Chairman's report

Reasons to be cheerful part 3

As I pick up the reins from Peter Winocour and survey the diabetes landscape I ask myself if even Ian Drury could have found reasons to be cheerful. The reasons to despair are legion. Financial constraints threatening to erode gains in diabetes care (where gains have occurred) or to destabilise already tottering diabetes ecosystems. People with diabetes denied access to specialist opinion because of perverse incentives, such as Payment By Results, with new to follow up ratios unthinkingly applied. More stringent driving regulations arising from European Law which, despite best efforts at mitigation by the Department of Transport Medical Advisory Committee, have made life significantly tougher for patients, and arguably in the case of nocturnal hypoglycaemia, without a basis of solid science. Trusts flailing in the deep water, trying not to be the first to drown and losing interest in anything which is perceived as not a big earner. Lord Crisp citing diabetes as an example when saying we have too many consultants and nurses can do all the work. Trainees so overloaded with acute medical commitments that they lack the time to engage with developing areas such as community care. Ditto consultants, the list is endless.

Hope springs eternal

However arguably the human race survives because of (often unreasonable) optimism and when I get out of bed in a morning I am not short of reasons to be cheerful. Like the economy the progress of diabetes care is cyclical. The darkest hour precedes the dawn with remarkable regularity and like investors who invest at the point of maximum pessimism, commissioners who invest wisely in quality models of care can expect to reap dividends for patients. While conferring wisdom on commissioners is beyond our control (unless more of us become commissioners) our role is to relentlessly educate them and to create, provide and promote affordable, quality models. As experts in behaviour change surely we can change our behaviour sufficiently to survive the buffeting of the recession and thrive? If the diabetes epidemic doesn't ensure that specialists in managing this often complex disease flourish then what will? We must be determined and patient preparing for the opportunities which will come.

Strength in our skills

Indeed there is ample evidence that diabetologists are creating new constructs and models of care with a combination of the enterprise and pragmatism that diabetologists have always shown. As a charity and an Association purely of volunteers our members are our main assets and the vibrancy of thought and action is apparent not least in younger committee members such as Niru Goenka, Partha Kar and Emma Wilmot.

Strength in collaboration

The increasing strength ABCD's relationships with other organisations and the number of collaborative projects is another cause for optimism.

This is exemplified by:

1. The Joint British Diabetes Societies In-Patient Group whose funding into the future is agreed in partnership between ABCD and Diabetes UK, and which is going from strength to strength under the able chairmanship of Mike Sampson. Workstreams with outputs planned include enteral feeding, e-learning, hyper and hypoglycaemia, admissions avoidance and self management. The Titan ACS * project which was funded jointly through NHS Diabetes and ABCD set out to show the safety and efficacy of the insulin infusion regime in coronary care units and Maggie Hammersley is preparing reports on its outcomes.

2. Diabetes UK's willingness to be co-signatories to the ABCD created letter on Pioglitazone to the European Medicines Authority.

3. The National CSII Audit which has been commissioned through ABCD on behalf of a consortium which includes Diabetes UK and JDRF (Ian Gallen leads the steering group for this project).

I recently attended the first programme board of the National Diabetes Audit, the governance of which has now been taken on by Diabetes UK, and was genuinely excited. This collection of national audits will assume increasing importance in the years to come and diabetologists have a vital role to play in translating the figures and statistics into outputs of value to people with diabetes and local diabetes care communities.

The nationwide audit programme led by Bob Ryder is also flourishing and new developments include the possibility of moving the audit tool within an NHS.net environment for future audits of new agents. By allowing retention of the NHS number this opens up exciting possibilities for data linkage. Bob's other key role is as website officer and he has now set up a website board to supervise an extensive revamp of the website; the fruits of these labours will become apparent over the months to come.

As chair of ABCD I am conscious of the need to work closely with the National Clinical Director Rowan Hillson and support the admirable work for which she and Gerry Rayman and others have been responsible, within the area of inpatient care.

ABCD continues to support the developmental needs of trainees with the Kings Fund course and to discuss and develop common initiatives with YDF. In addition, I have a strong wish to engage with the Primary Care Diabetes Society to ensure that they are at the table to bring the primary care perspective into the many areas of common interest.

The new executive and committee

Thanks must be expressed to Peter Winocour for his tireless and productive work as Chair and Secretary, and for ensuring a smooth transition; his continuing presence within the executive group as immediate past chair is a source of stability at a time of much change.

