Insulin in primary care: educating patients and healthcare professionals

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The impact of the NSF for Diabetes and the new General Medical Services (GMS) contract will affect primary care for many years to come. The increasing burden of devolving 'uncomplicated' diabetes to primary care and achieving the targets of the new contract will have put more pressure on an already overloaded system. Despite this, practices are still willing to take on further tasks which historically have been the responsibility of secondary care or more particularly, the diabetes specialist nurse (DSN). One such task is the conversion of type 2 patients to insulin. Since the publication of the United Kingdom Prospective Diabetes Study (UKPDS, 1998) there has been a rapid increase in the number of type 2 patients changing from oral therapy to insulin. This intervention is now introduced much earlier than previously, and not, as in the past, a last resort.

Delivering high quality education

The increased workload has swamped the specialist team and patients have to wait increasingly longer times to commence insulin therapy. It therefore seems logical that insulin starts take place within the practice. However, to do this the primary healthcare team must have the confidence to deliver that care and the patient must feel confident in their team. Professional and patient education is therefore of paramount importance for this to work. Nicholson et al (2001) believe that a combined approach between professionals and the patient is necessary for all diabetes education.

The Audit Commission (2000) recognised the need for high quality diabetes education in primary care and the inequality of the delivery of diabetes care over the country – both in the primary and secondary care sectors. Many healthcare professionals do not find teaching easy. Thankfully, through protected education time for practices, there is now more opportunity to attend education sessions, instead of relying on self-instruction. Formalised practice nurse education is in place in many areas with staff having to prove their qualifications or experience/knowledge before practising. Once this education is in place, confidence in passing it on to the patient will follow.

Many diabetes centres have set up their own excellent regular education sessions for insulin initiation in primary care, and many DSNs are now employed by PCTs and are working alongside the practice staff. Other centres have set up local Warwick courses, having attended the trainer's course. Group starts are popular in many areas, but not always possible within the confines of a smaller GP practice. Perhaps when more GPs with special interest are appointed, this will become the norm.

Transferring to primary care

Dignan (2001) believes that patients are not always happy to transfer to primary care as they have always been seen by the specialist team and have confidence in them. Hughes (2001) agrees with Dignan and believes that trust and confidence have to be earned.

However, there are advantages, in that the practice is usually familiar with the patient and is aware of the patient's and often their family history. Most practices are also easier to access for patients than the hospital and can offer a variety of appointment times. With the emphasis on empowerment of patients, it is essential that patients know the level of expertise in diabetes within their practice and can elicit this information without fear of causing offence. The practice must also be able to empower the patient to self-care and there is much excellent educational material to support this. In my place of work, insulin self-adjustment leaflets have been produced 'in-house' and are shared with primary and secondary care colleagues to great effect. Comprehensive shared care guidelines are also invaluable.

Dignan (2001) also believes that professionals from secondary care are not always happy to relinquish their patients but professional jealousy must be put aside and the best interest of the patient put first.

Insulin initiation has struck fear into the hearts of many primary healthcare teams and up to a few short years ago, there were many who considered that insulin dependent and insulin treated patients were far too complex to be seen in primary care. How times have changed. We now see total diabetes care taking place within some practices.

Whatever our views are of initiating insulin in primary care, we must not forget that intensive education of both patients and professionals must be at its heart. ■

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