Think Not What Primary Care Can Do For You, But What You Can Do For Primary Care

ASSOCIATION OF BRITISH CLINICAL DIABETOLOGISTS

SPRING MEETING 2016, RENAISSANCE MANCHESTER CITY CENTRE

Kevin Fernando FRCP Edin. MRCGP MSc Diabetes

- Graduated Edinburgh 2000
- 6-session GP Partner North Berwick Health Centre, near Edinburgh
- GPwSI Diabetes & Medical Education
- PCDS Committee Member
- Diabetes UK Clinical Champion
- Come Dine With Me Edinburgh Winner 2013

Professor Azhar Farooqi
Mary MacKinnon Lecture 2012

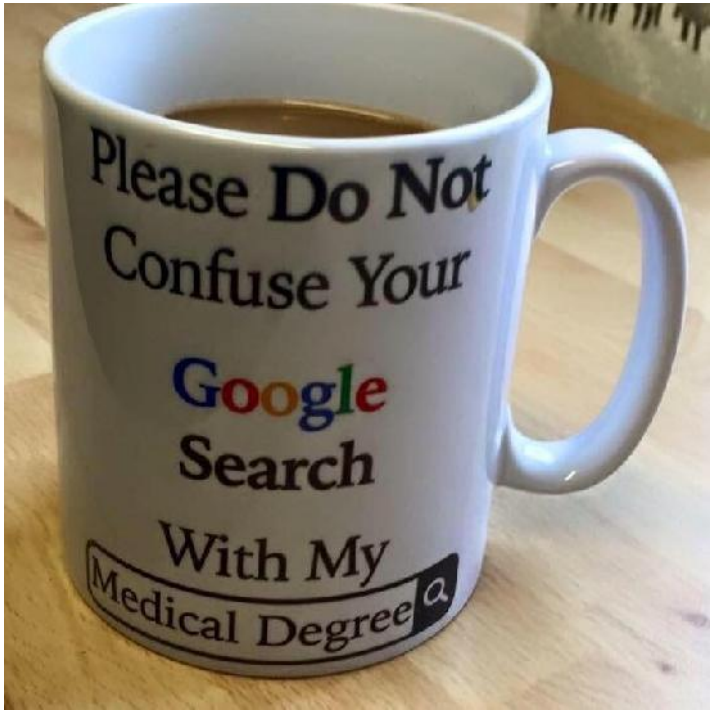
“Primary Care: The Custodian of Diabetes Care?”

"YOU CAN BE MY
WINGMAN
ANY TIME"

