# Chairman's Report

**Masters of our own Destiny – offering expertise with breadth and depth**

With the credit crunch in full swing, the NHS is bound to be feeling the pinch and seeking ways of economising. If there ever was a bargain for money it would have to be the consultant physician with an interest in diabetes and endocrinology – at least 3 jobs for the price of one!

Our specialist service survey already made clear our vital contribution to district endocrine services and acute-internal medicine, especially at a time when other medical specialties were opting out of Physician of the (seemingly never-ending) Week. Our passion- to develop the highest quality diabetes care in our locality – must not be compromised in the process.

Without wanting to sound too self congratulatory, acute trusts should be falling over themselves to appoint more accredited specialists to provide a pool of colleagues with skills that cover all these areas. In particular, the commitment of each trust to ensure consultant-led hospital wide in patient diabetes care is a key objective of ABCD alongside colleagues in the Joint British Diabetes Societies In Patient (JBDS-IP) working party. This core aspect of the Diabetes National Service Framework will receive increasing emphasis over the next 12 months as one of the top clinical priorities of the National Clinical Director for Diabetes (England), Dr Rowan Hillson. ABCD are vital to the success of this initiative and this has been strengthened with the appointment of our colleague and committee member Gerry Rayman who has been seconded to Rowan's team with a lead role in delivery of improved in patient standards and care. In addition, both Mark Savage and I are ABCD members of JBDS-IP.

One related area of work that has come out of our ABCD Clinical Audit programme was a 4-centre audit of current glycaemic care in acute coronary syndrome. I presented the findings at our autumn meeting, and confirmed variable protocols and less than optimal adherence by site to local guidance. Glycaemic care during acute coronary (ACS) remains a major challenge. I am therefore delighted that NHS Diabetes (the new name for the National Diabetes Support Team in England) have awarded ABCD over £100K to evaluate the benefits of tight glycaemic control, and to develop national standards alongside cardiology colleagues from MINAP (the RCP Myocardial Infarction National Audit programme), with the opportunity for routine input of new fields for glycaemic care during ACS. This project will be led by Maggie Sinclair-Hammersley so I know it will make a difference! ABCD consider input from a consultant Diabetologist and Diabetes In Patient Specialist nurse to ACS metabolic care is critical – and look forward to the time when we are all welcomed with open arms into every CCU in the country to see the 20% + of patients with hyperglycaemia.

Returning to the breadth and depth of the trained diabetologist, ABCD are actively working in developing the specialist services and training that is central to improving 'community diabetes'. Apart from the fact that our specialist survey demonstrated extremely patchy input, is the question just what this term means. This is not primary and intermediate nurse-led diabetes care (which of course remains a vital high quality need) but making certain that in England (to begin with) the mandated shift of chronic disease to community settings through government policy is NOT devolvement of clinical responsibility of diabetes from specialists. To quote one mantra – 'high quality diabetes care requires access to the right person in the right place at the right time'. This is not a tag line from a Martini advert but an exhortation to enable specialist engagement in diabetes community care.

I am in no doubt of the benefit this will bring for patient care, through training, integrated care, effective clinical governance of system wide diabetes teams, and facilitating earlier input to active care and research. I am keen that ABCD work closely with the Community Diabetes Consultant Group and Diabetes UK to ensure that the specialist medical input is central to future planning of such services. We are fortunate that quite a few of our committee are active in this area.

The evidence base from the 4T study, UKPDS 10 years on, ACCORD, ADVANCE, and the compelling Chinese study on insulin therapy from diagnosis in type 2 diabetes (Weng et al, Lancet 2008) now need to alter practice. Their reinforcement of the lessons from DCCT-EDIC in type 1 diabetes of the importance of metabolic programming and memory in type 2 diabetes make the case for active front end input to more intensive glycaemic care. The corollary of course from ACCORD was to severely question the benefits of intensive glycaemic control in older type 2 with established CVD.

The NICE type 2 diabetes guidelines in 2008 sensibly make a virtue of individualised glycaemic targets. Specialists should be pushing for an early warning system in younger type 2 DM and early onset microvascular disease, who may remain below the radar of primary care, especially if considered adequately treated by QuOF standards, with all process measures ticked off, and on the defined cocktail of statin, ACE Inhibitor, and (perhaps still?) Aspirin but with subtle progression of vasculopathy.

Diabetes services ultimately require effective commissioning by Primary Care Trusts and Practice Based Commissioning in England. This has been realised through an initiative which again we must thank Rowan Hillson for. The concept of Teams without Walls will facilitate integrated diabetes care, and provides the strongest counter to other Department of Health guidance for plurality of provision. ABCD co-authored a document with the NHS Alliance and other specialist societies making support for such a concept clear. The central role of the specialist in commissioning diabetes services is vital (ref) and we now have an opportunity to ensure a co-ordinated input through an initiative involving ABCD and all other stakeholder organisations which has been spearheaded by Rowan Hillson and the Royal College of Physicians of London to revitalise the Diabetes Commissioning Toolkit, and make it fit for purpose in the new era of… (sceptics avert your gaze) 'World Class Commissioning'.

ABCD are also working closely with the Royal Colleges of Physicians on other areas as well – namely in revalidation where Alan Jaap, Patrick Sharp and John Quin recently helped evaluate the Diabetes Practice Improvement Module and have identified the need for more work in both individual and service revalidation. Rob Gregory is our first ABCD representative on the RCP Joint Specialist Clinical Effectiveness Forum and will be reporting back to us in due course. One particular area has been in evaluation of the Map of Medicine on line diabetes guidelines. Talk about a 'can of worms'! The RCP Joint Speciality Committee on which Ken Shaw and I sit were tasked with reviewing that section. It became clear they were out of date and

often needed correction although they are laid out beautifully. The need to co-ordinate with the wider initiatives from JBDIPS, means quite a bit more work is required on this.

