

Community diabetes specialist nurses: Value for money or a luxury the NHS can ill-afford?



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People with diabetes require the individual providing their diabetes care to have certain characteristics embedded within their role (Lawton et al, 2005; Williams and Jones, 2006; Edwall et al, 2008; Forbes et al, 2010; Beresford, 2011; Diabetes UK, 2011). These include:

- Diabetes knowledge and expertise.
- Approachability.
- Continuity.
- Partnership working.
- Accessibility.
- Holistic approach to care planning.

These elements are the foundations of the Community Diabetes Specialist Nurse (CDSN) role and mirror those of the National Cancer Action Team Clinical Nurse Specialist (CNS) role. These elements are also identified in current diabetes policies (Department of Health [DH], 2012; Diabetes UK, 2012).

Unfortunately, with the Government's cost-cutting measures and shift to practice-based care, the CDSN workforce is already diminishing, resulting in more care being delivered by practice nurses (PNs; Diabetes UK, 2012). It has been suggested, however, that PNs do not possess the skills, or have the time required, to deliver the care identified by patients (Andalo, 2012). Locally, these assertions have been fortified by a declining workforce and anecdotal evidence from people with diabetes that PNs lack expertise and time, with care given in a dictatorial manner. Some GPs have also expressed their concerns, stating that they do not feel competent enough to manage their patients with diabetes effectively, but this notion conflicts with governmental policy. *Diabetes Without Walls* (NHS Diabetes, 2009) identifies the need for specialist staff and provision of a service based on competence to deliver care. This quite clearly will not be the case, if the shift to primary care continues and the CDSN role erodes as a result.

In order to address these issues, investment in

CDSNs is a necessity (Diabetes UK, 2012). It is crucial that quality of care outcomes should not be utilised in isolation to justify the role, but in combination with financial benefits. Thus, there is a need for a strong evidence base, highlighting that clinical specialist nurses (CSNs) deliver patient-focused care alongside cost-effective services (Vidall et al, 2011).

The NHS Institute for Innovation and Improvement (NHS III) identifies that the most successful organisations are those that can implement and sustain effective improvement initiatives that culminate in increased quality and patient experiences at lower cost (NHS III, 2013). It is clear that the implementation aspect has been achieved but we are failing to sustain it due to cost-cutting measures; this, in turn, will conclude in worsening quality and ineffective service provision.

According to Leary et al (2008), some Trusts have taken steps to address this and commissioned a database tool, named "Pandora" in order to demonstrate the contributions made by CSNs. The use of the tool identified the efficacy of the CSN role (Keenan et al, 2010; Oliver and Leary, 2010). The government supported the findings, particularly within diabetes and urged commissioners to invest in DSNs to potentially save upward of £20 000 per year (NHS Diabetes, 2012).

Despite commissioners being urged to invest in DSN teams, their numbers continue to diminish throughout the UK; vacant posts are being frozen, roles are being down-banded and an ageing workforce is evident. It is widely believed that investment is required (Williams and Jones, 2006; Forbes et al, 2010; Beresford, 2011; Diabetes UK, 2011). Unfortunately without evidence to identify the value and cost effectiveness of the CDSN service, this is unlikely to occur. CDSNs need to provide evidence of role value and cost effectiveness to ensure their survival. ■