Chairman's report

Now that the noughties are over...

So, how was it for you? It remains to be seen whether we have unwittingly lived through a (rather tarnished) golden age of diabetes with some of the increased NHS spend devoted to diabetes care – although predominantly through QuOF, registers and retinal screening enhancing primary care of diabetes.

What will the next decade hold for diabetes care in Britain? – theoretically there are opportunities with a wealth of data from NHS Diabetes and the National Diabetes Information Service (NDIS) advising commissioners how to assess needs and ensure provision of integrated diabetes services through the 'Commissioning Diabetes Without Walls' toolkit.

However this will be balanced by public service funding cuts. The impact of the possible change in government is more difficult to predict. I think it is likely that cost cutting for chronic diseases including diabetes will take place. It is vital that we ensure this does not lead to 'disintegrated' diabetes care.

Driving service changes

It is our role as leaders and specialists to drive service changes through our acute trusts, and by engagement with GPs-PBC and PCTs-SHAs. The challenge is whether they want to listen and work consensually or whether they will find it easier to employ simple minded dogma. A focus on new to follow up ratios can probably be viewed as a surrogate marker that the PCT conforms to the one dimensional stereotype.

PCT pharmacists are an interesting breed. I often wonder if they operate a bonus scheme for successful denied introduction of new therapies. An example is the challenge in accessing liraglutide, and we may need to await final NICE guidance. ABCD are keen to carefully manage the entry of GLP-1 analogues with our national independent database. Our inaugural ABCD clinical research fellow took up his post with Bob Ryder in February, and already we have accumulated extensive data looking at Exenatide use alongside insulin.

Since my autumn report I attended the IDF meeting in Montréal. The trip exceeded my expectations with plenty of high quality clinical research. There are many benefits from attending such meetings – mainly curricular, although I did attend an excellent jazz session with Ian Scobie as company after a hard day's conventioning.

Networking is a real bonus of our own ABCD clinical meetings, but a wider international perspective offers its own rewards and an opportunity for reflective thinking time away from base. I personally also value a natter with colleagues.

I returned from the IDF enthused and brimming with ideas how to change the world, but then inevitably met the inertia that characterises the NHS, the trust priority of cost savings, and delivery of acute medicine. As the old stalwart US Senator Tip O'Neil once said – 'In politics ultimately everything is local' – and I think the same applies to diabetes.

Analyses from our 2006 ABCD specialist survey with Diabetes UK is reaching completion. The issues raised in our survey of retinal screening have been brought to the attention of the Chair of the National Screening Committee on Diabetic Retinopathy. Most importantly was the disconnect of the screening process from holistic diabetes care and failure to enable urgent access to specialist ophthalmology and diabetes care for sight threatening retinopathy. Our earlier qualitative analyses of consultants documented frustration that I am sure remains as we try to direct our restless energy to improve services. Never mind pushing through metaphorical glass ceilings – we have brick walls to contend with.

The Kings Fund Diabetologist Leadership Course was recently reconvened in Blenheim Palace and rekindled in me the enthusiasm I came away with two years previously. It was invigorating to see that many delegates had undoubtedly benefited in grappling with 'the system', and ABCD fully support this training opportunity for consultants. At present we already fund the SpR course.

We heard about a pilot study where the independent sector helped community matrons avoid hospital admissions, which seemed of value. The majority of us carry out unselected medical take – how often do we have to manage frail elderly patients admitted unnecessarily to hospital and languishing for weeks awaiting the unrealistic verdicts of the therapists as to when they can leave hospital?

Given the choice I would see a future role for hospital based consultant diabetologists doing what we were put on this earth for – delivering specialist diabetes care. Historically the number of hospital beds a consultant was responsible for used to be almost viewed as a 'virility symbol'. I personally would prefer a modest number of perhaps 10 for in patient specific diabetes and endocrine care, with our commitment to in patient care for the 15-20% with diabetes throughout the hospital.

I am hopeful that the National Diabetes In Patient Audit day co-ordinated by Gerry Rayman will provide the evidence to compel SHAs, commissioners and acute trusts to ensure effective hospital wide consultant led in patient diabetes care.

Training SpRs to a high standard remains a core objective of ABCD. A recent ABCD survey found inconsistencies in regional training programmes. Our last committee meeting agreed that we progress ABCD-badged input to these sessions and ensure coverage of service development and preparation for the Specialty Certificate Exam (SCE). However I have to say that this is a two-way street and the trainees need to make their own efforts to seize such opportunities. As a forward thinking proactive chairman I arranged our own regional programme with a high calibre programme and a renowned international speaker who shall remain nameless! It was more than a little embarrassing that the audience turned out to be the equivalent of 'three men and a dog'. Next time perhaps more stick and less carrot?

ABCD incorporated

You will be pleased to know that at our November EGM in London we agreed to become an incorporated organisation, which makes our organisation more tax efficient and offers other benefits. Perhaps most importantly for the executive and committee it limits our own individual liability in the event that we are sued. Whereas this possibility might at one time have been fanciful, you only need to read the papers to see that Britain is currently a favoured centre for libel actions involving clinicians and scientists.

Following the EGM we had another top-notch ABCD meeting in London organised by Dinesh Nagi, attended by well over 100 delegates. As ever I feel the meeting provided a unique atmosphere – proven by your feedback. I hope to see many of you in Gateshead in May.

