



ABCD Newsletter

The Official Bulletin of the Association of British Clinical Diabetologists

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EDITORIAL

Diabetes care is a risky business

Peter Winocour
Editor, ABCD newsletter

Those caring for and living with type 2 diabetes continue to be challenged by the complexities of the disease. Most recently we have had to address adverse publicity regarding incretin modulating therapies featured in a Channel 4 television programme and at length in the *British Medical Journal*. Without covering the pros and cons of the issues in detail it struck me how far we have strayed in our risk averse culture from what doctors and medical treatments can and cannot achieve.

We have yet to acquire 20:20 foresight about the longer term safety and benefits of newer therapies, and rely on a process of basic laboratory research, animal model studies and carefully introduced phase 2-4 clinical studies, prior to a regulatory process. Beyond ensuring total transparency of data for scientific scrutiny I don't see a better way to make progress.

Inevitably every medical therapy has a biological effect with the potential for intended beneficial and additional adverse or 'off signal' consequences. The key has to be keeping a sense of perspective and helping health

care professionals and patients to better understand the balance of risk and benefit.

Winning a lottery ticket or being hit by a meteor fragment – what are the odds?


Should we make clear to patients the baseline level of cancer risk linked with diabetes, with obesity and with insulin use? How many extra cases of bladder or pancreatic cancer can be projected with worst case scenarios from diabetes therapies? Joe Jackson once sang rather tongue in cheek 'Everything gives you cancer'. Perhaps the provocative content contains a grain of truth?

If ever there was a time for a serious minded explanation of the concept of risk in medicine it is now. I would hope we may all benefit from the establishment of a Chair in public understanding of clinical risk. ABCD have been part of the JBS guidelines on CVD prevention which have gestated longer than an elephant foetus but I am hopeful when produced will offer a visual representation of risk versus benefit, enabling better informed patient choice.

We do face a challenge from a dumbed down approach to media reporting where hyperbole rules. Unfortunately it now appears medical journals

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have taken on the mantle of investigative journalism and taken a similar approach.

Scaremongering has a recent track record which should have been foremost in some minds. The medical press played an important role in the MMR vaccine story by first publishing bad science and then taking to task the proponents of the link with autism that was later refuted. In the meantime the seeds of public confusion were sown, the result being a resurgence of measles in Wales and England this year. Clearly balance is needed in clinical science and uncertainty and best judgement will remain a fundamental of best clinical practice. I think it is still important to have some introspection within our profession in respect of our own conflicts of interests regarding new therapies, which includes the desire to achieve the best outcomes for our patients and the satisfaction that comes with that.

Extended roles – generalism

I enjoyed my 'head to head' debate with Dinesh Nagi at our Spring meeting on the link between our speciality and general medicine. There may remain two inherent opposing philosophies but either way we need to ensure our trainees have the best outlet for their skills and fulfil their potential as specialists.

Acute medicine was previously a less popular but necessary escape route. Would a commitment to general medicine with a stint on the wards shared between colleagues be any less attractive with annualised input to the specialist services? Ultimately local solutions will have to be found. ABCD could certainly help by ensuring that colleagues looking to expand services have the opportunity to see what has proved successful in other areas – perhaps starting with Wakefield and Welwyn!

Reflections from the ADA

If I am lucky I get an opportunity to attend ADA every two years. Chicago was hot and steamy outside and air conditioned 'Frigidaire' cool inside. My highlight was the silver anniversary DCCT data which, by confirming the continued and in some cases increasing vascular benefits, is the strongest steer for us to intensify our efforts to optimise hypoglycaemia-free, tight glycaemic control in younger type 1 diabetes. As the technology and tools continually improve, the one constant remains the challenge of accessing and enhancing the care of teenagers and young adults. The National Diabetes Audit suggests we are still falling short in this respect.

Our ABCD 'Lost Tribe' campaign was designed to heighten awareness and ensure there was clear blue water between services for type 1 diabetes and the much larger group of non-complex type 2 diabetes. Most important was ensuring ready specialist access for those with type 1 diabetes. I carry out several roles which have given me a changing perspective on this issue. I have co-run our transitional adolescent diabetes service for 15 years. We used to pat ourselves on the back when we reviewed the annual National Paediatric Diabetes Audit data for our average HbA1c returns and our local audits of transitional care. More recently however I have started to look at the longer term transfer from this service to adult care. So far I

see that many attend adult services once or twice then go to ground. I have been carrying out general practice visits for the last three years to focus on high risk groups including type 1 diabetes. There they lurk with either poor control, ongoing absence from any support, or over-tight glycaemic control without structured education, and driving while potentially hypo unaware. Traditional clinics will not be the answer to this challenge. We need to free ourselves and our specialist teams to address this need in a quite different way. Who will commission such a service? To leave the care model as it is will consign many to avoidable longer term complications.

