Are diabetes nurse specialists adequately prepared for commissioning?

Jane DeVille-Almond

The central principle of the NHS, when launched in 1948, was to provide services free for all at the point of delivery. A noble pledge indeed, but with continuing medical advances and an increasingly ageing population, the sustainability of this principle has become a major challenge. The NHS is changing and those working within this institution will need to embrace these changes if both they and the NHS are to survive. As financial pressures continue to put the NHS under threat, the need to build an NHS that is fit for the 21st century has never been greater and spending money wisely will be high on the agenda. Specialist nurses in all fields need to make sure they have evidence to prove they are both cost effective and enhancing services; otherwise another provider may step in and take over their role.

In order to ensure sustainable health for future generations, the NHS White Paper *Equity and Excellence: Liberating the NHS* (Department of Health, 2010) brought about a major reorganisation of the NHS in England. The Health and Social Care Bill, introduced in July 2011, was granted Royal Assent through the Houses of Parliament and became the Health and Social Care Act, 2012 (RCN, 2012). This act led to Primary Care Trusts being disbanded on 1st April 2013 and replaced by 211 Clinical Commissioning Groups (CCGs), made up of clinicians, predominantly GPs. It is a legal requirement for all CCGs to have at least one nurse and one secondary care clinician in the group.

CCGs are responsible for commissioning health services for their local population and have control over 80% of the NHS total budget. The Department of Health (DH, 2010) defines commissioning as:

> *"The process of assessing the needs of a local population and putting in place services that meet those needs."*

The role of the DH has also changed. The NHS will no longer be directly managed by the DH; its role will simply be to ensure strategic leadership for both health and social care.

One of the responsibilities of the CCGs over the next few years will be to create effective savings, as well as providing high quality clinical services. To enable this to happen the NHS has opened its doors to competition, allowing a wider range of providers, such as private and voluntary groups, social enterprises and charities, the opportunity to compete alongside already-established providers of current health services. In light of these changes there has never been a greater need for specialist nurses to be able to compete on quality and costs and to have the skills to "sell" their services to commissioners.

Figure 1 shows the groups involved in the new commissioning structure.

Why the need for specialist diabetes services?

The number of people diagnosed with diabetes

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Article points

1. There have been significant changes in the NHS over the last couple of years. Clinical commissioning groups (CCGs) now have responsibility for commissioning services that are high quality and cost effective
2. As the number of people with diabetes increases, commissioning high-quality diabetes services will be high on the agenda for CCGs.
3. The new commissioning system now means that nurses will have to consider how their role contributes to diabetes services. In this new commissioning climate, they must now be able to describe exactly what they are trying to achieve and demonstrate cost effectiveness.

