Nurses leading change

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The theme of leadership remains a much debated topic in the medical press. Concerns regarding lack of leadership, particularly in diabetes nursing, remain and often focus on the perceived lack of 'heroic' leadership – the person leading from the front, saving the world; or within diabetes, saving services and personnel.

My personal view is that leadership has many styles, the heroic, traditional leader being one, but also the enabling or transformational leader. I discussed these views during the *Janet Kinson Lecture* at this year's *Diabetes UK Annual Professional Conference.*

The reason I favour the transformational leadership style is because enabling others to lead is at its heart. We need leaders, and we need to develop more, which this style ensures. It works in practice, because by developing leadership skills in others, it raises their performance, through greater job satisfaction and confidence, and turns them from followers into leaders. It is a competency expected of all nurse consultants, and there are examples of services and staff being led in this style, by nurse consultants in diabetes and senior DSNs.

To move services from one site, for example an acute trust, to another, such as a primary care trust, requires considerable vision, work and resolve. Key stakeholders need identification, their views and potential funding needs to be explored and business cases need to be produced, so that the agreed vision or goal does not only fulfil the needs of patients (safety, appropriate and easy access to skilled clinicians, quality services) but also those of the paying organisations and their political and local targets (care closer to home, earlier discharges, admissions avoidance, reduced waiting times and so on).

This is just the start, for once agreement is reached, then marketing and ongoing evidence of return on investment for the new service needs to happen. As you can imagine, this takes considerable time, and requires ownership by all involved, plus organisation and accountability. Someone has to have the responsibility and skills to lead these changes across organisations – senior diabetes nurses have these attributes and are doing so. This confirms that there is leadership in diabetes nursing, and my own experience in leading service changes and that of Lorraine Avery, as discussed in the following article, support this view.

Lorraine led service redesign, through moving specialist nurses from the acute trust, across to being employed by the PCT and based mainly in general practice rather than the diabetes centre. The reasons for this move will be shared by many readers – secondary care capacity being exceeded, long waits for appointments, junior medical staff conducting outpatient clinics, inequality in access, and many more. Increasing capacity in primary care was sought, which in turn reflected national targets of moving care closer to home.

Part of increasing capacity involved increasing specialist nursing resources; 4.4 wte for a population of 187 000; and ensuring close working with dietetic and podiatry services. The desired outcome was to deliver the majority of hospital-based diabetes services in localities nearer to the patients' homes by specialist clinics based in GP practices. This in-reach model also provided inpatient nursing services under a service level agreement with the acute trust, and a locally enhanced scheme ensured an initial payment to each practice to deliver this additional diabetes service.

Although this redesign is still developing, outcomes are available as Lorraine discusses. Her reflections are useful and could guide others in the process of changing their services. An assessment of PCT savings through avoidance of payment-by-results tariffs would be valuable in arguing the benefits and sustainability of this service. When we applied this rationale to our own service redesign, it demonstrated savings of £240 000 between August 2005 and March 2007, far in excess of DSN salaries! ■