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Community of Practice – Focus on Type 2 Diabetes

Primary Care Support for Long Term Condition management

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June 2020

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UCLP Community of Practice
Primary Care focus on Type 2 Diabetes

Agenda

Time	Item	Presenter
18.00	Welcome and introductions	Mandeep Butt
18:05 18:20	Primary Care Diabetes Support package Q&A	Dr Stephanie Peate and Laura Boyd
18:30	T2 diabetes: a case study from South London Q&A	Dr Neel Basudev and Anna Hodgkinson
18:45	Motivational interview training: developing an offer Feedback and Discussion	Jan Procter-King All
19:00	Close Next CoP event: is 30th July 2020,18:00 – 19:00	Mandeep Butt

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Primary Care Support for Long Term Condition management - Focus on Type 2 Diabetes

Dr Stephanie Peate–GP and UCLPartners Clinical lead for Primary Care Innovation team

Primary Care during & post COVID-19 and as we transition to the new normal

- COVID-19 has placed unprecedented pressure on our health system. Immediate focus has understandably been on supporting patients with, or at risk of the virus.
- However, there is a large cohort of people living with long term conditions that need **ongoing, proactive management** to prevent a wave of exacerbations in the months ahead.
- To help us adapt our care for people with long term conditions in the new world of primary care post COVID-19, UCLPartners has developed a **support package** based on new pathway development, virtual consultations, digital solutions and optimal use of the wider primary care team, e.g. **Healthcare Assistants, nursing associates and Pharmacists.**
- Additionally the package includes a selection of appraised **digital tools** to support patient activation and **self-management** in the home setting.
- This work has been **led by primary care clinicians** and informed by **patient and public feedback**.
- This support package is designed to help primary care teams deliver quality care to patients and meet QOF and other contractual requirements while releasing GP time at this time of unprecedented demand.

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“LTC management is at risk of neglect during national emergencies”

COVID-19 **Reset** also offers major opportunity:

- To do things differently in primary care for the benefit of patients and clinicians
- To build capacity in the primary care workforce
- To support patients in self management
- To reduce variation in quality of care

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2. The Framework – to be adapted for use in local systems

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Principles underpinning this work

- Virtual by default
- Mobilising and supporting the wider workforce (including pharmacists, HCAs, other non-clinical staff)
- Step change in support for self-management
- Digital innovation including apps for self management and technology for remote monitoring

Primary Care Support package includes

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1. Identification

- Pre-defined searches with Sno-Med/Read codes
- Virtual Training to undertake and access targeted searches

2. Stratification

- Comprehensive stratification tools
- Virtual training sessions on specific LTCs
- Virtual clinical insight, where required

3. Management

- Suggested pathways for local adaption
- Detail as to staff types who can undertake interventions
- Protocols for staff to follow informed by patient & public feedback
- Virtual training sessions for different staff types with content adapted to the needs of the individual staff, e.g. HCA, clinical pharmacist

4. Enabling patient-self management

- Self-management digital resources appraised and recommended
- Support for implementation available

All intended for local adaption

The LTC Pathway – Asthma, COPD, Diabetes

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Principles:

- Virtual first
- Wider 1º care workforce
- Step change in self management
- Digital technologies

Identify
Search for risk groups via health records

Stratify
Low risk
Medium risk
High risk

Communicate
Text/letter/ call to let patient know they will hear from practice

Management
Match risk/need to professional role

High Risk
GP/specialist nurse/clinical pharmacist

Medium Risk
Nurse/clinical pharmacist

Low risk
Health Care Assistant

Resources: comprehensive search tools, protocols, scripts for HCAs, training, education, digital tools, project management, communities of practice
https://uclpartners.com/long-term-condition-support/

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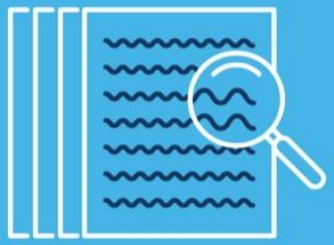
← Main website

Long-term condition support

This site contains tools and resources designed to enable primary care teams to continue to effectively manage patients with long-term conditions.

