Consultant nurses: Making a difference in diabetes care?

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Editor

The publication of the Government's document *Making a Difference* (DoH, 1999) is important for all nurses who work with people who have diabetes. The paper provides a strategic vision for the future for nurses, midwives and health visitors; within the document there are proposals for a package of measures to strengthen the contribution that these practitioners make to health care. The document discusses many aspects of care relevant to the new NHS, such as recruitment, education and training, leadership, improved working lives, enhancing the quality of care, the modernisation of professional self-regulation and working in new ways. This editorial, however, focuses on one of the aspects which may, perhaps, be of more immediate interest to many nurses in diabetes care.

Consultant nurses

The issue of consultant nurses is one that has been discussed by diabetes nurses in the past, particularly in relation to job titles. Following the announcement last year that such posts would be developed, more news has been awaited with anticipation.

Making a Difference provides some information about how they will be implemented. The Government proposes that consultant nurse posts lie within a new career structure, which will replace clinical grading. It is envisaged that they will enable some individuals to significantly extend their earning power to an upper limit of about £40,000, without moving into management or education. It is hoped that this will improve career opportunities and encourage expert practitioners to remain in clinical activities. Indeed, it will be obligatory for consultant nurses to spend at least half their time engaged in direct clinical practice. Other responsibilities will be 'professional leadership and consultancy, education and development, and practice and service development linked to research and evaluation' (DoH, 1999, p. 33). As a result, the role will help to ensure that many of the other aspects of care discussed within the document are appropriately addressed. For example, leadership will be strengthened and better outcomes for patients will be achieved as a result of improved services and quality of care.

As with other roles across the whole spectrum of the career structure, there will be competency frameworks, to judge whether individuals have the requisite abilities to perform in the role. As well as being competent it is proposed that consultant nurses will have been educated to masters or doctorate level and will have specialist-specific qualifications, in line with the UKCC's (1999) description of higher level practice.

However, the posts will not be 'awarded' to individuals; they will need to be applied for, once it is determined where such posts are required. NHS trusts will be able to decide for themselves what posts are needed but will have to consult with Regional Offices to ensure there is a broadly consistent approach across the whole NHS. The consultant nurse roles will be part of strategic health care plans, and may well be linked initially to National Service Frameworks (NSFs) and local health improvement programmes.

Comment

So, how will these proposals affect diabetes specialist nurses (DSNs) and our primary care colleagues? DSNs are already exploring their roles — through the joint working parties — including levels of practice and succession planning, and educational pathways for their preparation. This work could potentially be neatly integrated with the competency frameworks for the role of consultant nurse. The notion that roles will be related to NSFs also bodes well for DSNs, given that the NSF for diabetes is due in 2001. DSNs therefore appear to be in a good position to influence the process of consultant nurse development.

However, areas which need to be addressed include the issue of integrated

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working with primary care colleagues; particularly in the context of other political initiatives, such as primary care groups, and the fact that most diabetes care occurs in primary care. For instance, there is still a need for improved communication between primary and secondary sector diabetes nurses in many areas.

Also, the evidence base for diabetes nursing practice is somewhat 'thin'. The Government wishes nurses, whether they are consultants or not, to improve their research and appraisal skills to be able to use evidence to support practice, and, where appropriate, to undertake research to determine what best practice is. Ideal opportunities exist for diabetes nurses, in both primary and secondary care, to work together to devise relevant guidelines.

Conclusion

There are still many unanswered questions in relation to *Making a Difference*. However, now is the time for our professional leaders to be proactive and become involved in the work which will be generated by the Government's proposals, to ensure that diabetes nurses continue to make a difference to the health of people with diabetes. ■

Department of Health (1999) *Making a Difference: Strengthening the Nursing, Midwifery and Health Visiting Contribution to Health and Healthcare* DoH, London

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1999) *A Higher Level of Practice: Report of the Consultation on the UKCC's Proposals for a Revised Regulatory Framework for Post-Registration Clinical Practice* UKCC, London

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