

# The changing role of a diabetes nurse facilitator

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I recently re-read an article that I wrote over 10 years ago on my role as a diabetes nurse facilitator (Freeman, 1999). Writing this article has given me the opportunity to reflect on the changes that have taken place, both in my role and in diabetes care in general since then. The role of the facilitator is to standardise care across a district, and it was recognised at the time of my employment that well-established standards in diabetes care, introduced and maintained throughout a district, could make a major impact on the quality and quantity of diabetes care.

Reading the article I wrote for the *Journal of Diabetes Nursing* (Freeman, 1999) caused me to reflect on the changes to diabetes care over the past 10 years. The article was written after I had been in the post for 5 years and there was renewed interest in primary care diabetes due to the introduction of the “chronic disease management clinics” (also known as health promotion clinics). These were set up following the publication of the *Health of the Nation* document (Department of Health [DH], 1992). The consultant physician and I spent many lunchtimes visiting practices to forge links with GPs and practice nurses and answer any organisational and clinical queries that they may have. The remainder of the practices I visited on my own, meeting many dedicated staff, several of whom are still in post.

Just prior to the article, Diabetes UK recommended the establishment of local diabetes services advisory groups (LDSAGs) “to bring all important agencies of diabetes care together to plan how they can best collaborate for the benefit of people with diabetes” (British Diabetic Association [BDA], 1995). These were dedicated groups of people who met regularly to discuss local and national issues. The problem for some of the groups was that they had no

formal methods of reporting their concerns and no executive powers to deliver them. Our forward-thinking consultant had already involved me in the creation of a diabetes steering group, which converted easily to an LDSAG.

The health promotion clinics gradually changed in nature due to a reduction in central funding and, for a while, diabetes continued in primary care with few resources to support it. These were fairly static and frustrating years when the management of diabetes in primary care made little progress.

## *NHS Plan: A Plan for Investment, a Plan for Reform*

The NHS Plan (DH, 2000) outlined reforms of the health service to put people with diabetes at its centre. It also included new contracts for GPs and consultants, which were to have a far reaching impact on diabetes care. It brought in intermediate care services or “care, assessment and treatment services” (CATS). These services bridge the gap between primary and secondary care to relieve the pressure on specialist services and support care in general practice. Intermediate services such as these are ideal for people with diabetes who, despite needing more intensive

## Article points

1. The NHS Plan (DH, 2000) outlined reforms of the health service to put people with diabetes at its centre. It also included new contracts for GPs and consultants, which were to have a far reaching impact on diabetes care.
2. Enhanced services and increased insulin initiation in primary care have increased the need for the education of healthcare professionals. There is much expert knowledge of diabetes in primary care but further development of primary care skills is paramount if these services are to succeed.
3. I continue to feel strongly that keeping lines of communication open between members of the multidisciplinary teams in both primary and secondary care is absolutely vital and still feel that I, as facilitator, am in an ideal position to do this.

## Key words

- Diabetes nurse facilitator
- Education
- Professional roles
- Reform

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### Page points

1. There were only two areas of the NSF that had to be in place by 2006. First, retinal screening had to be offered to 80% of the population, progressing to 100% by 2007, and second, practice-based registers of people with diabetes had to be up-to-date.
2. The “virtual” register obtained from practice-based registers along with Quality and Outcomes Framework (QOF) are giving us previously unknown information and providing us with a clearer picture of diabetes in our community.
3. The new General Medical Services contract, which began with the NHS Plan, was drawn up, and with this contract came resources for diabetes in primary care, unlike the diabetes NSF, which did not provide extra resources.

input, are not yet ready and may never be ready for specialist services.

CATS are led by specialists in diabetes, such as GPs with a special interest (GPSI), diabetes specialist nurses, podiatrists, dietitians or pharmacists. We set up a lengthy “options appraisal project” to look at this type of service. This scheme was set up to evaluate CATS and support decision-making on the development of the diabetes service, to maximise the quality of care and reduce referrals to secondary care. This fell into a large hole never to be resurrected and the service remained the same!

### Diabetes National Service Framework

We eagerly awaited the arrival of the diabetes National Service Framework (NSF) (DH, 2001). It contained two big shifts: one in philosophy and one in organisation. The philosophical shift was to formally recognise self-management of diabetes, something that people with diabetes and healthcare professionals had encouraged for many years. The organisational shift was the devolvement of diabetes management into primary care.

