A decade of change: From the nursing perspective

Gwen Hall

Gwen Hall is a DSN in Primary Care, Haslemere, Surrey.

The first ever edition of *Diabetes & Primary Care* was published in 1999. Some of us were lucky enough to be involved then, and still value our connection as the publication comes to the end of its 10th year.

The changing face of the NHS?

Back in 1999, the journal's original editor Eugene Hughes was questioning whether the latest round of government reforms represented real change rather than the rehashing of old policies; I wonder if he's still thinking along the same lines? In 1999, clinical governance emerged. This is defined as the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish. We've been through several re-organisations, NHS reforms and a plethora of guidelines since then, the most recent being Lord Darzi's NHS Next Stage Review (Darzi, 2007).

In 1999, there were approximately 1 600 000 people with diabetes in the UK (Diabetes UK, 2004). There are now approximately 890 000 more people with diabetes based on the recent Quality and Outcomes Framework (QOF) data (The Information Centre, 2008; Department of Health Social Services and Public Safety, 2008; The Information Services Division, 2008; Welsh Assembly Government, HSA1, 2008; see page 334 for a full breakdown of the QOF data published this year). As the scale of the problem has increased, diabetes services have been shifting from specialist to primary care. Primary care nurses have risen to the challenge, but resources do not seem to have increased to meet the rapidly rising demand. We still strive to provide a high-quality service with – what appears to me now, and may have appeared to Eugene Hughes then – dwindling resources.

The nGMS contract and Agenda for Change

But it is not a case of dwindling resources for all! In 1990, we had the first GP contract, which provided additional funds to practices for chronic disease management. A huge leap in health promotion and management ensued. Likewise, the new General Medical Services contract has resulted in a massive improvement in diabetes care, and in the rewards that GPs, and their practices, can reap.

What about the nurses, I hear you say? Well, first there was a re-grading exercise and then, for some of us, the introduction of Agenda for Change. Now, if improvements in providing care rely on rewards, I'm glad I get mine from the rosy glow I get from looking after people (trust me, I'm a nurse) rather than financial gain. In my view, many nurses feel devalued by both of these reforms, and furthermore a system that was supposed to encourage personal development and ensure parity in salaries and roles has resulted in much rewriting of job descriptions and lengthy appeals. Practice nurses take heed!

But let's not get bogged down in that. What else was newsworthy back in 1999?

Self-monitoring of blood glucose

Stuart Bootle and Eileen Emptage discussed blood glucose monitoring in the first edition of *Diabetes & Primary Care* (Bootle, 1999; Emptage, 1999). This topic is still controversial now. Dr Bootle suggested that the information gathered from self-monitoring forms the basis for agreeing diabetes management plans that work in practice. I am sure that this is still correct today. So why have so few of us got care plans agreed with people with diabetes, outlining their goals and targets and supporting their endeavours? The Healthcare Commission review of individual primary care trusts' performances identified between 34% and 61% of people with diabetes as having care plans, and between 1% and 53% of people with diabetes as attending an education course (Healthcare Commission, 2007).

A consensus statement published in *Diabetes & Primary Care* in 2005 provided guidance on who should monitor blood glucose levels and the frequency of testing (Owens et al, 2005). This excellent piece of work was evidence-based and

Bootle S (1999) *Diabetes & Primary Care* **1**: 5–10

Commission for Healthcare Audit and Inspection (2007) *Managing diabetes. Improving services for people with diabetes.* Healthcare Commission, London

Darzi, Professor Lord (2007) *NHS Next Stage Review Interim Report.* Department of Health, London

Department of Health Social Services and Public Safety (2008) *Quality & Outcomes Framework (QOF) April 2007 - March 2008, Northern Ireland nGMS practices.* Available at: http://www.dhsspsni.gov.uk/qof_data (accessed 22.12.08)

Diabetes Control and Complications Trial (1993) *NEJM* **329**: 977–86

Diabetes UK (2004) *Diabetes in the UK 2004. A report from Diabetes UK.* Diabetes UK, London

Emptage E (1999) *Diabetes & Primary Care* **1**: 11–13

Information Centre, The (2008) *Quality and Outcomes Framework (QOF) for April 2007 to March 2008, England.* Available at: http://www.ic.nhs.uk/qof (accessed 22.12.08)

