NHS

UNIVERSITY OF LEEDS

ASPIRE
Action to Support Practices Implementing Research Evidence

Can your practice further improve the care of people with type 2 diabetes?

Dear Practice Manager and colleagues

Improving the care and outcomes of people with type 2 diabetes is a high priority for patients, practices, their CCGs, the CQC and NHS England. We have been working with local general practitioners, practice nurses and practice managers who have also identified type 2 diabetes as a priority.

As part of this initiative, supported by West Yorkshire CCGs, we plan to provide regular feedback on diabetes outcomes. This is the first report for your practice. We will provide quarterly updates on your practice's achievement. In addition we will offer two outreach meetings (CPD accredited), computerised searches to identify patients and additional pharmacist support to review patient notes. In the outreach meetings we will work with you to create an action plan (see attached Word template) or you can use this independently.

Please distribute this report to your practice team. We will be in touch to arrange a convenient time at a practice meeting to discuss how we can support you.

We know that practices are currently under a great deal of pressure and there are increasing demands within consultations. However, there is still considerable scope to improve the care and outcomes of people with type 2 diabetes.

We invite you to review your current care of people with diabetes and consider whether you can do more to help them improve their outcomes.

We will also send ten copies of this report for your practice team. If you require more, please contact Dr Tom Willis on **aspire@leeds.ac.uk** or 0113 343 6731.

"There is a three-fold variation between the lowest and highest achieving practices in West Yorkshire in the proportions of patients with diabetes who have achieved all recommended glycaemic, blood pressure and cholesterol levels. Much of this variation cannot be explained away by differences in patient characteristics and is related to how individual general practices organise their care."

Dr Ian McDermott
GP with a Special Interest in Diabetes, Leeds

Yours sincerely

Dr Robbie Foy
General Practitioner & Professor of Primary Care
on behalf of the ASPIRE team

For more information on ASPIRE, please see **http://medhealth.leeds.ac.uk/aspire**

Why review your care of type 2 diabetes?

Evidence-based care can make a real difference to patient outcomes. Yet the National Diabetes Audit found that **38%** of patients with type 2 diabetes do not receive all of the eight recommended care processes in 2012–13. Furthermore, **64%** of patients do not achieve all three NICE recommended glucose, blood pressure and serum cholesterol levels[1].

This feedback will focus on your practice achievement of these recommended levels.

We analysed data for 25,816 patients from 89 randomly sampled general practices across West Yorkshire. We found a 3-fold variation between the lowest and highest ranking practices in patients achieving all three target levels.

Women and people aged under 60 were less likely to achieve targets. People with co-morbidities were more likely to achieve targets – possibly because they have regular contact with health services. However, much variation cannot be explained away by patient (e.g. ethnicity) or practice factors (e.g. local deprivation or the number of practice partners) and is likely to be related to differences in clinician behaviour and how individual general practices organise their care.

Glycaemic control

Recommendations

- Agree and set a target HbA1c value with your patient. Consider **more stringent targets** for people with a short duration of disease, long life-expectancy, no co-morbidities, low risk of hypoglycaemia, adequate support systems and high motivation. Consider **less intensive targets** for older patients with a long history of diabetes, multiple or severe complications or co-morbidities, poor self-care capability and support and low motivation[2, 3].
- For people treated with lifestyle measures alone or who are taking one antidiabetic drug, the usual target HbA1c value is 48 mmol/mol. However, an individual's target may be set above this level.
- For people taking two or more antidiabetic drugs (including insulin), the usual target HbA1c is less than 59 mmol/mol. However, an individual's target may be set above this level.

Evidence

- For every 11 mmol/mol increase in HbA1c, the risk of death from a diabetes-related cause increases by 21%, microvascular complications increase by 37% and myocardial infarction by 14%[4].
- Reducing the HbA1c level can reduce the risk of complications from type 2 diabetes[2].
- Good control in the early years of type 2 diabetes may prevent long-term vascular complications[5].
- The risk of hypoglycaemia increases as soon as sulfonylureas or insulin are introduced, especially at lower HbA1c target levels[6].