A certain amount of disappointment greeted the delivery document 2 years later, partly due to the realisation that we had so many years in which to achieve the majority of the targets. There were only two areas of the NSF that had to be in place by 2006 (DH, 2001). First, retinal screening had to be offered to 80% of the population, progressing to 100% by 2007, and second, practice-based registers of people with diabetes had to be up-to-date. We were given until 2013 to achieve the rest of the targets and, therefore, there was no sense of urgency.

Here in the North West, the recommended retinal screening programme “as part of a systematic programme that meets national standards” seems to be progressing well, despite our initial reluctance to change from the status quo, as we already had a very efficient system. There have been a few cross-PCT problems due to accessibility; patients have to attend for screening in the same PCT as their GP, resulting, in some cases, in longer journeys and there are also fewer optometrists offering the service. Different IT systems in other PCTs also make

IT communication difficult between Trusts. However, on the plus side, quality control and audit of the service are excellent.

The “virtual” register obtained from practice-based registers, along with the Quality and Outcomes Framework (QOF), are giving us previously unknown information, such as the local incidence of diabetes, and if any practices need help providing diabetes care. The Metropolitan Borough where I work has a population of 300 000. We now know from the primary care registers that there are 12 000 people with diabetes. When I came into post there were an estimated 6000 people with diabetes in the borough. Unfortunately, due to anomalies in the coding system, we have no evidence-based data of inpatient statistics. There is no specific code for diabetes-related hospital admissions, so the true number of admissions due to diabetes is underestimated. Many areas set up district diabetes registers that provided this information but ours never materialised, despite the efforts of several members of our team, including myself.

At the time of my original article, 2000 people with diabetes came to our hospital clinic (two-thirds of our previous diabetes population) both for annual reviews and follow-up appointments. Now, under 1000 attend per annum (16–17% of our diabetes population). This has released time within secondary care to see and treat the more complex areas of diabetes.

### New General Medical Services contract

The new General Medical Services (GMS) contract (British Medical Association, 2003), which began with the NHS Plan (DH, 2000), was drawn up, and with this contract came resources for diabetes in primary care, unlike the diabetes NSF which did not provide extra resources. The resources came with the QOF, which offered financial incentives for quality care in areas such as diabetes. This sudden dramatic shift brought with it the need for increased support within the practices and greater demand on the optometry and podiatry services, especially towards the end of the financial year! Having spent years trying to persuade practices to take on annual reviews, most of the routine care, including annual reviews, was quickly transferred to the primary sector.

Creation of specialist GPs was also included in the NHS Plan, taking referrals from fellow GPs. These consist of practices that are highly skilled in the delivery of diabetes care, offering their services to other practices in the locality. Although we have no formalised locally enhanced services in our borough, several of the practices are looking at innovative ways to enhance their skills in diabetes within their own practices.

Insulin initiation continues to expand in several practices and this has furthered the need for practice education and has involved myself and other members of the team in delivering this through local and national education packages.

### Practice-based commissioning

Practice-based commissioning (PBC) was introduced in 2005. It gave the practices more freedom to develop their own local services targeted to the needs of their practice population. PBC provides services “in settings that are closer to home and more convenient to patients” (DH, 2004). It also stressed the importance of supporting people with long-term conditions. It identified alternative provision for long-term conditions, including primary care, to give people greater choice.

### National Institute for Health and Clinical Excellence

NICE guidelines came on the scene in 1999, providing guidance both for the NHS and people with diabetes. NICE is an independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health; it looks at such things as medicines and their uses, medical devices and surgical and clinical procedures. However, it is guidance, and as such is not a “must do”. Despite this, it has had a huge impact on diabetes in areas such as structured education for people with type 2 diabetes, continuous subcutaneous insulin infusion, pregnancy and many others.

### Diabetes clinical networks

The first National Clinical Director in Diabetes was appointed in February 2003, and the formation of the National Diabetes Support

Team (NDST), now NHS Diabetes, followed. The NDST recommended the formation of diabetes clinical networks across the country with the appointment of a network manager to coordinate. Clinical networks provide “integrated care across institutional and professional boundaries, raising clinical quality and improving the patient experience” (NDST, 2006). This is similar in philosophy to the existing LDSAGs and it is interesting to read in the *Guidance on Local Diabetes Services Advisory Groups* document (BDA, 1995) that LDSAGS should “contribute to the formation of a comprehensive local strategy for diabetes management ... to make recommendations and to advise on improvements to provide local people with a high quality service which meets their needs and wishes”.

