



# ABCD Newsletter

The Official Bulletin of the Association of British Clinical Diabetologists

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## EDITORIAL

# The Light is Still There.....

**Mark Savage**  
Editor, ABCD Newsletter

I entitled my first editorial in Issue 12 of this newsletter "Light at the end of the tunnel...". On re-reading it, it is clear that we have continued to move forward as judged by the general sensation of the breeze against our faces and the clattering of the trains' wheels upon the tracks.

My theme in that editorial revolved around diabetes Networks and interaction with commissioners of diabetes services as well as providers. In this edition of the newsletter Patrick Sharp, who used to work in an acute trust, but is now employed by the Primary Care Trust in Southampton, gives us his insight into the challenges he has faced. Patrick too thinks that the way to influence diabetes services, and the delivery of those services, is to interact with our primary care colleagues. I find it interesting that he too encountered difficulty when the primary care trust was separated into provider and commissioning arms. We have had similar issues locally in North East Manchester. Nevertheless all health care professionals, including managers, are employed to serve the wider community and despite

initial concerns expressed by some commissioners that perhaps they should not be "interacting" with providers, be they general practitioners or hospital consultants, good sense seems to be prevailing and initial difficulties we have had locally are resolving in a similar manner to those in Southampton. Commissioners do indeed, as Patrick knows, need clinical help.

In the Chairman's report our new Honorary Chairman Peter Winocour mentions the Joint British Diabetes Societies (JBDS) led by Maggie Hammersley. This is a profession-led group drawing up guidelines for the management of diabetes conditions such as diabetic ketoacidosis, foot care etc. ABCD has joined with Diabetes UK and other specialist societies representing diabetes professionals throughout the United Kingdom to draw up consensus documents based on the best available evidence for the management of each condition. There is a conference to be held in London

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on 15th December 2008 run by The Diabetes In Patient Network (DINN). At this conference the progress that has been made in the drawing up of various guidelines will be presented for debate and feedback from this meeting will contribute to the drawing up of the final guidelines. Exactly which form these guidelines will take is still being debated. It would seem that the "Map of Medicine" model, which is supported by the Department of Health in England and the Royal College of Physicians (London), as well as the national Clinical Director for Diabetes (England), Dr Rowan Hillson, may well end up being the preferred house style. There would seem to be much to support this as too many competing guidelines will probably have the same effect on diabetes healthcare as too many cooks have on a broth.

The NICE Type 2 Diabetes guidelines were eventually published in May 2008, shortly after the Spring Conference of ABCD. As one of the members of the Guideline Development Group I would agree with the position of ABCD that whilst the guidelines have much to commend them, particularly with regard to lipid and blood pressure control, NICE have failed to give guidance to practitioners on the newer agents such as the gliptins, and rather bizarrely, have not commented at all on the use of insulin detemir. These omissions are being addressed and a draft Rapid Update is available for comment on the NICE website, hopefully to be published in May 2009. The initial proposals seem positive with roles for Detemir and the Gliptins. ABCD are to consider these and submit a response, comments from members to Dr Ian Gallen most welcome.

In this edition of the newsletter the presentation by Professor Sir John Tooke to the spring meeting in Harrogate, summarised by James Wroe, will throw more light on the issues and challenges faced by our profession in the training of junior doctors; it is clear that a revolution of sorts is in progress although those of us who

have consultant posts in the National Health Service will have been aware of this for some time! As one of those privileged to hear Sir John's presentation I was pleased that our profession has someone such as he advising the Government and, particularly, that he is pointing out to Government that one of the main roles of the doctors is to deal with uncertainty and ambiguity as well as to work "off protocol". This is of course a difficult message for the Government to hear as they are very keen on replacing as many of the roles presently performed by doctors with other professionals, such as nurses. Whilst this is a "no brainer" for a lot of things, particularly for processes that are protocol-driven, it would appear that a well trained doctor needs to be on hand fairly frequently when things do not go according to plan i.e. we do not follow protocols..