Thanks also to the departing executives Ian Gallen and Dinesh Nagi and welcome to the new executives, Patrick Sharp (General Secretary), Rob Gregory (Treasurer), and

Ketan Dhatariya (Meetings secretary). Dinesh and Ian are continuing to be active within ABCD leading on the manpower survey and the CSII audit respectively.

Among departing committee members particular thanks are due to Anne Kilvert who has selflessly been involved in so many committee initiatives over the years and has recently represented ABCD in discussions with the NPSA over the insulin passport, and to Nick Morrish who after years of toil collecting manpower data has handed over the manpower survey (jointly funded by ABCD and Diabetes UK) to Dinesh Nagi.

ABCD will continue to support high quality diabetes care across the four nations and I welcome the new committee representatives from Northern Ireland (Hamish Courtney), and Wales (Aled Roberts). Johnny McKnight continues as Scottish Representative.

A warm welcome to our other new committee members Daniel Cuthbertson, Russel Drummond, Dipesh Patel, Tony Robinson, Dev Singh, and Jonathan Valabhji.

Conclusion

As ABCD, a relatively small society with limited means but growing activity, we must seek to catalyse change by influence and working collaboratively, achieving change while preserving that which is good.

As diabetologists we must align ourselves with, and focus on, the needs of people with diabetes; their needs are great at a time when political whim and false perception threaten to fragment the care pathway. We must seek to understand and influence the forces which are driving sometimes irrational changes in our local and national care systems. If we do this we will not go far wrong and perhaps end up just a tad more cheerful!

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Chris Walton

ABCD Position Statement: Analogue Insulins

ABCD welcomes the publication of Holden et al (BMJ Open 2011;**1**:e000258 doi10.1136/bmjopen-2011-000258) although with some caveats. Holden's analysis estimates the additional cost to the NHS of the use of analogue insulins rather than human insulin. Whilst the advantages of analogue insulins in terms of their more physiological profiles should not be forgotten, at a time when financial considerations are at their most pressing, a reminder of the cost implications of our clinical practice is appropriate.

Insulin was originally extracted from animal pancreas, but the introduction of synthetic insulin in the early 1980s opened the way for the production of human insulin. It was a logical progression, therefore, to analogues of insulin, initially with a more rapid onset of action and subsequently to longer acting analogues of insulin. An assessment of the clinical and cost effectiveness of the insulin analogues has been included in major clinical guidelines, most notably those issued by NICE for the management of type 1 and type 2 diabetes (CGs 15 and 66) and SIGN guideline 116. The practicalities of the short duration of action of rapid acting analogues and single daily dosing regimen of longer acting analogues were noted together with limited evidence for a reduction of hypoglycaemia with these agents. The published guidance is consistent in recommending human insulin as first line therapy with consideration of analogues in certain circumstances.

These circumstances include the use of long acting analogues where an individual needs external help to administer insulin or has suffered troublesome nocturnal hypoglycaemia. Rapid acting analogues could be considered where injection immediately before food is preferred and where there are marked postprandial glucose excursions with human soluble insulin. For those individuals treated with a basal bolus insulin regimen, therefore, rapid acting analogues will remain the treatment of choice.

Since their launch, there has been an increase in the use of analogue insulins to the point where their use may not be supported by published guidance in some instances. The value of the report of Holden et al. lies in the attention it focuses on the cost of use of analogue insulins in preference to human insulins. The authors discuss the limitations of their report. They comment on the assumptions used to reach their conclusions and likewise comment on the impracticality of replacing all prescriptions for analogue insulin with a human insulin preparation. Nevertheless, the point should be well taken: there is a cost associated with the use of such preparations.

While valuable, this report should not prompt any sudden changes in prescribing policy: many patients are well controlled on analogue insulin, and their treatment should not be changed in response to this analysis. The major clinical guidelines for diabetes leave the option of use of analogue insulin to the clinical judgement of the clinician and this report should not change that position. Nevertheless, the reported figures should act as a timely reminder that we should consider, with each prescription, precisely why it is judged that an insulin analogue will offer benefit over and above that conferred by a less costly human insulin.

ABCD welcomes innovative treatments for diabetes, including new insulins that offer those patients who are experiencing problems with established treatments the prospect of better control with fewer problems. However, the Association supports a view that prescription of analogues of insulin should be considered only when the use of human insulin has been considered and rejected.

Declaration of interest:

ABCD (Diabetes Care) Limited receives financial support from Lilly, NovoNordisk and Sanofi-Aventis, all of whom manufacture analogue insulins that are available in the NHS.