The pack includes:



Search and risk stratification tools

That can be used with EMIS (and SystmOne to follow), accompanied by user guidance.

Education and training resources

Including protocols, guidance, videos and virtual training sessions to upskill the breadth of primary care team members to proactively support patients.

Digital tools

A selection of a clinically appraised digital tools to support patient activation and self-management in the home setting.

Conditions included:

- Diabetes Type 2
- Asthma
- COPD
- Cardiovascular Disease (in development):
  - Hypertension and Heart Failure, AF and high cholesterol

The following slides show indicative frameworks for stratification and management that can be adapted for local use depending on existing activity, workforce and pathways

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Type 2 Diabetes

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1 Identify & stratify

Search tool identifies patients with Diabetes and stratifies them into high, medium and low risk depending on clinical characteristics.

High risk	Medium risk	Low risk

• HBA1c>75
• eGFR <45
• Insulin or other injectables
• Severe frailty
• History of foot ulcer in last 3 years
• Heart failure
• MI or stroke/TIA in last 12 months
• Metabolic syndrome
• Social complexity
  ○ LD, SMI
  ○ housebound, homeless,
  ○ alcohol or substance misuse
• Under c/o community diabetes team
	• HbA1c 58 -75
	• BMI >35
	• BP >140/90
	• eGFR 45-60
	• mild-mod frailty
	• Previous coronary heart disease or cerebrovascular disease
	• ED ever
	• Foot disease risk (PAD or neuropathy)
	• Proteinuria (includes ACR >3)
	• Retinopathy
		• HbAIC <58
		• BMI <35
		• Hypertension with BP <140/80
		• No other features in high or medium risk groups

2 Manage

Healthcare Assistants undertake initial contact for all risk groups to provide; check HBA1C up to date, provide information on risk factors, eg smoking cessation, diet and exercise, waist circumference

	High risk	Medium risk	Low risk
Staff type to contact	GP/Diabetes Specialist/ Nurse	Clinical pharmacist/ Nurse/ Physician Associate	Healthcare Assistant/ Nursing Associate

Intervention	• **Medication:**
	  • Adherence
	  • Titrate as appropriate
	• **Monitoring**
	  • Blood sugar control
	  • Lipids/lipid lowering therapy
	  • BP and proteinuria
	• **Education (inc online tools)**
	  • Sick day rules
	  • DVLA guidance
	• **Review & Discuss Red flags**
	  • Vision: floaters/flashing lights
	  • Feet/skin : pressure areas; virtual skin integrity check
	  • Blood sugar control: hypos
	  • Infections
	  • Signposting and Escalation
	  • Diabetes community +- secondary care team/advice
	  • Recall & Code
		• **Medication:**
		  • Adherence
		  • Titrate as appropriate
		• **Monitoring**
		  • Blood sugar control
		  • Lipids/lipid lowering therapy
		  • BP and proteinuria
		• **Education**
		  • Sick day rules
		  • Signpost online resources
		  • DVLA guidance
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		  • Vision: floaters/flashing lights
		  • Feet/skin: pressure areas; virtual skin integrity check
		  • Blood sugar control: hypos
		  • Infections
		  • Signposting and Escalation
		  • Recall & Code
			• **Medication:**
			  • Adherence
			  • Explore/ check understanding
			  • Confirm supply and delivery
			• **Education**
			  • Signpost online resources
			  • Risk factors – diet/lifestyle/smoking cessation
			  • DVLA guidance
			• **Review & Discuss Red flags**
			  • Vision: floaters/flashing lights
			  • Feet/skin: pressure areas; virtual skin integrity check
			  • Blood sugar control
			  • Infections
			  • Signposting and Escalation
			  • Recall & Code

Digital Support Tools to support patient self-management

General info & advice: www.diabetes.org.uk/diabetes-and-me; www.nhs.uk/apps-library/my-diabetes-my-way/

NHSE/I commissioned diabetes support phone line via Diabetes UK: 0345 123 2399; Mon – Fri, 9am – 6pm

MyDiabetesMyWay: structured education for people with diabetes that integrates with GP record

Oviva Diabetes Support: personalised one-to-one dietitian support

Asthma

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1. Long Term Condition Pathway: Asthma

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1 Identify & 2 Stratify

Search tool identifies patients with asthma. These patients are stratified into 3 groups depending on clinical characteristics, and then further stratified into high, medium and low risk using the Asthma Control Test™ score.