On another training matter, the Knowledge Based Assessment AKA the "exit exam", or the "MRCP Part 3" will shortly be with us and the Royal Colleges of Physicians of the United Kingdom will shortly be in a position to pilot this examination, which they expect approximately 80% of trainees to pass at their first attempt. The committee of experts of representatives of the Royal Colleges of Physicians, from both England and Scotland, are presently drawing up the details and refining the examination papers. As one of those who contributed to the KBA question bank, I will be one of those watching developments with keen interest. As consultants, after appointment, tend to specialise fairly rapidly, there are presently no plans for the KBA assessment to become part of the re-validation process (pew).

As I alluded to in the first paragraph we are indeed clearly moving forward and whilst there is definitely light at the end of the tunnel my belief is that it is a little like the Pot of Gold at the end of the rainbow...whilst we will never reach it we all need to continue to strive towards it.

## Address to Spring Conference by the new National Director for Diabetes



Dr Rowan Hillson, who resigned as an ABCD committee member on her appointment, was invited to address the meeting. She emphasised that she could not do what needed to be done on her own. She welcomed personal comments and suggestions from members of ABCD at her

email address, rowan.hillson@diabetes.nhs.uk. Quoting from the recently published National Diabetes Support Team document, *Improving emergency and inpatient care for people with diabetes* (which she commended to the meeting), she stressed that "health professionals should ... know the boundaries of their knowledge". It followed that specialists should be working with their colleagues in primary care to help plan services and prevent emergency admissions. The specialist team should be providing advice wherever needed as well as mentorship, support and training. It should work with patients and carers and local and national bodies to enhance personalised diabetes care district-wide. The development of proper Diabetes Networks in all parts of England was a top priority. The involvement of specialists would help prevent the inappropriate movement of services to primary care. Two other things she hoped to look at were QOF exclusions and an audit of commissioners. She finished by emphasising again the importance of inpatient care for people with diabetes, pointing out that up to 40% of hospital beds were occupied at any one time by people with diabetes or raised blood glucose.

## ABCD NATIONWIDE EXENATIDE AUDIT

ABCD is keen that all members contribute their exenatide cases, whether many or few, to the nationwide audit. As an organisation we are in a unique position to gather a tremendous amount of information very quickly on exenatide in real clinical use. The potential benefit of using modern technology to gather the information relatively rapidly has led ABCD to set up the audit on password protected members only ABCD website:

[http://www.diabetologists.org.uk/exenatide\\_audit](http://www.diabetologists.org.uk/exenatide_audit)

Use usual username and password. The aim is to undertake the audit over the next 3 or 4 months and present the findings at a satellite meeting of Diabetes UK next spring and also at the ABCD spring meeting. All contributors will be joint authors of any presentations or publications. Contact bob.ryder@swbh.nhs.uk

## ABCD Autumn Meeting 2008

**Date 27-28 November**

**Venue Hotel Russell, London**

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# Highlights of the Spring 2008 Meeting of ABCD

Harrogate, 10 April 2008

**The Spring Meeting of the Association of British Clinical Diabetologists saw the retirement as Chairman of Professor Ken Shaw.**

**The new Chairman of ABCD is Dr Peter Winocour, previously Hon. Secretary of the Association, who was elected unanimously at the AGM. Because of the volume of business involved the role of Hon. Secretary has been split into a General Secretaryship, to which Dr Ian Gallen was elected, and a Membership Secretaryship, to which Dr Dinesh Nagi was elected. Dr Chris Walton continues as the Hon. Treasurer. Professor Stephanie Amiel was elected to the new post of Senior Academic Representative on the Committee. Dr Mark Savage became the new Editor of the ABCD Newsletter.**

## Highlights from the AGM

At the Annual General Meeting, the retiring Hon. Secretary drew attention to the fact that the number of SpRs who had joined ABCD – currently 25% - was growing fast. The SpR representative on the ABCD Committee, Dr Partha Kar, had been succeeded by Dr Mark Atkin.

The difficulties of arranging the Spring Meeting of ABCD back to back with the highly scientific meeting of the British Endocrine Societies were aired and it was suggested that a better alternative might be to organise in partnership a day each year devoted to clinical endocrinology.