We continue to actively engage with Diabetes UK and its new chairman George Alberti. Together the organisations have

defined specialist diabetes services to support commissioning, and are assessing the status of community specialist services, and the opportunities for training within them. We have been better able to input to the NICE technology programme through coordinated nominations of experts and are working together to update the diabetes section of JBS3 guidelines on CVD.

We have met with the executive of the Primary Care Diabetes Society (PCDS) and had a fruitful meeting. We agreed to formulate an update of our joint position statement on integrating diabetes care and opportunities for training, joint operational research and audit.

I have just completed my term as our representative for diabetes and endocrinology on RCPL College Council. I am concerned that the current arrangement of alternating with endocrinology means that over the next two years we may not have college access at a critical time.

One area I feel strongly about is the interface between acute-general medicine and specialist work and our increasing commitment to acute medicine as other specialities opt out 'of the take'. Our 2006 ABCD survey recorded this and I reckon the situation has got worse. The College Manpower survey confirms we make the greatest contribution but suggests that some other specialities are in the same boat. The opt out of cardiologists etc. of course does not imply their intensity of work is any less but the point I put across when I tabled this item at RCPL Council was that our increased on call commitment is at the expense of specialist work and service development in contrast to those who opted out. I am not sure where this issue is going but we need to keep the momentum going. My solution – more diabetologists sharing the load.

The Specialty Certificate Exam (SCE) board for 2010-11 met in December. I think we agreed a fair but testing examination for May 2010.This is a vital educational exercise and I am positive we are engaged in a well organised project.

The wisdom of elderly statesmen

ABCD is a founder member of the Coalition of UK Specialist Medical Societies, which have together addressed areas of common interest including the acute medical-specialty interface, SCE, revalidation, academic training, finances, and education.

The Coalition meeting has enabled ABCD to share ideas and learn from other more established organisations. One helpful suggestion from the British Geriatric Society was to invite senior members to critique output from DH, NICE or write position statements. We had already exploited such an 'asset' in the form of Ken Shaw who produced an excellent practical paper on helping localities plan for the potential impact of swine flu on diabetes services.

By the time this newsletter is with you, winter will have passed and we will see whether the guidance came into play with Sir Liam's Doomsday scenario. Regardless, Ken's document sets a benchmark for future major events where contingency planning for diabetes care is necessary. Ken also continues to play an active role in supporting our input to ACCEA where our members continue to have a high success rate. I consider Ken my 'consigliere' – a bit like Robert Duvall supporting Al Pacino in the Godfather but with less pasta and gunfire!

Over the winter holidays I came across smiling shop assistants with the 'How Am I Doing' badge on their lapels and thought I should tempt fate by asking this question of myself 18 months into my chairmanship. I am sure you will let me know!

My main priorities were to increase our membership, improve our financial status and enhance our profile nationally.

I have of course benefited enormously from the great support from the other members of executive and the committee but to offer you progress to date:

We have around 400 consultant members, an increase of just 3.6% over past 18 months, way short of the 500 we need to ensure the loudest voice in all circles. We have by contrast been very successful in attracting a 40% increase in SpR members over that time.

Supported projects and new opportunities

I am extremely appreciative of the support of corporate sponsors who enabled ABCD to carry out national NHS–ABCD priority work. At present we have agreed to support a project reviewing current specialist provision and training in 'community diabetes', upgrading the educational section of our website and supporting our input to the writing of JBS3 CVD guidance. We are still looking to identify one additional project that could free up a consultant for a day a week over a year, so if you have a national project that you would like to take on behalf of ABCD please let me or Ian Gallen know.

Our efforts to raise our profile through a public communications company has delivered some returns and I expect this to continue – our upcoming position statements on HbA1c and the treatment of male hypogonadism in DM should prove cases in point.

There are many 'big tasks' for 2010. We will be looking to expand the portfolio of ABCD position papers under Ian Gallen's direction and updating our views on insulin pumps and gliptins-GLP-1 analogues over the next 12-18 months. A revalidation sub-group led by Patrick Sharp will be a priority to ensure the process is fair, meaningful and effective for diabetologists. Our input to diabetes information strategies is being led by Anne Kilvert. I am keen we progress the concept of core group work within the committee and financial and academic sub-structures have also been created.

2010 will also bring important output from the Joint British Diabetes Societies (JBDS) In Patient Group with the publication of guidelines on hypoglycaemia and diabetic ketoacidosis. JBDS are also pushing ahead to promote auditable standards for in patient diabetes care, derived in part from the findings of the National Diabetes In Patient audit day. Our joint meeting with RCPL in January on in patient diabetes was well attended and a testament to the importance of this area.

I want to pay tribute to our valued friend Jeff Goulder, who died earlier this year. Jeff was absolutely irreplaceable as a colleague from the pharmaceutical industry who was unswervingly dedicated to improving professional care for those living with diabetes, and who ABCD remains indebted to. I will miss him as will many of you.

Let me conclude with some lyrics from a classic Hollies number that emphasise the spirit of co-operation that will be needed in the year ahead, and which most of you are probably too young to recognise:

The road is long
With many a winding turn
That leads us to who knows where
Who knows where
But I'm strong
Strong enough to carry him
He ain't heavy, he's my brother

Peter H Winocour, Chairman