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ABCD Newsletter

The Official Bulletin of the Association of British Clinical Diabetologists

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EDITORIAL

Clinic pressures – trying to do the best for everyone

Peter Daggett
Editor, ABCD Newsletter

Diabetic clinics can be stressful places to work. We have all experienced the pressure of seeing a pile of notes growing on our desk and knowing that there are another 15 patients to come. You can then guarantee that at the busiest time a major problem will be found requiring 20 minutes to sort out and this will throw out the timing of the whole session. You can hear grumbling outside the door and then the telephone rings. You have to go to deal with an emergency elsewhere and that takes another 30 minutes. More grumbling and a written complaint ensue. Small wonder then that some specialists have found that the workload is getting on top of them. We want to see as many of our diabetic patients as possible, but we should now be starting to consider what is a reasonable number in a session. It has been traditional for diabetic clinics to have 3 or more doctors working at the same time. Changes in junior doctors' hours have however meant that planning of clinics has become increasingly difficult and it is not uncommon for one or two juniors to be absent. The options then are to cancel a list at very short notice, or for the consultant to see all the patients personally. Most do the latter, resulting in up to 30 being seen in a session. This causes greatly increased stress and leads to mistakes being made. Some centres have tried to plug gaps with nurse specialists and they do a good job, but they don't see as many patients as a specialist registrar or clinical assistant.

The NSF for diabetes gives specialists their first opportunity to reduce their work load and while this will be anathema to some, we should welcome it. Our colleagues in general practice, particularly GP specialists, are keen to shoulder some of the burden. Consultants should be telling their managers about the changes that are imminent, because some may think that we will be doing less work. In fact, we will be spending the same amount of time in clinics, but dealing with more complex cases that take longer. Now, the crux of the matter. How many? The figures produced by the Royal College of Physicians suggest that we should spend 30 to 45 minutes with a new patient and 15 minutes with

continued on page 2

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INSIDE

continued from page 1

a follow-up. In a 3 ½ hour session therefore, we should see 12 to 14 follow-ups, or seven new cases. In a mixed clinic, it would seem reasonable to see four new cases and six follow-ups. These lists will be considerably smaller than we are used to, but we should not feel embarrassed. Consultants in our specialty have been propping up the health service for years and the time has come to demonstrate that fact. If PCTs want more patients to be seen by specialists, they will have to fund the required expansion in consultant numbers. Finally, what should we do about lists assigned to junior doctors? They are needed for training purposes and so we can't scrap them completely, but hospital managers will have to accept that cancellation at short notice will be unavoidable when the junior is absent.

So we have a way forward that will prevent much of the stress that has become the norm. Do we have the courage to implement these suggestions?

The New ABCD Logo

The Committee felt that the existing ABCD 'logo' was visually uninteresting and didn't really say anything about the Association. The Chairman, drawing on his interest in Ancient Egypt, has designed a new logo based on the image of one of the pyramids at Giza. The pyramid of Khafré (Chephren, 2,558 –2,532 BC) has a number of features which appealed to us:

- The quality of the construction is superb.
- It was way ahead of its time, evidently constructed by superior and far-sighted beings who had access to and control of large numbers of low paid/slave workers.
- It is long established and immensely durable. It has stood the test of time and the ravages of successive invaders, notably the Arabs in the seventh and eighth centuries A.D., who removed much of the cladding in order to build mosques in Cairo.
- Despite this, the pinnacle has remained intact with its original smooth and superbly engineered limestone casing.
- It has hidden depths of internal passageways and chambers.

This image is the copyright of Historylink101.com and is found on the Egyptian Picture Gallery

It could be considered that some of these features are reminiscent of the position of diabetologists and ABCD in today's PCT-driven, target-fuelled NHS. We believe that ABCD is now sufficiently well established for us to see out these latest political enthusiasms and no doubt successive waves of invaders associated with future periodic reorganisations of the NHS.

