Are diabetes specialist nurses a dying breed?

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A debate at the "New dimensions in diabetes nursing" conference held in July this year provided a provocative but entertaining forum in which to discuss the potential and perceived threat to the DSN role in the current NHS climate. To make it more interesting, a DSN, Jill Hill, presented for the motion (that the role of the DSN was unsustainable) and a practice nurse, Jane Diggle, spoke in support of the DSN role. The key points from the debate are discussed in this brief summary.

For the motion

The role of the DSN is doomed; let me explain why. The NHS is struggling to meet the health needs of an ageing population within the current economic climate. The focus is now on cost-savings (which includes using other providers), increasing use of technology such as tele-care, keeping care closer to home and there is a greater emphasis on keeping people well rather than managing illness.

Many DSNs are expensive; a nurse at band 7 working in secondary care will be managing a ward of perhaps 30 patients, a team of staff and a budget. Use of skill mix and other providers (for example, practice nurses, pharmacists, private healthcare providers) may deliver much of the traditional DSN work at a lower cost. Practice nurses are becoming increasingly skilled in diabetes management, including injection therapy initiation, but will also manage hypertension, lipids, flu jabs, cervical smears and so on. Furthermore, the use of virtual clinics can enhance primary care diabetes services but also reduce the need for appointments with specialist diabetes healthcare professionals.

Diabetes, as a speciality, is disappearing and is now included in chapter 4, "Enhancing quality of lives with long-term conditions", of the generic NHS outcomes framework (Department of Health, 2012) People with long-term conditions have similar health issues that can be addressed by non-specialist staff. The ageing population means people will not just have diabetes on its own; for example, they will have diabetes and dementia, and the DSN focussing on just one condition without the managing the other does not make sense. The demise of NHS Diabetes, which is now incorporated into NHS Improving Quality, is an example of this "generic focus" in the NHS.

One area of action for new clinical commissioning groups (CCGs) to address is reducing avoidable admissions, particularly people with frequent admissions. These people with diabetes may have social problems, mental health problems or addictions that often make their diabetes unmanageable. Focussing just on their diabetes is ineffective. Assertive case management, involving non-diabetes specialists, such as social workers or mental health professionals, will be more effective than a DSN.

There is an emphasis on keeping people well, including prevention of long-term conditions and, for diabetes, ensuring people with the condition receive all nine care processes (HbA_{1c}, blood pressure, cholesterol, retinal screening, foot check, micro-albuminuria, creatinine/estimated glomerular filtration rate, weight and smoking assessment). CCGs will be measured on this so they will invest in people who can deliver these outcomes. Practice nurses will be focussing on these care processes, while prevention of diabetes, as recommended in NICE guidelines (2012) for identifying and intervening in individuals at risk of developing diabetes, will be the remit of lifestyle support groups such as leisure centre staff, slimming groups and health educators. No role for the DSN there!

And in case you are still not convinced, the evidence from the third DSN survey shows that this is already happening. The numbers of respondents has dropped from 838 in the first survey to 525 in the latest and respondents reported unfilled vacancies and DSN posts frozen to save money. Furthermore,

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one in five DSNs are due for retirement in next 10 years (James, 2012); will they be replaced?

Against the motion

The role of the practice nurse in diabetes management has expanded significantly over the last decade, with many taking a lead role within their practices. The *Quality and Outcomes Framework* (QOF; NHS, 2013) may have engaged general practice in delivering diabetes care and raised the standards of care, but as the National Diabetes Audit (Health and Social Care Information Centre, 2011) has shown, there are huge geographical variations across England in the number of people receiving all nine recommended essential checks. With incentive schemes like QOF, there is always the danger that practice nurses will be pressurised to concentrate on those aspects of diabetes care that generate QOF income rather than what matters most to the person with diabetes.

Whilst some practice nurses are diabetes specialists within their practice, most are generalists and may not have a particular interest in the condition. Practice nurses often possess a broad range of skills, enabling them to address the wider aspects of diabetes, such as blood pressure, cholesterol and depression, but do they have the time, capability and support to deal with these complex issues in any depth? In the typical 20-minute consultation, this is unlikely.

With "local enhanced services" in many areas, practice nurses may be under pressure to take on roles and responsibilities beyond their level of competence, with inadequate time, training or support. Insulin initiation is an example of this because many practice nurses will simply not see sufficient numbers of people on insulin and regularly enough to maintain their confidence and skill.

Many practice nurses possess some specialist skills but that does not make them specialist diabetes nurses. There are certain aspects of diabetes care, such as insulin pump therapy, paediatrics and antenatal care, which are beyond the scope of practice nurses or GPs.

There are, at any given time, a significant number of inpatients who have diabetes and DSNs have been shown to make important (and financially beneficial) differences in terms of reducing medication errors and lengths of stay (Kerr, 2011). DSNs bring clinical expertise, innovation and leadership in diabetes. Practice nurses may have similar skills but not the depth of knowledge or experience.

So there is still a need for DSNs BUT to survive in the future, they need to address some of following:

- Establish statutory training and a recognised qualification for diabetes specialist nursing, linked to the diabetes nursing competency framework (TREND, 2011) to formalise their credibility.
- Market the DSN role, emphasising their unique skills and providing evidence to support clinical outcomes and cost efficiency, for comparison with other competing providers when commissioners are considering who is best to deliver the required service.
- Improve cost effectiveness through skill mix and focus on specialist skills and services that no-one else can do. For example, delivering services to a group of people with similar needs, rather than individual appointments, reduces cost per person whilst maintaining quality.
- Embrace technology (for example, the use of virtual clinics).
- Stop doing things that can be done by someone just as effectively but cheaper (for example, delivering basic diabetes education). Stop doing things that are not in the service specification. NHS is a hard business world now and payment follows delivery of services that have been commissioned.
- Become specialist DSNs ("two for the price of one"). For example, specialise in diabetes and mental health, diabetes and renal, diabetes and older people. This is especially important as the relationship between diabetes and other comorbidities becomes more significant with the ageing population. Develop into diabetes assertive care managers, focussing on people who are costly to the NHS with very complex problems that other providers cannot, or are unwilling to, support.
- Be flexible with working hours; people do not have diabetes just on Monday to Friday, 9am to 5pm. The NHS is increasingly moving towards seven day availability and DSNs should be no different.

Conclusion

Happily, despite the many challenges in today's NHS and the strong case proposed for the motion, the majority of the audience at the conference remained optimistic about the future of the DSN and voted against the motion. However, DSNs need to adapt to the changes in the healthcare environment, ensure their services are cost-effective and provide outcome data that proves their worth! ■

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