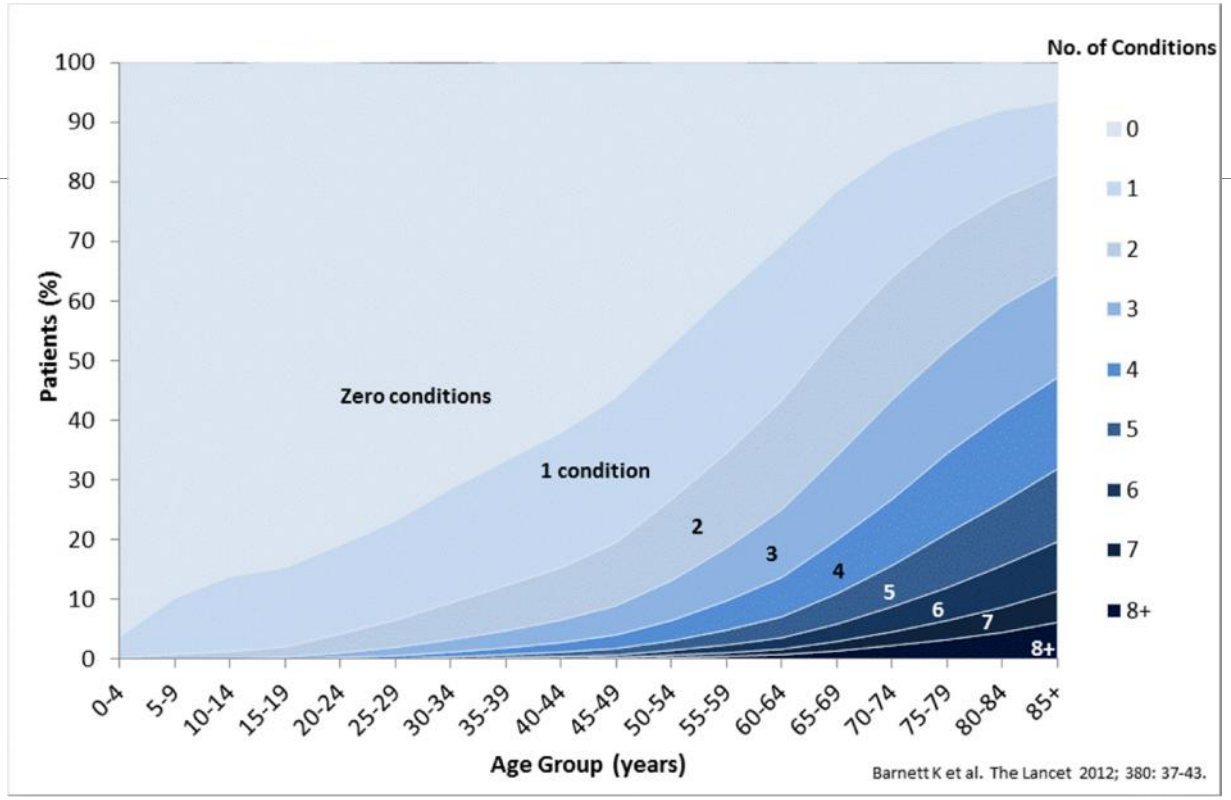
PICTUREQUOTES.com

“Specialist plus generalist approach in the community”

- Joint community clinics
- Flexibility, efficiency & effectiveness
  - Roles of Consultant & GP
- Advantages
  - Mutual education
  - Fewer investigations
  - Reduced clinic burden
- Primary Care - the last bastion of generalism
  - Evolving role, holism, managing uncertainty
- Benefits of collaborative approach

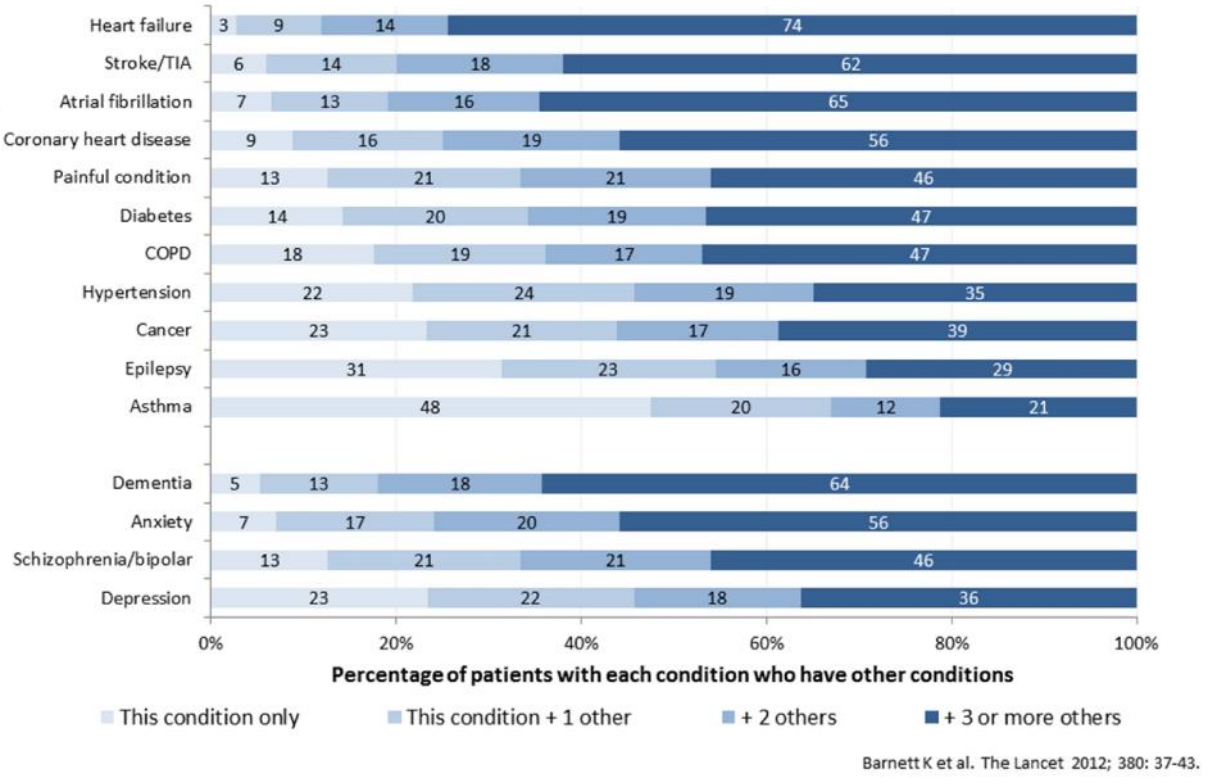


Multimorbidity is the norm



- 1.7m – 23% multimorbid
- Majority of >65y have 2+ conditions, and the majority of >75y have 3+ conditions
- More people have 2+ conditions than only have 1