The subject of the new KBA medical qualification was also raised. The underlying drive behind the initiative was to create a pan-European specialist medical qualification.

Dr Chris Walton, said that the feeling on the Committee was that a large part of the now substantial surplus money held by ABCD should be used each year to help SpRs attend the EASD meeting and the ABCD King's Fund Course for SpRs.

The Hon. Treasurer, in conjunction with a new firm of accountants, was looking at raising significant amounts of money to support major research projects in line with the aims of ABCD.

Dr Greenwood expressed warm thanks to Lord Kilpatrick and James Wroe, who were retiring from the Board of Trustees. Ian Gallen, as the new General Secretary of ABCD, was to join the Board.

## The ABCD Debate

**Joint diabetes-nephrology services provide few additional benefits to patients with diabetic nephropathy**

*Chairman: Dr Ian Gallen*

Proposing the motion, Dr Paul Stevens pointed out that joint diabetes-nephrology clinics had been around for twenty years or more but only 22% of Diabetologists had one, according to the ABCD Survey. Their aims, as set out on the ABCD website, were very worthy but were they being achieved? The

evidence of the Glasgow (Joss et al, 2002) and Carlisle (Jayapaul et al, 2006) studies was that the improvement in CHD and extension of life by eight and seven years respectively was at least as much to do with the use of statins and aspirin as joint clinics. Insofar as joint clinics improved compliance, they led to better results. But it was by no means certain that they were the only or best way to achieve this. Other ways were to increase public awareness of CKD, better education of health professionals and greater influence over the policy makers. Some strategies were already tackling these areas, for example the UK CKD and NICE Guidelines, eGFR reporting, QOF and the recently announced formation of a National Diabetes & Kidney Support Team. It was not just a question of diabetes and CKD, however. CKD also involved cardiovascular disease. Joint clinics could exacerbate the problem of follow-up of tests between specialists, because each specialist assumed the other was doing this.

Professor Jiten Vora opposed the motion. He maintained that the two studies cited by Dr Stevens demonstrated significant benefit from joint diabetes-nephrology clinics. These were all about abolishing so-called silo management, with the aim of achieving benefit for in-patients as well as out-patients. A large number of CKD patients with diabetes did not attend diabetes clinics, despite the fact that they generally had HbA1cs above 8%. Attendance at joint clinics meant it was more likely that non-renal health problems would be picked up and long-term glycaemic control improved with the help of the Diabetes Team. There was evidence from research studies that joint clinics led to an improvement in surrogate risk markers, particularly in high risk patients. The majority of patients liked joint clinics, in effect one stop shops. Joint clinics helped prevent last-minute referrals to nephrology clinics. CKD patients not attending them were at risk of their insulins not being adjusted or other complications evaluated before they went onto dialysis.

In plenary discussion, the question of costs was raised. Dr Stevens said research showed that the benefits which came from following CKD guidelines paid for enhanced care. Prof. Vora reiterated that joint clinics helped delay ESRD and anything that delayed ESRD also prevented death. A distinction was drawn between early prevention, which was a population-based strategy, and the treatment of established disease, where joint clinics might have a role to play. Dr Stevens agreed with the first part of the observation but said that all data from nephrology clinics was already available to patients and their GPs as well as nephrology health professionals.

Pressed on the role of joint clinics, Dr Stevens admitted that they could play a helpful role at a late stage of disease. However, the real problem was at an earlier stage of disease and his objection to joint clinics was essentially that they could represent a poor use of resources. What was the position of DNAs in joint clinics? Dr Stevens thought that the level of DNAs was directly related to the nearness of the service to patients and had nothing to do with joint clinics. But Prof. Vora pointed out that the rate of DNAs in an

ordinary diabetes clinic was 14-16% compared with 4% in a joint clinic. A delegate maintained that joint clinics allowed nephrologists to educate both the patient and the diabetologist. At what stage should they kick in? In Prof. Vora's clinic it was an at albumin creatinine ratio (ACR) of 16mg/mmol.

