Diabetes centres in the UK: adapting to change

The evolution of diabetes centres in the UK, with co-location of clinical teams, has resulted in examples of success in improving clinical efficiency, communication and patient-centred care.

'The diabetic clinic dinosaur is dying: will diabetic day units evolve?'[1] This was the developing philosophy of the 1980s, and the prediction was fulfilled. Without doubt there were good reasons for dissatisfaction with standards of diabetes care at the time, and problems with the traditional diabetic [*sic*] clinic were well recognised: poor clinic structure and 'standards of education woefully below those desired'.[2] Although a few pioneering general practitioner cooperative care schemes were in existence at the time, these were very much few and far between, with the vast volume of diabetes care still delivered primarily by the hospital specialist medical team and with the emerging involvement of diabetes specialist nurses.

Conception

In 1987, under the aegis of the Diabetes Education Study Group, a seminal workshop[2] was held to discuss and debate the concept of diabetes centres. Those of us who attended were very much aware that an exciting milestone in diabetes care was being witnessed. Remarkably, but probably not surprisingly, issues identified then are still as relevant today. Diabetes centres alone would not necessarily resolve identified inadequacies of care, but they offered the opportunity of better organisation, coordination and integration of district diabetes services; a dedicated and recognised environment facilitating multidisciplinary team working and, above all, a platform for education provision that had very recently emerged as so essential to improving outcomes in diabetes care.[3]

Growth and inevitable change

Every district was determined to secure a diabetes centre, and some 10 years later a further survey[4] by the British Diabetic Association (BDA; now Diabetes UK) found that, of an initial 132 UK centres reported, there were 96 which fulfilled the BDA's definition of a diabetes centre. Rather like Darwinian finches on the Galapagos Islands, many centres had evolved to meet local service needs within the constraints of local circumstances. Nonetheless, despite this degree of heterogeneity, a functional core common to all was evident and diabetes centres were seen very positively and very much as a source for good in the overall strategy of delivering good diabetes care to the community. For two decades, diabetes centres were in the ascendancy, undertaking increasing clinical activity and expanding other important related roles such as research.[5] However, with time, the laws of critical mass could not be challenged indefinitely and there was no way that diabetes centres and hospital based diabetes services could continue to provide the entirety of diabetes care; nor was it desirable that they did so. The shift of most diabetes management into primary care and the community reflects a logical and inevitable change to accommodate the burgeoning demands from increasing diabetes prevalence.

This new world...

Where has this left the future role for diabetes centres in this new world? That was the question raised in a recent further survey by Diabetes UK coordinated by Gillian Hawthorne (Newcastle), the results of which are published within this issue of *Practical Diabetes International* (see page xxx). Interestingly, fewer diabetes centres were identified compared to the 1998 survey[4] but, nonetheless, some respondents were still striving to secure a new centre for their locality. Core function of centres remains fundamental, with most multidisciplinary specialist clinical service management taking place within the centres and educational resource being a much valued facility.

However, diabetes centres have clearly evolved and many new initiatives are reported to indicate that adaptations to new ways of working and delivering diabetes care are being embraced. A dedicated 'helpline' (telephone, e-mail) and 'one stop shop' opportunity are evidently valued by patients. Facility to undertake clinical research is also that much easier within the centre, particularly with the increasing support of the UK Diabetes Research Network portfolio offering involvement in a number of diabetes related research studies.

Location

Location of diabetes centres within acute trusts has long been some source of contention and there is an argument for a community base. However, the specialist diabetes team remains heavily involved in supporting inpatient diabetes care, and we believe the results of NHS Diabetes' recent inpatient diabetes audit will confirm the essential need for this to continue. Specialist team support both helps minimise the need for hospitalisation and reduces the length of stay for those admitted with diabetes usually as a secondary consideration. Split site working is simply not efficient and priorities may be compromised. The concept of providing diabetes care within a polyclinic setting has caused some uncertainty as to how it would function and there are concerns about its flexibility and ability to cope with demand on a daily basis.

Key areas and integration

The evolution of diabetes centres, supported by evidence derived from this recent survey, has forged an understanding of what a diabetes centre offers in three key areas: (i) *multidisciplinary clinical care* with unique specialist clinics

(e.g. insulin pump clinics and an array of diagnostic technologies), (ii) *clinically based diabetes research*, and (iii) *patient and diabetes health care professional education* at a local and, in some centres, at a national level. A fully integrated service is fundamental. Appropriate and facilitated access to specialist diabetes nurses, dietitians, digital retinal screening and podiatrists can be provided, as well as clinical care pathways to dedicated diabetes vascular, orthopaedic, cardiological, microbiological and psychiatric teams, all supported by the extended subspecialty role of consultant diabetologists, and all members of the diabetes multidisciplinary team.

The centre concept is achieved to advantage by co-locating the multi-professional team, thus integrating several aspects of clinical service: *Inpatient care*, where a significant proportion of patients requiring admission, both elective and emergency, will have diabetes, and of which up to 50% will be newly diagnosed. These patients require very close joint management of their diabetes either during acute illness or in advance of surgical procedures; *Outpatient activity* with daily specialist clinics requiring multidisciplinary team input; *Emergency referrals and urgent 'drop-in'* being managed on an ambulatory basis thereby often avoiding need for admission; *'Diabetes hotline'* – with emergencies assessed by the team on the same day, while routine referrals are triaged to the relevant subspecialty clinic; and, finally, *Frontline technology and teaching* ensuring that the latest excellence of service innovation is embraced and disseminated.

Evolution – with new ways of working

Diabetes is the fastest growing chronic disease of our modern age. In parallel to the rise in numbers of patients with diabetes, is the awareness of the complexities of managing the condition and the explosion of new therapies. Diabetes centres have been at the forefront of clinical care over the past two decades. Adapting to change is a continuing reality within the NHS. There is now a pressing demand that diabetes centres be no exception to this. However, unlike the dinosaur image of the old traditional diabetes clinics, we believe diabetes centres in the modern diabetes service world, with the emphasis on community management, still have an important role to offer; they are indeed evolving with new ways of integrated working.

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Conflict of interest statement

Professor Shaw and Dr Feher are consultant diabetologists who work, in part, within a multi-professional diabetes centre.

References

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