The super moment of inertia

I used to be quite good at golf but have been on a downward spiral since the age of 16 so find myself observing more than playing. I noted that my driver has the logo 'the Super Moment of Inertia' emblazoned on it. It made me ponder whether this phrase has wider application in our NHS. Perhaps 'super' is not the correct adjective for that setting. What however is clear is that in diabetes there does appear to be a significant lag factor. The longer term evolution of complications is by definition a slow process but it strikes me that some areas of practice improvement do fit this categorisation. Examples include glycaemic care of type 2 DM early in the natural history and the sloth-like progress through oral therapies with high HbA1c to injectable therapy, or achieving best early control in type 1 DM using all treatment and monitoring modalities. What about inertia in gastroenterology regarding care of metabolic liver disease? Perhaps this is an area where diabetologists should reclaim the terrain?

Perspectives – I see/a geriatrician sees? Rose tinted or google spectacles?

Inevitably clinicians see issues from their own perspective. A recent case of an 80-year-old woman with type 2 diabetes, known ischaemic heart disease, and progressive CKD, clearly highlighted this. Treatment included sulphonylureas with HbA1c 42mmol/mol, creatinine rising to 250 and under elderly care for investigation of dizziness. You immediately made the diagnosis and it did not require 24-hour monitoring of everything! This may be the best argument for seeking a smarter way to manage long-term conditions. Would a regular medication review preempt such problems? That would appear to be one sensible approach to the issues of risk in diabetes.

Editor's note

I am delighted to take over the role of newsletter editor from Mark Savage who delivered a very readable publication for four years. I aim to maintain the high standard. In this I look to you all to contact me with any changes, innovations or articles you want me to cover. Mark took a sensible course of action and headed 'down under' earlier this year to take on an ambitious new role. Australia can be happy they have gained UK diabetologists' answer to Jeremy Clarkson. Mark – I hope the newsletter reaches you by kangaroo mail and you get a chance to read it over a 'barbie and a few tinnies'! Keep in touch.

National diabetes and endocrinology consultant workforce survey 2012 (ABCD/DUK/RCP)

Introduction: The survey is commissioned as a joint venture between ABCD, Diabetes UK, and RCP and highlights the changes in consultant numbers in England, Wales, Scotland and Northern Ireland during the period of September 2011 to October 2012. The survey report was presented at the DUK Annual Conference in Manchester on 12 March and at the ABCD Spring meeting on 19 April in Solihull. The detailed report of this survey is available on the ABCD and DUK websites.

New consultant appointments: There were 53 new appointments for the year 2012 and these numbers are comparable to the 2011 survey. These posts were in diabetes/endocrinology (48) and in acute medicine with sessions in diabetes (5). There were four long-term locum posts in place. The following graph shows trends in consultant appointment over the last six years.

Figure: Showing total number of appointments into the speciality 2006–2012

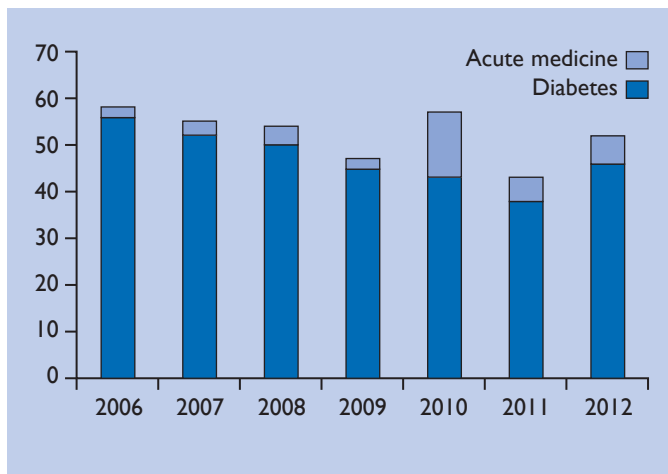


Figure: showing total number of appointments into the speciality as replacement and new posts (2006–2012)