Was not the question one of good structure of care, which did not necessarily involve joint clinics? Prof. Vora agreed that the key factors of success needed to be dissected and pointed out that what worked for one service did not necessarily work for another. However, he maintained that in general joint

clinics led to delay of dialysis and death. Dr Stevens felt that the diabetologist left BP to the nephrologist and the nephrologist left HbA1c to the diabetologist. This represented a silo mentality.

*The final votes were 24 in favour of the motion and 35 against, compared with 24 in favour and 33 against before the debate, so there was very little overall change of opinion. As usual, a significant number of delegates sat on their hands!*

*Conference Report: James Wroe*



## Meet the committee

# Working for a Primary Care Trust

### Patrick Sharp

Some four or five years ago, the wind of change started to blow through diabetes services in the UK. Working in an area with a business minded PCT, I felt the changes early.

Suddenly, decisions on the direction of the service were being taken by shadowy figures whom I never met, and who certainly never asked my opinion. The Secondary care service was relegated to a referral service which was only reluctantly used. The reasons for this are now well rehearsed, and I won't go over old ground. My own response was "If you can't beat 'em, join 'em". I took a post which was half secondary care, and half within the PCT as 'Director of Diabetes'. Astute move, or howling mistake?

Like all the best questions, there is no quick answer. Having moved to a new post in a new area, I had to get used to starting again. We are all trying to climb our own particular mountain, and it is true in the NHS that if you take a Consultant post in a new area, you slide to the bottom and have to start climbing again. I therefore have to try to separate the starting again pains from true change in culture of working in a PCT.

I had some strong first impressions, and at risk of offending my PCT colleagues who might read this, I would highlight two of them. Firstly, PCT managers have no idea how to organise clinical services. This will change, but for the present, there seems to be a distinct lack of understanding on how services are run. I was initially given a room in a GP Health Centre, and told to get on with it. On asking awkward questions, such as who is going to type the letters, what about reception staff, nursing staff, setting up the clinic on the computer systems, network to a clinical database and access to investigations, I was met by blank stares. Behind my back, I knew they were all saying that as a Consultant, I was a bit precious, but I dug my heels in. I can only explain away this lack of clinical insight on the basis that PCT managers have never had to organise services directly: the GPs organise services, and PCT managers poke them with a stick from a safe distance. So, secondly, PCT managers are in charge, and clinical staff work for them (not with them). On starting with the PCT, I was allocated a manager whose job it was to 'manage' me, and not, as far as I could tell to help. To rub salt into the wound, one can occasionally be peppered with grapeshot from GPs who assume you have taken on the mantle of a PCT manager, although for the most part, one can shelter behind clinical camaraderie.

In the 3 years I have been in post, this is all changing. Initial disquiet at changes in the diabetes service is only part of an ongoing process. PCTs themselves have been through difficult changes. Most have been reorganised with consequent loss of staff and reassignment of roles. Many have not yet found their feet, and it is still difficult to find the person responsible for any particular aspect largely because they haven't sorted it out themselves. The biggest change has been the separation of the provider and commissioning functions of PCTs. Initially this was a very self conscious change, with commissioners refusing to speak to anybody in case they were 'influenced' in their decisions. I think this is now settling, but the separation of roles remains a real one, and although there is some coming together, I wonder how long it will last. Locally, provision of the less complex aspects of the diabetes service has gone out to tender, the bidding parties being 2 GP locality groups .... and the PCT provider arm. One wonders how friendly the PCT provider and commissioning arms will be if they do not award the contract to their PCT 'colleagues', as looks likely.

Was a change to a PCT post a good move or not? I can't tell you yet as it is still a changing landscape. What I would say, however, is that I do not feel disengaged from the processes. Talking to many of my secondary care colleagues, I often hear expressed a feeling of being sidelined. I certainly feel the opposite, being rather in the direct firing line in a sometimes acrimonious struggle. I generally enjoy the experience, but at the end of the day, I will either crash and burn, or come out a better person. One regret I have from which others may learn (and indeed I may hope to rectify myself), and that is that I have drifted off with the Provider arm, and am no longer part of the commissioning process. This may be rectified by joining one of the commissioning committees, and I might stand a better chance than most in achieving this as being an 'insider'. That is not to say that Consultants in the hospital sector might not be able to join the commissioning service, and I have heard of some striking successes in that regard from colleagues around the country.