Group 1 criteria
- Any biologic therapy
- Frequent steroid therapy
- Frequent antibiotics
- Tiotropium
- Combination inhaler (LABA+ICS) at a high daily steroid dose
- ICS with:
  - Leukotriene Receptor Antagonist
  - Theophylline
- Plus individual patients where clinician concern

Group 2 criteria
- Exacerbation of asthma in last 12 months
- Prednisolone and/or antibiotics in last 12 months
- Asthma patients with 6+ issues of SABA per year
- Asthma patients on LABA *but no corresponding issue of an inhaled corticosteroid (ICS) inhaler*
- Asthma patients with 3+ issues of SABA in last 6 months *with no corresponding issue of an inhaled corticosteroid (ICS) inhaler*

Group 3 criteria
- Inhaled corticosteroids in last 6 months
- SABA in last 12 months

Phase for later review

Asthma Control Test™ (ACT) to risk stratify

Score <15 → **HIGH RISK**

Score 15-20 → **MEDIUM RISK**

Score 20-25 → **LOW RISK**

*The Asthma Control Test™ provides a snapshot as to how well a person's asthma has been controlled over the last four weeks and is applicable to ages 12 years or older. Available here: www.asthma.com/additional-resources/asthma-control-test.html

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3 Manage

Healthcare Assistants undertake initial contact for all risk groups to provide smoking cessation advice, inhaler technique, check medication supplies and signpost to resources

	High risk	Medium risk	Low risk
Staff type to contact	GP/ Nurse specialist/ Specialist Respiratory Pharmacist	Clinical Pharmacist/ Practice nurse/ physician associate	Health Care Assistant/ Nursing Associate
Intervention	• Titrate therapy, if appropriate • Ensure action plan in place • Check adherence, inhaler technique (video) , spacer advice • Rescue packs prescribed if necessary • Review of triggers, e.g. hay fever • Exacerbation safety netting • Follow up and referral as indicated	• Check optimal therapy; Titrate, if appropriate • Review triggers, e.g. hayfever • Check adherence, inhaler technique (video), spacer advice • Exacerbation management advice • **Repeat ACT as per recommendation from ACT test result and escalate to GP/Nurse if red or amber**	• Check inhaler usage & technique; signpost to education; spacer advice • Exacerbation management advice inc. mild hayfever symptoms • Signpost to appropriate information for: Lifestyle information/management of stress • Smoking cessation support • Exercise • Appropriate resources

Digital Support Tools to support patient self-management

Inhaler Technique: www.asthma.org.uk/advice/inhaler-videos/ www.rightbreathe.com
Asthma deterioration: www.asthma.org.uk/advice/manage-your-asthma/getting-worse/
General Health Advice www.asthma.org.uk/advice/manage-your-asthma/adults/
Smoking Cessation: www.nhs.uk/oneyou/for-your-body/quit-smoking/personal-quit-plan/ www.nhs.uk/smokefree/help-and-advice