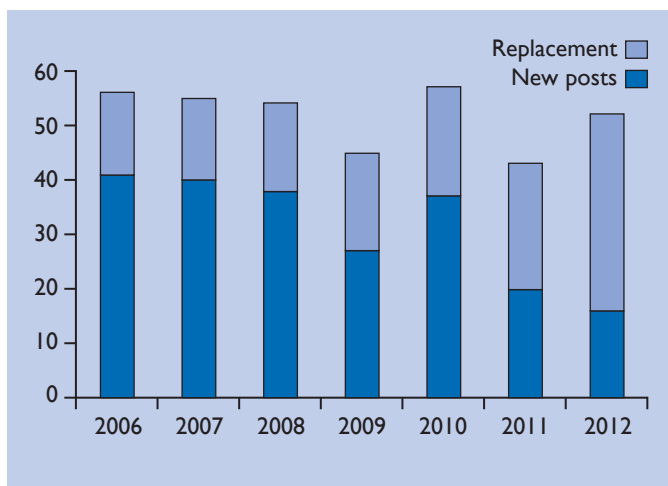


Table below shows the total head count and WTE for those practicing in the speciality in post for the four nations

Year	Head count	WTE
2012	860	739
2011	849	723
2010	823	702
2009	791	678

Origins of the new posts: Of the 53 appointments, 16 were replacement posts for retired colleagues, 20 for those who had left the posts to take up posts elsewhere. Therefore only 17 posts were new posts (net expansion). These numbers are the smallest number of consultant expansion in the last 10 years, at a time when diabetes prevalence and workload in the specialty is rising significantly. According to the recent RCP census the expansion in D&E was 3% compared to all other specialties in medicine at 5%.

Table below show the total number of posts (headcount and WTE) /100 000 population for the four nations for 2012

Country	Population	Headcount	Head count per 100 000	WTE	WTE per 100 000
England	53,107,200	691	1.28	591	1.11
Wales	3,0638,00	49	1.59	44	1.43
Scotland	5,254,800	87	1.65	76	1.45
Northern Ireland	1,801,860	33	1.83	28	1.55
UK	63,227,660	860	1.36	739	1.17

Retirement age: The average age at retirement would seem to be fairly constant at around 62 years. The number of predicted retirements over the next 10 years looks similar to retirements over the last few years. It is expected that between 2013 and 2022 there will be a total of 185 colleagues reaching age of 65 in UK and for England the figure is 143. The current number of CST being awarded in the specialty remains at about 70/year and therefore it is expected that a total of 700 CST will be awarded over this period. To achieve a balance whereby all CST holders are appointed to consultant posts, there will have to be a net expansion of new jobs at a rate of approximately 50 new posts/year, a number which is unlikely to be achieved mostly due to slow rate of net expansion over the last couple of years.

The survey for 2012 shows that although the number of new appointments has remained constant, the number of new consultant posts has slowed down significantly. Consultant appointments in acute medicine with interest in D&E has fallen this year and this trend will continue as more trainees in that specialty complete the training and are available to

Table shows recruitment into selected medical specialties including D&E at ST3 Level in 2012

Specialty	Total posts available (NTN + LATS)	Posts filled % Total (NTN)
Diab & Endo	41 (25 + 16)	53.7 (88)
AIM	67 (49 + 18)	22.8 (30.6)
Geriatric	73 (44 + 29)	15.1 (25)
Dermatology	18 (12 + 6)	100 (100)
Respiratory	41 (16 + 25)	46.3 (100)
Cardiology	25 (11 + 14)	22.4 (100)

take up posts in acute medicine. There are only a few vacancies which remain unfilled and only four locum posts were identified during the current survey.

The number of expected new CCT holders in the coming years remains difficult to predict, but has been constant for the last five years. Retirement vacancies do not look likely to vary much in the coming years. The rate of creation of new posts will determine the true expansion. Given the financial situation in the NHS and expected changes in the delivery of acute and general medicine in hospitals, there remains a danger that consultant expansion may slow down further. These are worrying times for the specialty and the workforce numbers are unlikely to be achieved as suggested by the Centre for Workforce Intelligence (CFWI) in England.

Dinesh Nagi, MBBS, PhD (Lond) FRCP
National Manpower Co-ordinator for Diabetes and Endocrinology (August 2013)

Current advice for clinicians caring for individuals with insulin treated diabetes who wish to drive group 2 vehicles

With the changes in European law, individuals with diabetes treated with insulin may now apply for, or to renew, their vocational entitlements to drive categories C1, D1, C, D or DE classes of vehicle. Drivers of caravans, large trailers, and horseboxes will also be affected by these regulations.

Clinicians who support the care of insulin treated diabetes may need to be aware of these changing regulations and the revised three stage process whereby the individual completes their application form, followed by a report from either the local consultant or GP, with the process completed by an independent regional consultant specialising in diabetes.

Both clinicians and those applying should ensure there is no loss of awareness of hypoglycaemia and no requirement for assistance to manage hypoglycaemia within the preceding 12 months. Drivers should be monitoring blood glucose at least twice daily using a memory meter with a record of at least three months measures, and recognise that blood glucose levels must be at least 5mmol/l to drive.

