## Title

Initial outcomes of *Starting Insulin Together*: A group education programme for the self-management of insulin treatment in Type 2 Diabetes.

## Background

*Starting Insulin Together* is a programme designed and run by Diabetes Specialist Dietitians (DSDs) and Diabetes Specialist Nurses (DSNs) in West Hertfordshire for patients with Type 2 Diabetes who are being commenced on insulin. There were several reasons for the creation of the programme:

-To give a more efficient use of both patients' and healthcare professionals' time

-To facilitate co-ordinated working

-To address common fears around insulin initiation (e.g. weight gain and hypoglycaemia)

-To provide the necessary tools to ensure effective transition onto insulin therapy (positive outcomes on glycaemic control and the prevention of excessive weight gain).

-To provide the opportunity for medication and dietary and lifestyle measures to be addressed together to maximise positive outcomes

-To give patients' ownership of their condition rather than a reliance on healthcare professionals

-To allow the opportunity for patients to discuss fears and worries with others in a similar situation

## Programme Aims and Target Patient Group

The aim of *Starting Insulin Together* is to manage insulin initiation in groups enabling patients to self-titrate and manage their insulin treatment within a structured guideline safely and effectively.

This group targets the following patients:
- Patients with Type 2 diabetes with a recent HbA1c above target (>58mmol/mol)
- Patients able to understand and speak English
- Patients comfortable learning in a group environment
- Patients on maximum tolerated oral therapies where GLP-1 mimetics are unsuitable (e.g. BMI <35kg/m2)
-Patients were there are no concerns regarding compliance and/or severe psychological issues

## Methods

The programme was piloted in the Watford area and then subsequently rolled out in the Hemel area. Unfortunately there were a few difficulties with running some of the groups in the Watford area due to staff turnover, staff annual leave and problems recruiting appropriate patients. Small group numbers were achieved in the Watford area of 1-2 patients. Recruitment was more successful in the Hemel area with, at the time of writing, one group of four patients being held and one group of eight patients booked on to be run in the next two weeks.

## Programme Structure

The pre-group recruitment procedure:

- The triaging DSN receives the new SPOC referral form from GP surgeries for patients who are poorly controlled and on maximum oral therapies
- The DSN assesses the patient need for insulin after considering potential for dietary and lifestyle intervention and/or other medications.
- The DSN assesses the suitability for patient attendance at a *Starting Insulin Together* and discusses the group with the patient via telephone
- If the patient is suitable and agrees, the patient is booked on to attend a *Starting Insulin Together* Group
- Patients may also be recruited to the groups from Multi-Disciplinary clinics and other DSN clinics when appropriate

The group sessions

- Two 195 minute sessions are held over two weeks and are run jointly by a DSD and DSN. Each session is divided into two parts with 15 minute break in the middle.
- Ideally the groups should have a minimum of 4 patients and a maximum of 8 patients per group.
- Family/friends are welcome (room space allowing)
- The sessions involve group discussion and activities, practical demonstrations, opportunity for questions and action planning
- Each patient is provided with a handout and an *insulin titration quick guide* to keep and use throughout course.
- An evaluation form is given at end of course for each patient to complete

Post group sessions:

- An individual one-to-one session is booked for each patient with the DSN three months after the group sessions
- The patients are provided with the DSN contact details should they require this before their follow up

- A blood form is given to each patient for a new HbA1c to be measured for each patient three months after the group sessions.
- Further follow up is arranged as required. DSN can refer patients to DSD if further support around dietary and lifestyle interventions is required
- Another HbA1c three months later should also be arranged to determine effectiveness of insulin intervention as insulin titration up to appropriate dosage may take several weeks

## Programme Content

The programme covers the following topics via group discussion, group activities and practical demonstrations. The content is also recorded in the handbooks provided.

- Diabetes pathophysiology
- Insulin types, storage, titration and adjustment
- Appropriate insulin injection
- Blood glucose monitoring
- Hypoglycaemia- causes, signs and treatment
- Driving and employment regulations
- Insulin and impact on diet
- Carbohydrates in the diet
- Healthy slow release carbohydrate options
- A healthy balanced diet
- Appropriate carbohydrate portions
- Prevention of weight gain
- Healthy meal examples
- Physical activity
- Alcohol and insulin
- Travelling and diabetes
- Illness awareness
- Summary and goal setting

## Initial Patient Feedback

Initial patient feedback has been positive. All the patients from the first Hemel group gave the maximum ratings for usefulness of course, suitability of length of course and suitability of location of course. They listed nothing as ‘least useful’. Below shows patient quotes gathered from the evaluation forms from the first course in Hemel.

**Question: What part/aspect of the group did you find most useful?**

‘Working on controlling dietary needs’

‘Sharing ideas and resolving problems’

‘…helpful and well-presented also helpful tips’

‘a lot of information and advice’

**Question: What part/aspect of the handout did you find most useful?**

‘setting myself targets’

‘covered all aspects necessary to help you control insulin’

‘what to eat and when’

**Other patient comments:**

‘A good course, I found information helpful, and some things I did not understand well explained’.

‘I thought the group session worked well with vastly different types of people coming together with a common problem’

‘This course has been the most useful and informative that I have had’

‘A brilliant course that has given confidence in controlling my diabetes, rather than it controlling me’

## Future Recommendations and Plans

The programme needs to be continued to be run in the Hemel area to gather more data so that an effective audit of the programme can be completed. The issues with patient recruitment need to be addressed in the Watford area. Further members of the diabetes team should be involved in running the courses to ensure consistency of running of the courses (ideally one programme per month per area) and so that the programme can be rolled out in the Hertsmere and St Albans areas. It would also be useful for GP surgeries to be informed of the programme so that they are aware that patients may be self-titrating and adjusting their insulin following the structured guideline. It may also be useful to consider doing follow ups from the group with both the DSDs and DSNs working joint or side by side.