Most people with any long term condition have multiple conditions



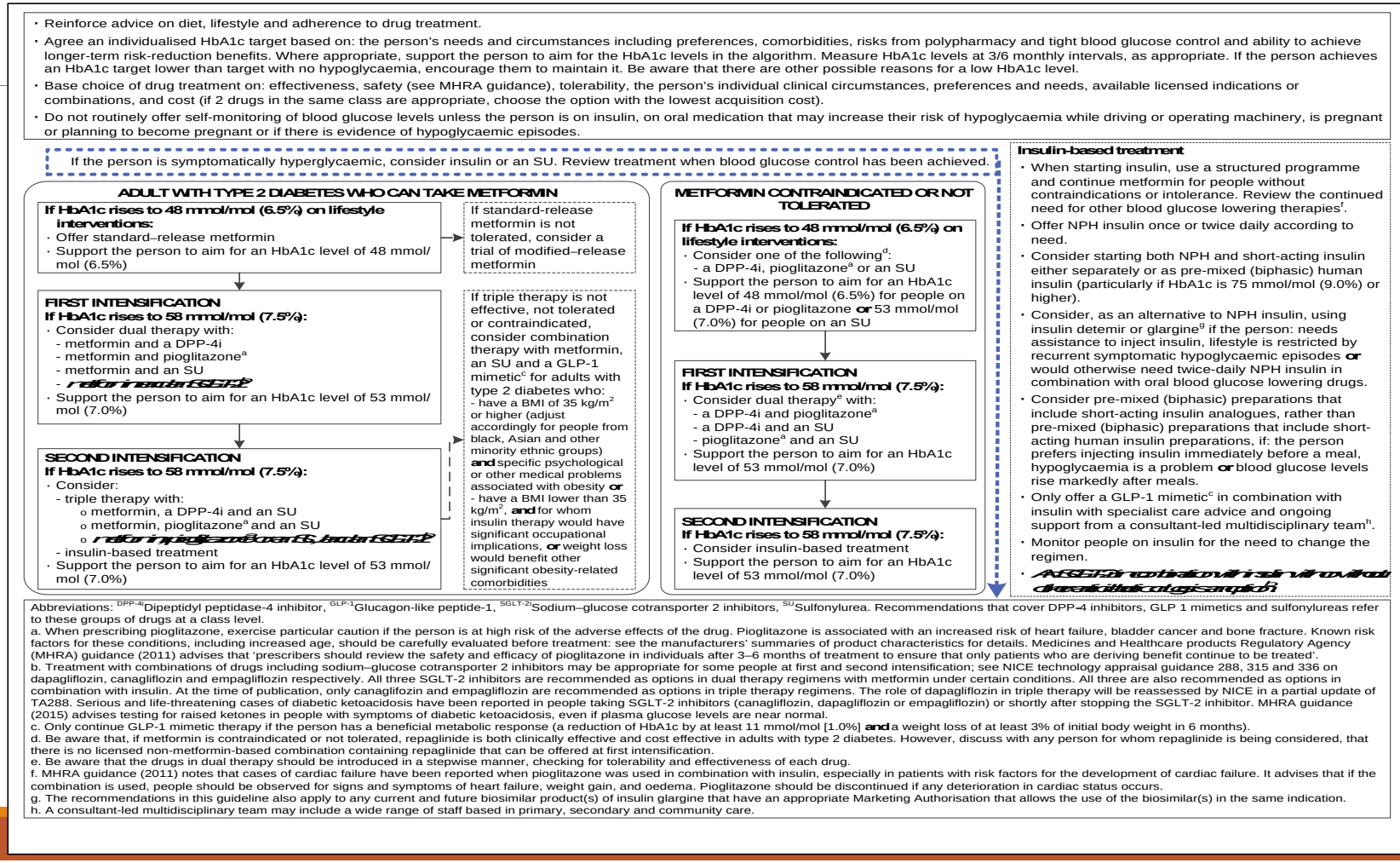
Barnett K et al. The Lancet 2012; 380: 37-43.

- Guidelines remain focused on patients with one disease
- Fragmentation of care – ADRs, ineffective care, unnecessary hospital clinic reviews & admissions
- Whole system interventions required – unified disease registers

