

The NSF Delivery Strategy: opportunities to be taken?

Now that the long awaited NSF Delivery Strategy has appeared via electronic and paper routes, I wonder what the thoughts of the Journal of Diabetes Nursing are as they read it? Those who are aware of the direction of recent policy documents produced by the NHS will not be surprised that there are only a few 'tick boxes' that are nationally set, that there is little central funding put aside and also that there is very little directive regarding exactly how the service and the standards are to be delivered.

The NHS Plan and subsequent 'offspring' policy documents (Shifting the Balance of Power, The Expert Patient) highlight the centrality of primary care trusts as the local decision-makers about needs and priorities, and the need to focus care for people with chronic disease in a model of care that is focused on assisting all to be effective in their own self-care.

Lack of prescriptiveness

Those readers who are not so aware of this direction may be frustrated at the lack of prescriptiveness as to how local PCTs (who are tasked with implementing the strategy) should go about improving services to people with diabetes and their carers. But the Diabetes NSF is the first of the 'new style' of NSFs, i.e. that do not direct PCTs specifically, but encourage these new power bases of local health care delivery plans to consider the development of services to people with diabetes in harmony with the development of their health care plans to reach all their local priority areas. PCTs will have the power to direct their monies to diabetes services. Experience of previous NSFs has been to direct resources specifically to certain areas of care, leaving the potential for other services to be under resourced.

While some PCTs have developed plans for diabetes services, most are now going to need a great deal of help to get to grips with this framework – this is the first opportunity for nurses to get involved. I used to think that PCTs knew of all the expertise within their localities and perhaps chose not to use them. The reality is somewhat different: PCT leaders are

often unaware of the nature of their local expertise. So now is the time to seek out and influence the appropriate leader within the PCT – this may be the Chief Executive or the health care professional on the PCT Professional Executive Committee with the remit for either diabetes or chronic disease services.

Making teamwork a reality

Within the diabetes delivery strategy, PCTs are encouraged to seek local clinical champions; an ideal opportunity for those nurses who have been the quiet local champions of patient-centred care to be part of the 'champion' team alongside a medical champion (if there is one) and a patient champion. You may need to prompt local PCT leaders that more than one clinical champion is ideal in the delivery of the local diabetes services – now is the time to make 'teamwork' a reality rather than just rhetoric!

This new direction also enables PCTs to consider fresh models of service delivery (again the 'spirit' of the NHS Plan) which provides an opportunity for nurses to start highlighting their expertise. The concept of clinical networks is not new to nurses who have probably already developed such networks – hospital/community/practice nurses all trying to streamline their working practices to benefit the patient but being hindered by the organisational boundaries within which others have expected them to work.

Organisational barriers

Now is the opportunity to demonstrate to others how it is possible to work in such a way and also highlight how the organisational barriers have prevented development of successful working arrangements – and, importantly, to suggest how these may be changed. The concept of a clinical network enables people who are employed by different organisations to work seamlessly between them.

The third opportunity that the Delivery Strategy brings is involves the nature of the care to be delivered. The care will be expected to include structured education programmes, personal diabetes records,



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agreed care plans and a named contact. All of these initiatives are designed to assist with the fundamental principle of helping the person with diabetes better look after themselves, access healthcare services effectively and improve their short- and long-term health outcomes. As the largest workforce delivering diabetes care, nurses are the group at the centre of these initiatives.

Patient-held records

Some of us have experience of how past attempts at such initiatives have failed. For example, how many 'patient-held records' never really engaged the patient in active self-management? In my experience, not many – but that is not surprising given the passive nature of the patient's role in most instances. They were often simply the 'postman' taking the record from one healthcare professional to another. The challenge is now to set up structured education programmes that enable people with diabetes to acknowledge their own responsibility for their diabetes and to become active in their self-management (which is not the same as doing everything the professional tells them to do – that

is another article!), and know what they are doing, why they are doing it and how successful they are at achieving their initial goals. The education process will naturally involve teaching how the diabetes record and care plan works to help them – and their role in this starts to emerge.

The Delivery Strategy on its own will make little difference to the care of people with diabetes. However, those delivering care using the document, along with the associated publications, can make the difference. Using this as an opportunity not to be missed should be in the minds of all nurses delivering diabetes care. Consider this for a moment: How many times have you said to yourself: 'Why do we do this this way; surely it would be better done another way, and would represent a better use of the available resources.' If, after reading this, every diabetes nurse decided to approach his/her PCT leader and discuss one aspect of the NSF they would like to help with – that that would mean several thousand conversations and potentially several thousand improvements in services to people with diabetes – often not requiring major investments financially. Good luck! ■

Letter

DRIVING ON INSULIN – DIABETES UK POLICY

We are grateful for the opportunity to respond to the recent correspondence on these pages about driving on insulin (Vol 6 No 6 p.167). We have been accused of recommending a 'blanket ruling' that people do not drive if they have just commenced insulin therapy and their diabetes is not yet properly controlled. We have done no such thing.

Diabetes UK has a long record of campaigning to remove unnecessary restrictions on people with diabetes. We believe that automatic bans that restrict the lifestyles and life chances of people without taking into account individual circumstances are unjust. People with diabetes are individuals and have the right to be treated as such.

That is why we successfully pressed the Driver and Vehicle Licensing Agency (DVLA) to lift the longstanding ban on insulin users driving road vehicles between 3.5-7.5 tonnes. A system of case-by-case assessment is now in place and almost 1000 insulin users have secured a licence to drive these vehicles since the changes came into effect last year.

The same principle underpins our continuing negotiations with the emergency services, where we are pressing for an end to the long-standing ban on recruitment to the police and fire

services (incidentally, this ban affects all people with diabetes, not only those treated by insulin). We take the view that such bans are based on an outdated understanding of diabetes and remain in place more as a result of bureaucratic inertia than any valid medical justification.

Our advice to patients is that they do not drive at all if they have just commenced insulin therapy and their diabetes is not yet properly controlled. Yet, the judgement about when the patient is controlled should be theirs alone, in consultation with their health team. It would be foolish of the DVLA to try to establish a standard minimum time before which people cannot claim to be properly controlled, and as far as we know they have no plans to do so (such a minimum time threshold does apply to drivers of heavier vehicles, despite our protests to the authorities on this specific issue).

Our advice is the same now as it has been for several years. However, since it is clearly open to misinterpretation, we shall revise our written guidance to clarify the specific point about who we are referring to and how to interpret 'properly controlled'.

Stephen Fishwick (National Campaigns Manager) and Simon O'Neill (Head of Care Developments), Diabetes UK