Change is good... so long as we don't leave our patients behind!

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Since my last editorial, it seems to me that the pace of change has not only continued, but has speeded up! Major re-organisations within primary care trusts and acute trusts continue and many services and providers remain under threat of reduction or closure. Although I work across both primary and secondary care, I spend more of my time in the acute setting where the following issues are dominating my working week.

Despite the push for care closer to home, I believe that the fate of chronic conditions such as diabetes still remains linked to hospital services. This is frequently overlooked as it takes place in a hospital, rather than a community, setting. However, many people with diabetes do need hospitalisation for a variety of valid reasons. This is supported by evidence from our inpatient audit, which revealed that over a 6-month period (August 2006 to January 2007), between 750 and 850 people were admitted each month to our 30-bed emergency ward. Of these, 7.75–12.5% had diabetes. Even though few of these individuals were admitted with acute diabetes related problems, for example hypoglycaemia or hyperglycaemia, they still comprise a significant number of patients requiring hospital-based care. Therefore, this number and need must be included in diabetes service planning so that these people continue to have access to specialist diabetes services when they are acutely ill.

Junior medical staff may not have the knowledge and training to deal with the complexities of diabetes during illness, whereas DSNs do and patients should be able to access them promptly and benefit from their skills and knowledge. These DSN consultations with inpatients provide treatment review and optimisation, planned discharge by linking with primary care services, and reduced length of stay. This not only improves patient safety and outcomes, but also helps acute trusts in their constant battle to release beds to avoid breaching A&E targets.

Payment by results (PbR; DoH, 2002), which was to have funded specialist outpatient work, is being compromised in some areas by new tariffs being negotiated by Strategic Health Authorities, or appointments being significantly reduced according to referral management systems. PbR for group insulin starts or group education is said to be outside of tariff and must be locally agreed. It does feel like ever-decreasing circles. While the money is being argued about there is a real risk that if specialist services who are paid for by acute trusts do not bring in funding they will be cut. There seems no time for good information to be obtained to make good decisions and many former diabetes networks who could influence decisions have disbanded through redundancies and resignations. Who knows what this will mean for patient choice and safety?

In this difficult arena, change is still being made and led by nurses, as shown in the following two articles.

The first article by Sharon Burgess and Alison McHoy (page 99) describes the impact of our service redesign from two perspectives; firstly that of a nurse practitioner based in a GP practice who is responsible for diabetes clinics and secondly a primary care DSN responsible for developing collaborative clinics. These clinics were the building blocks of their service redesign, enabling primary care healthcare professionals (practitioners, practice nurses) to be up-skilled through experiential learning with a DSN, a validated diabetes course (including those run by the Royal College of Nursing) and ongoing support from the DSN team.

The second article by Doug Robertson and Noreen Barker (page 103) describes partnership with a pharmaceutical company to provide DSNs to resolve a hospitals staffing shortage. The trained nurses were also contracted to do work with the sponsoring company. This article raises questions regarding how DSNs can remain non-promotional in clinical work as well as the retention of these nurses within the hospital setting, which appears to be the aim of this project. ■

DoH (2002) *Reforming NHS financial flows: introducing payment by results*. DoH, London