Insulin initiation: A secondary care perspective

Julie Wilkins

Article points

1. The current initiatives to provide routine care for people with diabetes in primary care have changed secondary care services.
2. When people with type 2 diabetes are admitted the DSNs use the opportunity to check their knowledge and understanding of their condition and ensure they are aware of what services are available to them and what care they should expect.
3. The shift of care to primary care, has had many benefits.
4. It is essential that commissioners and service providers understand the skills and experience DSNs can offer.

Key words

- Insulin initiation
- Secondary care

Julie Wilkins, Diabetes Clinical Nurse Specialist, University Hospital of North Staffordshire NHS Trust

The Government initiative outlined in the NHS Plan (DoH, 2000) encouraged a review of services for people with long-term conditions, such as type 2 diabetes. Over the last few years there have been considerable changes to service delivery both locally and nationally in response to this and other key policies such as the NSF standards document (DoH, 2001), the NSF Delivery Strategy (DoH, 2003) and the recent White Paper (DoH, 2006). This article looks at these changes from a secondary care perspective.

The impetus for change within diabetes services began over a decade ago due to the concern that we as healthcare professionals were facing 'a burgeoning epidemic of type 2 diabetes' (Amos et al, 1997). Research published around this time showed new evidence that people with type 2 diabetes had a cluster of risk factors, including hypertension and hyperlipidaemia, and that reducing these risk factors was necessary to reduce the burden of diabetes on both those with the condition and the NHS (UKPDS, 1998a; 1998b). This evidence, together with the increasing number of people with type 2 diabetes, led to the reorganisation of diabetes services in order to improve care outcomes and increased vigilance to improve early detection of diabetes.

For at least 10 years, while secondary care has been the main provider of services for people with diabetes, many initiatives (for example the nGMS and associated QOF) have been developed to enhance primary care based diabetes services.

North Staffordshire NHS Trust

The current initiatives to provide routine care for people with diabetes in primary care have changed secondary care services. The first change was a move away from the traditional annual review clinic held in secondary care. The majority of annual review clinics are now run in primary care. This has allowed the service to develop.

The current secondary care diabetes team has been in post for approximately 11 years. It is comprised of three WTE DSNs graded at band 7, one part-time support staff nurse graded at band 5 and a part-time healthcare support worker. The team also includes three consultants who run six diabetes outpatient clinics per week. There are also additional clinics on a less frequent basis; for example a monthly joint renal diabetes clinic, a monthly paediatric to adult transitional clinic, and a busy weekly joint obstetric clinic where up to 50 women with diabetes (types 1 and 2 and gestational) are seen each week. The service

is also supported by three dedicated dietetic sessions per week and a part-time specialist podiatrist.

DSN services

The secondary care DSN team provide a service to all inpatient areas and also to 4 outpatient clinics per week, reviewing the care and management of people with diabetes referred to them. This includes people with type 2 diabetes where an enhancement of their normal medications may be required following admission for other complications. This is a valuable aspect to the role and has been shown to reduce both readmissions and length of stay elsewhere in the country (Cavan et al, 2001; Davies et al, 2001). This finding was also supported by a local audit of the service.

It is acknowledged that junior medical staff may not have the same level of knowledge and skills for looking after people with diabetes during illness as an experienced DSN (Da Costa, 2007). Recently the amount of time DSNs have spent covering acute wards has had to increase nationally due to increasing pressures on the ward-based staff because of reduced staffing levels and vacancy freezes. The long-established teaching programme which enables the general staff to commence basic dietary education for people with type 2 diabetes almost ceased due to staff pressures and the support nurse having been deployed onto the wards.

When people with type 2 diabetes are admitted the DSNs use the opportunity to check their knowledge and understanding of their condition and ensure they are aware of what services are available to them and what care they should expect; for example whether they are accessing foot care and having their HbA_{1c} checked by primary care. Such interventions ensure that a robust package of care is provided for the patient which can prevent readmissions and reduce length of stay.

As recently as 5 years ago, most people requiring intensification of therapy and insulin initiation were seen by secondary care as the primary care DSNs were not able to respond to requests to see people quickly enough, and practice nurses did not have the time or the skills. The secondary care service based at the diabetes centre was able to see people quickly, in one location and often in groups, which made the service more cost-effective.