Richard Greenwood
Chairman, ABCD

From the ABCD Membership Co-ordinator

Membership of the Association continues to rise steadily. By the time of the Spring Meeting in Cardiff, our membership included nearly 60% of all consultants specializing in diabetes. This meeting was one of our best and was particularly successful in attracting new members. We have established a database of all consultant diabetologists and final year SpRs, who are also eligible to join ABCD. Part of my role involves monitoring all new appointments of consultant diabetologists, so that they can be invited to apply. It would be very helpful if readers would be kind enough to assist in this process by:

- Letting me know the name and address of any consultant diabetologist appointed to their hospital trust.
- Providing me with details of final year SpRs so that they can be invited to become members.
- Encouraging any colleagues who have not yet taken up membership to do so. An information pack containing details of the benefits of ABCD membership is available on request.

I am very happy to be contacted by any member or colleague considering a membership application.

Jeremy J Bending
ABCD Membership Co-ordinator

ABCD AUTUMN 2003 MEETING

Thursday/Friday, 13/14 November 2003

Radisson Marlborough Hotel
Bloomsbury Street
London
WC1B 3QD

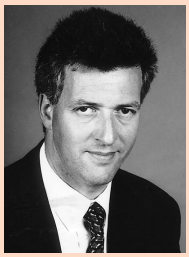
The Meeting will be back-to-back with a Meeting of the British Thyroid Association on Thursday, 13 November

The ABCD Meeting programme will include:

- The ABCD Debate: The NSF retinal screening strategy will not prevent blindness from diabetic retinopathy
- Lecture: Coagulopathy *(Professor Peter Grant)*
- Lecture: Problems in reliable HbA_{1c} measurement *(Dr Eric Kirkpatrick)*
- Lecture: The Diabetes NSF – what is the role of secondary care physicians? *(Dr Sue Roberts)*
- Short audit presentations **(please submit abstracts to the Hon Secretary)**

Registration/programme details: Dr Peter Winocour, Hon. Secretary, ABCD (see front cover for contact details)

Can the National Service Framework and new GP Contract make a difference?



Peter H Winocour,
Hon Secretary ABCD

The Diabetes NSF focuses on developing structures to improve diabetes care. Its main thrust is to have local diabetes registers and retinal screening programmes in place by 2006, with service targets reached by 2013. It is reasonable to ask whether the NSF will actually help us to deal with the real challenges in providing effective care to reduce complications. The incidence of diabetes is reaching epidemic proportions. Consequently the currently acknowledged spend of 6% of the NHS budget on diabetes could increase further. The purpose of the NSF is to have health care centred in the community. Diabetes is a highly prevalent chronic condition, which leads to considerable morbidity and premature mortality, and is intimately linked with cardiovascular disease, which has its own NSF and where again primary care targets are one critical component of the framework. The recent Diabetes UK survey of current primary care services, however, makes stark reading and shows that the NSF delivery will fail without a major expansion of all services for diabetes.

The most disappointing aspect is that there is no funding to enable the 10-year plan to be developed. There is no compulsion to establish minimum core staffing levels in the primary and secondary care settings. Many services throughout the UK do not have adequate medical, nursing, podiatric, and dietetic personnel, or IT support to enable a fully integrated diabetes service. The only funding that the NSF states will be made available for new service development is for retinal screening. For a health authority population of 600,000, the set-up costs may be £167,000, plus £823,000 for the screening programme and screen-detected disease in year 1, with an annual expenditure of £150,000 thereafter.

The Department of Health has linked the Diabetes NSF with documents from NICE on the effective treatment of glycaemia, blood pressure, lipid abnormalities and the approach to the care of retinal and renal disease. Indiscriminate application of the numbers selected by NICE will create inappropriate pressures on both patients and health providers, who will be unable to meet the targets in at least 50% of cases. These metabolic and blood pressure targets have now been included in the proposed new GP Contract. It would appear that the Department of Health believes that coercion though payment will be the basis for primary care to improve diabetes care.

