

A celebration of the Primary Care Diabetes Society's first decade

PCDS
Primary Care Diabetes Society



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As we reach the 10th anniversary of the founding of the Primary Care Diabetes Society (PCDS), there is a great opportunity to review the Society's past and to look ahead to the future. Below, Martin Hadley-Brown (Chair, 2005–12) and Gwen Hall (Vice Chair, 2005–13) provide their personal reflections.

Martin's reflection

“The first multidisciplinary Primary Care Diabetes group, PCDUK, formed in the 1990s as a response to the increasing diabetes-related work being taken on in general practice. That group became a part of Diabetes UK; however, as it became apparent that this structure was not suited to the sometimes disparate priorities of primary care clinicians, specialists, researchers and patient advocates, a steering committee for a new society, to become PCDS, was set up under the visionary leadership of Dr Colin Kenny. Specialist diabetologists took a similar path, founding the Association of British Clinical Diabetologists.

The PCDS's priorities were established as the promotion of educational and other opportunities, so as to strengthen and improve the services provided to people with diabetes within primary care. All professionals involved in that care have been welcomed to the Society from its foundation, and the Committee continues to seek and include not only GPs and nurses but also practitioners of pharmacy, podiatry and dietetics.

An early and highly successful alliance was formed with Simon Breed and his publishing and conference firm, SB Communications Group. Simon and his team's commitment and expertise enabled us to plan our first conference for the autumn of 2005 in Birmingham and to adopt the journal *Diabetes & Primary Care* as our society periodical. More recently, that same collaboration has led to the Society working with SB Communications Group on online materials, hosted at www.diabetesonthenet.com. A wealth of educational information, much of it produced by PCDS members, can be found here,

suitable for all students and professionals with a diabetes interest. It is a work in progress; keep watch.

With a journal, online work and annual conferences, together with involvement in a multitude of smaller regional meetings, PCDS's educational aims continue to be a top priority.

It cannot have escaped readers' notice that the period since our foundation has coincided with ceaseless production of guidelines, policies and targets from an array of bodies. The PCDS's members and Committee have had much involvement in these, though they have also often been frustrated by their number, content and value. Of course, actions speak louder than words. A particular frustration of mine is the widespread lack of provision for structured patient education despite it supposedly having been a priority within policies and guidelines from the start of this century! However, there have been demonstrable improvements in UK diabetes care during the time of our existence and I believe that the PCDS has contributed to this through the support offered to its members – those who undertake most clinical practice in the diabetes community.

Committee members try to be available to inform and advise policy and political people and groups – with varying success, but we can try. We are a constituent organisation within Primary Care Diabetes Europe. This is an organisation focused on the promotion of research in diabetes in primary care as well as some political liaison at a European level. Through it we can have contact with colleagues from other nations and systems, who deal with similar problems but sometimes find different solutions. There is much more to be learnt together.

The PCDS also has a research sub-group, led by the eminent Professor Kamlesh Khunti at Leicester. We have been able to collaborate in a number of studies, and the ambition is to better extend the reach of clinical research into primary care. After all, we see the patients, know the issues, and have the contacts.

There is more to come. Work in hand includes collaborations and further educational projects that I hope will become apparent over the coming months.

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These recent years have been both clinically and politically challenging. At the same time that we are able and expected to do more for people with diabetes in our practices and communities, pressures from elsewhere in our practices continue to grow. Perhaps we have to an extent been victims of our own success. Where we used to have dedicated practice diabetes clinics, these have increasingly been overtaken by generic “long-term conditions” clinics, built largely upon our models. An advance on one hand, but sometimes detracting from the special skills and attention that diabetes may require. One answer has to be to spread the skills needed for effective diabetes care to a wider community, and here the PCDS will do its best.

We have never sought to be an “exclusive” organisation – indeed, we are just the opposite. The success of PCDS is, has been and must continue to be founded upon the people who come together under its name. We have brought together a blend of diverse characters and skills who have truly enjoyed working together and playing to each other’s strengths. Our Committee meetings have been at the same time focussed, enjoyable, inclusive and productive. Our events and conferences are remarked upon not only for quality but for their enjoyable and collaborative atmosphere. We are determined that they shall continue to improve – complacency does not sit with the PCDS.

So, that is a quick reflection on a decade of the PCDS. A foundation is laid and work underway. We are always looking for new colleagues to join us. Some of us are looking not just for collaborators but for our successors! To date, we have attracted people from allied professions, based in all areas of the UK and Ireland, and of varying ages and complementary interests. From a personal point of view, I say a huge and heartfelt “thank you” to all with whom I have worked in and through the PCDS. It has been a joy and a privilege – and still is.

Gwen’s reflection

“Way back in 2004, Drs Colin Kenny and Eugene Hughes were lamenting the lack of support for primary care, with Primary Care Diabetes ceasing to be a section of Diabetes UK. They were looking forward to the changes and challenges the new General Medical Services contract would have on

primary care, and to forming a vision for a new society – the PCDS.

I too was looking forward to the contract, having been recognised in the earlier National Service Framework for Diabetes (remember that?) for being involved in setting up one of the first diabetes clinics in primary care. I was a practice nurse/nurse practitioner then and did so with the full support of my specialist colleagues at the hospital. We didn’t have diabetes specialist nurses (DSNs) specifically working in the community. We didn’t have community NHS trusts. We didn’t have commissioning. We didn’t have who-pays-for-what getting in the way of working together to improve the care of people with diabetes (remember that?).