COPD

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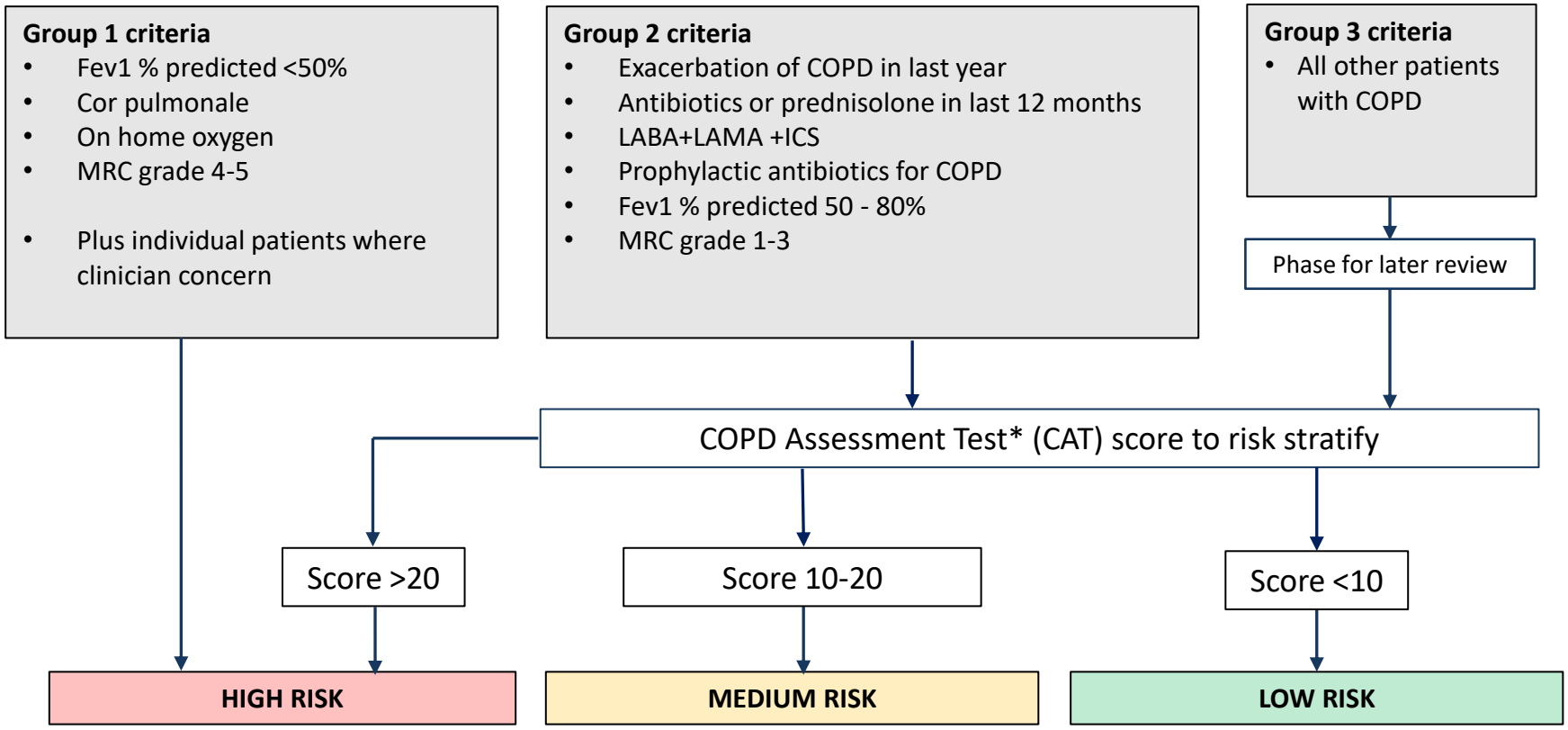
1 Identify & 2 Stratify

Search tool identifies patients with COPD. These patients are stratified into 3 groups depending on clinical characteristics, and then further stratified into high, medium and low risk using the COPD Assessment Test score.



*The COPD Assessment Test (CAT) is a questionnaire for people with COPD. It is designed to measure the impact of COPD on a person's life, and how this changes over time. Available here www.catestonline.org/

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3 Manage

Healthcare Assistants undertake initial contact for all risk groups to provide smoking cessation advice, inhaler technique, check medication supplies and signpost to resources

	High risk	Medium risk	Low risk
Staff type to contact	GP/ Nurse Specialist/ Specialist Respiratory Pharmacist	Nurse/ Clinical Pharmacist/ Physician Associate	Health Care Assistant/ Nursing Associate
Intervention	• Titrate therapy if appropriate • Ensure action plan in place • Check adherence & inhaler technique • Spacer advice • Rescue packs – prescribe if needed • Exacerbation safety netting • If MRC 4/5 - offer Pulmonary Rehab via video consultation /My COPD App	• Check optimal therapy; titrate if appropriate • Check adherence & inhaler technique (video) • Spacer advice • Exacerbation management advice • Repeat CAT test at 4 weeks and escalate to GP/Nurse if red or amber	• Check medication compliance - regular inhaler usage. Signpost to education (video) • Spacer advice • Lifestyle info/ stress management/ exercise • Smoking Cessation advice • Exacerbation management advice • Signpost to British Lung Foundation and other resources

Digital Support Tools to support patient self-management

MyCOPD app offering patient information & education, inhaler technique, online pulmonary rehab classes, smoking cessation support, self-management plan.

