Starting insulin in type 2 diabetes: From secondary to primary care

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There has been a recent trend to shift services for long-term conditions like diabetes out of hospitals into primary care, as recommended by the White papers *Shifting the Balance of Power: The Next Steps* (DoH, 2002) and *Our health, our care, our say: a new direction for community services* (DoH, 2006). The aim is to benefit people with long-term conditions like diabetes by providing easily accessible services closer to home. Practice-based commissioning (PBC) and the effects of payment-by-results (PbR) will support this by encouraging the commissioning of cost-effective services that meet the needs of the local population (Hill, 2007). The movement of resources into primary care from secondary care, however, may be seen by some as a threat to traditional hospital diabetes teams. A good example of how this shift of workload has affected nurses providing diabetes services in primary and secondary care can be seen in the conversion of people with type 2 diabetes to insulin therapy.

Traditionally, individuals requiring conversion to insulin therapy were referred to the hospital diabetes service. The process of insulin initiation was seen as difficult, time consuming and dependent on specialist skills. However, with diabetes now making up a significant proportion of QOF indicators in the nGMS contract (and therefore affecting practice income) and an increase in the number of practice nurses with the skills to manage long-term conditions, there has been a rapidly increasing trend for insulin initiation to be undertaken in community diabetes clinics or by practices themselves (British Medical Association, 2003; Kenny, 2005).

This supplement considers two perspectives of this evolution: the challenges of initiating insulin in primary care are discussed by Colina Sanderson, who is a practice nurse in Devon, and how secondary care diabetes nurses are responding to the loss of less specialist workload is described by Julie Wilkins, who is working as a DSN in Stoke.

Primary care

Starting insulin in the GP practice can have many benefits for the person with diabetes. Diabetes management is often continuous and patient centred with the same GP and practice nurse carrying out most diabetes reviews. The nurse in particular supports the individual with:

- coming to terms with the diagnosis
- education and development of self-management skills
- annual reviews and the development of a management plan
- signposting to additional support such as smoking cessation.

There can be a gradual preparation for insulin during routine diabetes clinics over the individual's diabetes history: for example, the identification and treatment of hypoglycaemic events can be discussed when sulphonylureas are introduced and the safe disposal of sharps is covered when the person with diabetes starts self-monitoring their blood glucose. Thus, by the time the individual is ready to start insulin, they have already obtained much of the relevant information and many of the skills. This may make insulin initiation a more simple process as the practice nurse is aware of the individual's existing knowledge and competencies and these can just be revised when starting insulin.

Diabetes management can be more holistic in primary care as the practice nurse is usually involved with, or aware of, all the individual's healthcare needs and also has a wider set of skills to meet those needs. For example, in her article, Colina describes giving travel advice: she is able to give relevant travel immunisations as well as specific advice related to diabetes.

However, developing confidence and competence in initiating insulin as a practice nurse can be difficult. Lack of support can make nurses feel isolated and, unless the practice list is sufficiently large, starting people with type 2 diabetes on insulin may be infrequent. Therefore, skills gained in workshop sessions are not put into practice. Colina describes gaining familiarity with a small number of insulin types initially, but this may lead to individuals not receiving the most appropriate insulin regimen, a problem highlighted by Julie.

Secondary care

Diabetes services in secondary care can have many benefits: the wealth of experience in routine and complex management issues plus the economies of scale of having sufficient numbers of individuals to deliver services in groups. The availability of specialist services will always be an important part of a local diabetes economy: the person with non-complex type 2 diabetes who is managed in primary care today may require the diabetes renal clinic, the diabetic foot clinic or the diabetes obstetric clinic in the future. Julie describes how the loss of the more routine diabetes workload in secondary care enabled the development of more specialist services in Stoke.

Conclusion

Ideally, primary and secondary care providers should be working with local networks and commissioners to identify which setting can deliver the most appropriate and cost-effective diabetes services for the local population. Kaiser Permanente, a healthcare system based primarily in California, US, emphasises integration of care, which enables individuals to move easily between the primary and secondary care settings as their condition needs require. Specialists work with GPs together in one organisation so there is no incentive to build up facilities and resources in hospitals. Supported by risk stratification and a population management approach, the system enables the person with diabetes to receive their care in the most appropriate setting. Although this system has been compared to the NHS and pilot sites have implemented some of the principles in England, in reality, it is difficult to achieve such a seamless approach in the NHS with separate primary and secondary care settings in addition to the effects of PbR and PBC (Feachem et al, 2002; Ham, 2006).

Both authors in this supplement describe some of these difficulties of working across primary and secondary care. Colina describes a gulf between primary and secondary diabetes care: there are courses for insulin initiation run by hospital teams but these have insufficient support to develop competencies. Julie talks about the difficulties of working closely with primary care with different employers and of funding sources, targets and agendas. Hopefully, the embedding of diabetes networks in local diabetes economies will address these problems. ■

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