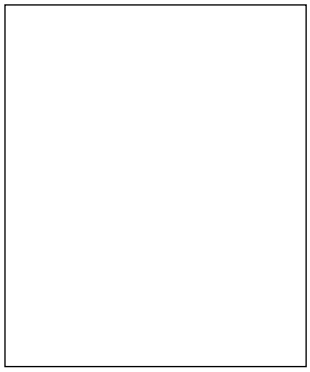
Diabetes specialist nurses: what care to provide?



Jill Rodgers

Cost effectiveness is a recurrent theme within today's NHS. In previous issues of this journal, we have seen evidence that DSN roles are often undervalued, and that the wisdom of investing in such roles is increasingly being questioned at a local level.

In this issue, the article *Development and audit of a home clinic service* (page 51) raises the idea of using DSNs to provide a diabetes service for those who would find it difficult to attend a hospital clinic. It is clear that those patients with limited mobility or those who depend on others to care for them should not receive an inferior level of diabetes care. Provision of a service by DSNs will undoubtedly remedy this, although the complex medical problems that often arise in this type of patient may also necessitate a doctor's visit or appointment.

Best use of a DSN's time?

However, is this the best use of a DSN's time? The demands on their services are numerous and the DSN role has developed considerably from a decade ago when its main function was to obviate the need for hospital admission in those patients requiring initiation of insulin therapy — a system providing clear financial benefits. Since then, many other aspects have also become integral to the role, providing specialist nursing input into areas such as paediatric diabetes care, pregnancy services, erectile dysfunction clinics and specialist foot care services to name but a few.

Patient education groups, particularly for the newly diagnosed, are provided by DSNs in many areas. Participation in professional education is also common, although the degree of this involvement varies considerably depending on local university provision, perceived need, and the degree of participation of others in providing diabetes care.

In the light of this expanding DSN role, it is important to be clear where local priorities lie. The major dilemma we all have is: should the DSN spend the majority of the time providing clinical care to individual or groups of patients, or in providing education opportunities and developing others to provide the majority of that care? It would be foolish to debate who should provide care for groups of patients such as children, adolescents, and pregnant women with diabetes, as the small numbers in these groups preclude many generalist health professionals developing expertise in these areas.

It is also true that most DSNs have developed a high level of patient education skills, which can be used to help many more people than these small groups. Despite all this, the 'numbers game' is threatening to beat us all, and we cannot afford to let our wish to provide care stop us from recognising that we also need to involve other health professionals in this process.

It is also important to take into account the shift towards care provision of health services — and diabetes is no exception. In 1990, we saw the introduction of payments to general practices for the provision of structured care for people with diabetes, resulting in many more individuals receiving proactive care. The latest NHS White Paper (Secretary of State for Health, 1997) brings with it the promise of Primary Care Groups and their increasing accountability regarding the quality of their service provision. It is likely that many of these groups, although still at pilot stage, will begin to set their own strategies about how they wish to organise diabetes care. Secondary care teams who are autocratic, or who appear to be clinging on to areas of care which might be provided by others, may find themselves in a difficult situation.

Community nurses may prove more cost effective

In the scenario described in the article on page 51, concerning elderly and increasingly dependent patients, is it reasonable to expect a DSN to provide for all types of patients — increasing in number all the time? Would it be better for this type of

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work to be carried out by district and practice nurses who are, in general, based closer to the patients' homes and are already providing reviews for many people with diabetes? Although community nurses may require additional resources to provide this service, the latter option appears to be more sensible and ultimately more cost-effective. It might therefore be wise to invest the energies of local DSNs into developing this existing workforce further.

In localities where this has already happened, community nurses appear far more confident in their approach to diabetes care, whilst still maintaining close liaison with DSNs when they are uncertain how to proceed. Local experience has suggested to me that once nurses have accessed some diabetes education, they develop a 'thirst' for further educational opportunities, and respond positively when offered the chance to further develop their skills.

In other areas, some secondary care teams have found that trying to be the main providers of the majority of diabetes care has resulted in the practices accessing their services less frequently — a clear sign that GPs and practice nurses feel they have a greater part to play.

Longer term strategies

What is the most cost-effective method of providing diabetes care? We as DSNs need to take a step back from trying to fulfil all the patient needs we may identify in our districts, and try and put into place longer term strategies to ensure that care is indeed equitable. We cannot achieve this without greater numbers of nurses being able to provide high quality care, but they do not all need to be in the diabetes centre — in fact they are already out there. ■

Secretary for State for Health (1997) *The new NHS: Modern, Dependable*. HMSO, London

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