

**WEDS Position Statement**

**Use of injectable therapy for diabetes in primary care**

Overview

The ability to initiate injectable therapies for diabetes in primary care could have a number of potential benefits however there is currently no agreed Welsh guidance to assist primary care practitioners in their safe and appropriate use.

Such assurance would support the continuation of a managed transfer of appropriate diabetes care into the community (with appropriate resources) and would facilitate care being delivered nearer to patients homes, in line with the Welsh Government’s health policy “Setting The Direction”.

Across Wales, health communities are at different stages in their development in relation to ability to undertake this transition. Some of this is accounted for by differences in resource available. Additionally there are differences in opinion between primary and secondary care doctors as to how to develop this activity.

This paper is an attempt to reach a mutually acceptable position and discusses the possible benefits as well as difficulties in developing the skill set required to safely deliver injectable therapy in primary care for patients with diabetes.

Historical perspective

Primary care focus on diabetes was stimulated by the 1990 GP contract which began to reward structured chronic disease management. At that time initiation of injectable therapies for diabetic patients was almost exclusively a secondary care responsibility though some practices had experience in insulin dose adjustment. The introduction of the 2004 primary care contract and the Quality and Outcomes Framework which supported and rewarded evidence based care of diabetes stimulated a significant transfer of diabetic care from secondary to primary care in some areas.

The development of insulin analogues with improved delivery devices coupled to pharmaceutical support of primary care directed education programs (Insulin for Life, Merit) has led to increasing levels of confidence amongst primary care practitioners.

The more recent development of GLP-1 receptor agonist injectable therapies has added to this potential therapeutic area. Though costly, these agents do not carry insulin’s risk of hypoglycaemia. They also have user-friendly delivery devices and far less requirement for monitoring and dose adjustment. They thus provide a far simpler solution than insulin for many Type 2 Diabetic patients when tablet control is inadequate. Practices that have already developed skills in insulin initiation find this class of drug an easy addition to their options. The GLP-1 agonists can now also be usefully co-prescribed with insulin in certain patients. As licensing indications develop combination prescriptions will be increasingly used in primary care.

Benefits of primary care use of injectable therapy in diabetes patients

* Primary care has access to detailed patient records and is more aware of patients’ social circumstances. This knowledge puts the GP in a good position to decide whether to initiate potentially hazardous agents such as insulin.
* Staffing is more consistent in primary care as is ease of access for review. Both of these are advantageous to primary care in this context.
* Proximity to patient’s homes and the ability in occasional defined circumstances to undertake reviews at the home has clear benefits.
* The ability to undertake primary care initiation of injectable therapy would mirror the movement of diabetes management in to the primary care setting.
* The ability to undertake such activity will produce a far more responsive service than at present avoiding sometimes long waits for secondary care appointments.
* Offloading of large hospital clinics to a more responsive service in primary care will give better access to secondary care when problems develop and will allow specialist hospital clinics to concentrate on management of inpatients with diabetes, complicated Type 2 diabetes, Type 1 diabetes, complex diabetic foot disease, diabetes in adolescence , diabetes in pregnancy and insulin pump therapy.

Problems associated with the development of injectable therapy use in primary care

* One issue relates to the amount of additional activity and workload that such a development would generate. How such activity could be resourced is not currently clear although in some localities Local Enhanced Services have been designed to facilitate this.
* For safe practice a significant level of expertise is necessary. This includes acquisition of factual knowledge through attendance at an accredited diabetes course, of which several are available in Wales. However the award of an accredited qualification is not sufficient; practical experience and training plus a commitment to ongoing professional development are also vital. These aspects can be monitored within the standard appraisal process.

Additional practical experience, particularly for practices without prior experience in this field is required. This could be obtained either via attendance at secondary care clinics, through virtual clinics (with secondary care support) or via links with practices already undertaking this activity. The extent and duration of any mentorship period will be dependent on previous levels of competence and should be discussed and agreed to from the outset. Members of the Welsh Endocrine and Diabetes Society will support any primary care practice wishing to develop this activity.

