Diabetes nursing: Holding out for a hero?

A debate into the current leadership in diabetes nursing in the UK initiated in *Journal of Diabetes Nursing* volume 10 issue 9 continues with comments from the Diabetes Nurse Consultant Group.

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The Diabetes Nurse Consultant Group.

The Diabetes Nurse Consultant Group (DNCG) welcomes the opportunity to respond to the previous issue's editorials on leadership in diabetes nursing (Roberts, 2006; Scott, 2006): both articles raise some interesting issues.

The first question to ask is what are the authors looking for: where leadership in diabetes nursing is or where the leaders have gone? Role models and nurses working in national organisations are suggested as missing, which itself implies that what diabetes nursing lacks is a figurehead in the heroic style of leadership: somebody who leads from the front.

However, we believe that leadership is not all about hierarchical structure. If given the opportunity all nurses can lead regardless of their grade, for example when working as part of a multidisciplinary team. Opportunities need to be created for all members to lead.

From a national perspective there is clear evidence that nurses are leading in clinical practice, service development and patient education. Examples of good practice are frequently published, demonstrating the leadership roles in diabetes nursing. Not all leaders are visible from a national perspective, but this does not mean that they do not exist!

Past and present

The National Diabetes Support Team (NDST) has developed what is known as the 'town planning model' (*Table 1*; NDST 2006). Level 2 of this model is certainly where senior nurses in diabetes care can contribute at a national level, especially around competencies and patient education criteria. All of the current national nursing groups could contribute and should seek to contact the NDST to participate.

Levels 3 and 4 of this model are for locally defined services where all diabetes nurses are most likely to be active and demonstrating leadership. It seems that this model has been developed intentionally to devolve decision making to a local level, acknowledging that it is no longer appropriate for local service design to be dictated nationally by a small group of figureheads.

Nationally, a number of DSN posts are being frozen: there appears to be a lack of support from senior nursing management in acute trusts, which is almost certainly related to the change in direction in the care of long-term conditions. When DSNs were first appointed as far back as the 1950s, the context of health care was very different. Many of us appointed years ago set about creating centres of excellence: we invested a significant amount of time demonstrating the value of our role in patient care, but we invested less time in sharing those skills. With the advent of a primary care-led NHS, we are increasingly being asked to educate our primary care colleagues.

While we accept all DSNs (including nurse consultants) have a role to play in enhancing self-management skills and education, the future role of DSNs may have to move with the times. Unfortunately, it is still possible for nurses to specialise in diabetes care with little preparation for the role and there appears to be a lack of agreement regarding the varied nursing roles now emerging in diabetes care. It is possible that

Table 1. Levels of care

Level 1	Headlines for major components of a service.
Level 2	Outline of the core principles of each headline in Level 1 and their quality standards.
Level 3	Design and redesign of a local service to match standards set in Level 2.
Level 4	How components in Level 3 work together in practice using local protocols and guidelines.

this has led to the poor national profile of diabetes specialists.

Responsibilies within the structure

The role of the nurse consultant was linked in the editorial to the introduction of a hierarchical structure in diabetes nursing (Scott, 2006). We would challenge this, in that such a system already existed in the form of previous H or I grades and the more recent introduction of the Agenda for Change bandings, where a number of senior DSNs occupy the same band as nurse consultants.

The creation of the nurse consultant post aimed to introduce a career structure for nurses, enabling them to work at a senior clinical level without management responsibilities. There was clear national guidance for the introduction of the post and it is clear what is expected from such individuals.

At a national level the nurse consultants have sought to work with existing nursing groups and have membership in both the UK Association of DSNs (UKADSN) and the Royal College of Nursing (RCN). The DNCG was formed purely for peer support and clinical supervision. As such, the group is not asked for opinions other than via the UKADSN or the RCN. There is no evidence to suggest that if an opinion is required a nurse consultant will be asked over and above a DSN. Alongside this, less than a third of the diabetes nurse consultants sit on advisory boards – those who do are part of a nursing team – and nurse consultants do not sit in isolation on advisory boards – this would not be desirable or appropriate.

The call for diabetes nurses to unite to raise our profile is a sound concept, however what would the group hope to achieve? A committed group of nurses could potentially clarify the nursing role in diabetes care; this may raise the profile and enable us as a profession to influence the national clinical and political agendas. The Association of British Clinical Diabetologists and the Primary Care Diabetes UK (both consisting of a subgroup of healthcare professionals professionals) were developed to meet the needs of their particular members and have certainly achieved a national profile. The RCN and the UKADSN are not dissimilar in their aims to meet the needs of their members, but this does not preclude the groups collaborating more.

The Department of Health and in particular the NDST surely have a role in bringing together a multidisciplinary group to 'lead' diabetes care by developing services that meet the needs of our diabetes population and the healthcare professionals working within the speciality.

Conclusion

As a nursing speciality perhaps we have been complacent – there is still a paucity of evidence to suggest that having a DSN in a multidisciplinary team makes a difference to patient care. We should have spent more time in those early years demonstrating and evaluating the effectiveness of our roles via robust research, rather than rely on the abundant anecdotal evidence. Where we are now is not about a lack of national leadership – there is evidence of this at the coalface. We are all responsible for demonstrating our leadership skills and engaging others in the process, for example by continuing to publish and present.

The issue of context is vital: we cannot look to the past to identify the future of diabetes nursing – the roles should have evolved in the same way as the healthcare system we are currently facing. We need to embrace these challenges by collaborating as a professional group. However, what we cannot do is continue to look for national leaders or heros. We need to acknowledge our current leadership roles and continue to make a difference to the services we are providing. ■

National Diabetes Support Team (NDST; 2006) *Levels of care: A new language for service planning and design* NDST, London

Roberts, S (2006) Service redesign: Why diabetes nurses need to get involved. *Journal of Diabetes Nursing* **10**(9):326

Scott, A (2006) Leadership in diabetes nursing: Where is it? *Journal of Diabetes Nursing* **10**(9):324