

The development of diabetes services



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It is less than 100 years since the discovery of insulin, but the evolution of diabetes care since then is considerable. In those early days, the management of people with diabetes was very doctor-led, based in hospitals, with the patient as a passive recipient of prescriptive instructions (Bliss, 1982). The development of GP “mini-clinics” in the 1990s enabled people with diabetes to receive some diabetes services (mainly systematic checks) in primary care but the healthcare professional was still very much in charge.

Testing Times (Audit Commission, 2000) demonstrated the wide variation in diabetes care, the lack of involvement by individuals in their own management, and how certain sections of the population found it difficult to access diabetes services. The report suggested that much of the routine management of diabetes could be done in primary care rather than traditional hospital outpatient clinics.

The introduction of the Quality and Outcomes Framework, as part of the revised General Medical Services contract in 2004, has significantly engaged primary care in the involvement of diabetes care, with almost all GP practices signed up to the scheme (Lester and Majeed, 2008). Local negotiation has resulted in local enhanced services providing high quality additional services for people with diabetes by their GP practice, such as insulin initiation. Increasingly, secondary care diabetes teams are focusing on people with complex diabetes needs, leaving most people to receive all of their diabetes care from their local GP practice. The advent of nurse prescribing may also mean that most of the support in managing diabetes is now nurse-led.

More recently, there is increasing emphasis on the person with diabetes being in charge of their own diabetes management rather than the healthcare professional, with the promotion of patient education and empowerment, choice and care planning (Department of Health, 2001). Care planning encourages well-informed people to work with their diabetes

team to decide how they want to manage their diabetes (DH and Diabetes UK Care Planning Working Group, 2006)

To enable high quality primary diabetes care, and realistic care planning with informed people with diabetes requires education and training, both for individuals and their diabetes team. NICE has published guidelines for structured diabetes education (NICE, 2003) and a number of programmes are now available for people with type 1 and type 2 diabetes. Diabetes training for healthcare professionals is now widely available, either as accredited courses from certain universities, local initiatives run by secondary or community diabetes teams, events sponsored by pharmaceutical companies, or by organisations such as Diabetes UK and the Primary Care Diabetes Society. The development of diabetes knowledge has widened considerably from the early days of diabetes specialists based in hospitals.

The role of the diabetes specialist nurse (DSN) and facilitator has had to evolve to match the changing needs of the deliverers of diabetes care. In hospitals, diabetes nurses now usually have a specific diabetes specialty (for example, a diabetes specialist midwife, or a paediatric diabetes specialist nurse). Many are now employed in the community, often running nurse-led clinics for people with more complex needs than the GP can manage, but who do not require referral to the hospital diabetes team. Many DSNs are involved in running the diabetes training programmes for primary care staff and, in the process, developing networks and supportive relationships with practices. DSNs often deliver structured education programmes in the community, providing a cost-effective way of informing and empowering groups of people with diabetes and their carers.

The following article describes the changing role of a diabetes nurse facilitator, reflecting the impact of increasing competence and autonomy of GP practices in the delivery of diabetes services. ■