Overview of COPD – diagnosis, treatment, and managing flare ups: www.blf.org.uk/support-for-you/copd

Step-by-step guidance on physical activity : https://movingmedicine.ac.uk/disease/copd/#start

3. Training package & support available

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Overview of training package

Search

Search tools for EMIS, System one to identify patients
- Pre recorded webinar as to how to use the searches
- Online Q&A to troubleshoot challenges with delivery of the search tools

Workforce training

Sessions tailored to each staff grouping (e.g. HCA/ pharmacist etc)
- **Delivery:** Protocols provided/ training on how to use these
- **Practical support**: e.g. correct inhaler technique; peak flow, Very Brief Advice for smoking cessation
- **Health coaching:** How to have productive, adult to adult conversations
- **Digital implementation** support: how to get patients set up with appropriate digital
- Specialist sessions on conditions
- **Communities of Practice**

Digital Support Tools

Digital resources identified per condition
Implementation toolkits available where required, e.g. MyCOPD
Support available from UCLP's commercial and innovation team for implementation

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4. Expert input

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UCLPartners tested the Primary Care support package with patient and public representatives via a virtual engagement session. Key themes included:

Communication	Patients were concerned about not having regular communication with their usual GP but would be happy to hear from someone who was confident and consistent in their messaging & who had access to their existing health information
Holistic approach	Support offered needs to consider more than just the specific condition the individual is calling about but take into account and be responsive to the person's wider mental and physical wellbeing.
Trust	Patients raised concerns of fraud or breach of confidentiality when being contacted. They also wanted to have a single number/ named person to call if they needed support urgently

Clinical Advisory Group

Aiysha Saleemi, Pharmacist Advisor

Dr Deep Shah, GP

Helen Williams, Consultant Pharmacist

Dr John Robson, Reader in Primary Health care; Clinical Lead Clinical Effectiveness Group

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Thank you

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Q&As

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T2 diabetes: a case study from South London

Dr Neel Basudev – Specialist Diabetes GP

Anna Hodgkinson – Consultant Pharmacist, Diabetes

Proactive care for people with type 2 diabetes

@HINSouthLondon

healthinnovationnetwork.com

Health Innovation Network South London

During COVID-19- South London response

- Initial rapid learning and coordination of information regarding diabetes
  - Atypical case presentations were being seen
  - Disproportionate representation of diabetes as both case load and mortality
- Expert opinions and consensus led to a proactive care strategy for people with diabetes
  - Main aim to keep people well and out of hospital
  - Focus on glycaemic control with inbuilt stratification and prioritisation
  - Sick day rules
  - Key messages and signposting to relevant information e.g. Diabetes UK
- Utilisation of a full team approach in primary care
  - Health care professional (HCP) redeployment and change in roles e.g. health care assistants meant that HCPs were not being efficiently used
  - Rapid upskilling using a scripted approach to care and safety netting ensured support and guidance to manage large cohorts of patients
- Reduced secondary care activity as COVID-19 progressed
  - Proactive work on foot care ensued using same methodology
  - Increased referrals and secondary care activity for people with high risk diabetes foot disease

Proactive care- Identify, stratify and manage

http://gp.selondonccg.nhs.uk/
[COVID-19: Diabetes High Risk Cohort Pro-active Management](#)
[SEL COVID-19 Insulin de-escalation](#)

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COVID-19: Diabetes High Risk Cohort Pro-active Management

We are seeing an increasing number of people with diabetes (PWD) develop COVID-19. People living with diabetes are more likely to be self-isolating or shielding themselves at home during the pandemic. The following guidance has been co-produced by local experts to support the delivery of diabetes care in London during the pandemic. It is aimed at sites in the community where routine care is still taking place.