Key words

- Clinical commissioning groups
- Diabetes services
- Diabetes specialist nurses

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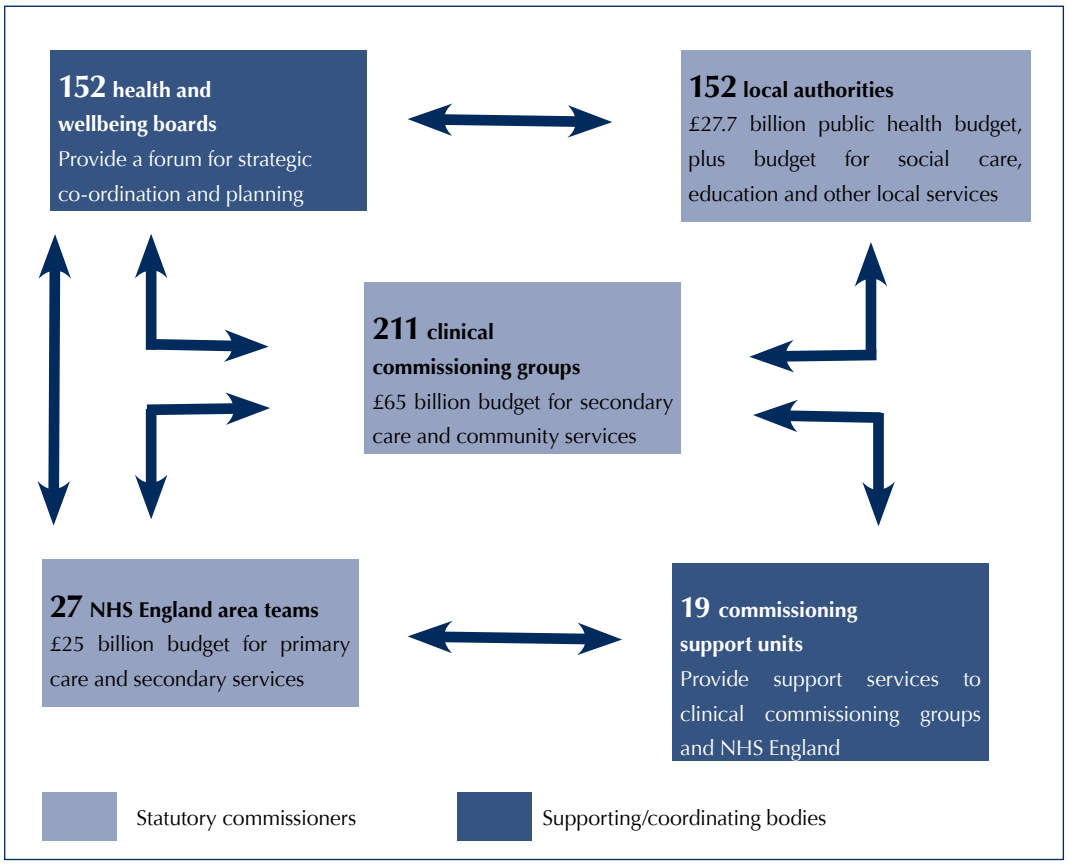

Figure 1. Groups involved in clinical commissioning (adapted from Naylor et al, 2013).

increased 25% within a 5-year period from 2006 to 2011 and is now thought to stand at around 2.5 million people (Diabetes UK, 2012a). However, this is a very conservative estimate and it has been suggested that a further 850,000 people are still unaware that they have the disease (Diabetes UK, 2012b)

More importantly, not only has diabetes increased, but there has been a huge growth in complications, with diabetes now being the biggest single cause of amputations, strokes, blindness and end-stage kidney failure (Diabetes UK, 2012b). Current spending on diabetes has risen to around £10 billion, which accounts for almost 10% of the total NHS budget (Diabetes UK, 2012a). It is estimated this will increase to 17% of the total NHS budget by 2025.

It is clear from these statistics that diabetes services will be high on the agenda of commissioners. Type 2 diabetes continues to increase year on year, partly due to people living longer and partly down to lifestyle choices, such as poor diet and lack of physical activities (Day, 2001), placing an even greater burden on the NHS. As costs rise it is increasingly important for commissioned services to include prevention strategies, as well as to encourage self-management and to improve access to care (NICE, 2012).

Diabetes specialist nurses' (DSNs') roles currently include education, managing, counselling, clinical expertise and a professional role model; but they do not work alone. DSNs work within a multidisciplinary team and will be commissioned as part of this team. Specialist multidisciplinary diabetes teams will usually comprise doctors, nurses, podiatrists, dietitians, pharmacists and clinical psychologists (Goenka et al, 2011).

The new commissioning system now means that nurses will have to consider how their role contributes to diabetes services. Historically, nurses may not have considered how much they cost and what they offer the diabetes team and people with diabetes. In this new commissioning climate,

they must now be able to describe exactly what they are trying to achieve and demonstrate cost effectiveness, and consider whether there is another provider who could provide their service at a lower cost.

What will nurses have to consider when selling themselves to commissioners?