* The time commitment to undertake appropriate training and experiential learning must be considered particularly in areas where there is no enhanced service agreement. In reality it is likely that training will need support from Local Health Boards and Enhanced Service arrangements agreed before such activity is adopted..
* Resource also needs to be allocated to supporting staff in primary care (e.g. dietetics).
* Access to patient education courses needs to be considered and resourced.
* Many patients still express a desire to be seen in a secondary care environment when their condition is perceived to be more complex.

Practical considerations

Safety concerns relating to the initiation of the GLP-1 receptor agonists are much lower than for insulin. Hypoglycaemia is only an issue if they are co-prescribed with hypoglycaemia inducing agents (e.g. insulin and sulphonylureas) and dose adjustments are not necessary beyond the initiation phase.

The cost of GLP-1 agonists needs to be considered and their side effect profile can cause problems initially. It is important to be aware that a proportion of patients do not respond and should discontinue therapy at 6 months.

It is likely that practices wishing to develop the capability to initiate these agents currently can source appropriate training supported by the pharmaceutical industry. This would be finite and is invariably associated with an element of promotion. Health Boards may therefore wish to consider funding more independent education.

Insulin initiation and dose adjustment does require a different and more evolved level of expertise. Although the decision to initiate insulin and often the type of insulin (basal or mixed) will come from the responsible doctor, the decision on starting dose, delivery device, patient education and monitoring is usually the role of a nurse specialist or practice nurse. A primary care team therefore should consist as a minimum of a GP and practice nurse, both trained to an agreed standard in the use of injectable therapies.

Areas with Community Diabetes Nurses have the benefit of some assistance with these aspects though such posts are not widespread. The cost effectiveness of primary care initiation of insulin in particular needs to be considered. This will be dependent on the efficiency and experience of primary care nurses. An appropriate level of qualification and experience is imperative as is continued support from secondary care. In certain areas an intermediate care capability may be available that can facilitate the development of expertise. Such ventures will see secondary care teams present in person or virtually in primary care to aid the decision making processes.

It is not reasonable to suggest that all primary care practices develop the capability to prescribe and initiate insulin and/or GLP-1 receptor agonists. Some will be of insufficient size to generate a patient body large enough for the skill set to be developed and maintained. Other practices may feel that this activity does not represent a clinically and/or economically efficient addition to their activity, particularly if it can be delivered in secondary care.

In certain primary care settings insulin and GLP-1 initiation may be well established. In such centers practitioners will need to consider, as part of their professional development, the maintenance of skill sets and succession planning with appropriate mentorship. Secondary care should always be available to aid with such issues as required.

As the use of both insulin and GLP-1 receptor agonists becomes more common in Wales their use in primary care is also likely to increase. It therefore is important that robust clinical audit procedures are employed. This activity also has associated time and thus financial commitment which requires consideration in the commissioning process.

Summary

* The initiation of injectable therapy for patients with diabetes is a potential addition to primary care activity. In many areas however there is no defined resource for the development or maintenance of this.
* GLP-1 analogue initiation is significantly safer, less complex and requires lower levels of training and competence in comparison to insulin initiation.
* A primary care team wishing to develop insulin initiation capability should obtain recognised qualifications. We would also recommend undertaking an insulin management course. Practices wishing to develop GLP-1 initiation activity should also hold a recognised qualification as above.
* Areas already undertaking this activity need to ensure maintenance of skill sets and timely succession planning. We would recommend a minimum of 5 insulin initiations per year is sufficient to maintain levels of competence in this area.
* Any practice wishing to undertake such activity should consider initial discussions with their Health Boards and local secondary care teams to evaluate the needs/requirements of their population for such a service.

Welsh Endocrine and Diabetes Society May 2014