The area which concerns me most is the 'numbers game', which government departments routinely use to measure quality of service. The most contentious aspect of the points system upon which primary care payments will be paid for diabetes services relates to attainment of metabolic and biological measures. For glycaemic control, 16 points (the second biggest allocation) are available for the number of diabetic patients whose HbA_{1c} is 7.4% or less over the preceding 15 months. This target has been set at a minimum threshold attainment of 25% and a maximum of 50%. Thus it would appear that if 50% attain this level of HbA_{1c} in the practice, 16 points towards payment would accrue. If 85% of patients have an HbA_{1c} at 10% or less then 11 points will accrue.

Who can be included in this tally needs clarification. Is it all patients registered in the practice, including those in secondary care? Type 2 diabetes is a slowly progressive condition and the level of HbA_{1c} will deteriorate with time despite progressive polypharmacy. The estimated period of time pre-diagnosis may be several years and, undoubtedly, glycaemic control will be better early in the natural history of type 2 diabetes. The approach to case detection in practices could seriously skew the percentage of patients attaining a HbA_{1c} below 7.4%. Screening of groups at high risk of diabetes is only currently practised in some centres. Inconsistency in this area alone will give different rates of attainment.

A similar quandary arises when it comes to attainment of blood pressure targets. The proposed GP contract states that between 25% and 55% of individuals in the practice should have attained a blood pressure of 145/85 or less over the preceding 15 months. The issue, however, is much more complex than appears, because of competing risk factors and therapies and issues of poor compliance. Additionally, the spectre of postural hypotension through over-treatment of the increasingly prevalent elderly frail diabetic does not appeal. Efforts to create unrealistic targets create unsettling pressures in health care systems. For example, the hospital waiting list debacle has led to instances of fabrication of data.

When it comes to lipid data the targets for payment only relate to cholesterol, and 6 points are available if 25-60% of diabetes subjects have a cholesterol measured at 5 mmol/l or less within the previous 15 months. If statin use becomes widespread then this particular target is achievable. The drug cocktail for type 2 diabetes may then require up to 10 different treatments if a slavish approach to target attainment is set for all individuals without due regard to their total health status.

It is interesting that there is no target for payment based on the success rate for smoking cessation, rather on the number who have been offered advice.

In conclusion, the proposed GP contract offers a carrot and stick approach to target attainment for primary care of diabetes. Health care systems are unlikely to reach the biomedical targets in more than 50% of cases. A more suitable system would utilise mutually agreed individualised targets.

ABCD now represents over half of Consultant Diabetologists

Highlights of the ABCD Spring 2003 Meeting

Cardiff Thistle Hotel, Cardiff , Thursday/Friday, 8/9 May 2003

At the Association's 2003 AGM the Chairman, Richard Greenwood (Norwich), announced that membership had increased by 10% since the last meeting and now included over half of all Consultant Diabetologists in the UK. Dr Greenwood was re-elected Chairman, along with the Hon. Secretary, Peter Winocour (Welwyn) and the Hon. Treasurer, Ken Shaw (Portsmouth).

At the AGM, the following additional matters were decided. In future ABCD support for distinction award applicants would be restricted to ABCD members. The successful back-to-back meetings with the BTA and training meetings for SpRs would both be continued. Short audit presentations would be included at future conferences. ABCD's associated charity was being renamed the 'ABCD Diabetes Trust'. Corporate sponsorship and bequests were being sought to fund ABCD research projects.

THE ABCD LECTURE: IMPLICATIONS OF THE WORKING TIME DIRECTIVE

Dr Hugh Mather (Ealing), the RCP Specialist Registrar Adviser, said the European Working Time Directive (WTD) would become law in August 2004, as a result of the SIMAP judgement which ruled that sleeping at the hospital counted as working time. It was likely that on call rotas would be abolished and all resident trainees put onto full shifts. The resultant blocks of night duty would have a huge impact on continuity of care, training and quality of life of Specialist Registrars (SpRs). Ten SpRs would be needed to staff a workable shift rota, ie working one week of nights in eight. SpRs said this was not an acceptable work pattern.

When you are working full shifts in 2004, what impact do you think this might have on the following?