Information Services Division, The (2008) *Quality & Outcomes Framework (QOF) for April 2007 - March 2008, Scotland.* Available at: http://www.isdscotland.org/isd/3305.html (accessed 22.12.08)

NICE (2008) *Quick reference guide. Type 2 diabetes. The management of type 2 diabetes* NICE, London

Owens D, Pickup J, Barnett A et al (2005) *Diabetes & Primary Care* **7**: 9–21

UK Prospective Diabetes Study (UKPDS) Group (1998a) *Lancet* **352**: 837–53

UKPDS Group (1998b) *BMJ* **317**: 703–13

Welsh Assembly Government, HSA1 (2008) *Hlth1108: Patients recorded on QOF Disease Registers.* Available at: http://www.statswales.wales.gov.uk/TableViewer/tableView.aspx (accessed 12.12.08)

built on expert opinion. It surprises me that in my travels around the country, I frequently meet with health professionals reporting restrictions on the number of test strips allowed to be prescribed to people with diabetes. Some patients are limited to as little as one pot (50 strips) per year! Where is the evidence base for one pot of strips per year? I don't know, and it seems that NICE doesn't either. There is, undoubtedly, wastage of test strips, but in its 2008 guidance on the management of type 2 diabetes, NICE states that:

> *"The necessary lifestyle changes, the complexities of management, and the side effects of therapy make self-monitoring and education for people with diabetes central parts of management." (NICE, 2008)*

NICE advocates self-monitoring for people with diabetes who understand it, and who will take action based on the results. Education is essential for people with diabetes to take this central role in their own care.

Advances in diabetes research over the last 10 years

In the last decade, there have been, of course, considerable advances in our knowledge of diabetes and how best to manage it. Increasingly, "empowerment" and "engagement" appear in our NHS language. We have targets to meet, and we should work with people with diabetes to achieve them. The evidence is there: in 1993, the DCCT (Diabetes Control and Complications Trial) demonstrated conclusively that tight glycaemic control was highly effective in preventing complications in type 1 diabetes (DCCT, 1993). We had to wait until 1998 for the results of the UKPDS (United Kingdom Prospective Diabetes Study) to highlight the same in type 2 diabetes.

The results showed that better blood glucose control reduced the risk of major diabetic eye disease by 21% and the risk of early kidney damage by 33% (UKPDS Group, 1998a).

Furthermore, better blood pressure control, in the many individuals who have high blood pressure, reduced the risk of death from long-term complications of diabetes by 32%, risk of stroke by 44%, and risk of serious deterioration of vision by 47% (UKPDS Group, 1998b). New information is still emerging from this unique study (see Rury Holman's comment on page 329).

Keeping up-to-date

In the context of the importance of good metabolic control, again, primary care nurses rose to the challenge. Results from the QOF (e.g. The Information Centre, 2008) demonstrate their commitment to reducing multiple risk factors and targeting long-term conditions.

In order to keep up-to-date with all these changes, nurses have become more educated in diabetes, and have changed the way they work. As an example, to date, over 8000 people have registered for the University of Warwick Certificate in Diabetes Care (CIDC). Doubtless many, probably most, will be nurses. Development opportunities are available to nurses; a colleague of mine, Mary Braddock, a Nurse Practitioner, and I, undertook the advanced leader course at the University of Warwick, and have now organised the CIDC locally in Surrey. In my locality, this has led to the establishment of GP and nurse diabetes leads in almost all of our practices, with ongoing education and updates extremely well attended. We have great links between primary and secondary care due to the enthusiasm and commitment of local healthcare professionals.

Nurses are now working with GP teams on raising diabetes standards through practice-based commissioning. They can be key members of those organising structured education courses such as Expert Patient Education versus Routine Treatment (X-PERT) and Diabetes Education and Self Management for Ongoing and Newly Diagnosed (DESMOND). They can become Consultant Nurses. They have become partners in practices.

What will the next 10 years bring?

It is clear that the future will see the emergence of new therapies, and more guidance on how to use them. The Year of Care project (http://www.diabetes.nhs.uk/work-areas/work-areas/year-of-care) will provide effective methods of working with people with diabetes to improve their health through true, active involvement – and we'll have the resources to do so. Integrated care will become the norm. More nurses will take on clinical leadership roles. Nurses will be adequately recompensed for the work they do… and all pigs will be fed and ready for flight! Oh, and I will retire! To those nurses who will take us into the next decade, keep up the good work. ■