Guidelines vs. Individualised Care

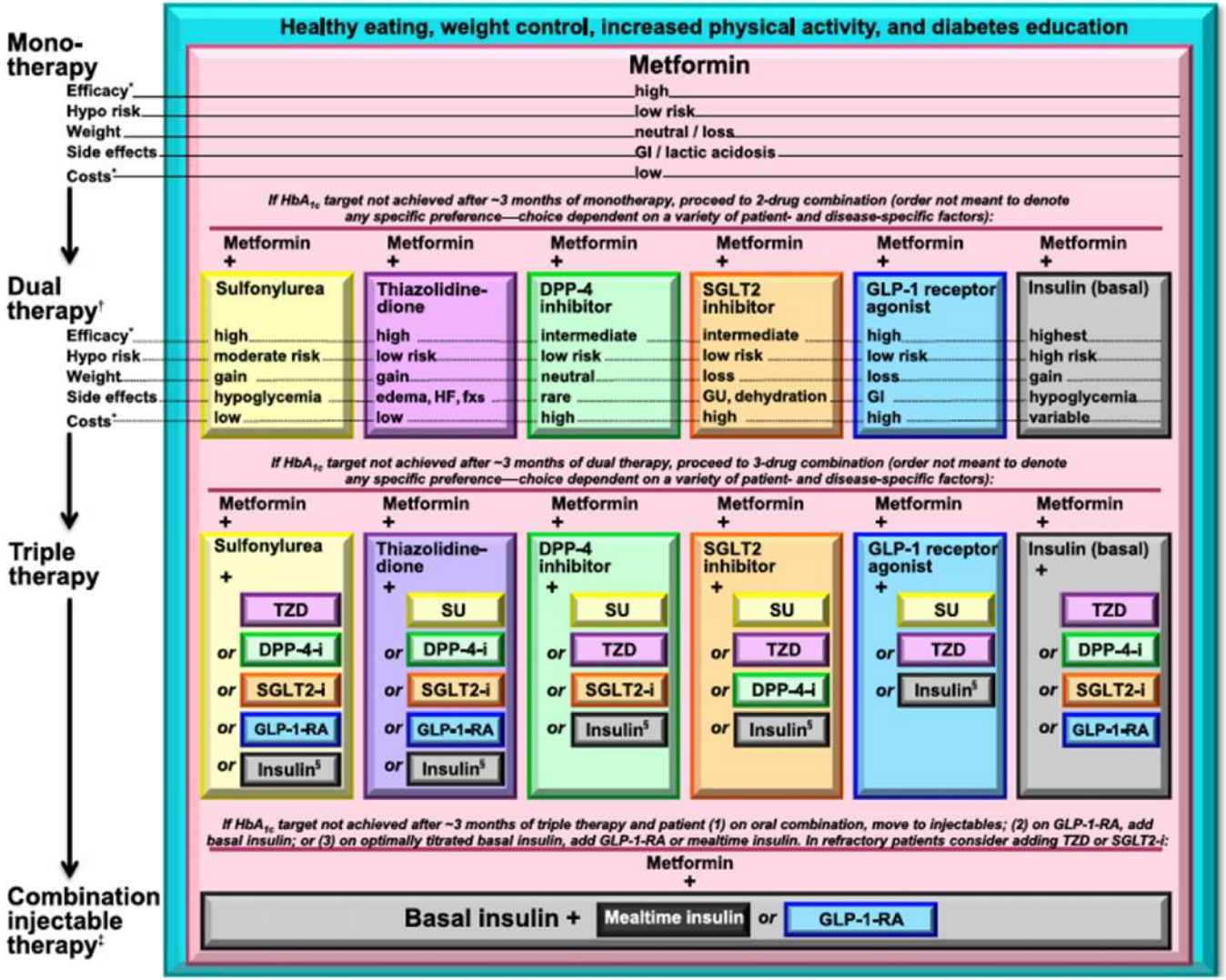
NICE National Institute for Health and Care Excellence

Algorithm for blood glucose lowering therapy in adults with type 2 diabetes



'Type 2 diabetes in adults: management', NICE guideline NG28 (December 2015)

Guidelines vs. Individualised Care



SIGN T2DM Treatment Algorithm[1]

1st LINE OPTIONS in addition to lifestyle measures; START ONE OF

Metformin (MET)	**Sulphonylurea* (SU)** • If intolerant to metformin • If weight loss/osmotic symptoms

Review and if not reaching target move to 2nd line

	Usual approach
	Alternative approach
*	**Continue medication if EITHER individualised target achieved OR HbA_{1c} falls >0.5% (5.5 mmol/mol) in 3-6 months**

2nd LINE OPTIONS in addition to lifestyle measures, adherence to medication and dose optimisation; ADD ONE OF

SU*	**Thiazolidinedione*** • If hypos a concern (e.g. driving, occupational hazards, at risk of falls) and if no congestive heart failure	**DPP-4 inhibitor*** • If hypos a concern (e.g. driving, occupational hazards, at risk of falls, or if weight gain a concern

Review and if not reaching target move to 3rd line

3rd LINE OPTIONS in addition to lifestyle measures, adherence to medication and dose optimisation; ADD OR SUBSTITUTE WITH ONE OF

ORAL (continue MET/SU if tolerated)		INJECTABLE (if willing to self inject; continue MET/SU if tolerated)	
Thiazolidinedione* If no congestive heart failure	**DPP-4 inhibitor*** If weight gain a concern	**Insulin* (inject before bed)** • If osmotic symptoms/rising HbA_{1c}; NPH insulin initially • If hypos a concern, use basal analogue • Add prandial insulin with time if required	**GLP-1 agonists*** • If BMI > 30 kg/m^2 • If a desire to lose weight • Usually <10 years from diagnosis

1. Adapted from: Scottish Intercollegiate Guidelines Network. Management of diabetes: a national clinical guideline. March 2010. Prescribers should refer to the British National Formulary (www.bnf.org) and the Scottish Medicines Consortium (www.scottishmedicines.org.uk) for updated guidance on licensed indications, full contraindications and monitoring requirements