At the end of the day, what we all want is engagement in the whole process of delivering a diabetes service. Joining a PCT is only one way of achieving this, but there are more ways than one of skinning a cat. However, I feel that PCT provider arms need not just clinical staff, but individuals experienced in setting up clinical services. Whether they acknowledge it or not, the commissioners also need clinical help. More Consultant staff in PCTs will not be a bad thing.

## Special Report on the Future of Medical Education



**Professor Sir John Tooke, Dean, Peninsula College of Medicine & Dentistry**

Sir John spoke to the members attending the ABCD Spring Meeting in Harrogate (Spring 2008). He said that Governments had promoted the concept of the “skills escalator” to find rapid and less expensive solutions to their populations’ evolving health needs but skill mix was not always cost-effective because cheaper professional substitutes found it difficult if the problem did not match the protocol. Basic medical abilities were still essential. Modern Medical Careers (MMC) had developed from a desire to increase the number of “fully trained specialists” but ignored the fact that clinical proficiency and expertise required knowledge and experience as well as demonstrable competence. The post-CCT role of medical trainees was unresolved against a background of deficient knowledge of what a doctor brings to the healthcare team. Sir John maintained that, without such clarity, outcome-focused medical education and medical workforce planning were impossible. The enduring functions of the doctor’s role included the clinical reasoning that underpinned diagnosis, the ability to deal with uncertainty and ambiguity and to work “off protocol” and leadership, when appropriate. Scientific training was essential, something that was well recognised by the public. Implementation of DH policy development and governance in relation to educational matters needed to be strengthened. A medical education lead was required at a high level in England, including perhaps a “Medical Education England”(MEE), run by doctors and services, not by DH (see table). Yet medical professional engagement on the MMC workforce had been limited and its influence weak, weakened further by disagreement between specialties. The split in responsibility for finance and expertise between GMC and PGMET in England created diseconomies. A welcome merger between these bodies had been accepted in principle by DH but would not happen until 2010. Many of the issues identified by the Inquiry were being taken forward as part of Lord Darzi’s Next Stage Review of the NHS. There was an emerging acknowledgment by the DH that the doctor’s role was different to that of other professionals and that role substitution was not cost-effective. Doctors should stop fretting about activities that other clinicians could do as well or better and pursue enhanced roles in policy, management, education, research and public health. Practical steps that could be taken included *inter alia*: removal of the “binary divide” between research and practice; involvement of researchers in planning; lengthening GP training from three years (the shortest in Europe) to five years; creation of intermediary specialists; abandonment of the division between primary and secondary care; a return to the principle of “broad-based beginnings” in medical education (Core), because most medicine is complex and to provide future flexibility in workforce design;

### Table: the centrality of NHS:MEE

- Define the principles underpinning PGMET
- Act as the professional interface between policy development and implementation on matters relating to PGMET
- Develop a national perspective on training numbers for medicine working with the revised medical workforce advisory machinery
- Ensure that policy and professional and service perspectives are integrated in the construct of PGMET curricula and advise the Regulator on the resultant synthesis
- Co-ordinate coherent advice to government on matters relating to medical education
- Promote the national cohesion of Postgraduate Deanery activities
- Scrutinise SHA medical education and training commissioning, facilitating demand led solutions whilst ensuring national interests are safeguarded
- Commission certain small volume, highly specialised areas of medicine.
- Hold the ringfenced budget for medical education and training for England

strengthening of links between health and education; making SHAs accountable for the health of academic partnerships; incentivising Trusts to engage in high quality education; greater emphasis on Applied Health Research. Doctors in response must accept that the Health Service would continue to evolve. But in future they must play a more central role in shaping that evolution. Medical education should prepare doctors better for this. There was now a singular opportunity to grasp the agenda.

