Being politically aware in paediatric diabetes nursing

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As the journalists move out of their camps in Westminster, nurses and other professionals in the public sector can take stock of the outcome of the general election and the change in policy makers as a result of the new Conservative–Liberal Democrat coalition government. Whatever our political persuasion, over the past month we have all come to recognise that change is inevitably going to happen.

As it stands, the NHS has a massive deficit, departments have huge cost savings to achieve year on year, and health service management speak of "working creatively". But the Conservatives have pledged to continue to back the NHS with its core beliefs and values, detailing in their "contract for a better NHS" (Conservative party, 2010) how:

- Healthcare should be free and based on need, not ability to pay.
- Patients should be given more choice.
- Doctors and nurses should be trusted.
- Access to drugs and services should be increased.
- Patients should be given more control over long-term care.
- Public health should be improved.

New government policy

The Conservatives plan to "publish detailed data about the performance of healthcare providers online, so everyone will know who is providing a good service and who is falling behind". This data will certainly contain information about doctors, yet it is unclear as to whether the initiative will extent to nursing staff.

As specialist nurses, we need to be aware of the possibility that services could be directly compared across institutions – this could be seen as both as a threat and an opportunity as Health Secretary Andrew Lansley pledges to "hand back power to clinicians and patients" (Department of Health [DH], 2010a).

Almost 60 MPs have signed a cross-party Early Day Motion calling for specialist nursing provision to be available to all people with long-term conditions. This is one of the six health priorities for the new government which the Royal College of Nursing (RCN, 2010) called for in its *Nursing Counts* general election campaign. It will be interesting to see whether this pledge will become reality over the coming weeks.

Role of specialist services

It is important that we take stock of our services and reflect on what we do in the current economic environment. Can we prove that we are providing value for money and that we are earning funds for our departments? The fundamental health economy of coding procedures has started to code every action within an outpatient consultation. Do you code for "review by multidisciplinary team from more than one profession"? Are we sure that our trust is capturing data about home visits and telephone consultations? Payment by results is a bureaucracy that may take some time to change and may well be increased over the coming years.

As we reflect on our practice, we need to consider that paediatric diabetes is a highly specialised service – we work closely in small teams in a relationship that could be described as a "marriage". Many of us have been in the post for more years than we care to remember; we have become independent prescribers and may hold masters qualifications.

We work with increasingly complex cases, using complex insulin regimens and technology such as continuous glucose monitoring and insulin pump therapy. Our services have evolved to provide these facilities; we run nurse-led clinics as we are "cheaper" than consultants, and regularly advise other healthcare professionals on inpatient diabetes care. We are, however, becoming difficult to

replace, and as staff retire or move on we must consider how to fill these gaps. If our role is not fully understood, the current economic climate may dictate that we are replaced by cheaper, less experienced staff.

Current legislation – hindering development of specialist staff?

The RCN Paediatric Diabetes Special Interest Group (1998) produced its guidance *Specialist Nursing Services for Children and Young People with Diabetes* in 1998. The document suggested that there should be three levels of nurses working in paediatric diabetes care, specifically:

- Specialist nurse (Agenda for Change [AFC] band 6).
- Clinical nurse specialist (AFC band 7).
- Consultant nurse (AFC 8B minimum).

Twelve years on there are still no consultant paediatric diabetes nurses in England. But it seems to come down to a "chicken and egg" scenario when it comes to someone filling our role. A new-in-post nurse may require a minimum of 1 year of experience within their field of practice to be considered eligible to take the independent nurse prescriber course.

Nurse independent prescribers are professionally responsible for their own actions. Where a nurse is appropriately trained and qualified as an independent prescriber so that he or she may prescribe as part of day-to-day nursing duties with the consent of the employer, the employer may also be held vicariously responsible for the nurse's actions. It is therefore advised that all nurse prescribers ensure that they have professional indemnity or insurance, for example through membership of a professional organisation or trade union (DH, 2010b).

The prescribing of insulin has become the bread and butter of our role. Yet we would be asking staff to work outside of the law if they are independently titrating insulin doses or instructing others to do so without the necessary qualifications. In effect, the legislation that helps us practice could also hinder our succession planning.

Framework for practice

TREND-UK (Training, Research and Education for Nurses in Diabetes-UK) has recently published a competency framework for DSNs, available on its website (TREND-UK, 2010). This is a valuable tool that provides a defined structure of practice and demonstrates the level of practice at which a DSN may be performing. The document describes the progression of knowledge and skills across five competency levels – unregistered practitioner, competent nurse, experienced or proficient nurse, senior practitioner or expert nurse, and consultant nurse – and suggests ways in which nurses can progress their career; I would urge all DSNs to use this framework as a reference for their next appraisal.

Conclusion

As health care looks set to remain at the top of the political agenda, it is important for trusts to evaluate the services that they offer, particularly in the current economic climate.

One thing that will not change quickly with the election of the new government is the conflict in Afghanistan. Many of us may have encountered children of "forces families" – those in which the parents work for the armed forces. When children of such families are diagnosed with diabetes the parents are understandably concerned about postings abroad with regard to healthcare provision. Jo Dalton is currently working as a Community Children's Nurse with British Forces Germany. Her article on page 230 can serve to inform us of the healthcare provision for these children in Germany so that we can advise our "forces families" accordingly. ■

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