Simplifying complex care and celebrating simple successes

Working through my diabetes clinic this week, and later that evening discussing guidelines with healthcare professionals on the University of Warwick/iHeed Postgraduate Diploma in Diabetes Care course, I was struck yet again by just how complex type 2 diabetes can be, and how daunting decision-making must feel for people with type 2 diabetes or for healthcare professionals beginning to deliver care.

As a new GP partner in 1985, non-insulin-dependent diabetes (NIDDM), as it was called, was managed largely in secondary care. Treatment choices were simple – lifestyle, gliclazide and insulin. Numbers with diabetes in our practice were small. As we developed our early clinics, dietitians and podiatrists worked in our practices and were deemed an integral part of our team (Hegan et al, 1991), roles that we later had to take on ourselves.

Fast forward 35 years and choices and decision-making are more complex, causing us all to face difficult decisions about treatment choices to individualise care. For glucose-lowering, we have a choice of 8 oral drugs (plus combinations), five injectable GLP-1 receptor agonists and 11 types of insulin. The Cardio-Renal-Metabolic (CaReMe) UK Partnership (https://bit.ly/3qnZ1fv) reminds us to think not just about glycaemia and the metabolic aspects of type 2 diabetes, but to consider cardiovascular risk, renal protection and mortality. Most people are on at least two glucose-lowering drugs, as well as several for their hypertension, cardiovascular disease (CVD), heart failure and kidney support. Guidelines are abundant, and differences between them can confuse. For example, the NICE guidance on the management of type 2 diabetes in adults (NG28) states that GLP-1 RAs are not cost-effective as a class for CVD protection, so we should not use them for this indication (NICE, 2022), while other guidelines support use of liraglutide, dulaglutide and semaglutide for reducing CVD risks. Studies and guideline updates relevant to primary care diabetes are published frequently, making it challenging to stay up to date.

So, set against this complex and rapidly changing landscape, we risk decision-making becoming so challenging that clinical inertia creeps in. To combat this, it can be useful to dismantle complex decision-making into simple steps, and I am sure most of you have your own structured way of doing this.

I start by reflecting on what individualised glycaemic target might be appropriate and whether further glucose lowering is needed. I list the comorbidities/complications and prioritise them, then look at current medications (and adherence). What drug class does my chosen guideline recommend to manage either the glycaemia or the comorbidities? Within the class, are there "best choices"? Do any existing medications need to change (e.g. dose reductions for eGFR or hypo risk) when adding new therapies? One final check – are the proposed options compatible with the person's renal function and their personal wishes? I then have the confidence to involve the person with diabetes in discussion of each of these steps. I ask about lifestyle changes that the person feels able to make, which might help achieve HbA_{1c} goals. However, even if agreed glycaemic targets are met, guidelines make recommendations for use of drugs to treat CVD, heart failure and chronic kidney disease. This needs careful explanation.

It helps enormously if we have time to review records and have support from our healthcare assistant to gather data before the consultation, and have a clear understanding of the recommendations of our chosen guideline. We are increasingly likely to initiate an SGLT2 inhibitor or a GLP-1 RA, so having a counselling checklist to ensure safe use of each class and an *aide-mémoire*, such as our *Need to Know* guide to SGLT2 inhibitors discussed below (which summarises the licensed

Pam Brown
GP in Swansea

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indications for CVD, heart failure, renal benefits and eGFR starting and stopping guidance) can help with a smooth-running consultation and, again, improve our confidence.

Even with a trusted decision-making framework, we will still have to face particularly challenging decisions from time to time, often with older, frailer people. For example, if NICE recommends an SGLT2 inhibitor for my 80-year-old patient, how can we reconcile the significant mortality and morbidity benefits for her heart failure and secondary prevention of CVD with the risk that she may drop her blood pressure, have a fall and fracture her hip? We know that the weight loss associated with newer drugs is beneficial for younger people and can help address the cause of their type 2 diabetes, but is there a downside in the frail elderly with established sarcopenia? We know that gliclazide can increase the risk of hypoglycaemia and weight gain, and some colleagues believe it should never be initiated – but are there times when gliclazide is the safest choice, be it short term to gain control of symptomatic hyperglycaemia as rescue therapy at diagnosis, or instead of insulin initiation in the housebound at the other end of their disease journey?

Clinical inertia and failing to add a potentially beneficial drug or stop one that could have adverse effects also have consequences that we need to consider and discuss.

We would love to hear what helps you deal with complex consultations, or about recent management dilemmas you have faced, so do share these with us at dpc@omniamed.com. Beverley Bostock, Chronic Disease Nurse Practitioner, PCN Nurse Coordinator and PCN Nurse Lead, recently shared her very elegant prescribing plan that "usually involves driving down the M21 or sometimes the M12 – **M**etformin first line, followed by an SGLT**2** inhibitor, then a GLP-**1** RA or *vice versa*."

Doing simple things well

So, in this potentially challenging landscape, what simple things can we all aspire to do well? Re-reading the papers about the development of primary care diabetes, the importance of individualised care, listening well, having good call and recall systems, and helping people have easy access to our clinics and self-management education were repeatedly highlighted. These feel just as important now as they were in the 1990s.