How can practice organisation improve diabetes outcomes?

Accumulating research shows that how you organise care within your practice can improve diabetes outcomes[10,11]:

- Ensure you have a clear system and shared understanding for coordinating the diagnosis and on-going treatment of patients.
- Review your team structure to ensure the right skill mix, e.g. nurses trained in diabetes care.
- Actively promote personal goals for patients, ensuring that patients have printed action plans and agreeing how they will be monitored.

Blood pressure control

Recommendation

- If the person with diabetes has kidney, eye, or cerebrovascular damage, the target BP is less than 130/80 mmHg. For other people, the target BP is less than 140/80 mmHg.

Evidence

- People with diabetes achieve greater reduction in the risk of total major cardiovascular events and death with regimens targeting intensive BP lowering goals than do people without diabetes[7].
- More intensive treatment reduces stroke risk compared with less intensive treatment[8].
- High BP is associated with a more rapid decline in renal function than lower BP[8].

Cholesterol control

Recommendations

- Start a statin in patients of any age with known cardiovascular disease.
- Consider a statin irrespective of baseline cholesterol in all people with diabetes who are 40 years of age or older.
- Start a statin (atorvastatin 20 mg) in all adults aged younger than 40 year of age with type 1 diabetes if:
  - have established nephropathy or
  - have other CVD risk factors.
- Offer atorvastatin 20 mg for the primary prevention of CVD to people with type 2 diabetes who have a 10% or greater 10-year risk of developing CVD.
- Estimate the level of risk using the QRISK2 assessment tool **http://www.qrisk.org/** . Also available on SystmOne.
- Consider intensifying cholesterol-lowering therapy (with a more effective statin or ezetimibe), if there is existing or newly diagnosed cardiovascular disease, or if there is an increased albumin excretion rate, to achieve a total cholesterol level <4.0 mmol/L (and high-density lipoprotein cholesterol not exceeding 1.4 mmol/L) or a low-density lipoprotein cholesterol level <2.0 mmol/L.

Evidence

- Lipid-lowering therapy prevents cardiovascular events with a number needed to treat of 34 over 4 years for primary prevention (i.e. in patients with risk factors) and 14 over 5 years for secondary prevention (i.e. in patients with known cardiovascular disease)[9].