Local audit data show that the number of people with type 2 diabetes initiated onto insulin in secondary care in 2002 was 70 but this fell to 45 in 2006. This indicates that primary care practitioners are now initiating individuals onto insulin.

Primary care services

There are two PCTs in North Staffordshire; the primary care health professionals have varying levels of knowledge and skills for initiating insulin. Some practitioners have completed the Warwick Certificate in Diabetes Care course, some have completed an insulin initiation programme; other practices use specialist contract nurses to initiate insulin. Primary care DSNs are involved in providing education and support for those initiating insulin within their own practices.

Service delivery

The shift of care to primary care, has had many benefits. Over the last year in the author's area, a rapid access service has been developed to allow patients to be fast-tracked into a joint DSN and consultant clinic. Urgency of referrals is decided by consultants when they arrive in the post. Any very urgent referrals are called or faxed through by the GP. These individuals may be referred by their GP or the primary care DSN. They are seen within four weeks and all aspects of their diabetes care and management are reviewed. The service has been expanded to the renal clinic where a monthly clinic is now run by a DSN, diabetologist and nephrologist. These renal patients may have CKD, be pre-transplant or pre-dialysis with stable or unstable diabetes. This joint clinic provides an enhanced service to patients as they are able to see both disciplines at the same time thereby reducing follow up time. Further specialist clinics are planned, including the development

Page points

1. The secondary care DSN team provide a service to all inpatient areas, reviewing the care and management of people admitted for various reasons.
2. When people with type 2 diabetes are admitted the DSNs use the opportunity to check their knowledge and understanding of their condition and ensure they are aware of what services are available to them and what care they should expect.
3. The secondary care service based at the diabetes centre was able to see people quickly, in one location and often in groups, which made the service more cost-effective.
4. The shift of care to primary care, has had many benefits.

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1. A project team has been developed that the author is involved with and which includes commissioners to discuss the transfer of services to primary care.
2. Over the last three years the author's diabetes team has been able to develop their structured education programme and are currently running three carbohydrate counting courses per year.
3. It is important that the role of the secondary care diabetes team including the DSN, built up over many years and largely pioneered in the UK, is not eroded or devalued.

of an insulin pump service.

Practice-based commissioning has not impacted upon the service and as talks have begun one PCT has expressed a preference to use local skills for service provision while the other PCT is still considering options. There is evidence in some areas of new tariffs being set by the Strategic Health Authority which compromise the funding of specialist outpatient work as all joint clinics are outside the current tariff (Da Costa, 2007). Group education, carbohydrate counting courses, structured education and group insulin starts are also said to be outside of the payment-by-results tariff and must therefore be agreed locally (Da Costa, 2007).

Recent developments

A project team has been developed that the author is involved with and which includes commissioners to discuss the transfer of services to primary care. The involvement of primary and secondary healthcare professionals will allow for better service and promotion of the role of the hospital based DSN.

The project is in its infancy and the initiative is to define what is best managed by the specialists and what is the generalists role. One option which is being considered is to provide satellite clinics in the community which will be run by secondary care consultants and DSNs, to which GPs will refer their more complex cases. This has been tried successfully in other areas (Burgess and Mchoy, 2007). This strategy could lead to an improvement in the knowledge and skills of primary care practitioners, a more holistic approach to care and a service that is more accessible to people with diabetes. One option for achieving this is to discharge the patient back to primary care after one or two visits with a detailed care plan for the primary care team and details of when to refer.

Over the last three years the author's diabetes team has been able to develop their structured education programme and are currently running three carbohydrate counting courses this year compared with two courses in previous years.

Conclusion

It is important that the role of the secondary care diabetes team including the DSN, built up over many years and largely pioneered in the UK, is not eroded or devalued. It is essential that commissioners and service providers understand the skills and experience the specialist team can offer to the ever-increasing population with diabetes.

However it must be remembered that there will always be a need for the secondary care team to continue to provide support for inpatients and groups with more specialist needs, such as those who are pregnant; paediatrics and adolescents; many of those with type 1 diabetes; those with advanced complications and cystic fibrosis. ■

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