Sir William Osler 1849-1919

"The good physician treats the disease; the great physician treats the patient who has the disease"

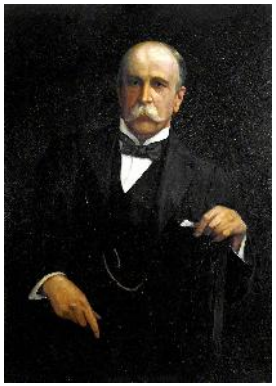
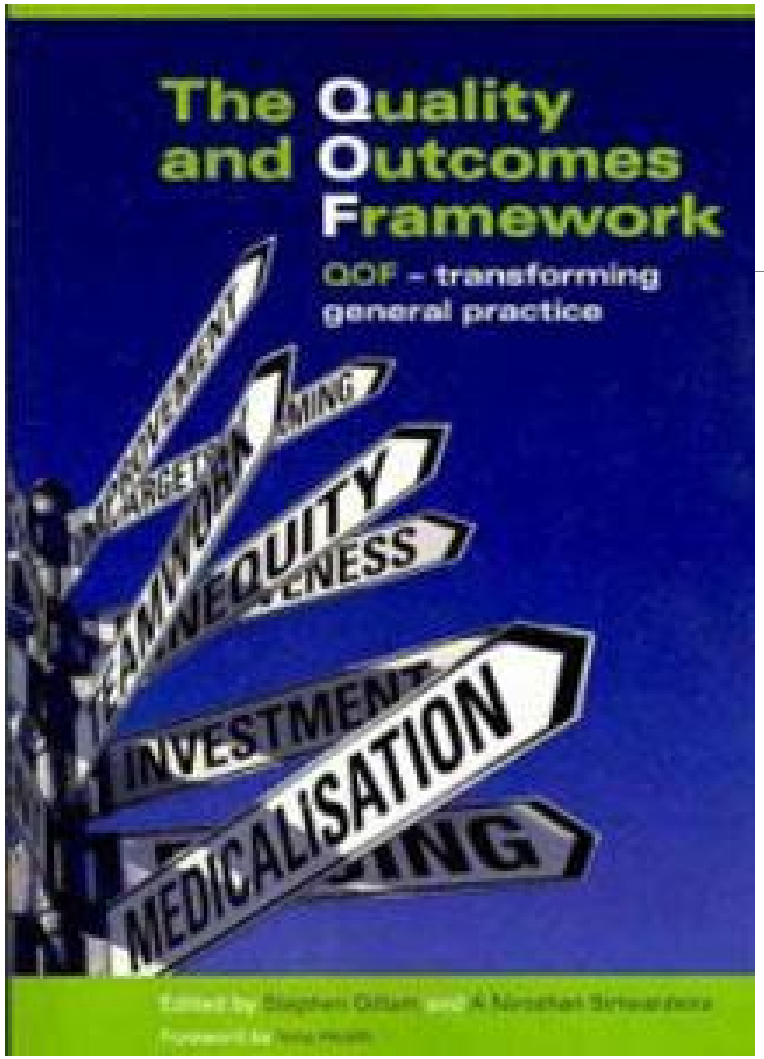