I had a very enjoyable day at RCPL in setting the Specialty Certificate Examination (SCE) as a member of the examination board led by John Connell. Our meeting secretary Dinesh Nagi also took an active part – he was so keen he turned up a day early and boosted Virgin Rail profits by having to make the return journey twice! The first diet of the exam is in May 2009 and along with the Society for Endocrinology and Diabetes UK, we will be working closely with the Federation of Royal Colleges of Physicians to make this a success, enabling the award of MRCP (Diabetes and Endocrinology) UK to successful candidates in UK training programmes.

Talking of specialty societies, the last year has brought about the extremely important opportunity for us to learn so much about other more established specialist organisations. As a result of our input to the SCE (the new name for the Knowledge Based Assessment (KBA)), there was a realisation of common areas of interests and themes which we had no opportunity to discuss other than in the College Council forum. ABCD have now met with colleagues from cardiology, gastroenterology, thoracic medicine, dermatology, rheumatology, endocrinology, neurology, elderly care, and renal medicine in the rather grand surroundings of Fitzroy Square through the hospitality of the British Association of Dermatologists and the British Cardiovascular Society. We covered issues such as academic training, relationships with PMETB and entry criteria to the specialist register, revalidation, the Darzi white paper, and common input to SCE and other work with the RCPL. We all agreed that we must ensure our national specialist society work requires explicit support agreed centrally through job planning. I realised quickly that ABCD are clearly the poor relations in this and this was one of the triggers for our recent committee EGM.

I was able to offer the committee a view of my priorities over the next 2-3 years. Apart from membership expansion amongst both consultants and specialist registrars we need to increase our revenue and in turns our national activities and profile. With this in mind the committee supported my efforts to secure funding to enable consultants to undertake national projects through identified sectional support. Currently our corporate sponsors have been extremely helpful and it is likely that the equivalent of a full time locum costs for 1 year will be feasible for our work programme. I am enthused by the real commitment and enthusiasm of our committee. Without naming everyone in turn, it is clear that every member is taking on key roles which our newsletter editor Mark Savage will ensure is covered in future newsletters.

One important development that we have contributed to has been in supporting NHS Diabetes in introducing the modified HbA1c measurement from June 2009, using the IFCC standards with continued expression as DDCT equivalents. Alan Jaap and Patrick Sharpe fed into this process on our behalf, and I was able to attend an earlier meeting when we had a helpful discussion about the related issue of estimated average glucose. I was relieved that this was felt a step too far and that a great deal of research in this area was required before it was considered as a routinely reported measure in the UK.

I do need to express our thanks and send our best wishes to Trevor Blair. Trevor has been our Northern Ireland representative pretty much since we established our 4-nation perspective in 2006, and a stalwart attendee of our meetings. Unfortunately due to ill health Trevor has had to stand down from the ABCD committee, but I am enormously grateful that Kate Ritchie has agreed to step into the breach.

The secretariat function of ABCD had been performed incredibly well by Elise Harvey at Gusto events. I was somewhat concerned when Elise advised me the day before Christmas that she would be leaving Gusto! However my relief was almost palpable when she explained that she would now be joining Tricia Bryant in Red Hot Irons. Tricia has been helping us at committee meetings for some time and their collaboration will not only ensure we have an efficiently run organisation, but is set to help us expand and develop our website where a strong educational section is planned.

Our new general secretary Ian Gallen has been a busy bee working on ensuring our stakeholder input to NICE technology and guidelines appraisals, to developing a regional structure with regional champions (see box) and active efforts to provide regional training meetings for training registrars, to develop our programme of position statements (see report), and ensuring the continued success of the ABCD Clinical Audit programme. Our most recent ABCD Clinical audit award (supported by MSD) was hotly contested and on this occasion I was delighted that we were able to support Gerry Mackay in Glasgow, who is extending earlier work to audit current practice and training needs of junior doctors in the UK seeking a career in diabetes. This fits well with our full commitment to training and support of junior doctors and our provision of funding for a Kings Fund Management course for Specialist registrars which we are repeating in 2009.

An important example of our national role is the Exenatide audit, led by Bob Ryder. This will provide a vital opportunity to have independent post-marketing data on safety and efficacy to help specialists better place GLP-1 analogues. Subject to our members contribution we should end up with the largest international database of cumulative experience, and an opportunity to review current practice in difficult clinical scenarios where treatment may have been used out of license. An ABCD position statement on gliptins and GLP-1 analogues from Mark Edwards should be following 'hot on the heels' of this newsletter.

Our collaborative survey of specialist services with Diabetes UK is coming to an end with information on retinal screening and specialist nurses submitted for publication. The issue of paediatric-adolescent-transitional services will be the final piece of this work which is currently being finalised. Together this provides the important information to assess progress in service provision since 2000, and offers ammunition for future service reconfiguration; ensuring models are commissioned to fully provide specialist services in all settings.

Our meetings remain a highlight in our calendar and I was grateful how smoothly our London meeting went last November –mainly I suspect as our meeting secretary Dinesh Nagi was in charge rather than me. We had hoped to meet with the Primary Care Diabetes Society on the topic of integrated care but unfortunately this has been deferred. We are on stronger ground in our planned joint meeting with RCPL on Diabetes-a hospital perspective, focusing on in patient diabetes and scheduled for early 2010.

Let me finish with an old (rhetorical) Scottish toast – 'Here's tae us. Wha's like us?'… 'Damn few, and they're ae deid !'

***Peter H Winocour***
***Chairman***