The UKPDS reminded us of the value of tight glycaemic and blood pressure control (UKPDS, 1998a; 1998b; 1998c), and STENO-2 demonstrated how improving glycaemia, blood pressure and lipids, even if not to targets that we see as optimal today, could make a significant impact on clinical events, quality of life and mortality rates (Gaede et al, 1999; 2008). We all have a tendency to collude with people when targets are not yet met – even if it has been "summer holidays" and "BBQ weather", minimising the glucose burden or gaining other benefits are so important. Today, we work in exciting times and newer, multifunctional drugs make it easier to achieve such goals, but still we should not underestimate how much time and how many consultations it might take to work through a person-centred and individualised plan with each person. For example, we all know the components of managing chronic kidney disease – tight blood pressure control, ACEi/ARB titrated to maximum tolerated dose if albuminuria, tight glycaemic control, SGLT2 inhibitors added independent of need for glycaemic control and, if CVD risk remains high or glycaemia not achieved, adding a GLP-1 RA. If people also develop new incident events, intolerance to medications, difficulties arranging blood tests and attending for reviews, it is very easy to see how many conversations and contacts will be needed, and how easy it would be to let inertia creep up on us before optimal care is achieved.

These last two years have been tough and in primary care it has been challenging to ensure we deliver even the simplest of diabetes care consistently. Most of us are still clearing the post-pandemic backlog of reviews and, as we grapple with delayed diagnoses and high HbA_{1c} measurements, it is easy to feel frustrated. Instead, we should be patting ourselves on the back for delivering the care we have achieved. And when our QOF and QAIF results showcase our achievements at the end of this month, I hope we will all make time to celebrate our successes. 75% achieved an HbA_{1c} ≤59 mmol/mol or a

blood pressure <150/90 mmHg? Congratulations to the whole team for doing the measurements and titrating all those drugs to achieve this. 75% received a foot examination? A huge thank you to everyone who helped with these opportunistically whenever people stepped into a face-to-face consultation. And for the achievements such as measurement of ACRs no longer recognised by QOF or QAIF – well done to our receptionists, district nurses, community pharmacies, families and friends who collected and delivered all those urine pots to make sample collection possible.

In a recent comment piece, Simon Griffin reminds us just how far away we still are from being able to implement precision medicine in diabetes (Griffin, 2022). However, I wholeheartedly agree with him that in primary care we are excellent at delivering personalised or individualised care, and we have demonstrated our ability to get back on track with this despite the worst that the pandemic threw at us. Feedback tells us that people with diabetes appreciate our care, even if they don't always make the time to tell us.

In this issue

There has been much debate over whether primary care teams should be actively involved in continuous glucose monitoring. In her comment piece, Laura Willcocks (University of Leicester) puts the case for why we should get involved, and shares resources to help us learn about these technologies, which can transform care for people with diabetes. In our next issue, Nicola Milne's updated "How to initiate and support continuous glucose monitoring" will provide additional guidance.

In their thought-provoking comment, Anju Gupta and Richard Clements share findings from their quality-improvement work in a deprived area of North East London, where they were able to rapidly demonstrate significant reductions in healthcare delivery variation.

Jane Diggle's "How to correctly diagnose and classify diabetes" clarifies an important area of practice and sets the scene for David Morris to share his interactive case study exploring the often misdiagnosed pancreatogenic (type 3c) diabetes. SGLT2 inhibitor use continues to increase and a further licence change to allow empagliflozin use in those with heart failure with preserved ejection fraction (HFpEF) as well as heart failure with reduced ejection fraction (HFrEF) is included in our updated *Need to Know* guide on SGLT2 inhibitors. Publication of the DELIVER study in the *New England Journal of Medicine* (Solomon et al, 2022) to coincide with data presented at the European Society of Cardiology Congress in August, confirms the efficacy of dapagliflozin in reducing the risk of worsening heart failure or cardiovascular death in people with mildly reduced or preserved ejection fraction. It is hoped this will translate into a licence change in the near future, so always ensure you are looking at the latest version of our guide.

In *Diabetes Distilled*, Kevin Fernando highlights new guidance on peripheral neuropathy, and a study that challenges the idea that different blood pressure targets are needed for those with and without diabetes. I share potential benefits of time-restricted eating in type 2 diabetes, and updated American Diabetes Association heart failure guidance. We hope you continue to find these a useful way to stay up to date.

Earlier in the year, we were excited to host our first face-to-face, post-pandemic Primary Care Diabetes Society (PCDS) conference here in Wales. In *Conference over Coffee*, we share practical messages on insulin, frailty and abnormal liver function tests from the three masterclasses. If you missed the conference, the plenary sessions are available on demand. You now have the opportunity to meet face to face and network this year at PCDS Northern Ireland (15 September), PCDS Scotland (25 October) and at our PCDS National conference (23–24 November) – you can register here. If you feel you can contribute to the successful running of the Society and are interested in standing for election to become a committee member, we would love to hear from you. Read the call for candidates and submit your application as soon as possible – the results will be announced in November.

Jane and I are very much looking forward to meeting up with as many of you as possible at the upcoming conferences. For those of you

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unable to attend, we will share key messages here in the journal, so you don't miss out. Until then, enjoy this issue and I hope you find something to interest and inspire you. ■

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