Insulin initiation: who should do it and who could do it?

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Introduction

Insulin initiation has traditionally been done in secondary care. The rapid increase in the number of patients with diabetes has meant that more people with type 2 diabetes are being transferred to insulin and earlier than in previous years. This article outlines how initiation of insulin in primary care could help ease the burden on secondary care and might be as effective or even more effective than hospital care. A DSN-led *Starting Patients on Insulin* course for GPs and practice nurses is described. As a result of the course, patients have been seen faster and earlier and DSN time has been freed for other patients.

ARTICLE POINTS

1 In the past, primary care referred patients to secondary care for insulin initiation.

2 There is mounting pressure on secondary care as the number of people with diabetes increases.

3 Group sessions could be a possible solution to facilitate insulin initiation in overstretched practices.

4 In Stockport, since the implementation of a DSN-led course for GPs and practice nurses, ten practices now start their own patients on insulin.

5 Patients are now seen faster and DSN time has been freed for other patients.

KEY WORDS

- **Insulin initiation**
- **Secondary care**
- **Primary care**
- **Group sessions**
- **DSNs**

Historically, primary care has referred their patients with diabetes who require insulin to secondary care, with only a few practices taking on the day-to-day management of their patients who take insulin. Farooqi (2003) found that within his own primary care trust (Eastern Leicester) less than 10% of practices initiated insulin therapy for patients with type 2 diabetes. He postulated that this reluctance among GPs might be due to the potential pitfalls, especially the heightened risk of hypoglycaemic coma. However, Griffin (1998) in a meta-analysis of diabetes care in general practice found that shared care schemes with intensive support could be as good or better than hospital care.

Too many patients need insulin

Over the past few years the situation has been changing rapidly. The 'explosion' of diabetes, the increase in the numbers of elderly people and the struggle to achieve better metabolic control in our patients has meant that more people with type 2 diabetes are being transferred to insulin more quickly than in previous years (Home et al, 2003). Initiating insulin therapy early rather than as a 'last resort' can help correct underlying pathogenic abnormalities associated with type 2 diabetes and improve insulin secretion (Farooqi, 1998). However, this has caused system overload in secondary care and most patients are now being 'handed back' to already overloaded practices for their regular reviews. In addition, the new General Medical Services contract has put added pressure on GP practices to achieve healthcare targets (which in some cases are unattainable) in order to obtain maximum points (Hughes, 2004).

On the other hand, Home et al (2003) argue that there can be no excuses for not considering insulin therapy in any individual who might benefit from it, which they say could apply to all those whose HbA_{1c} rises to 7.5%. However, they also point out that none of this will be possible without an expansion in the support available to primary and secondary care from Diabetes Specialist Nurses (DSNs), educators and counsellors.

Where is the time?

Without the additional resources alluded to by Home et al (2003), where do overloaded staff find the time to take on this extra work and initiate insulin therapy in their surgeries? Group

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1 Patients who started insulin in groups reported greater treatment satisfaction than those who started insulin in a conventional one-to-one nurse-led setting.

2 In Stockport, there were 56 general practices, with a minority caring for the patients on insulin.

3 As a result of the DSN-led *Starting Patients on Insulin* course for GPs and practice nurses, ten practices now start their patients on insulin.

4 Patients are seen more quickly and the practice is closer to home than the hospital and hence more convenient.

sessions could be a possible solution (see *Figure 1*). Erskine et al (2003) describes the efficacy of group teaching over one-to-one teaching for the transference of type 2 patients to insulin. Erskine et al used similar resources in terms of staff and time but they managed to treble patient contact time. The researchers also found that patients starting insulin in groups expressed significantly greater treatment satisfaction compared with those starting insulin in a conventional one-to-one nurse-led setting. It would appear then that group sessions are well received and enjoyed by the patients who attend them. Similar findings were reported by Hill and Gilroy (2002) who also found that patients were very supportive of one another.

The Stockport experience

Insulin initiation was always considered to be a secondary care issue, but more GPs and practice nurses are taking on this role in primary care and doing it well.

Starting Patients on Insulin course

In Stockport, there were 56 general practices, with a minority caring for their patients on insulin. Approximately 18 months ago, a *Starting Patients on Insulin* course was set up by DSNs for any practice nurses and GPs who were interested in carrying out insulin initiation within their own practices. As a result there are now ten practices that start their own patients on insulin therapy. Uptake for the course has been slow, however, there continues to be a steady trickle of applicants and this has meant that with the small numbers, DSNs have been able to spend more time discussing relevant issues.

Figure 1. Initiating insulin in group sessions

Benefits from course

There have been a number of benefits from the course:

- Patients are seen more quickly and insulin is started earlier.
- Their own practice is closer to home than the hospital and therefore more convenient.
- Patients are dealing with health professionals who know them well.
- Practice nurses and GPs feel more confident to deal with their other patients who take insulin.
- DSN time has been freed for other patients.

Due to the number of type 2 patients who are being referred to DSNs for insulin therapy, the waiting time is increasing. For patients whose practices are trained and willing to take on insulin initiation, their wait is usually days rather than weeks, which is clearly a major advantage for these patients.

Course content

The *Starting Patients on Insulin* course content includes:

- Who needs insulin? (case histories)
- Insulin types and regimens
- Insulin pens and devices
- Hypoglycaemia/hyperglycaemia
- Current dietary advice
- Everday issues, e.g. driving, illness etc.
- Monitoring diabetes and blood glucose meters.

After the course

On completion of the course DSNs visited the practices to sit in with the GP or practice nurse for their first (or first few) insulin initiation sessions to provide advice and support where required. Some of the primary care staff declined this offer and felt confident enough to 'go it alone'. Although there are at present only ten practices that initiate insulin therapy in Stockport, more primary care staff are booking onto the forthcoming courses. Hopefully, this will increase the numbers of practices willing to take on this role.

All patients who are transferred to insulin therapy are encouraged from day 1 to adjust their own insulin and they are given clear guidelines plus literature produced 'in house' to enable them to do this. They are also asked to telephone their particular healthcare professional on a weekly basis to report on their progress and the dose of insulin that they are now taking. Much encouragement is given to these patients, and as their diabetes control improves telephone contact is gradually reduced (although they can ring at any time if they require advice). Patients are incorporated back into the clinic at 3 months where they will have their HbA_{1c} rechecked. By taking this approach from the outset, control is given to the patient and encourages them to take responsibility for their own health in keeping with the diabetes NSF standards for patient empowerment (DoH, 2001).

Conclusion

We are very fortunate in Stockport in that there are excellent relations between primary and secondary care, particularly amongst the nurses. The practice nurses are a very motivated group of professionals who are keen to learn and keen to improve the health of their patients whatever it takes. Times are changing and we must all change with them. We need to look for new ways of doing things together – transferring patients to insulin in general practice is one such change. After all, Einstein once quoted: 'If you always do what you've always done, you'll always get what you always had.' ■

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PAGE POINTS

1 Although only ten practices initiate insulin therapy in Stockport at present, more primary care staff are booking onto forthcoming courses.

2 All patients transferred to insulin are encouraged to adjust their own insulin and are given clear guidelines to enable them to do this.

3 Telephone support is also offered to patients, which is gradually reduced over time.

4 Patients return to the clinic at 3 months to have their HbA_{1c} levels checked.

5 Primary and secondary care need to find new ways of working together to improve the health of patients.