Primary care diabetes: Current challenges and potential solutions

Managing diabetes is among the biggest challenges facing the NHS. All of us in primary care know that the number of people with the condition is rising and that both type 1 and type 2 diabetes are taking up an increasingly large proportion of GP clinic time.

Diabetes is manageable, but every individual's experience of the condition and its control is different. It is a major concern, then, that policy makers are looking at the numbers and reaching for "one-size-fits-all" solutions. In addition, there is concern among clinicians about the recent draft NICE guideline for type 2 diabetes, which, if implemented, is likely to add variation and confusion to the treatment of people with the condition (O'Hare et al, 2015).

There has been significant change and progress in the past few years that should not be overlooked. We now have an even clearer idea of what should be done to help people with diabetes best manage their condition. But aiming to do "just enough" is not sufficient for our patients.

These concerns were crystallised for me when participating in *A Diabetes Snapshot* (Association of the British Pharmaceutical Industry [ABPI] Pharmaceutical Diabetes Initiative [PDI], 2015) – a report based on in-depth stakeholder interviews conducted by an independent party, with funding and initial direction from the eight pharmaceutical companies making up the ABPI PDI*. The ABPI PDI was closely aligned with the Primary Care Diabetes Society (PCDS) in work on this project. The findings demonstrate just how overwhelmed and under-supported primary care clinicians are feeling.

At a time when the burden of diabetes is really starting to snowball, health reforms have led to the loss of NHS Diabetes, and the dedicated National Clinical Director in Diabetes has now been expanded to a wider role. Interviewees for the report have felt the loss of national leadership and practical programmes. The PCDS is endeavouring to support primary care clinicians by filling the gaps in leadership and practical programmes, but efforts would be strengthened by a renewed national NHS policy commitment.

From the GP perspective, several respondents reported the acute lack of time available to undertake the full range of assessments required. We all know the huge pressure that general practice is under. Putting GPs in a position where they constantly have to firefight is not an environment that will result in optimal care. Some interviewees reported an environment whereby clinicians are battling with prescribing committees. Prudent healthcare would suggest an environment where clinicians spend their time treating patients and therapy costs are based not purely on drug acquisition but also on efficacy, durability, tolerability and the prevention of complications. I want to see precious clinician time spent in the best possible way.

Prevention of diabetes must be the best and most cost-effective means of managing this condition; however, it is not without problems. Primary care is already under huge pressures owing to a lack of resource and increased workload. Clinicians will now be expected to shoulder the responsibility of a new risk assessment programme, spotting those at risk of developing diabetes and referring them on to community-based weight-loss and nutrition services. Selective screening for "pre-diabetes" must be supported, but the bureaucratic burden is as yet unquantified. There are critical comments that diabetes is already poorly managed, with failure to achieve targets. Primary care is already under pressure with lack of time and resource to manage those already living with this condition. There are 3.2 million people in the UK living with diabetes and an estimated 600 000 yet to be found (Diabetes UK, 2014). For these people, weight loss, nutrition and exercise is only a part of the solution. We should also be

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*The ABPI Pharmaceutical Diabetes Initiative is a collaboration of the main pharmaceutical companies developing and manufacturing diabetes medicines and devices with the aim of supporting optimal treatment for people with diabetes. Companies include Abbott, AstraZeneca, Boehringer Ingelheim, Janssen, Lilly, MSD, Novo Nordisk and Sanofi.

aware to not neglect the 400 000 who are living with type 1 diabetes.

The challenge of diabetes is an existential one for the NHS because it marks a huge shift in the service's purpose. Diabetes is one of the key things driving general practice towards long-term condition management. But we still have an NHS whose organising principle is based on acute care. "Patching up and sending home" is a disastrous response to diabetes because many people with the condition rebound with increasingly devastating (and costly) comorbidities. More sophisticated solutions are needed to offer a high level of tailored support and treatment. While there has been undeniable progress over the past decade – major variation and gaps in support still exist and they will not go away unless the problems raised by *A Diabetes Snapshot* are addressed.

A way forward?

Primary care has changed significantly from the traditional model founded on reactive family doctors. As primary care clinicians we are expected to continue our traditional role but also embrace chronic disease management, offer proactive screening and provide care for many conditions that would previously have been dealt with in hospitals.

Diabetes is a condition that, given both time and expertise, can have its management based in the primary care setting. This has been recognised in several areas around the country, including Portsmouth, with its "Super Six" model.

To try to improve the quality of care for diabetes, an integrated care service would seem an ideal solution. In my locality, for instance, investment has been made to employ community diabetes specialist nurses. The role of these nurses will be to support the primary care team by helping manage injectable therapy, improving education of both patients and clinicians, and helping to facilitate discharge of patients from secondary care clinics. The nurses will be supported by primary care specialists in diabetes as well as secondary care diabetologists. Secondary care consultants have divided the locality into areas so that they have responsibility to support certain primary care practices and make themselves available by email advice and virtual clinics.

I strongly believe that it will only be with good integration of primary and secondary care that we can we fully support individuals with diabetes and help ensure that they receive optimum care. ■

Association of the British Pharmaceutical Industry Pharmaceutical Diabetes Initiative (2015) *A Diabetes Snapshot: A report from the ABPI Pharmaceutical Diabetes Initiative*. ABPI, London

Diabetes UK (2014) *Diabetes: Facts and stats*. Diabetes UK, London. Available at: http://bit.ly/1v0MhGr (accessed 02.06.15)

O'Hare JP, Millar-Jones, Hanif W et al (2015) The new NICE guidelines for type 2 diabetes – a critical analysis. *Br J Diabetes Vasc Dis* **15**: 3–7

Erratum

Article: The Primary Care Diabetes Society's response to NICE on the draft type 2 diabetes guideline. *Diabetes & Primary Care* **17**: 67–70

In the first bullet point in the second column on page 67, in the section titled "Metformin", the word "methotrexate" was inadvertently used instead of "metformin". This was an error introduced during the editing process and does not reflect the official submission made to NICE by the Primary Care Diabetes Society.

This has been corrected in the online version of the article.

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