# The changing face of diabetes specialist services: Making it work

## David Kerr

**Clinical services for people with diabetes are changing. The changes that diabetes services are being forced to face up to today can at times seem overwhelming and scary: more money, less money, changing job descriptions and so on. So should we be looking with pessimism and fear at the changes looming over us? Certainly not, writes David Kerr. Below he describes his vision of the way change can be embraced by specialists working in diabetes care, the impacts this will have on the GPSI in diabetes and the benefits to all areas of the multidisciplinary team and, of course, people with diabetes.**

*'I get up every morning determined both to change the world and have one hell of a good time. Sometimes this makes planning my day difficult.'* **EB White**

Change is a strange concept and can mean different things to different people. For some, the idea of change is threatening, destabilising and something best avoided. For others, change brings with it possibilities of new opportunities, challenges and, therefore, should be welcomed and embraced. In the business world, there is now a whole industry devoted to 'facilitating change management'. Indeed, many self-styled 'consultants' are making a living around change, including within the NHS. Unfortunately for state run organisations, the norm has been to instinctively take the former view and specialist NHS diabetes services are no different in this respect. Change within specialist diabetes services seem to be happening without any input from the specialists themselves. At the moment, there is a palpable sense of nihilism, angst and no small amount of paranoia at the hospital level. In one sense, Robert Tattersall's oft-quoted description of the service is as true today as it has always been:

*'Diabetes is common among the old and the fat, causing crippling disabilities affecting unromantic organs such as the foot and can be managed with negligent ease by those inclined to do so.'*

**Article points**

1. Specialists have a vital function in diabetes care and must not become an endangered species.
2. Collaboration across the multidisciplinary team and with the person with diabetes is necessary when selecting and implementing a treatment regimen.
3. With the opportunity to make decisions regarding their own treatment, people with diabetes are likely to choose to be seen by the specialist best placed to deal with their problem.
4. Over-arching diabetes care can remain in primary care.

**Key words**

- NHS reforms
- Specialist services

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**Page points**

1. Choosing which therapies at which point and in which combination is not going to be straightforward and will require collaboration across the health spectrum including the active involvement with the individual with diabetes.
2. The opportunity to change the provision of diabetes services cannot occur in a positive and productive sense without specialist input.
3. Specialists should be able to make sense of the standard of care on offer and introduce changes to drive standards upwards.
4. Specialists should be able to provide specific services that would otherwise not achieve an acceptable standard if left to primary care.

The disappointing and depressing spin-off from the negativism is that a career in diabetes appears to be no longer attractive for a majority of trainees. This is unfortunate as the proposed changes have the potential to be a fantastic opportunity to improve and develop specialist services in a way that will be beneficial to all involved. It will also make the job far more interesting and fun.

## The ghost of diabetes past

The reality is that, unless one has masochistic tendencies, traditional diabetes clinics were a grind for doctors and probably for the people with diabetes. Too many patients, too little time, different junior doctors at every visit, the emphasis on numbers (glucose, lipids, blood pressure), the obsession with feet and eyes and little else in between meant that the system produced chaos and, in the author's experience, failure-to-attend rates that were embarrassingly high.

On a positive note, the very nature of the condition meant that some clinicians and people with diabetes got to know each other well. Divorce from this cosy situation is not going be straightforward or painless. The problem developed when hospital clinics kept patients on their books, who could be just as easily have been managed by their GP. The reasons for this were varied, but presumably most often it was a fear of the unknown and a concern that transferring people with diabetes out of the safety of the specialist clinic would lead to them receiving sub-optimal care. There was no convincing evidence that this was actually the case; it was more likely that this unhappy situation merely demonstrates the poor relationships between the healthcare professionals involved.

## The ghost of diabetes present

Another fact of life is that health care costs money, doctors are not omnipotent and the therapeutic options within diabetes are developing at a mind-boggling rate. Not only do we have ever-increasing choices for diabetes therapies, but also the decision about the timing of introducing these regimens is a science in itself (Kerr, 2006). Choosing which therapies at which point and in which combination is not going to be straightforward and will require collaboration across the health spectrum, including the active involvement of the individual with diabetes.

For example, the impact of introducing insulin on the families of people with diabetes has probably been underestimated (McLean, 1986). Hypoglycaemia still remains undervalued by some healthcare professionals as an important factor for people living with the condition. New techniques involving continuous glucose monitoring have highlighted just how under-recognised this complication of insulin treatment is, yet the impact on other family members can be missed (Kerr and Cheyne, 2002). Solving the problem of hypoglycaemia is not easy, and takes time, lateral thinking and education of the health-care team. In the author's opinion, the opportunity to change the provision of diabetes services cannot occur in a positive and productive sense without specialist input. Excluding them from service planning will not work to the advantage of people with diabetes.

Diabetes also suffers due to the nature of the condition: the best result is if nothing happens, with the person remaining well and living a normal life. Managers and other specialists find this concept difficult to come to terms with: doing almost nothing (no inpatient stays, a few blood tests and lots of conversation) does not make much money, yet in the long term has the potential to be significantly cost saving.

