

We need the right tools to do the basics well

John is fortunate. Where he lived before, he was told he had “mild” diabetes and to watch what he ate, cut out sugar and try to lose some weight. He had an annual review for his diabetes when a variety of tests were done. He wasn’t told the results but he assumed he wasn’t doing too badly.

Like Mo in Dr Hillson’s comment piece opposite, John was in his thirties. In recent years he has moved to an area with a GP and a nurse trained in diabetes. They take an interest in John and together they work out a plan for his management, which includes how to take care of himself. He understands that he is actively involved in his own care and in interpreting his test results. He could tell you, if you asked, how his medication worked and why he is taking it. He also understands that funding issues could affect his care. His nurse is sad that she has no access any more to ongoing training and apologises that they have no education course for patients in their area either. The GP would like to encourage John to monitor his blood glucose levels but is following a policy of providing two pots of testing strips per year to save money. Both are pressed for time.

Yet, John is fortunate. With help and support he is free of complications and expects to have a long, healthy life. He doesn’t know what the nine care processes are but he is benefitting from them – he and the other 52.9% of people with type 2 diabetes (NHS Information Centre, 2011). But his care is more than ticking boxes. It takes time to educate. It takes time to plan care. It takes time to involve people in their own care. It takes time to motivate (and that goes for healthcare professionals too). Yes, we must get the basics right but constant reform and financial constraints are not helping.

Jean has type 1 diabetes. She used to attend the specialist centre but now attends the practice

clinic where they have “visiting” specialists. It is easier and cheaper to park and sometimes she can get an early or late appointment, which is easier to get time off from work to attend. Her young daughter, Jennifer, also has type 1 diabetes and Jean is pleased that she does not have to sit in a crowded outpatient clinic with her watching people with multiple complications caused by diabetes. She used to default from clinic quite often due to these concerns. Having specialist input in her local GP health centre has made a huge difference but she wishes the same was available for her daughter.

Some key facts from the National Diabetes Audit (NHS Information Centre, 2011) show no room for complacency:

- Nine per cent of children and young people with diabetes experienced at least one episode of diabetic ketoacidosis (DKA) in 2009–10.
- Only 14.5% of children and young people with either type 1 or type 2 diabetes achieved the NICE recommended HbA_{1c} target of <7.5% (<58 mmol/mol).
- Over 30% of children and young people have a high risk (for future complications) with an HbA_{1c} level of >9.5% (>80 mmol/mol).

Jean used to be in the 6.8% group who received less than basic care but would be glad to know she has moved up to join the 31.9% who get the nine care processes.

Dr Hillson is right. We must do better basic care. We must find new ways of working to achieve it. We also need stability and access to training and education. We need time to have effective consultations with patients. We, like our patients, need to be encouraged to succeed and motivated to get involved. Give us the tools to do the job properly and we can, and will, do it. ■

NHS Information Centre (2011) *National Diabetes Audit Executive Summary 2009-2010*. NHS Information Centre, Leeds. Available at: <http://bit.ly/pBlNhY> (accessed 03.08.11)



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