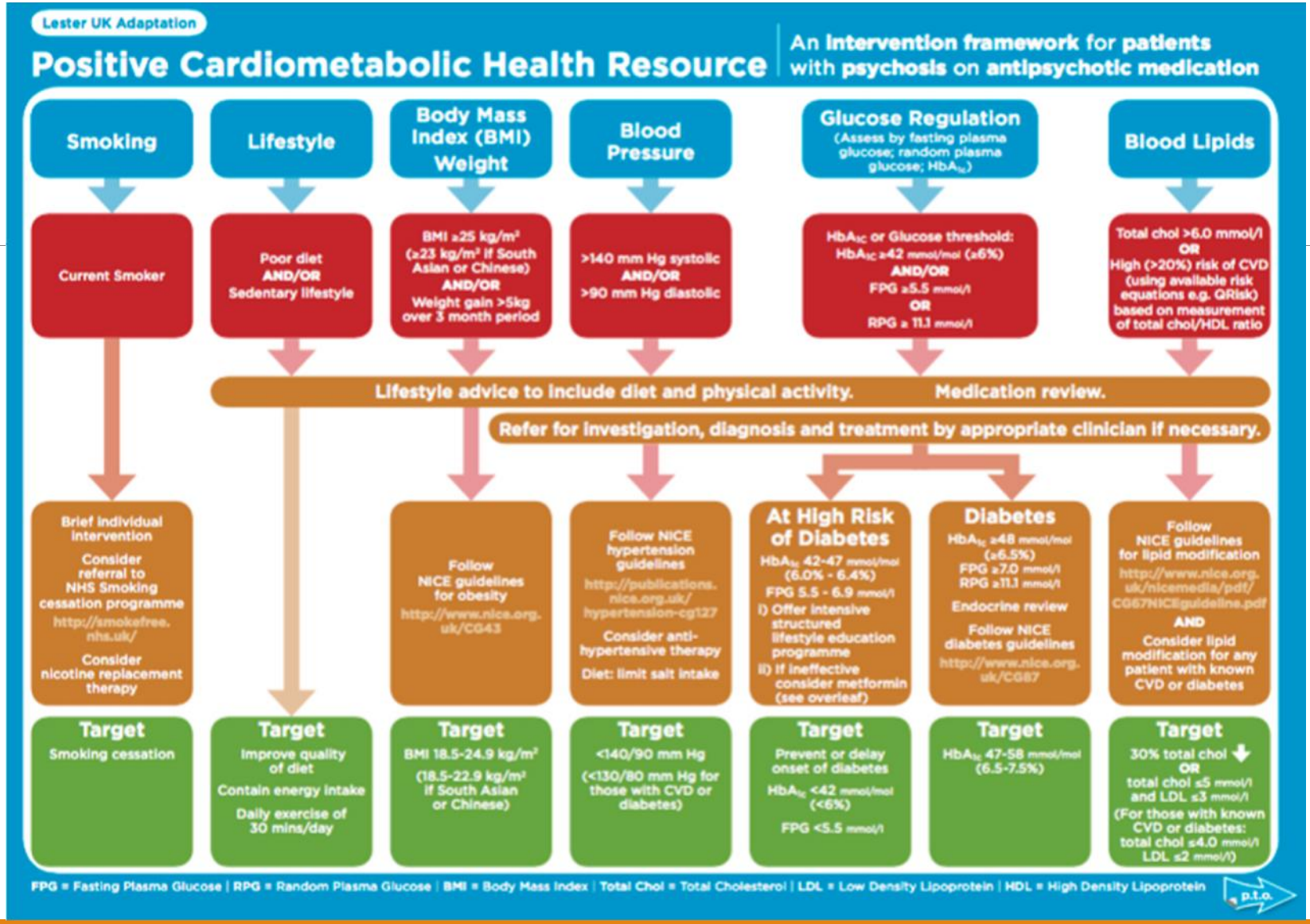
photo credit: Wellcome Library


The Quality and Outcomes Framework
QOF – transforming general practice
INEQUITY
INVESTMENT
MEDICALISATION


The target most GPs are looking for is one that gets rid of QOF targets
jantoo
Search:01435649

Julian Tudor Hart, 1971

"The availability of good medical care tends to vary inversely with the need for it in the population served"


Lester UK Adaptation
Positive Cardiometabolic Health Resource
An intervention framework for patients with psychosis on antipsychotic medication
Smoking
Lifestyle
Body Mass Index (BMI) Weight
Blood Pressure
Glucose Regulation
(Assess by fasting plasma glucose; random plasma glucose; HbA1c)
Blood Lipids
Current Smoker
Poor diet AND/OR Sedentary lifestyle
BMI ≥25 kg/m² (≥23 kg/m² if South Asian or Chinese) AND/OR Weight gain >5kg over 3 month period
>140 mm Hg systolic AND/OR >90 mm Hg diastolic
HbA1c or Glucose threshold: HbA1c ≥42 mmol/mol (≥6%) AND/OR FPG ≥5.5 mmol/l OR RPG ≥ 11.1 mmol/l
Total chol >6.0 mmol/l OR High (>20%) risk of CVD (using available risk equations e.g. QRisk) based on measurement of total chol/HDL ratio
Lifestyle advice to include diet and physical activity. Medication review.
Refer for investigation, diagnosis and treatment by appropriate clinician if necessary.
Brief individual intervention
Consider referral to NHS Smoking cessation programme
http://smokefree.nhs.uk/
Consider nicotine replacement therapy
Follow NICE guidelines for obesity
http://www.nice.org.uk/CG43
Follow NICE hypertension guidelines
http://publications.nice.org.uk/hypertension-cg127
Consider anti-hypertensive therapy
Diet: limit salt intake
At High Risk of Diabetes
HbA1c 42-47 mmol/mol (6.0% - 6.4%)
FPG 5.5 - 6.9 mmol/l
i) Offer intensive structured lifestyle education programme
ii) If ineffective consider metformin (see overleaf)
Diabetes
HbA1c ≥48 mmol/mol (≥6.5%)
FPG ≥7.0 mmol/l
RPG ≥11.1 mmol/l
Endocrine review
Follow NICE diabetes guidelines
http://www.nice.org.uk/CG87
Follow NICE guidelines for lipid modification
http://www.nice.org.uk/nicemedia/pdf/CG67NICEguideline.pdf
AND
Consider lipid modification for any patient with known CVD or diabetes
Target
Smoking cessation
Target
Improve quality of diet
Contain energy intake
Daily exercise of 30 mins/day
Target
BMI 18.5-24.9 kg/m²
(18.5-22.9 kg/m² if South Asian or Chinese)
Target
<140/90 mm Hg
(<130/80 mm Hg for those with CVD or diabetes)
Target
Prevent or delay onset of diabetes
HbA1c <42 mmol/mol (<6%)
FPG <5.5 mmol/l
Target
HbA1c 47-58 mmol/mol (6.5-7.5%)
Target
30% total chol ↓ OR total chol ≤5 mmol/l and LDL ≤3 mmol/l
(For those with known CVD or diabetes: total chol ≤4.0 mmol/l LDL ≤2 mmol/l)
FPG = Fasting Plasma Glucose | RPG = Random Plasma Glucose | BMI = Body Mass Index | Total Chol = Total Cholesterol | LDL = Low Density Lipoprotein | HDL = High Density Lipoprotein
p.t.o.