References

1. The Health and Social Care Information Centre, *National Diabetes Audit 2012-2013; Report 1: Care Processes and Treatment Targets*, 2014.
2. *HbA1c targets in type 2 diabetes: guidelines and evidence*. Drug Ther Bull, 2013. **51**(4): p. 42-5.
3. Ismail-Beigi, F., *Clinical practice. Glycemic management of type 2 diabetes mellitus*. N Engl J Med, 2012. **366**(14): p. 1319-27.
4. Stratton, I.M., et al., *Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study*. BMJ, 2000. **321**(7258): p. 405-12.
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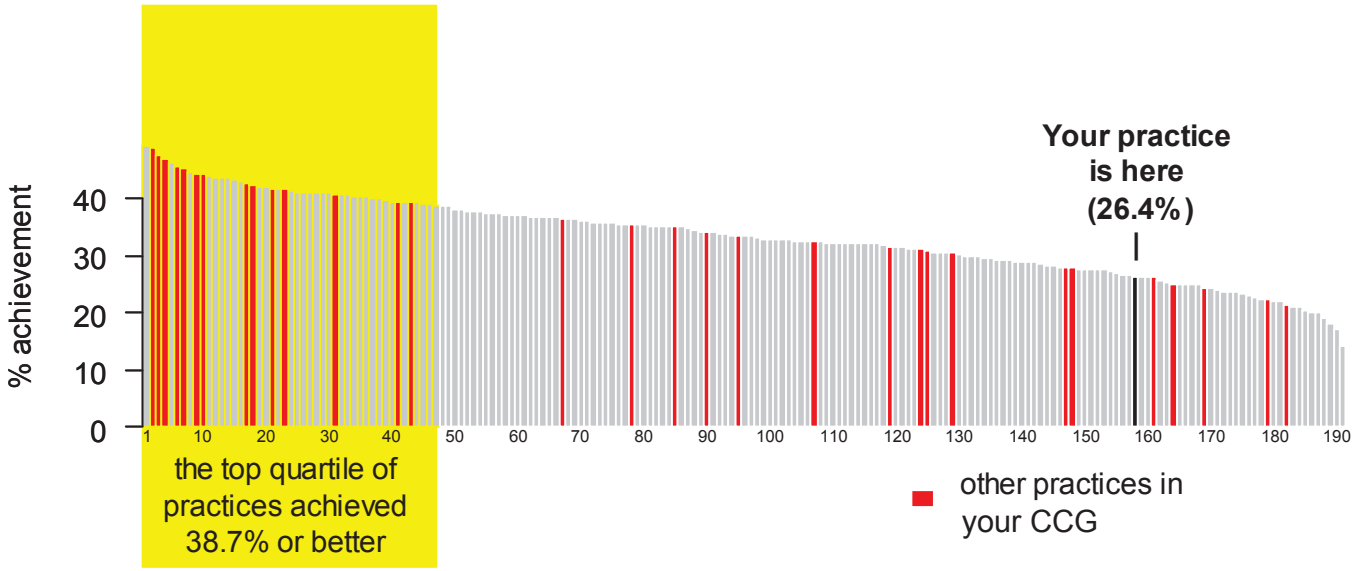
6. Inzucchi, S.E., et al., *Management of Hyperglycemia in Type 2 Diabetes, 2015: A Patient-Centered Approach: Update to a Position Statement of the American Diabetes Association and the European Association for the Study of Diabetes*. Diabetes Care, 2015. **38**(1): p. 140-149.
7. National Institute for Health and Care Excellence. *Clinical Knowledge Summaries: Diabetes - type 2*. 2010 July 2010 [cited 2014 01/12/14]; Available from: http://cks.nice.org.uk/diabetes-type-2.
8. Turnbull, F., et al., *Effects of different blood pressure-lowering regimens on major cardiovascular events in individuals with and without diabetes mellitus: results of prospectively designed overviews of randomized trials*. Arch Intern Med, 2005. **165**(12): p. 1410-9.
9. Vijan, S., R.A. Hayward, and P. American College of, *Pharmacologic lipid-lowering therapy in type 2 diabetes mellitus: background paper for the American College of Physicians*. Ann Intern Med, 2004. **140**(8): p. 650-8.
10. Tricco, A.C., et al., *Effectiveness of quality improvement strategies on the management of diabetes: a systematic review and meta-analysis*. Lancet, 2012. **379**(9833): p. 2252-61.
11. Shaw, R.J., et al., *Effects of nurse-managed protocols in the outpatient management of adults with chronic conditions: a systematic review and meta-analysis*. Ann Intern Med, 2014. **161**(2): p. 113-21.

How well is your practice doing?

Achievement in participating practices across West Yorkshire 2014/15 QOF year

- Your practice (black bar) and % achievement (26.4%)
- Achievement throughout West Yorkshire overall (range 14 to 49.2%)
- The top quartile of practices within West Yorkshire (yellow box – achieving 38.7% or above)
- Other practices within your CCG (red bars, n=31)



Your practice achievement on indicators for diabetes

Indicators	Proportion of patients (%)	Number of patients	Number of patients to be reviewed	Proportion of patients to be reviewed (%)
Last recorded HbA1c below or equal to 59 mmol/mol	**58.1**	**209/360**	**151**	**41.9**
Last recorded blood pressure below 140/80 (or 130/80 if there is kidney, eye or cerebrovascular damage)	**57.8**	**208/360**	**152**	**42.2**
Last recorded cholesterol level below or equal to ≤5.0 mmol/l	**66.9**	**241/360**	**119**	**33.1**
Achieving all three of above recommended levels	**26.4**	**95/360**	**265**	**73.6**
Recording all nine recommended processes of care in previous 12 months: BP; HbA1c; total cholesterol; urine ACR or PCR or proteinuria coded; eGFR or serum creatinine testing; foot care review; retinal screening; BMI; smoking status	**40.8**	**147/360**	**213**	**59.2**

What next?

