow in Diabetes, Endocrinology & Obstetric Medicine, Chelwest in May 2023.	Slides and recordings can be found here. NW LONDON TRAINING HUB workforce education training THE NWL DIABETES GUIDELINES: OPTIMISING THERAPY FOR PATIENTS WITH TYPE 2 DIABETES WEBINAR Friday 19th May 1pm-2pm MS Teams
Lipid Management: Effective management and how to fulfil QoF Webinar	The training will provide a greater understanding of the Lipid Management pathways and the use of the novel agents. This webinar was run by Dr Neville Purssell, NW London CVD Lead and Dr Jai Cegla, Consultant in Metabolic Medicine, ICHT & NHS England clinical advisor on 19th July 2023. Link to NW London statin intolerance pathways National_statin_intolerance_algorithm.pdf (nwlondonicb.nhs.uk).	You can see the slides from the event here, as well as the recording here. IMPERIAL COLLEGE HEALTH PARTNERS

For further information...

Please find the MDT service specification 2024/25 here

Find guidance & support here

Do raise any additional queries you may have relating to the service specification with the NW London Diabetes Team via: nhsnwl.diabetes@nhs.net

Regarding queries as to funding and finance please raise these with your borough Primary Care Team.