Measure	'Slightly worsen' or 'severely worsen'
Continuity of patient care	92%
Your specialty training	86%
Your quality of life	75%
Quality of patient care	62%

Table. Views of SpRs on the impact of the WTD (Mather)

There were unlikely to be sufficient applicants to increase NTNs and Trust grades to the number needed. The WTD would create a crucial problem with middle-grade cover in acute medical specialties. If the Government forced it through there could be at worst a complete collapse of services and at best dangerously demoralised SpRs, training jeopardised and a negative impact on clinical governance and patient safety. It was a stark choice between public safety and bad EU law.

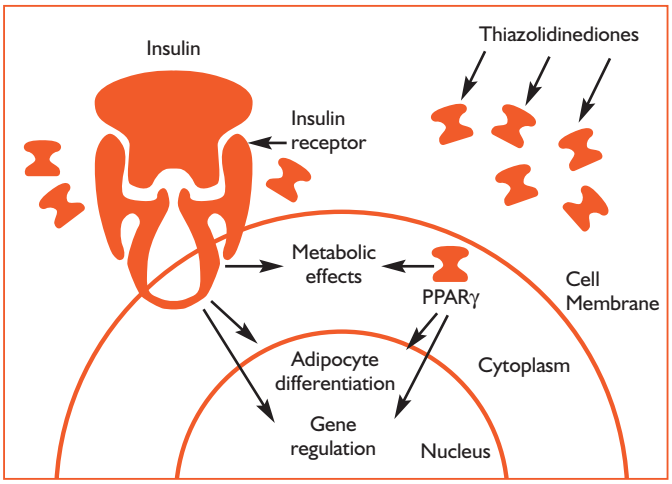


Figure. Schematic of glitazone action (Barnett)

THE ABCD DEBATE: 'GLITAZONES REPRESENT A MAJOR ADVANCE IN THE TREATMENT OF TYPE 2 DIABETES'

In the debate chaired by Steve Olczak (Boston), Tony Barnett (Birmingham) welcomed the thiazolidinediones (TZDs), which enhanced insulin action without directly stimulating insulin secretion (Figure). In Europe, the very restricted license was due to concern about hepatic safety, but the hepatotoxic reactions with troglitazone did not seem to apply to the other TZDs, rosiglitazone (rosi) and pioglitazone (pio). Studies showed that using rosi or pio in combination with metformin or sulphonylureas improved HbA_{1c} by c.1%. There was also a small but significant positive effect on BP and, with pio a significant reduction in triglycerides, an increase in HDL and a small increase in LDL. But the strongest evidence in favour of TZDs was clinical experience.

Speaking against the motion, Professor Gale (Bristol) said that there had been no properly conducted head-to-head studies of the TZDs. Regulatory requirements did not include comparative data. Like steroids, TZDs turned genes on, altered cell lines and affected many body systems. No one had been on a TZD for more than four years. Did we really know what the long-term consequences were? And there was no proven unique clinical benefit.

On a show of hands, Steve Olczak declared that there had been no real change from the vote before the debate, ie a small majority against the motion.

continued on page 5

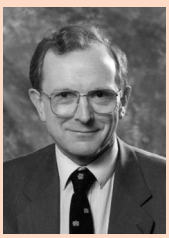
ABCD conference report continued from page 4

OTHER LECTURES AT THE SPRING MEETING

The following state-of-the-art lectures were also presented at the meeting:

Treating to target in type 2 diabetes	*Professor Hannelle Yki-Jarvinen (Finland)*
New approaches to treatment of erectile dysfunction in diabetes	*Dr David Price (UK)*
Surgical treatment of obesity	*Mr Steve Pollard (UK)*
Pitfalls in the diagnosis and treatment of phaechromoctoma	*Dr Pierre Bouloux (UK)*
Recent advances in hypolipidaemic therapy	*Dr Alan Rees (UK)*

A fuller report on the ABCD Spring 2003 Meeting can be found on the ABCD website and in Practical Diabetes International *(October 2003).*
Conference report by James Wroe



