

Getting the best out of our consultations

As summer draws to a close and our attention returns to diabetes care delivery, we have much to encourage and re-enthuse our readers in this issue. Matt Capehorn provides an update on obesity diagnosis and management in our latest CPD module, while Neil Munro and colleagues share practical guidance from their experience running a bariatric surgery service. For those who want to read more about bariatric surgery for treating diabetes, an open-access review in *BMC Endocrine Disorders* discusses current challenges and perspectives (Koliaki et al, 2017).

In addition, Partha Kar, joint creator of the NHS RightCare diabetes pathway for England, discusses the target areas of this new initiative, while William Jeffcoate and colleagues help us apply the findings of the National Diabetes Footcare Audit to our practice. The links between gum disease and diabetes may not be immediately apparent, but they are explained by Penny Hodge on page 162.

Our regular sections in this issue include our review of the Steno-2 study, which highlighted the long-term microvascular, macrovascular and mortality benefits as well as improved longevity achievable with short-term, targeted, multifactorial intervention. I am sure this will inspire us to try even harder to achieve those benefits for the people we look after. In this editorial, and in the “Food for thought” box on our news pages, I include several calls to action. I hope you will choose to explore at least one of them.

Heart failure – still room for improvement

In our news pages, we share data from the recently published *National Heart Failure Audit* demonstrating that, although more people are being diagnosed with the condition and receiving all three disease-modifying drug classes, even those who are newly diagnosed in the hospital setting are not always discharged on optimal therapy (Donkor et al, 2017). So,

despite care improving significantly over the last 10 years, we still have the opportunity to make a real difference in primary care. Since admissions are short, heart failure therapies often need upward titration after discharge, and people need encouragement to understand and adhere to complex medication regimens.

We now understand the role of sodium–glucose cotransporter 2 inhibitors in reducing hospitalisations for heart failure and that some of the mortality reductions in people with established cardiovascular disease may be partly attributable to effects on heart failure. However, it is important that this does not distract us from ensuring people receive full benefits from conventional heart failure therapy. Encouraging adherence with angiotensin-converting enzyme inhibitors/angiotensin receptor blockers, beta-blockers and mineralocorticoid receptor antagonists, as well as diabetes medications, statins and antiplatelets, is no easy task. Many of us now have support from pharmacists working in our practices who are skilled at managing heart failure, so delegation ensures the best support for patients and optimises outcomes. Pharmacists may also be happy to help us optimise multifactorial interventions, as in the Steno-2 study.

We know that heart failure is at least twice as common in people with diabetes; therefore, significant numbers of those attending for diabetes reviews are taking heart failure medication. Choosing to review concordance with heart failure drugs at the same time as we discuss antidiabetes medication in those with both conditions could provide beneficial returns for the time invested. Perhaps something to consider.

Real-world versus clinical trials – adherence makes the difference

A study in August’s *Diabetes Care* (Carls et al, 2017) and an accompanying editorial (Edelman and Polonsky, 2017) highlight the significant role non-adherence plays in the gap between drug efficacy in clinical



Pam Brown
GP in Swansea

“In my experience, people rarely bring meters or monitoring diaries to clinic. Could we add this to our invitation letters and might people then prompt us to discuss their results, adding value to testing?”

trials and what is achieved in the “real world”. In the study, the mean HbA_{1c} reduction overall with glucagon-like peptide-1 (GLP-1) receptor agonists was only 6 mmol/mol (0.52%) in real-world studies, compared with 14 mmol/mol (1.30%) in clinical trials. For dipeptidyl peptidase-4 (DPP-4) inhibitors, HbA_{1c} reductions were only 5.6 mmol/mol (0.51%), compared with 7.4 mmol/mol (0.68%) in trials. Poor medication adherence was the main reason for reduced real-world effectiveness in this study, contributing around three quarters of the gap (5.6 mmol/mol with GLP-1 analogues and 2.0 mmol/mol for DPP-4 inhibitors). Likewise, in a study of liraglutide, the HbA_{1c} reduction was 9 mmol/mol (0.8%) in those with good adherence and 5 mmol/mol (0.4%) where this was poor (Buysman et al, 2015).

A recent meta-analysis looking at the association between adherence and outcomes in people with type 2 diabetes failed to find any randomised controlled trials comparing outcomes by adherence (Khunti et al, 2017). However, eight observational studies were included, and these demonstrated that the mean rate of poor adherence was high, at just under 40%. Good ($\geq 80\%$) versus poor adherence was associated with a relative risk of all-cause mortality of 0.72 (95% confidence interval, 0.62–0.82; three studies) and of 0.90 (0.87–0.94) for hospitalisation (seven studies).

Sadly, with pharmacy ordering of repeat prescriptions for most of our patients, it is more difficult to review adherence by examining the drug history on the computer. Many pharmacies routinely request all repeat medication every month, whether needed or not, depriving us of a useful tool. It is likely that this is contributing to significant unnecessary costs, as medication is dispensed and then destroyed by pharmacists after being declined by patients. We are often unaware this is happening, as not all pharmacies have systems in place to inform practices when patients refuse repeat medication or take it erratically. Encouraging pharmacies to work alongside us and ensuring the two-way sharing of information could facilitate identifying and managing non-adherence at an early stage.

SMBG

If test strips and lancets used for self-monitoring of blood glucose (SMBG) are issued on repeat prescriptions, there is a risk that these will be issued each month with other repeat medication, or that pharmacies will request these monthly whether the patient requires them or not. A recent review of a small cohort of our patients with type 2 diabetes undertaking SMBG demonstrated that six out of 10 had been prescribed 100 or 200 lancets (standard pack sizes) monthly for the last 6 months. As they only received 50 test strips per month, they were accumulating or refusing the lancets dispensed. Scripts for monitoring and devices cost NHS England £187 million in 2016/17, from a total diabetes drug spend of £983.7 million (NHS Digital, 2017). Staff training, liaison with pharmacies and patient discussions about SMBG monitoring requirements could make a significant impact on the cost of dispensing unwanted items, while still ensuring that those who benefit from testing have access to supplies.