Diabetes networks formalised the role of existing clinical networks such as LDSAGs and recommended the election of core team members “who are senior enough to make decisions on behalf of their organisation”. It is important that the networks meet local needs and reduce inequalities. Network managers were appointed to provide managerial leadership to the network and to coordinate the work of network members in the provision of diabetes services. This succeeded in putting the whole structure on a more formal footing.

### Changes to the role of diabetes facilitator

So how has my role changed? I’m pleased to report that I still have continuing contact with our practice nurses and GPs through a variety of avenues, including regular meetings that deal with interesting topical national or local issues and professional education.

I continue to manage the Diabetes Task Force, and although we never changed to a more formal network, we have changed the structure to spread the responsibility and ensure that its members feel more involved. Its membership includes representatives from primary and secondary care and continues to be a very committed group. We also now have a formal reporting structure through the long-term conditions group.

Perhaps the greatest change in the role comes with the increase in diabetes education, both to healthcare professionals and service users. Due

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2. Practice-based commissioning was introduced in 2005. It gave the practices more freedom to develop their own local services targeted to the needs of their practice population.
3. NICE guidelines have had a huge impact on diabetes in areas such as structured education for people with type 2 diabetes, continuous subcutaneous insulin infusion, pregnancy and many others.
4. The National Diabetes Support Team recommended the formation of diabetes clinical networks across the country with the appointment of a network manager to coordinate. Clinical networks provide “integrated care across institutional and professional boundaries, raising clinical quality and improving the patient experience”.

to changes in diagnostic criteria and the policy of looking for at-risk patients in primary care, the ever increasing number of people being diagnosed with diabetes has influenced all of our roles. The recognition of self-management of diabetes also makes it key that a variety of education packages are available to people with diabetes.

The NICE (2003) guidance on structured education has had a great impact on my role as well as those of my colleagues. We are all trained to deliver X-PERT (for people with type 2 diabetes) and BERTIE (Bournemouth type 1 intensive education programme) structured education. Unfortunately, until now we have had very few extra resources to deliver these and have had to (like so many others) incorporate it into busy schedules. However, we are running six X-PERT courses a year that are over-subscribed and much appreciated and we hope for more help in the near future. We hope to commence BERTIE for people with type 1 diabetes towards the end of this year.

Enhanced services and increased insulin initiation in primary care have increased the need for the education of healthcare professionals. There is much expert knowledge of diabetes in primary care but further development of primary care skills is paramount if these services are to succeed. This development is provided in a variety of ways, sometimes by the local diabetes team or by accredited national courses.

I think it would be fair to say that in recent years the facilitator role has become slightly blurred around the edges. With the devolvement of diabetes care into the primary sector, many diabetes specialist nurses have found that they are facilitating in various ways – maintaining the links with the acute Trusts, but in many cases, employed by the PCT. Since the advent of the PCTs and acute Trusts – some of them foundation, such as ours – it has been more important than ever to maintain these links and this remains a very important part of my role.

There have been some difficult cross-Trust situations within diabetes since the formation of the new Trusts but thankfully these are beginning to resolve. The most difficult

situation that has arisen is the fragmentation of the diabetes team. Prior to the formation of the foundation Trust and PCT, the team was based in the same premises. This changed when all PCT staff moved off the acute site, including the diabetes specialist nurses, who moved 3 miles away from the hospital team. It has been necessary to maintain relationships and this has been done by joining together, whenever possible, with meetings held on both sites. Diabetes care cannot be delivered if it is fragmented.

My role became gradually more strategic over time, with continuing involvement in the production and updating of diabetes care guidelines and the recent Map of Medicine care pathways. I am also involved in updating our local diabetes strategy, which keeps abreast of our progress with the diabetes NSF and continue to manage the Diabetes Task Force. I have less time to visit practices than I used to, despite giving 2 days per week to the role instead of one at the time of the original article. This is something that I regret and I still feel it is very important. However, I retain contact with the practice nurses and GPs at our education days and enjoy these greatly. I continue to feel strongly that keeping lines of communication open between members of the multidisciplinary teams in both primary and secondary care is absolutely vital and still feel that I, as facilitator, am in an ideal position to do this. I remain convinced, after 18 years, that this is a key part of my role.

### Conclusion

I am amazed at the developments that have taken place since 1997. There are others that I haven't the space to discuss that have influenced our care, such as nurse prescribing and the ever increasing list of new therapies. However, I have one big concern: that through all this, we have, in some cases, forgotten that the person with diabetes must come first. The NHS Plan (2000) was drawn up to put them at the heart of health care, but in these days of targets, waiting lists and league tables, there is evidence that health care is suffering as a result. We must not let that happen in diabetes. ■

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