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The National Service Framework for Diabetes: Delivery Strategy is now available. It aims to reduce variations in diabetes care in England. Mary MacKinnon outlines the implications for nurses working with people with diabetes

KEY WORDS

**National Service Framework
Delivery strategy
Nursing practice**

REFERENCES

Department of Health (2003) *National Service Framework for Diabetes: Delivery Strategy*. London: DoH

DoH (2001) *National Service Framework for Diabetes: Standards*. London: DoH

National Institute for Clinical Excellence (2002) *Management of Type 2 Diabetes: Retinopathy – Screening and Early Management. Inherited Clinical Guideline E*. London: NICE

FURTHER READING

DoH (2002) *Current and Future Research on Diabetes: a Review for the DoH and the Medical Research Council*. London: DoH

DoH (2002) *Diabetes Information Strategy*. London: DoH

DoH (2002) *Workforce Matters: a Guide to Role Redesign in Diabetes Care*. London: DoH

DoH (2001) *Shifting the Balance of Power in the NHS*. London: DoH

DoH (2000) *The NHS Plan: A Plan for Investment. A Plan for Reform*. London: DoH

USEFUL WEBSITES

NSF for Diabetes: www.doh.gov.uk/nsf/diabetes

Diabetes UK: www.diabetes.org.uk

Care group workforce teams: www.doh.gov.uk/cgwt

NHS Modernisation Agency: www.modernnhs.nhs.uk

National Institute for Clinical Excellence: www.nice.org.uk

Quality Indicators for Diabetes Services: www.quids.org.uk

The delivery strategy for the National Service Framework for Diabetes

After publication of the *National Service Framework for Diabetes: Standards* (Department of Health, 2001), the long-awaited NSF delivery strategy (DoH 2003) is now available. The strategy sets out the staged programme for the delivery of the NSF over 10 years with implementation from 1 April 2003. The diabetes NSF is the first of its kind to be written with clear links to other NSFs and to the DoH modernisation and reorganisation programme.

Local service providers are advised to ensure that they have the necessary resources to implement the delivery strategy and to develop diabetes networks for an integrated service in a specified time frame. Underpinning the local delivery strategy are the 12 standards for diabetes care (DoH, 2001).

Organisational change 2003–2004 The responsibility for the implementation of the diabetes NSF lies with local primary care trusts. In the first year they should review existing services for diabetes care and set up a strategic group for diabetes. This group will form the core of a local ‘managed diabetes network’ and will determine local diabetes policy. In addition, PCTs are advised to undertake a ‘workforce skills profile’ to enable them to identify skills and development opportunities.

It is suggested that PCTs should consider redesigning the local framework for the provision of future diabetes care as traditional roles and settings may not be the best way to deliver diabetes services. This first year of organisational change will lay the foundation for the delivery of the NSF in the next decade.

Implications for nurses Nurses will need to conduct their own diabetes skills profile at their workplace, ensuring that the service that their team delivers conforms to the locally agreed standard. They will need to obtain feedback on their care from service users and the local specialist team.

Organisational change 2004–2006

Retinal screening and treatment programmes Targets for improvement, expansion and reform have been set for the next three years. Local providers will need to ensure that a systematic eye screening programme in line with national standards is in place (National Institute for Clinical Excellence, 2002). By 2006, a minimum of 80 per cent of people with diabetes will be offered systematic screening and treatment if required. By the end of 2007, screening will be available to everyone who is at risk of retinopathy.

Implications for nurses Nurses will need to find out about their local diabetes eye screening programme and check that people with diabetes who are in their care have their eyes screened regularly.

Diabetes registers Practice-based diabetes registers will underpin all eye screening and programmes of care, including call and recall systems, clinical care, prevention, continuous quality improvement, clinical audit, benchmarking, resource management, internal and external monitoring.

Implications for nurses Nurses will need to check that any person with diabetes in their care is on the diabetes register at their general practice.

Personal diabetes record and care Regular systematic review and structured education for groups or individuals is recommended for all people with diabetes starting with those who are newly diagnosed after April 2003. Structured programmes of education are being prepared and in time many of these will be delivered by trained ‘expert patients’ through the DoH expert patient programme, currently being piloted.

The personal diabetes record should include an agreed care plan documenting occupational, social and educational needs and how these will be met. The personal goals of the person with diabetes should also be recorded. The record should contain details of agreed diabetes management plans and the named contact who will liaise with the person with diabetes.

Implications for nurses Nurses need to ensure that the record of care held by people with diabetes is used in accordance with local guidance and that the person with diabetes has a named contact for their care.

Organisational change 2006–2013 PCTs must set their own local targets to achieve each diabetes standard by 2013 with the aim of reducing inequalities in health and focusing on those people with diabetes who are most at risk of long-term complications. In addition, prevention and overall risk reduction programme strategies for coronary heart disease and diabetes will need to be set in place at the local level.

Implications for nurses Nurses will need to be ‘diabetes aware’ and keep their clinical knowledge up to date. It is also important for them to be aware of the local diabetes strategy development and implementation programme. ■