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Access to specialist nurses in diabetes care: A postcode lottery?

Delivery of diabetes care is changing... and so it should. The numbers of people with diabetes, particularly type 2, are increasing in epidemic proportions. We need new ways of working within limited resources to tackle the problem.

The new joint position statement (Diabetes UK et al, 2007) states that 'moving more ongoing care out of hospitals into the community can be positive, as long as people with diabetes continue to have access to the skills and facilities they need'. In the best cases primary care teams work together with their secondary care colleagues to gain the knowledge and skills required to provide a high-quality service involving people with diabetes in their own management. Much has been made of 'choice' in health care and in many cases the voice of those with diabetes goes unheard. They have no *choice*. It appears some blanket letters informing people that their follow-up care is to be moved are being sent: a practice that should be unacceptable. Diabetes UK et al (2007) confirm that: 'evidence is emerging that the redesign of diabetes services is being implemented in some areas through cutting specialist diabetes services'.

Historically, before the 1990 GP Contract, people with diabetes were referred to specialist teams for review when problems arose. For example, insulin initiation was considered difficult, time consuming and required specialist skills not available in primary care. However, the system today is capable of becoming divisive due to NHS reforms. Those in secondary care feel their specialist skills are not given the significance they deserve while GPs are encouraged to cut back on referrals and manage people with long-term conditions in the practice. The previously unbelievable has happened in a few centres: specialist nurses employed in secondary care teams have faced redundancy due to the changing patterns of care while others have adapted and work with practices through employment in primary care

or as part of an intermediate service funded by PCTs or equivalent. Many are feeling devalued due to Agenda for Change and what is seen as a backdoor method of cutting salaries in a system that was supposed to create uniformity and reward for skills.

Practice nurses have responded to the challenge of working in new ways and acquiring new skills – the results of the QOF amply demonstrate that. Pressure on them to take on a more specialist role without providing the resources to do so results in anxiety and lack of confidence at a time when the individual with diabetes needs reassurance (Sanderson et al, 2007). People with diabetes need time and easy access to support at times of change; particularly if insulin is required. Many practices do not have sufficient numbers of people with diabetes for the practice nurse to become proficient in insulin initiation and management and it is imperative to continue to provide specialist nursing care. Some are finding none available.

Much importance has been put on empowerment of people with diabetes and on

structured education to underpin it (DoH, 2001; NICE, 2003). The average GP practice does not have the capacity to devote the time and expertise needed to meet NICE criteria. Courses such as DESMOND and X-PERT benefit from specialist nursing input and may help bridge any primary–secondary care gap, assisting people with diabetes in their *choice* of where and when to receive their care.

Health professionals only see a person with diabetes for 2–3 hours in a year. More resources are needed to cope with the increasing numbers of people being diagnosed. This is not the time for uncertainty in diabetes specialist nursing. ■

Diabetes UK, ABCD, PCDS et al (2007) *Joint position statement: Integrated care in the reforming NHS – ensuring access to high quality care for all people with diabetes*. Diabetes UK, London

DoH (2001) *National Service Framework for Diabetes: Standards*. DoH, London

DoH (2006a) *Diabetes commissioning toolkit*. DoH, London

DoH (2006b) *Care Planning in Diabetes: Report from the joint Department of Health and Diabetes UK Care Planning Working Group*. DoH, London

NICE (2003) *Guidance on the use of patient-education models for diabetes: Technology appraisal 60*. NICE, London

Sanderson C (2007) Insulin initiation: A primary care perspective. *Journal of Diabetes Nursing* 11: 344–7

Box 1. Principles that should be addressed to ensure consistency of approach and to reassure people with diabetes that their standard of care will not be compromised (from Diabetes UK et al, 2007).

- The new model of care, detailing local care pathways and roles and responsibilities, must be clearly defined. Local agreement of the model should involve the diabetes network including people with diabetes and their carers.
- Paediatric diabetes services and children and young persons with diabetes, and their families, must be engaged in the needs assessment and service specification process, working with commissioners to ensure appropriate care delivery and support.
- It is recommended that the Diabetes Commissioning Toolkit is used in England to assess the needs of the local diabetes population, including children, and to specify all parts of the diabetes service (DoH, 2006a).
- Locally, people with diabetes should be fully informed of the implications of any proposed changes and reassured about their ongoing access to a competent and skilled workforce in the new care environment.
- Any proposed changes to the ongoing care of individuals with diabetes should be based on individual assessment. Discussion with people with diabetes and their carers about the impact of service changes should be undertaken in a sensitive and timely manner, with particular consideration given to the importance that people attach to continuity of care.
- Where necessary, arrangements should be in place to commission appropriate follow-up care from 'out of area' services to meet the individual needs of the person with diabetes.
- The choice of the person with diabetes should be respected.
- Communication between all members of the integrated diabetes care team is essential to assure the provision of appropriate shared care.
- Individual care plans provide a focus for discussing and agreeing changes to care with each person with diabetes, including the details of where ongoing care will be provided. Each individual should have the opportunity to agree who their lead health care professional will be (DoH, 2006b). Block letters informing people that their follow-up care is to be moved are not acceptable.
- The impact of change on people with diabetes must be closely monitored