Paracelsus 1493-1541

"Poison is in everything, and no thing is without poison. The dosage makes it either a poison or a remedy"

New Therapies

Pre-Pregnancy Counselling


Quality • NHS Clinical • Linkage • Real World • Randomised • PROs • Population 52m+
About | Contact | Disclaimer | Unsubscribe | Sitemap
CPRD
MORE DIMENSIONS TO DATA
You are here: ▸ Home
Enter search word ...
Search
INTRO
HOME
CPRD NEWS
BIBLIOGRAPHY
CUSTOMER AREA
Vacancies
NHS National Institute for Health Research
Welcome to The Clinical Practice Research Datalink
The Clinical Practice Research Datalink (CPRD) is a governmental, not-for-profit research service, jointly funded by the NHS National Institute for Health Research (NIHR) and the Medicines and Healthcare products Regulatory Agency (MHRA), a part of the Department of Health. We have been providing anonymised primary care records for public health research since 1987. Research using CPRD data has resulted in over 1,500 publications which have led to improvements in drug safety, best practice and clinical guidelines. Examples include confirming safety of MMR vaccine, informing NICE cancer guidance, safeguarding use of pertussis vaccine in pregnancy, influencing the management of hypertension in diabetics. CPRD is now also using primary care data in clinical trials. Examples include a real world diabetes studies comparing a new therapy to standard of care, and randomised controlled trials on myocardial infarction and COPD patients.
This e-health secure research service combines the expertise of the MHRA's General Practice Research Database (GPRD) and the Department of Health's NIHR Research Capability Programme (RCP) which piloted the service over the last four years. CPRD combines the activities of GPRD and RCP.
Researchers using CPRD data and services will benefit from:
the unique nature of the NHS as essentially the single provider of health care (free at the point of care)
the NHS unique patient identifier - NHS number [It is only used by a trusted third party for linkage and is never released to researchers. It is a benefit in ensuring records can be validly linked within the approved governance process]
the NHS Primary Care gatekeeper approach to care