Looking at the clinical indicators in that contract, all were (and still are) suitable to become nurse-led initiatives. Some people saw that as a barrier to progress, but the newly formed PCDS promoted it as an opportunity for teams to develop and forge links with specialist colleagues. So I greatly welcomed the PCDS’s stated aim of supporting primary care practitioners in the delivery of high-quality, clinically effective care, in order to improve the lives of people with diabetes.

You may be familiar with the topics that were discussed then through the pages of this Journal, the PCDS’s official periodical. They have changed little, but become much more complicated. . . Blood glucose monitoring, integrated care, guidelines, targets, new therapies, insulin initiation, best support for people with diabetes (pre-dating the boom of social media), Tier 2 funding, and who does what (role redesign, primary care trusts, practice-based commissioning, networks and now clinical commissioning groups).

Then, in 2004 a momentous edition of the Journal (Vol 6 No 4) announced on page 156 the formation of the PCDS, with its first national conference to be the following year. I don’t know how many nurses attended that event, but then, as now, we had a plethora of job descriptions. The PCDS was open to all. Only this year, 2014, I was asked to speak at the MIMS conference on the qualifications needed to become a DSN. The short answer is still none! After 10 years of debate, we seem no nearer to a solution.

By 2005, the PCDS had grown to 1000 members. In October that year, the PCDS jointly published a position statement titled *Ensuring access to high quality care for people with diabetes* with Diabetes UK



A page in the Journal from 2004 announcing the founding of the Primary Care Diabetes Society.

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and the Association of British Clinical Diabetologists decrying block transfer of patients from secondary to primary care. Primary care nurses were feeling unprepared for such an increase in their workload. It is not noted what the patients thought!

To cope with the increasing complexity of primary care diabetes management, nurse prescribing became topical. Dr Mike Kirby expressed his view that many nurses, especially DSNs, were becoming more skilled than their GP colleagues in managing diabetes medication. Independent nurse prescribing was on its way and the PCDS provided advice and practical information to support innovative nurses, who welcomed the role (Kirby, 2005).

In 2005, I wrote: “Structured education is expected to save money by providing group sessions, thereby cutting the need for one-to-one contacts. It is also anticipated that it will enable us to cope with the increasing numbers of people diagnosed” (Hall, 2005). Primary care trusts were given a legal obligation to pay for implementing structured patient education (Freeman, 2006). I’m still waiting. So are people with diabetes. The DAWN2™ Study found that only 14% (type 1) and 6% (type 2) of people with diabetes had attended a structured diabetes education programme (Munro et al, 2013).

By 2007, PCDS members could enjoy a wide range of forums and access to past issues of this Journal, as well as the *Journal of Diabetes Nursing*, *The Diabetic Foot Journal* and other titles. Members could book PCDS and other events online. Things were moving fast.

Many nurses were participating in the Year of Care project and the PCDS highlighted some excellent resources available to primary care. The project provided effective methods of working with people with diabetes to improve their health through true, active involvement. But service redesign was coming under criticism from Diabetes UK, among others, as evidence merged that it was resulting in cuts in specialist diabetes services.

By 2010, the PCDS’s membership was 4500... and growing. Meanwhile, the Department of Health expected everyone with a long-term condition to be offered an integrated care plan. I’m still waiting for that to be a reality. Nursing members of the PCDS committee published many articles and spoke at many educational events extolling the virtues of care planning. NHS Diabetes (which was disbanded

shortly afterwards and is still greatly missed) produced some excellent practical information.

Then it was announced that Mixtard 30 insulin was being discontinued. Much training was required by primary care nurses. The PCDS stepped into the breach with lectures, articles and online activity. Shortly after, rosiglitazone was withdrawn and the PCDS published a clear statement outlining the facts and quashing the hyperbole. Interestingly, in 2011, Paul Sheldon was wondering why, if sulphonylureas are more harmful than rosiglitazone, the latter had been withdrawn and the former has not (Sheldon, 2011). Anybody got an answer? As a nurse prescriber, I’m still wondering too. Further evidence has since emerged (Hall et al, 2013).

A worrying trend to reduce access to health professional education was emerging in the drive to cut NHS costs (Hall, 2012). Again, the PCDS stepped up to the mark by enabling its CPD modules, which had been available since 2009 through the Journal, to be completed online as part of a personal education profile. This is extremely valuable to – and well evaluated by – nurses in primary care, who may find it increasingly difficult to get time off. And it’s not just education that is squeezed. A survey of DSNs found that 43% of vacant DSN posts are unfilled owing to cost-saving initiatives in trusts and that one in five DSNs will retire by 2016 (Young, 2012). Also, we now had to prove our worth... financially (DeVile-Almond, 2013).

By 2012, PCDS membership had reached 7500. Our wonderful PCDS Committee Secretary, Claire Holt (now Vice Chair), listed many of our achievements and aspirations (Holt, 2012). It makes one proud to be part of the PCDS.

But on to the present... Following on from the substantial, and continuing, successes of our national conferences, we have developed annual All-Irish, Northern Irish, Scottish and Welsh events, dealing with the issues facing our members in those nations. In the Journal, we continue to commission articles that will keep you up to date with current diabetes knowledge.

And the future? 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 taking us into the next decade, keep up the good work. ■

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