



Nurses in development



The earning curve

Nurses seeking a career in diabetes face an uncertain future, with new opportunities being offered on the one hand, while on the other established roles seem under threat. In the third of our series examining the challenges for healthcare professionals pursuing careers in diabetes, **Brian Burns** talks to two nurses about what the future may hold for diabetes nursing

As Diabetes UK's 2006 User Survey testified, the care and support provided by nurses working in primary and secondary care is invaluable to people with diabetes.

"Diabetes specialist nurses have a key role in supporting those working in the community to deliver high standards of integrated care across all localities," says Bridget Turner, Head of Healthcare Policy at Diabetes UK. "Primary care organisations, practices and all providers employing nurses who work with people with diabetes must ensure that education and training is made available to ensure that services are safe and staff are confident and

competent to deliver the care that all people with diabetes have a right to expect."

So far, so straightforward. But how exactly is that education and training being provided, and how well are those traditional routes likely to weather the winds of change currently blasting the NHS workforce? Can we be sure that training and education for nurses in diabetes will continue to be provided adequately in the future?

Diabetes specialist nurses

"There is no standard training path to becoming a diabetes specialist nurse (DSN)," says June James,

DSN and Vice-Chair of Diabetes UK's Professional Advisory Council. "Though diabetes is covered as one of many medical areas when training to be a registered nurse, you can't take a specialist diabetes pathway prior to registration. So people come to be DSNs via different routes. They may work, as I did, in other areas, such as district nursing or in hospitals or acute care, and develop an interest in diabetes because it spans all the different specialties. Basically, you showed an interest, kept your eyes peeled for a job and applied. That's what I did."

Having got the job, June then did the English National Board 928 diabetes course, a course in diabetes counselling, a health studies degree, independent nurse prescribing training, and is now doing her Masters in Health Studies (Diabetes) with Warwick University. "Today," she says, "you are generally expected to have either done a diploma-level diabetes course or have significant experience of working in diabetes before applying for DSN posts. Many Health Education Institutes provide diploma-level courses and others, such as Warwick and York Universities, provide higher level training, such as degree or masters level courses. Not all DSNs want to undertake entire degree courses but extend their knowledge and skills by taking specific modules to support and enhance their practice – such as diabetes counselling courses, teaching modules and nurse prescribing training."

In diabetes healthcare there are always new initiatives and new ways of teaching, as well as new drugs coming on to the market all the time. Consequently, DSNs – like all specialist nurses – need continuous professional development. "Without it," June asks, "how can you hope to maintain the quality of evidence-based care?"

However, getting the funding to support such training is becoming more difficult because of the NHS's current financial difficulties. This has led to some nurses seeking sponsorship from pharmaceutical companies. "However," June says, "some primary care trusts (PCTs) are now putting an embargo on taking sponsorship from that particular source. So, if you can't go for study leave because it has to be funded, and your PCT isn't going to fund it, and you can't ask anybody else for the funding, you're scuppered really. I know some DSNs who have self-funded courses and conference attendance and take annual leave to attend for professional development."

NHS cutbacks have also led to vacant diabetes nursing posts being frozen. "The NHS might start to

recruit again once things have settled down," says June, "but this is not a good time for diabetes nursing. Whilst there may be exciting new opportunities for PCT-based DSNs in supporting general practice in diabetes management, in-patient diabetes specialist nursing is being challenged by the shift towards primary care-led services."

It is argued that fewer secondary care nurses will be required, as less people living with diabetes will be admitted. "In fact," retorts June, "people with diabetes are mainly admitted to hospitals for reasons other than diabetes, and it is known that once admitted they tend to stay twice as long as those without diabetes and their recovery is often compromised by poor glycaemic control. Inpatients DSNs have a valuable role to play in supporting

those admitted to hospital, enabling self-management where possible, and supporting and educating junior medical staff and ward-based nurses in up-to-date diabetes care."

"PCTs and trusts need to take a more integrated approach to diabetes," she explains. "DSNs have a wealth of knowledge and skills that are easily transferable. It may be that those DSNs traditionally working in the acute setting can use their skills to support high-quality primary care and vice versa."