Chairman's Report

I am pleased to report that the Association is making steady progress. Our meetings continue to be successful and membership is growing at a healthy rate, thanks to the efforts of Jeremy Bending, our membership coordinator. Nevertheless, we are keen to recruit more members because we believe that ABCD is becoming "the only game in town" as far as specialist services are concerned. Following its recent reorganisation, Diabetes UK seems to have largely disengaged from secondary care and there is no other obvious forum in which diabetes specialists can be heard. We are producing a series of folders and leaflets incorporating the new ABCD logo (see separate article) and will shortly be launching a recruitment drive aimed at consultant non-members, newly appointed consultants and final year SpRs.

The Committee has agreed that we should keep the subscription level low and if possible continue to subsidise meetings for members. We would also like to sponsor clinical audit and research. In order to do this, we shall need an increase in funding and we will soon be launching a corporate membership scheme designed to maximise our income from the pharmaceutical industry. Several companies have been very supportive of ABCD in the past – indeed without their help, we would never have got started. However, this support has been on an "ad hoc" basis and not organised in a tax-efficient way. Now that we have the support of our registered charity, the ABCD Diabetes Trust, we can utilise the Gift Aid Scheme to maximise income.

Being "the only game in town" does have practical consequences. The Association is receiving an increasing number of requests for input into national initiatives such as the NICE Appraisals, guidelines and manpower issues. We hope that our substantial input into the "GP with a Special Interest in Diabetes" initiative will bear fruit. There are yet more challenges, including the new GP contract, with its "points mean prizes" scoring system. Does anyone know who invented the strange scoring system with its inappropriate emphasis on HbA_{1c}? ABCD was not consulted about this and that is regrettable.

We could find that GPs will be paid for work traditionally done by specialists, such as retinopathy screening and the change in emphasis will almost certainly have an adverse effect on hospital practice. Some diabetes services are being threatened with the wholesale removal of resources, which will then be redeployed to support the development of diabetes care in general practice. ABCD would be interested to hear of such instances and may be able to give support if required. It has been suggested that where there is a high quality specialist service accompanied by a good relationship with local primary care then there is less threat from PCTs, but only time will tell.

Further challenges loom including the European Working Time Directive, Foundation Hospitals and the uncertain future of general medicine. Most diabetologists do a large amount of acute general medicine and it has been suggested that the pressure arising from this and the uncertainty surrounding it is one reason why diabetes is losing its appeal as a speciality. We are receiving reports of poor-quality applicants for Endo/DM SpR posts. This does not seem to be affecting the other acute medical specialities to the same extent. ABCD would be very interested in the views of members as to why this is happening and what can be done about it. How can we make our speciality more attractive to trainees? Answers on a postcard (or E-mail) please.

Richard Greenwood
Chairman, ABCD

DETAILS ON YOUR ABCD WEBSITE!

www.diabetologists-abcd.org.uk

A more detailed report on the ABCD Spring meeting appears in the October 2003 issue of *Practical Diabetes International* as well as on the ABCD website (address above), along with other interesting and useful information relating to the activities of ABCD and its members. If you have any comments or suggestions about the website, please contact the ABCD Website Officer, Bob Ryder on Tel No: 0121 507 4591 Email: bob.ryder@swbh.nhs.uk

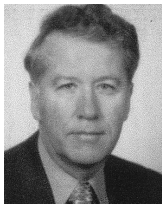
SEND US LETTERS, NEWS, ARTICLES AND SUGGESTIONS

Please send us your comments on this issue of the ABCD Newsletter as well as your suggestions for contents of future issues. Or send a Letter to the Editor or a contribution to the Controversy column. Information about future meetings of interest to Diabetologists is also welcome, as are corrections to wrong addresses and notifications of change of address of members.

Finally, the Editor is pleased to receive news of recent appointments in diabetology or of pending vacancies, which he will be pleased to mention in the Newsletter. All communications to the ABCD Newsletter should be addressed to the Editor at the publishing address *(see front cover for details)*.