The focus is to identify PWD who may be at highest risk of decompensation should they develop COVID-19. These people need to be identified and proactively managed. It should be noted though that this is not an exact science and the evidence base is still emerging. A pragmatic approach needs to be adopted as there are still many unknowns with COVID-19 and practices are encouraged to pro-actively engage with patients as early as possible.

The COVID-19 pandemic has changed care delivery in primary care as well as the roles of some health care professionals with it. Many people will be working in less familiar surroundings and team work is vital due to the scale of the pandemic. This guide has been designed and written so that it can be used by allied health care professionals (HCPs) working within a primary care setting such as health care assistants and pharmacists with guidance and support from the practice diabetes lead. It encourages a team effort during the COVID-19 pandemic and supports the continued delivery of diabetes care at this important time. The use of allied HCPs is actively encouraged due to the volume of work and speed of action required.

Searches

This list is suggestive and is not exhaustive. Please add any patients who you feel may fall into being at high risk of severe illness should they become sick with COVID-19. Searches have been developed for use on EMIS IT systems. The searches can be edited and adapted as need be by practices.

- **High HbA1c>=75mmol/mol**
  - This search should identify approximately 10-15% of your diabetes population who would reasonably fall into a group considered to have a high HbA1c. This is a reasonable cohort to start proactive work with. It allows QOF searches to be used where EMIS searches are not readily available.
- **High HbA1c>=75mmol/mol, stratify by age >50years and BMI>30**
  - Initial insights from managing people with COVID-19 and diabetes have shown that there are numerous atypical cases and presentations. People of older age and higher BMI are potentially at highest risk and so a separate search has been created to identify this subset. Gender bias has not been factored as yet as the reasons are unclear for male predisposition to COVID-19. This search should identify approximately 2-5% of your diabetes population depending on practice demographics. Subject to time and resources, you may wish to focus your initial efforts on this subset of PWD.
- **People with co-morbidity regardless of HbA1c such as Chronic Kidney Disease stage 4/5, Chronic Obstructive Pulmonary Disease, Ischaemic Heart Disease and Congestive Cardiac Failure. Other patients known to practice with increased frailty and/or multiple co-morbidities. This may include those who are vulnerable, elderly and live alone**

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- These people can be considered to also be at higher risk of decompensation and would benefit from proactive management. This search is likely to identify the largest cohort of PWD and possibly around 25-30% of your diabetes population may fall into this category subject to practice demographics.
- **People who have required insulin initiation or intensification during COVID-19**
  - Many people with type 2 diabetes who develop COVID-19 are being newly started on insulin. We are seeing increased insulin resistance in some people and atypical presentations. In some cases, due to secondary care limitations at this time of crisis, they may be discharged in less than ideal circumstances. Their insulin doses may be higher than expected and we do not yet know what their continuing need for insulin will be like upon discharge. They therefore need active follow up to help with either insulin intensification or de-intensification if their insulin requirements fall.

Diabetes high risk EMIS searches.zip

Management of Diabetes High Risk cohorts

Once a cohort has been identified, each PWD will require a phone call so that an individual conversation can take place to explain areas of concern to them and explore their heath understanding. The prompts and script below have been written so that they can be reasonably given by an allied health care professional with supervision by the practice diabetes lead. The wording is there to act as a guide and help steer the conversations. Please work within competencies and comfort zone at all times and seek help from senior colleagues as appropriate.

You may find it easier to send people being called a preliminary text message before cold calling them. The following text message can be sent:

As someone who has diabetes, you may have specific queries about how Coronavirus might affect your health. Diabetes UK is the national charity for people living with diabetes and they have put useful information on their website which can be accessed at www.diabetes.org.uk/covid-updates This information is regularly updated. We strongly encourage you to read this information. Someone from the surgery will contact you to discuss more specific advice to help support you to stay safe.

