PbR and PBC: The challenges for diabetes nursing

Jill Hill

Diabetes nursing is currently experiencing a challenging time. Some aspects of the traditional DSN role in secondary care diabetes teams are being taken over by others – particularly by practice nurses and diabetes nurses employed by PCTs. Cutbacks by financially struggling trusts are resulting in a reduction in specialist nursing time, either directly through redundancies, indirectly through vacant posts not being filled or by DSNs being asked to work on hospital wards for some of their working week. An apparent lack of leadership in diabetes nursing (Scott, 2006) may make many DSNs feel lost in the ever-changing NHS and the new world of Practice-Based Commissioning (PBC) and Payment-by-Results (PbR): just where do DSNs and diabetes nursing fit in?

In PBC, commissioners have the task of identifying the needs of the local population (for example, within a group of GP practices within a locality) to agree what services would best meet those needs and who should provide such services. In a cash-limited NHS, they also need to ensure they get value-for-money and that services are cost-effective as well as high quality.

PbR is a method of costing a package of care that facilitates commissioners to 'buy' certain services – the components and costs of which are clear so commissioners know what will be provided and costs for the number of people in their area who require that service. Although multidisciplinary episodes of care are not yet covered by PbR, the concepts of value-for-money and alternative providers may be seen as a threat to traditional providers, including DSNs. However, they should be seen as opportunities, both for the role of nurses in the commissioning process and for the providers of diabetes services.

How nurses can influence commissioning

Before commissioning services to meet local needs, commissioners need to be aware of what those needs are. Nurses involved in diabetes, whether working in primary or secondary care, have a wealth of knowledge surrounding the needs of people with diabetes (for example, education for those who are newly diagnosed and the number of individuals requiring transfer to insulin each month). They also represent the needs of the often 'invisible' diabetic population, such as those who are housebound, people living in residential homes and the homeless. DSNs often bring a sense of reality to the concept of individuals 'slotting into a package of care' as experience shows that for a given task (for example starting someone on insulin) individuals vary in how much support they require. Particular groups of people with diabetes (such as those who do not speak English or those with learning difficulties) will require particular skills and resources that need to be identified if appropriate services are to be commissioned for them. Nurses are therefore essential in identifying local needs for diabetes and can influence services that are commissioned to meet those needs.

Nurses as providers

Many diabetes nurses reading this editorial will feel more comfortable in their role as a care provider than in their role as an influence on commissioning. However, we are working in a changing health service and DSNs need to evolve their services to survive. Rather than being seen as a threat, this should be viewed as a real opportunity.

In many areas the traditional role of the DSN in secondary care has moved to practice nurses or to community DSNs. Many individuals with uncomplicated type 2 diabetes are now started on insulin by their practice nurse who, if suitably trained and motivated, can give a high-quality and cost-effective local service to someone they have known since diagnosis. This is the sort of service the Government wants provided for people with diabetes (DoH, 2006). However, those with more complex needs will always require the

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services of experienced DSNs who can then focus on providing a 'specialist-specialist' service, with the future development of more renal diabetes specialist nurses, more diabetes midwives, insulin pump specialist nurses and so on, supplying a niche that no-one else does. Nurses are very adaptable: for example, we have seen the development of the practice nurse in response to the demands of the new General Medical Services contract (Kirby, 2005).

Even if hospital DSNs continue to provide services that are seen as routine, providing them in a cost-effective way will be even more important and will drive changes in practice and skill mix. For example, starting groups of people on insulin rather than individually is more cost-effective as it uses economies of scale, which are not usually possible in a GP practice. Using lower-banded health workers to teach tasks such as blood glucose monitoring instead of the DSN will lower the costs of a service. This releases the skills of the DSN to support people with diabetes in using the results of their monitoring to make decisions about their self-management, which will increase care quality.

Identifying all the costs of the services provided is important. This, and being clear about what exactly your service provides, ensures everyone has the competencies to provide it. Being able to demonstrate the outcomes of your services will inform commissioners when they consider who to commission services from. In the following article (page 144) Sally Brooks and her colleagues discuss the impact that nurses could have on PBC and wider system reform.

Working together across primary and secondary care

Ideally, primary and secondary nurses working in a local diabetes economy can deliver high-quality and cost-effective services to meet the needs of people with diabetes in the most appropriate place for them. Through diabetes networks (formal and informal) nurses can work together to identify what services are needed to meet local needs and influence where those services are delivered, which can avoid duplication of services and focus scarce resources where they are needed. For example, guidelines (DoH and Diabetes UK, 2005) state that people with diabetes should have structured education and recommends the use of nationally recognised courses like DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed; Skinner et al, 2005) and DAFNE (Dose Adjustment For Normal Eating; DAFNE study Group, 2002). Both of these have implications for financial and human resources. Nurses working in primary and secondary care can influence a decision supporting the hypothesis that group education for people with newly diagnosed type 2 diabetes is most appropriately delivered in community settings by community diabetes nurses or practice nurses. As a result, secondary care diabetes nurses can then focus on delivering the more specialised DAFNE course.

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