Equally worrying when we delved further into our prescribing of SMBG products was that some people using insulin or gliclazide, including drivers with documented evidence that DVLA guidance had been discussed, had failed to request lancets or test strips for months. In subsequent discussions, people reported broken meters or not knowing how or when to test, despite us believing we had provided detailed instruction. I am sure our findings are not unique and that many practices will unearth both under- and over-prescribing if they look.

This issue, in our regular “How to” series, we review the DVLA’s updated *Assessing Fitness to Drive* guidance related to diabetes (DVLA, 2017). The guide raises important areas to discuss in clinic, and I hope it will encourage all of us to be more vigilant in asking about driving and reminding those who should inform the DVLA to comply, and to ensure that those who should test at times relevant to driving have the knowledge and tools to do so. In my experience, people rarely bring meters or monitoring diaries to clinic. Could we add this to our invitation letters and might people then prompt us to discuss their results, adding value to testing?

“Completing forms, printing labels, reviewing and annotating results and, where necessary, discussing results by telephone or in consultation takes time – it is surely better to do it once than twice?”

“Diabetes hacks”

Wikipedia defines “life hacks” as “productivity techniques used to solve everyday problems”. As our diabetes-related workload is high and the problems complex, it set me thinking about whether we should be collating and sharing “diabetes hacks” that could help improve care. My first suggested hacks are below.

During a recent 2-hour wait to have blood tests in our (excellent) phlebotomy service, I realised the inconvenience we impose when we ask people to undergo blood tests, and I understood why so many default. Over the next week, I noted how often I requested annual diabetes blood tests in people with recent incomplete testing. Surprisingly, nearly half of those due to have HbA_{1c} checks had undergone other blood tests in the preceding 3 months. Spending an additional 30 seconds reviewing the patient summary, medication and previous abnormal results could increase the likelihood that all relevant tests are organised at once. Not only could this save patients time and inconvenience, but it would also reduce our own workload. Completing forms, printing labels, reviewing and annotating results and, where necessary, discussing results by telephone or in consultation takes time – it is surely better to do it once than twice? Perhaps a “hack” for discussion with the rest of the team?

A “hack” we borrowed from another practice is to schedule annual diabetes reviews in the month of peoples’ birthdays. This makes it easy for them to remember their annual appointment. Dividing our diabetes register into 12 roughly similar-sized recall groups this way has made it easier to identify non-attenders at the end of each month and make further appointments. One colleague uses the time when someone doesn’t attend to dictate a letter to them, sharing their results, encouraging medication adherence and reminding them to make another appointment. Adding

alerts to records in order to encourage other team members to arrange bloods or do foot examinations opportunistically when people are seen takes little effort and has a potentially big impact, provided we all act on the alerts.

When signing repeat prescriptions, I find it useful to pick out scripts with diabetes medication. I then review investigation results, medication and missed clinic visits, and can add messages to scripts prompting attendance and attach blood forms. Pre-prepared printed labels with common requests (e.g. “Please make an appointment for diabetes clinic to review your results”) replace writing illegible messages and save time.

I am sure each of you has at least one “diabetes hack” to share to help us all make care more efficient or effective. Please email them to the editor at dpc@omniamed.com, with “Diabetes hacks” in the subject line. Alternatively, you can tweet us [@pcdsociety](https://twitter.com/pcdsociety). I look forward to learning from you, and we hope to publish a selection of hacks in an upcoming issue. ■

Buysman EK, Liu F, Hammer M, Langer J (2015) Impact of medication adherence and persistence on clinical and economic outcomes in patients with type 2 diabetes treated with liraglutide: a retrospective cohort study. *Adv Ther* **32**: 341–55

Carls GS, Tuttle E, Tan RD et al (2017) Understanding the gap between efficacy in randomized controlled trials and effectiveness in real-world use of GLP-1RA and DPP4 therapies in patients with type 2 diabetes. *Diabetes Care* 11 Aug [Epub ahead of print]

Donkor A, McDonagh T, Hardman S (2017) *National Heart Failure Audit: April 2015–March 2016*. National Institute for Cardiovascular Outcomes Research, London. Available at: <https://is.gd/uMx45F> (accessed 29.08.17)

DVLA (2017) *Assessing fitness to drive: a guide for medical professionals*. DVLA, Swansea. Available at: <https://is.gd/Wj3zN7> (accessed 25.08.17)

Edelman SV, Polonsky WH (2017) Type 2 diabetes in the real world: the elusive nature of glycemic control. *Diabetes Care* 11 Aug [Epub ahead of print]

Khunti K, Seidu S, Kunutsor S, Davies M (2017) Association between adherence to pharmacotherapy and outcomes in type 2 diabetes: a meta-analysis. *Diabetes Care* 11 Aug [Epub ahead of print]

Koliaki C, Liatis S, le Roux CW, Kokkinos A (2017) The role of bariatric surgery to treat diabetes: current challenges and perspectives. *BMC Endocr Disord* **17**: 50

NHS Digital (2017) *Prescribing for Diabetes, England – 2006/07 to 2016/17*. NHS Digital, Leeds. Available at: <http://digital.nhs.uk/catalogue/PUB30043> (accessed 25.08.17)

Let us know your “diabetes hacks”

To share your tips and tricks to improve diabetes care and increase the productivity of consultations, please email: dpc@omniamed.com with “Diabetes hacks” in the subject line.
Alternatively, tweet us [@pcdsociety](https://twitter.com/pcdsociety)