a partnership with the NHS National Institute for Health Research (NIHR)
a partnership with the NIHR Clinical Research Network
the extensive coded Electronic Health Record (EHR) IT systems
powerful coding systems
data quality markers, developed over many years
rapid data query tools even though CPRD data volumes are substantial
extensive data & research knowledge of CPRD staff and NIHR partner colleagues via the CPRD Knowledge Centre
CPRD services will develop incrementally over time increasing the population cover of primary care data and number of linked datasets. CPRD will also link to data from other domains such as Social Care.
All access and use of data via the CPRD are carefully controlled under UK and European law and the rules and regulations operating in the NHS.
See CPRD Governance for more details
The CPRD provides three key services to academic, pharma/biotech/devices and CRO researchers both in the UK and globally, subject to legal arrangements and approvals:
Interventional services and IT systems for clinical trials, bio-sample collections and Patient Reported Outcomes (PROs)
Research Services Full Pharmacoepidemiology, Pharmacoeconomics, Outcomes & risk benefit
Observational data Access to NHS and other health related data and linked data (suitably anonymised)
Many CPRD services are unique as they offer researchers capabilities which are impossible or hard to gain elsewhere and are provided in a way that gives added value to the research experience and its outputs.
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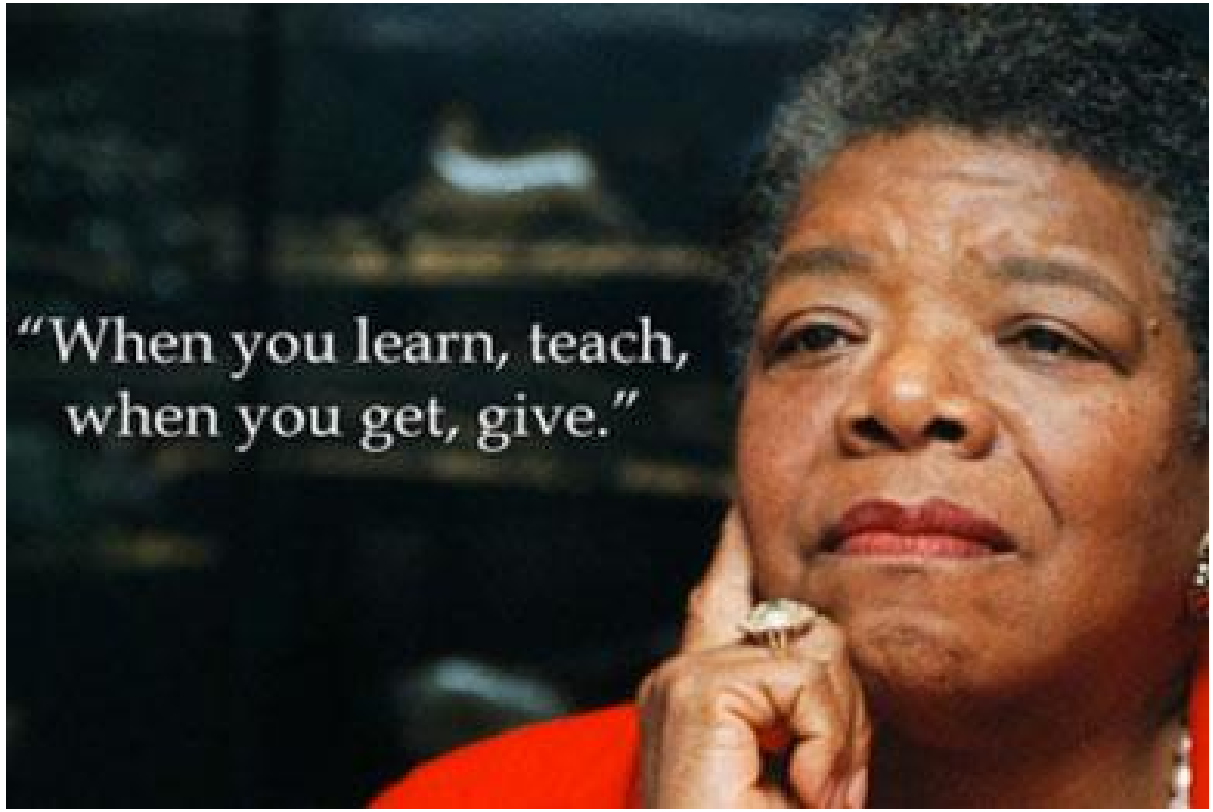
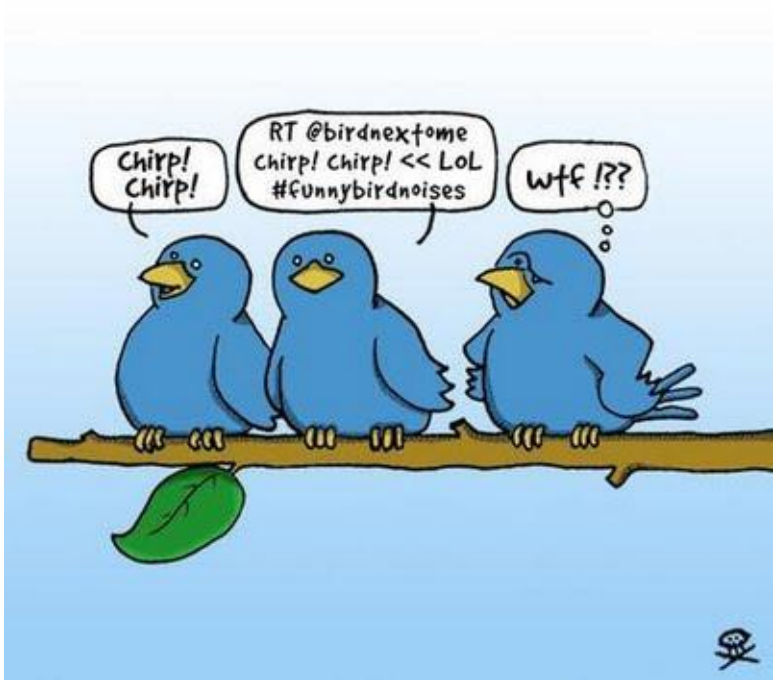
CPRD
Observational Data
Data Access
Record Linkage
Clinical Trials
Interventional Services
Global Data
Research services
ISAC
CPRD Charges
CPRD Knowledge Centre
Collaborations
Researcher / Research Funder
Member of the Public
Research GP Practice
General Practitioner
CPRD Governance
CPRD NHS Partners

Education & Networking



Social Media

@drkevinfernando



Alain de Botton

"There is no such thing as work-life balance. Everything worth fighting for unbalances your life"

Bill Withers 1981

“Just the two of us, we can make it if we try

Just the two of us,

Building castles in the sky

Just the two of us, you and I”