When commissioners select a provider for a clinical area such as diabetes, they will consider if "the provider" can demonstrate and show previous success in delivering a service that meets the objectives of the service provider. This will mean that nurses working in diabetes will need to understand what those objectives are. These objectives may vary slightly in different geographical areas, as these will depend on the needs of people in the community with diabetes; however, there will be key elements that CCGs will be expecting their provider to consider and these have been summarised in *Box 1*.

Assessing need and reviewing service provisions

To ensure diabetes services are meeting the need of the population, nurses working in that area must carry out a "needs assessment" for their community; this should include identifying disadvantaged groups and data collection on ethnicity. Carrying out a service user profile is crucial to ensure that a well-integrated diabetes service is commissioned. To help prioritise DSNs should consider the following:

- What are the demographics of the population?
- How many people with diabetes are under their care?
- Do they have a greater or lesser proportion of people with diabetes than the national average?
- How can they improve access and services for high risk groups that may require a specifically designed service. For example, do they have a higher proportion of people with diabetes from minority ethnic groups?
- How can they ensure that local standards meet the nationally agreed criteria?
- How can they ensure efficient and effective medicine management?

Personalising services to meet the needs of the DSN's diabetes community will enable the DSN to negotiate what kind of diabetes service should be provided to meet the needs of his/her local service users, rather than the needs of the national average. Understanding the specific needs of the people with diabetes in the local area will help to ensure the correct staffing levels are in place to run and manage the service. Carrying out a needs assessment for a clinical area will require working with other organisations, and even letting other organisations take on the responsibilities of areas that have traditionally fallen into the nurse's jurisdiction.

Designing, shaping and planning a service

Diabetes is a complex condition and it is imperative that those involved in the designing and planning of a service should have experience working within the service. Getting involved in helping shape a diabetes service will enable the DSN to define what the responsibility of the nurse will be within an integrated service. It will be important that the DSN can show the need for his/her specialism and persuade the commissioners that their contribution to the service will enhance the service and improve the experience of people with diabetes. It is also important to be able to demonstrate positive outcomes and to prove that they are cost effective.

NHS Diabetes (now part of NHS Improving Quality) has said that a well-planned service should not only improve the experience of people with diabetes but also provide clearly defined roles and responsibilities for healthcare professionals and other providers, as well as improve efficiency of the service (NHS Diabetes, 2013).

Box 1. Key elements that commissioners will look for in a service (adapted from Naylor et al, 2013).

- Enhancing quality for patients
- Quality services and value for money
- Improving outcomes
- Safety and experience
- Extending choices of services
- Involving the general public in the design of services

Page points

1. When commissioners select a provider for a clinical area such as diabetes, they will consider if "the provider" can demonstrate and show previous success in delivering a service that meets the objectives of the service provider. Therefore, nurses will need to understand these objectives.
2. To ensure diabetes services are meeting the need of the population, nurses working in that area must carry out a "needs assessment" for their community; this should include identifying disadvantaged groups and data collection on ethnicity.
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1. Nurses will need to provide evidence of audit, with data collection being a key component for all nurses working in diabetes, regardless of their level within the team.
2. It is important that all details are recorded, starting from the person with diabetes booking an appointment. This includes the length of time spent with the person, the frequency of follow-up appointments, clinical outcomes and the satisfaction of the person with diabetes.
3. The challenge for nurses may be for them to develop skills in areas that are currently unfamiliar to them, such as involving people with diabetes in planning and developing services. However, the greatest advantages DSNs already have are that they are already highly skilled and know what people with diabetes need and want.

Monitoring and evaluation of a service

Nurses will need to provide evidence of audit, with data collection being a key component for all nurses working in diabetes, regardless of their level within the team. The audit should include measuring both quality and outcomes. The focus should not be on clinical outcomes alone, such as improved HbA_{1c}, but also the process of the service that is being delivered, ensuring people have a positive experience of care. An example of this is ensuring that the service is accessible to people in the local area.

