



21/07/2011
Professor David Cousins,
Head of Patient Safety,
National Patient Safety Agency
4-8 Maple Street
London
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Dear Professor Cousins

The Association of British Clinical Diabetologists is the specialist society representing the majority of UK diabetes specialist physicians. While we recognise the issues surrounding errors in prescribing and administration of insulin and the need to improve the safe use of insulin, we are concerned that the current scheme for an Insulin Passport lacks clarity and practicality.

Our concerns are centred on four areas
Responsibility for ensuring the passport is used
Practical aspects of design of the passport
Cost in relation to potential for benefit
Inconsistencies in information provided

Responsibility

Ultimate responsibility for ensuring that all patients taking insulin are provided with an information booklet and Insulin Passport lies with Chief Executives (of both PCTs and Acute Trusts?) but the responsibility for completing and maintaining the document appears to be shared between the patient and the health care professional (HCP). The expectation is that the patient will complete and update the document but the HCP remains responsible for replacing when full, lost or illegible and for documenting when a patient chooses to opt out (implying that the HCP will be checking up on the patient). Responsibility for the scheme will therefore be shared at several levels, reducing the chances of successful implementation.

Practicality

Although the document is designed to fold to credit card size it is not credit card thickness and when folded it is likely to be too thick to fit into the average wallet. This will deter people from carrying it routinely. We believe that the passport attempts to include too much information – eg other medications and treatment of hypos – and this will reduce the chances of widespread use and introduce risk of error - the more information that is included, the greater the chance that it will not be updated. Some of the insulin producing pharmaceutical companies already produce credit card style information identifying the type of insulin product and device and this is more practical than the proposed document.

Many patients already carry a copy of their repeat prescription and to some extent this serves the purpose of the passport. Previous experience of patient held information suggests that the patients who carry a copy of their repeat prescription are likely to complete and carry the new insulin passport and those who do not carry documentation will not carry the passport. Therefore although the proposals are well intentioned it is likely that they will not achieve the expected benefit.

Cost

The cost of providing the proposed documentation will fall on PCTs and Acute Trusts. This may be acceptable if the introduction of the insulin passport improves safe use of insulin, but for the reasons given above there is a real risk that it will not achieve this aim. An alternative would be to require insulin producing pharmaceutical companies to provide credit card sized information to identify the insulin product(s) used. The cost of supplying the information would therefore be met from the profits of the insulin producing companies rather than the hard-pressed NHS.

Inconsistencies

There are inconsistencies in the accompanying information leaflet, which lacks focus and clarity and would benefit from editing.

The leaflet states that insulin doses are not to be included in the passport but also states (page 23) that when patients are discharged from hospital, dose changes should be recorded in the passport

It refers to patients being able to record what should be done if they have hypo OR hyperglycaemia (page 22) whereas the passport (correctly) only states what should be done if the blood glucose is low. (It would not be safe to advise non qualified people to take action to treat a high blood glucose if the person with diabetes were not in a position to deal with the problem themselves.)

It recommends that inpatients should be empowered to take responsibility for managing their own diabetes when in hospital but then disempowers them by expecting the patient to tell the nurse what they have taken so the nurse can record this on the prescription chart. True empowerment would allow the patient to record what they took -preferably in their own record book - and it should be sufficient for the nurse to record that the patient took their own decision.

We are very supportive of the NPSA drive to ensure that insulin is used safely, but hope you will consider the points we have made, as modification and clarification will strengthen the project which we are aware has now reached implementation. Our points could more usefully have been made at an earlier stage but as far as we are aware ABCD was not consulted as part of stakeholder engagement in this process.

Yours faithfully,

Dr Chris Walton

Dr Anne Kilvert

Dr Peter Winocour

Honorary Chair ABCD

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