Developing the diabetes workforce: No longer a priority?

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The 2004 publication of the Wanless Report, *Securing Good Health for the Whole Population,* highlights type 2 diabetes to be a major health concern, as all of us working with people with diabetes are so keenly aware (Wanless, 2004). This report stressed diabetes as being a major public health concern of 2006. 'At last!' we may shout, 'thank goodness diabetes care is getting some national recognition!'

It is with astonishment, therefore, that in some areas we are witnessing a lack of investment in ongoing learning opportunities for practitioners. Anecdotally at least, these restrictions take the form of study leave embargoes (mentioned in British Medical Association, 2006) and constraints in workforce development funding. These measures appear to be cost-cutting exercises attributed to the NHS's well-documented financial deficit or to have their foundations in the re-configuration of Strategic Health Authorities earlier this year. In my opinion, this state of affairs is not ameliorated by a Health Secretary who appears to be disconnected with the current NHS employee's concerns – let me remind you of the famous phrase 'the NHS has just had its best year ever' (BBC, 2006).

Diabetes prevalence

Diabetes is a growing problem. Recent evidence suggests that people with diabetes will account for 5.05% of the population in England by 2010 (Yorkshire & Humber Public Health Observatory [YHPHO] and the National Diabetes Support Team [NDST], 2006) and that there are 12 times as many people with type 2 diabetes than type 1, with type 2 diabetes making up 92% of the total diagnosed population of diabetes (YHPHO and NDST, 2006).

Against this backdrop, and given the restriction in ongoing educational opportunities, how can we maintain a dynamic and informed workforce for diabetes care where practitioners are under pressure? Is diabetes not sexy enough for workforce investment, other than by the pharmaceutical giants? Currently, for many practitioners, this source of funding is the only one which enables further study. However, this support cannot alleviate the leave embargoes apparently enforced by many trusts.

This situation is of particular frustration at a time when the pilot stage of the national diabetes specialist nursing degree is around halfway to completion (see the progress report article written by Clare MacArthur and myself that begins on page 208).

Access to education

As diabetes gains national public health recognition (and certainly the majority of healthcare practitioners will have contact with someone with diabetes on a virtually daily basis), why is investment not being made to protect and support the workforce in developing excellence in care and maintaining care on the cusp of evidence-based delivery? Such short-termism in NHS planning affects and frustrates us all in our diabetes care delivery (Buchan and Edwards, 2000).

Education should not be seen as a luxury, but a necessity, as part of the clinical governance agenda of life-long learning (Thomas et al, 2005). Having access to good-quality education for healthcare practitioners is an essential component of the clinical governance agenda of engaging with life-long learning and supporting and developing good practice and a quality marker for employers to gauge practice against.

It will surely benefit people with diabetes, in their encounters with practitioners, to know that the care they receive is informed and the best options for them are provided. For education providers also, it is vital to ensure that the currency, vibrancy and vitality of the programme is suitable and clinically focused to develop good diabetes care skills within the participants.

It is for these reasons that all healthcare practitioners, as part of the multi-professional approach to diabetes delivery, need more support to continue to develop their practice and also to keep engaged and dynamic under a cloud of current NHS bureaucracy. ■