To put this in simpler terms, every action carried out should be measured and recorded in order to provide commissioners with the evidence that the service is working efficiently. It is important that all details are recorded, starting from the person with diabetes booking an appointment. This includes the length of time spent with the person, the frequency of follow-up appointments, clinical outcomes and the satisfaction of the person with diabetes.

Measurable outcomes might include: feedback from people with diabetes; changes in HbA_{1c} levels; evidence of behaviour change, such as weight loss or improved physical activity; reduction in hospital admissions; early discharge from hospital; reduced complications associated with diabetes; improved independence and self-management in people with diabetes and improved management of medication.

In the past, the culture of nurses has been for them to be seen as carers, developing the belief that the more people rely on their care, the more it proves they are offering a good service. This type of care is unsustainable and diabetes nurses should aim to teach people with diabetes to become independent by self-managing their diabetes.

Conclusion

The good news for nurses is that, in order for CCGs to meet the challenges ahead and procure the best services, they will need to rely on the knowledge and experience of senior nurse leaders and other healthcare professionals; this is because such leaders are likely to:

- Already be working in, and understand, their local communities and current services.
- Have access to people in the community through their nursing roles. This allows them insight into current areas of poor care and will help them identify necessary improvements in the service.
- Have experience of working across organisations.
- Challenge current poor quality care.

The challenge for nurses may be for them to develop skills in areas that are currently unfamiliar to them, such as involving people with diabetes in planning and developing services; strategic planning; business planning; costing of services; writing proposals; understanding the bidding process and embracing new technology, such as telehealthcare.

It is often difficult to imagine working in a different way and historical constraints may have dampened the innovative streak of nurses. DSNs now need to take on the challenge of working smarter by offering the best possible services for less money. The greatest advantages DSNs already have are that they are already highly skilled and know what people with diabetes need and want.

Furthermore, in most cases, people with diabetes trust the services and healthcare professionals they are familiar with. However, nurses will need to be vigilant and safeguard their service by continuing to offer a first-class service, with measured outcomes that meet the Quality Standard for Diabetes (NICE, 2011). If they fail to provide evidence that these standards are being met, then another provider might be waiting in the wings to take over the role of providing the efficient and cost-effective services that the CCGs desire. ■

Day C (2001) The rising tide of type 2 diabetes. *Br J Diabetes Vasc Dis* **1**: 37

Department of Health, (2010) *Equality and Excellence: Liberating the NHS*. DH, London. Available at: http://bit.ly/1dlPicG (accessed 12.11.13)

Diabetes UK (2012a) *State of the Nation 2012*. Diabetes UK, London. Available at: http://bit.ly/JzwEzZ (accessed 12.11.13)

Diabetes UK (2012b) *Diabetes in the UK 2012: Key statistics on diabetes*. Diabetes UK, London. Available at: http://bit.ly/MoJ1Nv (accessed 12.11.13)

Goenka N, Turner B, Vora, J (2011) Commissioning specialist diabetes services for adults with diabetes: summary of a Diabetes UK Task and Finish Group report. *Diabetic Med* **28**: 1494–1500

Naylor C, Curry N, Holder H et al (2013) *Clinical commissioning groups: Supporting improvement in general practice?* The King's Fund and Nuffield Trust, London. Available at: http://bit.ly/1bzPOSY (accessed 12.11.13)

NICE (2011) *Diabetes in adults*. QS6, NICE, London. Available at: http://guidance.nice.org.uk/QS6 (accessed 12.11.13)

NICE (2012) *Preventing type 2 diabetes: risk identification and interventions for individuals at high risk*. NICE, London. Available at: http://guidance.nice.org.uk/PH38 (accessed 12.11.13)

NHS Diabetes, (2013) Best practice for commissioning diabetes services. NHS Diabetes, Newcastle upon Tyne. Available at: http://bit.ly/1bmBIlk (accessed 12.11.13)

Royal College of Nursing (2012) Health and Social Care Bill 2012. RCN, London. Available at: http://bit.ly/LUNidw (accessed 12.11.13)