In plenary discussion, it was asked how the proposed changes were going to impact on medical students? The proposal that there should be a three-year core programme, followed by one year’s practical training, although overwhelmingly supported as part of the consultation was now meeting resistance. Sir John thought it was important that there should be a basic foundation to enable doctors to change direction should scientific advance render their original subspecialty less relevant. Another delegate said that, while everyone agreed that MMC was terrible, there had been widespread consensus that “it had to happen”. Sir John thought that because healthcare was nationalised it was inevitable that it was also politicised but the ability of medicine to withstand political intervention had been considerably weakened by the medical scandals in the 1990s. He reiterated that, whatever changes there might be in medical education and training, there was no substitute for clinical experience being brought to bear in the construct of health policy, and for medical professionals to play a lead role in the construct and implementation of future curriculum reform.

James Wroe.

## ABCD MEMBERSHIP APPLICATION

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. At present, the annual membership fee is £50.00. If you are interested in joining the Association, please write to the ABCD Membership Secretariat at the following address with your contact details, professional qualifications and your current post title.

**Elise Harvey, ABCD Secretariat, Gusto Events Ltd,  
PO Box 2927, Malmesbury SN16 0WZ  
Tel: 07970 606962  
email: [elise@gustoevents.com](mailto:elise@gustoevents.com)**

*When your application has been approved, you will be sent a Standing Order Form for your annual subscription.*

## Chairman's Report

# The glass half-full

Diabetologists should be looking forward to better times, but in my first report as Chairman, I wanted to first indulge myself in a bit of nostalgia. Twelve years ago I was encouraged by Brian Frier to attend a meeting of consultant diabetologists at the Royal College of Physicians in London, in order to discuss the establishment of an independent professional organisation of diabetes specialists. I went full of scepticism, but was persuaded of the need. I am glad I went! I have remained involved with ABCD since its inception, initially as a committee member, as secretary for 6 years, and now elected as Honorary Chairman. I have not taken this role on lightly, and preparing this editorial has helped me put our challenges in perspective. ABCD is a mere stripling in comparison to the other professional organisations of medical specialties in the UK. Prior to our formation, consultant diabetologists and trainees operated within the Medical and Scientific section of the British Diabetic Association. This structure was unique to our specialty, which also supports the dual discipline with endocrinology, which has had separate representation for over 50 years.

In this context we must look at our achievements over the last 12 years with considerable pride. Currently over 2 out of 3 consultants and 1 in 4 specialist registrars are members of ABCD. We have key roles alongside other specialist organisations in the RCPL Council and Joint Specialty Committee, and will be leading the Knowledge Based Assessment to enable MRCP in Diabetes and Endocrinology attainment for trainees alongside the Society for Endocrinology and Diabetes UK. We advise NICE on new technology and clinical guidelines and nominate individuals for these activities. Most recently ABCD have offered input to insulin pump and Rimonabant appraisals, with I feel a successful outcome. I have been much less happy with our inability to persuade NICE to produce guidelines for type 2 diabetes that were fit for purpose. We originally had concerns with the original inherited guidelines in 2002, which as an organisation we had no input to. On this most recent occasion we had stalwart colleagues pushing for a document that covered gliptin therapy and the other 'novel therapy' detemir insulin (!), but to no avail.

We have had real engagement with the work of the 1<sup>st</sup> National Clinical Director for Diabetes, as part of the Strategic Services Liaison group, chaired by Jiten Vora. This led to the Kings Fund Leadership Courses for Consultant Diabetologists and Specialist Registrars, and the production of the booklet on commissioning and providing specialist services. I am personally delighted that Rowan Hillson is the successor to Sue Roberts as our new Diabetes Czar in England. Rowan had been an active committee member of ABCD and inevitably has had to stand down during her tenure of the national post. It is however a tremendous opportunity for a continued close collaborative working relationship. On behalf of ABCD I wish Rowan every success in her role.