CONTROVERSY

Overseas Meetings



Peter Daggett
Editor, ABCD Newsletter

We all like going to overseas meetings. You can tell the regulars when you get to the airport. They have brought one change of clothes in their cabin luggage and can stroll out to get a taxi. First timers have brought luggage, in the belief that they must be smartly dressed. They pay for this by waiting ages for bags to be unloaded and then finding that the transport to hotels, promised by "Cuddly Conferences of Crawley", is not there. Eventually, you make it to a hotel, where your room is on the eighth floor, with a view of the dustbins. Never mind, off to registration at the conference centre. You find it's conveniently situated ten miles away on a metro line, as promised, but not the same one as your hotel. Once there, you start to queue. The organisers have decided to have a different position for every letter of the alphabet. Twenty-four are empty; yours has fifteen people in it, but it's against the rules to go to another place.

Still, it's worth waiting. You receive your knapsack, emblazoned with a strange device representing the sponsor's interest in erectile dysfunction. You head for the welcoming reception, but you know you have made a bad mistake when you see the platform party. It includes the Conference Chairman, the President of the Organisation and the host country's Minister of Sausage Production (the Minister of Sanitation was scheduled to come, but there has been an explosion in a public lavatory and he is unavoidably detained). The speeches last for two hours but, at last, the audience is invited to sample the gastronomic pleasures of this city. The smart guys run to the next door marquee, because they know that the "taste of the town" is just that. The food runs out after fifteen minutes and, while the local wine is plentiful, you can feel your fillings dissolving after the first mouthful. The next morning, commuters are puzzled to see people carrying a bag with a picture of a carrot on it and the word "Phallussy". There is safety in numbers, though, and no one gets arrested.

When the meetings starts, you suddenly find that it's rather good. There are world class experts who give beautiful summaries of their field. The papers are brief and interesting and the chairmen cut short long-winded questions. The trade exhibition is well organised, with fun quizzes and some really good toys. You decide that it was worth going after all and you look forward to next year. On the way home, though, you wonder why do you really go. You have learnt about a dozen new facts during the course of four days, but you have gained 28 hours CPD credit. Most people could learn the same amount during an afternoon spent in the library. The answer, of course, is that we need to get away in order to maintain sanity. It's a mini-sabbatical and, as such, should be funded by our employers. Without sponsorship, most doctors couldn't afford to go to these meetings. The fact that drug companies are so generous should be acknowledged with thanks by the government.

MEMBERSHIP APPLICATION FORM FOR ABCD

HOW TO JOIN ABCD

About the Association and Membership

The Association of British Clinical Diabetologists (ABCD) was founded in June 1997 to meet the perceived need for an independent forum in which Consultant Physicians could meet together and discuss specialist diabetic patient care in the NHS. ABCD feel the views of Specialist Diabetologists in the development of diabetic patient services have been overlooked and are important if the highest level of care is to be maintained and developed. ABCD is involved at present in three spheres of activity: meetings; training; and the organisation and delivery of patient care.

Membership of ABCD is open to all Consultant Physicians with an interest in diabetes patient care in the NHS and all SpRs in Diabetes and Endocrinology in their Final Year, ie post-PYA. At present, the annual membership fee is £25.00.This helps to reduce the cost of the six-monthly meetings for members as well as providing this Newsletter. If you are interested in joining the Association, please fill in the application form alongside and return it to the ABCD Membership Co-ordinator at the following address:

Dr Jeremy Bending
Consultant Physician
District Diabetes Centre
Eastbourne District Hospital
Kings Drive
Eastbourne
East Sussex, BN21 2UD
Tel: 01323 648526

When your application has been approved, you will be sent a Standing Order Form for your annual subscription.
Please note that all enquiries for other information about ABCD should be addressed to the Hon Secretary, Dr Peter Winocour (see contact details on front cover).

Membership Proposal Form

I wish to apply for membership of the Association of British Clinical Diabetologists.

Please use block capitals

Name (in full, please)
Professional Qualifications
Position held
Address
Post Code
Tel. No.
Fax No.
Email
Signed
Date