What about Agenda for Change (AFC), the Government's comprehensive reform of NHS pay and working conditions (now fully rolled-out in England, though not yet in Scotland or Wales)?

Two years ago, June was already concerned that AFC would adversely affect the recruitment of DSNs and paediatric specialist nurses. In 2006, to assess the impact of both NHS financial cutbacks and AFC, Diabetes UK organised a Specialist Staff Survey, in which 484 questionnaires were sent out to nurses working in acute trusts and primary care (roughly half and half) but not to practice nurses.

A total of 162 nurses responded. Key findings from the survey were:

- 43 per cent said vacant posts had been frozen
- 29 per cent said funding for specialist diabetes teams had been reduced
- 45 per cent said ongoing professional development had been cut through lack of funds
- 40 per cent said study leave requests had been denied
- 55 per cent said time with patients reduced
- 55 per cent said patients are waiting longer to see a DSN or consultant
- 49 per cent said there was less education available for patients.



Without continuous professional development for specialist nurses, how can you hope to maintain the quality of evidence-based care?

practice is going to have to embrace AFC eventually – but there is no obligation to do so because of GPs' independent status."

And what effect, if any, will Modernising Medical Careers (MMC), the complete revamp of postgraduate medical education and training for all specialties, including general practice, have on specialist practice nursing?

"MMC will probably filter slowly into practice nursing," says Prue. "More people who are already aware of career structures will come into practice nursing with a clear idea of their career structure and what they are working towards. It will be very much a case of: 'If you want to employ me, it will have to be on this basis.' It will be slow to affect general practice because each one is an entity in its own right and it is very difficult to change everything all at once. There is no national standard, and that goes back to the fact that there is no recognised qualification to become a practice nurse."

In general practice, there is also the question of patient care. How, for example, do patients with diabetes know that the specialist practice nurse they are seeing is someone with specialist knowledge about diabetes and not just someone

who's figuring it out as they go along? According to Prue, there has been very little reaction from the public. If they notice at all, it seems, they are generally pleased because it cuts down their waiting time.

"Now, though, that PCTs, as commissioning bodies, are overseeing standards of care," she adds, "I think they're going to start looking at this quite closely. Prior to the current GMS contract, diabetes was treated as an enhanced service. If a general practice could demonstrate that it provided a particular standard of diabetes care, it could claim extra payments. In order to do that, practices had to make sure that the clinicians looking after patients with diabetes had the necessary qualifications. Under the new contract, that no longer applies."

In particular, the extension of prescribing to specialist practice nurses (along with pharmacists) has caused some to mutter darkly about the downgrading of skills, particularly around diabetes. In the past, nurses would see patients and have to get – one way or another – a doctor to prescribe for them. Now, a lot of nurses, including Prue, have done a six-month prescribing course. So, with certain medications, a prescribing nurse can sign the prescription and give it directly to the patient. "Non-medical prescribing has been widely taken up in general practice," says Prue, "and probably more so than in the acute sector simply because, in the past, practice nurses have worked quite autonomously."

GPs, however, do not always take a positive view. "Some feel that we are underqualified," says Prue, "that it's dangerous and that we should not be doing it. Others feel that as long as we don't step outside the areas of our competence, then it's basically a good thing."

It should, anyway, be stressed that most specialist practice nurses who have done the qualification require a doctor as a mentor. As they are usually the GPs the nurses have worked with, they effectively contribute to their training. "So," says Prue, "the GPs should be very aware of our competences. Or any lack. Besides, if I were ever less than 100 per cent confident about signing a prescription, I simply wouldn't do it. That's a matter of personal responsibility, which we all have to take on."

Given the widely acknowledged complexity of prescribing diabetes medication, she is very clear about her approach.

"Of course, different practices may do things differently – and the quality and level of care can vary greatly – but in our diabetes clinic I discuss with our lead GP all patients before and after their consultation and prescribing decisions will be discussed and confirmed at this time."