Our 2<sup>nd</sup> joint survey of specialist services alongside Diabetes UK is a reflection of our close collaborative working. The results from the consultant survey have been published in Diabetic Medicine and Clinical Medicine and were the proverbial curate's egg. In comparison to 2000 there were more consultants and some improvements in sub-specialist services, but 1 in 10 services operate single-handedly, there is important continued regional disparity in service provision, psychology support is dismal, and 'community diabetes' consultant services were the exception. Frustration in being disengaged from service development and commissioning was almost palpable. Reports have gone to all who supported the survey. I would encourage all members to use this information locally and push to get involved in service reconfiguration and enhancement. You may want to remind your local commissioners that when Alan Milburn put his name to the NSF delivery strategy in 2002, he anticipated a rise in the number of consultants in diabetes and endocrinology of 'well over 50%' by 2010. We are at least 300 short of that number, which makes no concession for the increased number of part time consultants in our speciality (13% overall), and our increasing commitment in job plans to acute-GIM at the expense of specialist

service provision. I am very grateful to everyone involved in this project, particularly Charlotte Gosden from Diabetes UK who has worked tirelessly on the project. I recognise the risk of 'questionnaire fatigue' but I was advised on the Kings Fund course that information is power – assuming we deploy it strategically! There is plenty more to follow – including surveys of retinal screening (which Dinesh Nagi has led on), paediatric-adolescent services and diabetes specialist nurses.

I am conscious as an expat that the challenges we face in England are somewhat parochial in that the great leap into community diabetes has been an experiment so far limited to south of Hadrian's Wall (Tyneside excluded!). Colleagues in Scotland may see shades of the Poll Tax in reverse and be infected with a little Schadenfreude – but please do not become too complacent. There is no doubt that seismic political changes aside there is a clear move towards integrated diabetes care which I think will be coming soon to Gretna and beyond! This is an issue which I feel we must embrace, whilst not throwing the baby out with the bathwater. If we had fully established operational hospital based specialist services with a correct complement of specialist teams and adequate resources, then I am sure we could spend more time supporting community nurse specialists and primary care based teams. We have very clear evidence from our specialist survey that this is not the case. Our MDT teams were reduced at time of acute trust financial shortfalls. In addition there has been a quite correct emphasis on a core area for us – namely enhanced in patient diabetes care. Clearly we have lots more to do. ABCD have helped establish the Joint British Societies In-patient care work programme, led by Maggie Hammersley, an evangelist for the very best standards in diabetes in-patient care.

I feel we will drive service redesign and ensure adequate core specialist support if we make it our job to be indispensable to local service planning – we need to be at the centre of commissioning services. In this regard ABCD have already taken this challenge on with a very progressive document produced by our erstwhile chairman Ken Shaw. This followed discussions held with the NHS Alliance and apparently deposited on Lord Darzi's desk. Lets hope he reads it and gets back to us!

At this point I need to put in writing my gratitude to Ken Shaw who remains on our committee in his ex-officio capacity. Clearly you can't keep a good man down, and I know that Ken plans to be very active in this year on the committee with us.

I believe (and in many ways hope) that Ken has steered ABCD through the most difficult phase of diabetes practice with the financial and structural turmoil in the NHS. I hope because I really don't know if I would be as effective as him in dealing with what has hopefully been termed 'creative destruction' – having said that the changes just seem to keep coming.

I am looking forward to the next 3 years as a period of great opportunity – we need to be 'in it to win it' for the benefits of our services and all living with diabetes. I am heartened that my job will be made easier by the 'A team' elected to the executive alongside me – Ian Gallen, Dinesh Nagi, and the continued safe pair of hands (hopefully!) of our treasurer Chris Walton.

One key change in our committee structure has been to formalise a young consultant position (Niru Goenka) and establish a new senior academic representative post, which we are fortunate to have filled by Professor Stephanie Amiel. As we are called on to take more and more national training and service responsibilities we will need each member of committee to take a strong and active role. I also want to welcome Rob Gregory and Alan Sinclair onto the committee, and the re-election of Anne Kilvert and Jiten Vora to keep me on my toes. I am pleased that Mark Savage has taken on the role of Newsletter editor with great enthusiasm and you should see his mission is designed to both entertain and educate you. This committee of 'all the talents' will hopefully fare a good deal better than Mr Brown's cabinet.

So back to the future – I think we must be optimistic (my old boss George Alberti will think this impossible for me) and seize the opportunities ahead for us. Next time the glass may even be full to bursting!

*Peter Winocour*