# Diabetes specialist nursing: The current state of play

*June James*

June James is Consultant Nurse in Diabetes, University Hospitals of Leicester, Leicester.

Three years ago, Diabetes UK instigated the first of the annual DSN workforce surveys. These audits aimed to identify workforce qualifications and trends, gaps in service and the impact of government policy on the profession and people living with diabetes. The last survey (2011–2012) was completed by 525 DSNs, 61% of whom work for acute trusts, with the remainder working in the community setting or for mental health trusts.

The 2011–12 results reflect those of previous surveys in that they demonstrated that most DSNs are well qualified, with an average of 2.6 post-registration qualifications, are multi-skilled and provide complex care and education for people with diabetes and non-specialist healthcare professionals.

We know from looking at the previous workforce trends, along with other means, that the number of DSNs is reducing (Gosden et al, 2010; Diabetes UK and NHS Diabetes, 2011). In 2011–12, 52% of vacant DSN posts reported were unfilled compared with 43% reported in the previous year.

One in five DSNs intend to retire between 2012 and 2025; this will come during a time-span during which the incidence of diabetes is expected to total nearly 5 million. Where DSNs are retiring or moving, posts are being frozen to meet cost-saving demands.

Data from 2011–12 showed that 57% of responders worked full-time and 90% of all were banded at Band 6 or 7. Leadership and clinical support by medical consultant colleagues has diminished over time (66% in 2011–12 compared with 82% in 2009) and nurse leadership increased (32% in 2011–12 compared with 26% in 2010). This is in spite of national recommendations that DSNs work in multi-professional teams with access to a diabetologist (Diabetes UK, 2010).

In the latest survey, 50% of responders had no protected time for continual professional development and 71% reported a lack of protected funding. Where services have been reduced, DSNs reported the effect on specific care areas, including in-patient work, help-lines and structured education programmes. All 525 participants were asked how this impacted on local care provision; 50% said it increased the workload of DSNs, 40% said that it led to increased waiting times and 10% said that it decreased clinical support.

These results are disappointing but not entirely unexpected. It was evident from previous surveys that DSNs were a prime target for cost-cutting exercises. It was inevitable that this would influence the ability to provide care and education provision for people living with diabetes and clinical support for non-diabetes specialist healthcare professionals. Specific comments sent in by individual DSNs reflected the challenges faced, and a general feeling of general of despondency and low morale was a recurring theme.

The workforce survey has not been repeated this year and the full results of the 2011–12 survey have so far not been published. However, the information already gathered will provide a foundation for new initiatives to support the profession; these may include the introduction of a more effective data-collection system and a directory of DSNs, as well as the exploration of a specific DSN qualification. It would be naïve to think that the majority of changes to the DSN workforce have taken place. New

***"I believe that many of our more traditional roles will be transferred to other competent healthcare professionals, so in order for the profession to survive, DSNs will needs to become even more specialist."***

commissioning guidance will demand that DSNs continue to demonstrate their worth and cost-effectiveness so ongoing local audit is important.

I believe that many of our more traditional roles will be transferred to other competent healthcare professionals, so in order for the profession to survive, DSNs will needs to become even more specialist. This may include areas such as the complex care of people with severe chronic kidney disease, those with foot disease, in pregnancy care, or for those on insulin pumps.

As DSNs, we could also offer economies of scale, such as the expansion of group-education activities, which have already been proven to be cost-effective. Another area that DSNs can take on is the care of people with diabetes who are frequently admitted to hospital; this would enable the meeting of specific admission avoidance targets set by the Commissioning Outcomes Framework (NICE, 2012), and then commissioners will see we are really worth our salaries.

If you want DSNs to continue to have a voice, then please do register for the Diabetes UK collaborative network as your views are essential if the survey work is to lead to real change for the provision. ■

*Acknowledgement*

The author would like to acknowledge Gavin Terry, Policy Manager at Diabetes UK.

Diabetes UK (2010) *Commissioning Specialist Diabetes Services for Adults with Diabetes – Defining A Specialist Diabetes UK Task and Finish Group Report (Oct 2010).* Diabetes UK, London. Available at: http://bit.ly/TwXj21 (accessed 08.11.12)

Diabetes UK, NHS Diabetes (2011) *2010 Diabetes specialist nursing work force survey report.* Diabetes UK, London. Available at: http://bit.ly/naBDLq (accessed 08.11.12)

Gosden C, James J, Anderson U, Morrish N (2010) UK workforce survey of DSNs and nurse consultants. *Journal of Diabetes Nursing* **14**: 250–7

NICE (2012) *Commissioning Outcomes Framework Indicator Development Programme.* NICE, London. Available at: http://bit.ly/ZcCnTB (accessed 08.11.12)

***Following the results of the 2011–2012 DSN workforce survey, it is important that DSNs continue to have a voice to ensure that the survey work leads to real changes that serve to support the profession.***