Our team will be in touch to offer an outreach visit to support any changes your practice would like to make. Or you can use the attached template to guide a discussion about who will do what by when. It may involve one or more of the following:

1. Reviewing current arrangements in your practice for recalling and reviewing patients with one or more of suboptimal glycaemic, BP or cholesterol control.
2. Negotiating and sharing written, individualised action plans and goals for patients with diabetes.
3. Agreeing who, when and how to step up therapy with patients or who to refer patients to for initiation of insulin.
4. Reinforce healthy eating and physical activity advice at every appointment
5. Review your progress in light of further feedback we will send you later.

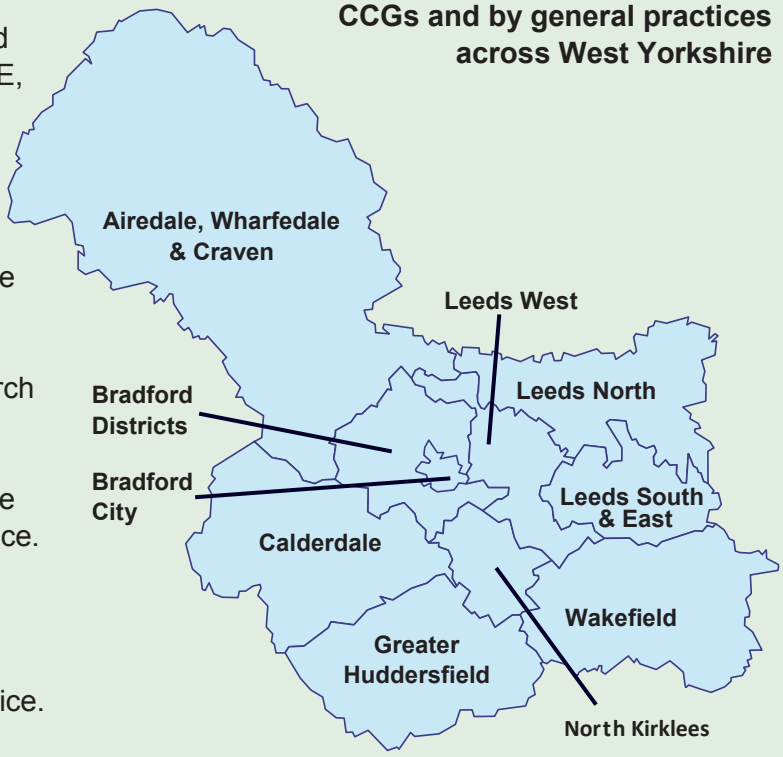
About ASPIRE

We are a multi-disciplinary group involving experienced researchers (from Leeds, Bradford and York), general practitioners, clinical leads from NICE, managers and patients. We also have panels of patients and international experts advising our programme. For further information see: **http://medhealth.leeds.ac.uk/aspire**.

Clinical research continually produces new evidence that can benefit patients. Despite the best efforts of many professionals, this evidence does not reliably find its way into everyday patient care. Much research suggests that we can do better for our patients – everyone knows this, and knows that achieving it is often easier said than done. We also understand the many competing demands that general practices face.

Our mission is to develop and test ways to support general practices in implementing evidence-based practice effectively and realistically within the constraints and challenges of real-life general practice.

ASPIRE is already supported by all CCGs and by general practices across West Yorkshire



What next?

Learning Modules/ Resources

NICE Clinical Knowledge Summaries:
http://cks.nice.org.uk/diabetes-type-2

BMJ Learning Module on HbA1c targets:
http://dtb.bmj.com/content/51/4/42.abstract?sid=99cc21d5-77bf-45ec-abbe-d0fa83f9a708

Patient resources

Patient.co.uk
http://www.patient.co.uk/health/type-2-diabetes

Diabetes UK Charity
http://www.diabetes.org.uk/
http://www.diabetes.org.uk/Guide-to-diabetes/Managing-your-diabetes/

DESMOND Project
http://www.desmond-project.org.uk/

X-PERT Health
http://www.xperthealth.org.uk/