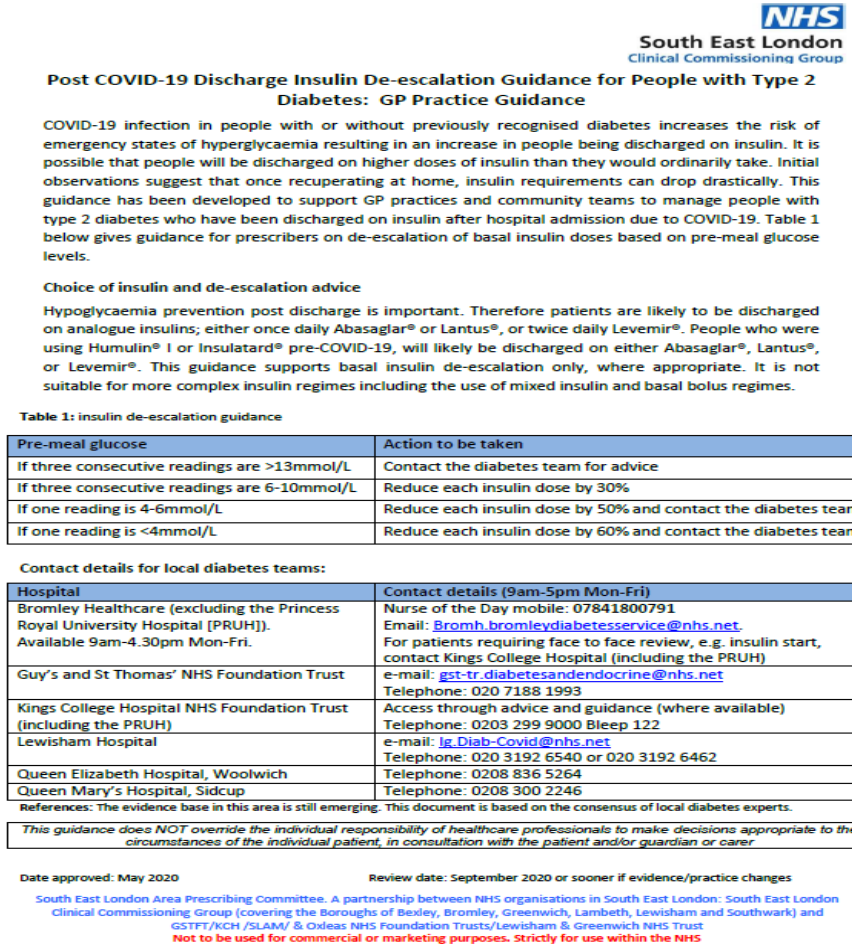
The following topics should be covered during the telephone call (suggested speech in italics):

1. Start with general advice and check understanding regarding the difference between shielding and social distancing. If unsure, reinforce the Diabetes UK website link as per text message

2. *I am just going to cover a few different topics with you. Please stop me if you are very familiar with some of these things I am saying or if anything is unclear.*

Date approved: May 2020 Review date: September 2020 or sooner if evidence/practice changes
South East London Area Prescribing Committee. A partnership between NHS organisations in South East London: South East London Clinical Commissioning Group (covering the Boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark) and

Insulin de-escalation guidance



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Post COVID-19 Discharge Insulin De-escalation Guidance for People with Type 2 Diabetes: GP Practice Guidance

COVID-19 infection in people with or without previously recognised diabetes increases the risk of emergency states of hyperglycaemia resulting in an increase in people being discharged on insulin. It is possible that people will be discharged on higher doses of insulin than they would ordinarily take. Initial observations suggest that once recuperating at home, insulin requirements can drop drastically. This guidance has been developed to support GP practices and community teams to manage people with type 2 diabetes who have been discharged on insulin after hospital admission due to COVID-19. Table 1 below gives guidance for prescribers on de-escalation of basal insulin doses based on pre-meal glucose levels.

Choice of insulin and de-escalation advice

Hypoglycaemia prevention post discharge is important. Therefore patients are likely to be discharged on analogue insulins; either once daily Abasaglar® or Lantus®, or twice daily Levemir®. People who were using Humulin® I or Insulatard® pre-COVID-19, will likely be discharged on either Abasaglar®, Lantus®, or Levemir®. This guidance supports basal insulin de-escalation only, where appropriate. It is not suitable for more complex insulin regimes including the use of mixed insulin and basal bolus regimes.