### How special?

Specialists are 'specialist' for important reasons and should remain so. They must not become an endangered species. They have and continue to have vital functions in diabetes care. However, it is important

for specialists to do more than say that they are doing a good job – assessment of their own performance is crucial to their future existence and should not be feared. If one aspect of their service is not working, it needs to change or even be discarded. The best advice for maintaining a specialist position is to be able to do something that no-one else can do, or be able to do something better than anyone else.

*Arbiters of quality*
Specialists should be able to make sense of the standard of care on offer and introduce changes to drive standards upwards. Spending time seeing large numbers of individuals with diabetes who could easily be well managed by primary care makes no sense and is inefficient. Specialists, in a sense, are guardians of care: poor care is not acceptable and is certainly not inevitable.

*Exceptional service providers*
Specialists should be able to provide specific services that would otherwise not achieve an acceptable standard if left to primary care.

For example, specialists should provide tailored diabetes services for children and young people with the condition; rapid access clinics and inpatient multidisciplinary services for individuals with problems related to the diabetic foot and other serious complications; pregnant women with diabetes; and people requiring intensive therapy (including the use of technologies such as insulin pump therapy and glucose sensing). It is clear that providing these services will continue to require collaborations with a number of other healthcare professionals.

*Uniquely placed*
Specialists are in a unique situation in that they can work closely with other specialists, for example by participating in combined clinics with ophthalmologists and podiatrists. They also should provide on-going education and training for all of those involved in diabetes care including the teams in primary care. However, it is important that this education is of an acceptable standard.

*Active in clinical research*
At the same time as all of the above, specialists must understand published data and how it can be applied to general practice and will affect their area, and recognise the power and influence of industry.

*Political responsibilities*
Specialists are also in a position to question and debate the politics of health with their political leaders. For this to function they have to retain a degree of independence and be able to see the future outcomes of health-related political issues.

## The ghost of diabetes services yet to come

For primary care teams the key to a successful partnership with specialist services is *access*. Specialist services will have to organise themselves so that people with diabetes can been seen rapidly by all relevant members of the multidisciplinary team.

In addition, focussing on specific areas related to outpatient services will allow specialists to devote more time and energy to a key area within diabetes services: managing inpatients with diabetes and hyperglycaemia.

There is increasing evidence that improving inpatient glycaemic control is beneficial from clinical and economic perspectives. This applies across all specialities and is not confined to critical care. Unfortunately, at present, inpatient management of diabetes invariably involves trouble-shooting acute problems while the bulk of care is delivered by non-specialist teams with little or no interest in the subject and even less formal training.

## Multidisciplinary teams or multidisciplinary individuals

The current model of diabetes care includes

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1. Diabetes care practitioners should be experienced in areas covering the above disciplines yet would be free from the rigidity of the individual professions.
2. The shifts in diabetes care are an opportunity for specialists to focus on defined areas and develop them to a standard which is specialist in the true sense of the word.

a multidisciplinary team comprising of a specialist nurse, dietitian, podiatrist and physician as well as the primary care team. Within these groups, it is accepted that certain individuals do certain things: dietitians advise on diet, doctors prescribe pills and nurses start insulin.

Perhaps it would be more sensible to develop the concept of a diabetes care practitioner (DCP). Such individuals should be experienced in areas covering the above disciplines yet be free from the rigidity of the individual professions. In addition they would be trained in dealing with disease prevention as well as in other areas of public health and health economics. Thus, DCPs would be skilled in dietetics, be able to perform a home insulin conversion and at the same time be able to recognise when an individual needs urgent and formal intervention from a medical colleague. They would be able to examine the lower limb and organise a training session for ward-based nurses. Training for the DCPs would take place in primary and secondary care with sub-specialisation at a later date to encourage career development.

## Conclusion

The role of the hospital doctor is undergoing continuous change and not always in the right direction. Within the author's speciality of diabetes there has been a politically driven shift to move decision-making processes towards primary care and away from specialists. This move has been associated with publication of a National Service Framework for diabetes (DoH, 2001) and the inclusion of performance payments for diabetes quality indicators within the nGMS contract. The overall idea is to develop locally-led implementation and investment policies to the benefit of people with diabetes. The key element in all of this is developing the role of the GPSI and having confidence in that individual. This will be a remarriage of two distinct but interdependent groups and hopefully this time it will be for life.

The shifts in diabetes care are an opportunity for specialists to focus on defined areas and develop them to a standard which is specialist in the true sense of the word. Subsequently, the modern emphasis on patient choice is likely to mean that individuals will choose to be seen by the specialist best placed to deal with their problem. Over-arching care can safely be left to primary care teams who also act as the gatekeepers.

These changes are radical and may be at odds with traditional medical and nursing models of training and care. Yet times have changed and demands and expectations are different. The use of personalised care plans would encourage individual responsibility. An interest in diabetes needs to begin early and needs to be nutured and rewarded. Diabetes is a wonderful speciality – it demands practitioners skilled in the art of medicine more than the art of science. Diabetes is about to become so much more interesting and, hopefully, worth getting out of bed in the morning for. ■

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