Table 1: insulin de-escalation guidance

Pre-meal glucose	Action to be taken
If three consecutive readings are >13mmol/L	Contact the diabetes team for advice
If three consecutive readings are 6-10mmol/L	Reduce each insulin dose by 30%
If one reading is 4-6mmol/L	Reduce each insulin dose by 50% and contact the diabetes team
If one reading is <4mmol/L	Reduce each insulin dose by 60% and contact the diabetes team

Contact details for local diabetes teams:

Hospital	Contact details (9am-5pm Mon-Fri)
Bromley Healthcare (excluding the Princess Royal University Hospital [PRUH]). Available 9am-4.30pm Mon-Fri.	Nurse of the Day mobile: 07841800791 Email: Bromh.bromleydiabetesservice@nhs.net. For patients requiring face to face review, e.g. insulin start, contact Kings College Hospital (including the PRUH)
Guy's and St Thomas' NHS Foundation Trust	e-mail: gst-tr.diabetesandendocrine@nhs.net Telephone: 020 7188 1993
Kings College Hospital NHS Foundation Trust (including the PRUH)	Access through advice and guidance (where available) Telephone: 0203 299 9000 Bleep 122
Lewisham Hospital	e-mail: lg.Diab-Covid@nhs.net Telephone: 020 3192 6540 or 020 3192 6462
Queen Elizabeth Hospital, Woolwich	Telephone: 0208 836 5264
Queen Mary's Hospital, Sidcup	Telephone: 0208 300 2246

References: The evidence base in this area is still emerging. This document is based on the consensus of local diabetes experts.

This guidance does NOT override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer

Date approved: May 2020 **Review date:** September 2020 or sooner if evidence/practice changes

South East London Area Prescribing Committee. A partnership between NHS organisations in South East London: South East London Clinical Commissioning Group (covering the Boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark) and GSTFT/KCH /SLAM/ & Oxleas NHS Foundation Trusts/Lewisham & Greenwich NHS Trust

Not to be used for commercial or marketing purposes. Strictly for use within the NHS

- Specific guidance produced for insulin de-escalation following reports of atypical cases
- Prioritise patient safety and supporting primary care
- Rapid consensus and production
- All of this guidance has been through SE London and London CAG

During COVID-19 - challenges

- Access to blood tests, blood glucose readings, urinalysis, blood pressure readings & weight
- Changes to lifestyle
  - Diet & exercise
- Changes to physical and mental health
- Changes to financial income
- New diagnosis/new presentations
  - Atypical, unexpected
- Pace of change

Post COVID-19 reset period

- Risk stratification
  - Utilisation of higher risk searches
  - Transition to QOF and 8/9 care processes
    - Bloods
    - Physical checks
- Optimising HbA1c and cardio-renal risk factors
- Maintaining proactive safety netting
  - Tools to stay well
  - Sick day rules card & advice
  - Reporting changes to eyes/feet

Post COVID-19 reset period- opportunities vs challenges

- Service and pathways redesign
  - New models of care vs Resistance and unknowns
  - Take time vs Do it now
- Technology & innovation to support people
  - Remote access vs Face to face
  - Transactional consultations vs Relationship
- Patient and health care professional engagement
  - Captive audience vs Workload escalation
  - Embrace change vs Innovation saturation

Contact details

Ground Floor, Minerva House,
5 Montague Close, London SE1 9BB

Closest stations:
London Bridge or Monument

020 7188 9805

@HINSouthLondon

healthinnovationnetwork.com

Jan Procter-King

Motivational interview training: developing an offer

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Feedback and discussion

Close and next steps

Primary Care Support package

- Available via UCLPartners' website (https://uclpartners.com/long-term-condition-support/)
- T2 Diabetes materials will be available from w/c 29th June
- Your feedback continues to shape the training and education package that is offered

Next Community of Practice: 30th July 2020, 6pm-7pm

(last Thursday of every month excluding August and December 2020)

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Thank you

For more information please contact

Primary Care enquiries Primarycare@uclpartners.com

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