In addition individuals must know to check their glucose within 30 minutes of driving and every two hours if driving longer distances. There should be access to fast acting carbohydrate in the vehicle for managing a hypoglycaemic episode, but the driver should then ingest longer acting carbohydrate to maintain normoglycaemia, and wait for at least 45 minutes after confirming restoration of normoglycaemia before resuming driving.

Failure to answer all questions satisfactorily has led to revocation of both group 2 and regular vehicular licensing, despite individuals having hypoglycaemic awareness.

Peter H Winocour

The 2nd joint meeting of the Association of British Clinical Diabetologists and the Renal Association

Diabetes and kidney disease: advances and controversies

13 February 2014, National Exhibition Centre, Birmingham

- 09.30 Incretin based and other new therapies in DM renal disease
Professor Steve Bain
- 10.15 When and how to treat anaemia in DM CKD
Professor Ian MacDougall
- 11.30 The changing face of DM CKD epidemiology
Professor Per Henrik Groop
- 12.15 The role of inflammation in diabetic nephropathy
Dr Andrew Frankel
- 14.30 Debate: metformin is effective and safe in diabetes with stage 3–4 CKD
For: Dr Damian Fogarty
Against: Professor Cliff Bailey
- 16.00 Renovascular disease, lipid management and CVD prevention in DM CKD
Dr Phil Kalra

For further details visit: www.diabetologists.org.uk

Diabetes and the NHS in England in 2013

Jonathan Valabhji

National Clinical Director for Obesity and Diabetes,
NHS England

I started as National Clinical Director (NCD) for Obesity and Diabetes in England on 1 April this year, the day on which the changes in the NHS in England, resulting from the Health and Social Care Act 2012,¹ came into effect. This was the day on which PCTs and Strategic Health Authorities ceased to exist, and CCGs and NHS England took on the responsibility for the effective spend of around £95 billion of public money through commissioning of healthcare in England. The changes involve the creation of NHS England as an arms-length body from the Department of Health, through which, although the Secretary of State for Health still carries overall responsibility for the National Health Service in England, government sets its ambitions for health outcomes via a mandate.²

Focussing on outcomes, not process targets

Consistent with the current mandate, the NHS Outcomes Framework³ introduces a new language and structure based on achieving improvements in health outcomes, through which NHS performance can be judged, commissioners of healthcare in England can be held to account, and quality improvement throughout the NHS can be driven. The Outcomes Framework describes five domains, based on Lord Darzi's model of quality – clinical effectiveness (Domains 1–3), patient experience (Domain 4) and safety (Domain 5):

- Domain 1: Preventing people from dying prematurely
- Domain 2: Enhancing quality of life for people with long-term conditions
- Domain 3: Helping people to recover from episodes of ill health or following injury
- Domain 4: Ensuring that people have a positive experience of care
- Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.

Commissioners – both NHS England in its direct commissioning role and Clinical Commissioning Groups (CCGs) as commissioners of secondary care – are mandated by the government to make improvements against the indicators in all five domains of the Outcomes Framework.

The new commissioning system

Broadly speaking, the new commissioning roles, and their approximate budgets are as follows:

1. NHS England will directly commission primary care (£13 billion) and specialist services (£12 billion). There is also a responsibility for commissioning justice services.
2. CCGs will commission secondary care, including non-elective/emergency services (£65 billion).

While NHS England has a responsibility to ensure that CCGs are fulfilling their commissioning roles effectively, NHS England cannot tell CCGs what to do, how to commission

services or which services to commission.

Supporting commissioners to improve services, NHS Improving Quality (NHS IQ) is an improvement body that has been designed to be much more closely aligned with the new commissioning system than had been the case for improvement bodies previously. Many of our colleagues from NHS Diabetes now have new roles within NHS IQ. Other legacy improvement body organisations absorbed into NHS IQ include: NHS Kidney Care, National Cancer Action Team, National End of Life Care Programme, NHS Improvement and NHS Institute for Innovation and Improvement.

Clinical reference groups (CRGs) have been created within NHS England to create service specifications for the commissioning of specialist services – complex and severe obesity/bariatric surgery is an example.

However, almost all diabetes specific services are to be commissioned locally via CCGs. While there is a Specialised Diabetes CRG its work plan includes mainly rare syndromes of which diabetes is one aspect, as well as the areas of islet cell and whole pancreas transplantation to treat type 1 diabetes.

While CCG membership can involve a hospital-based consultant, such a consultant cannot work within provider organisations associated with that CCG due to a potential perceived conflict of interest. There are two other possibilities for consultant diabetologists to contribute to the new NHS systems: as a member of a strategic clinical network (SCN), or as a member of a clinical senate, both of which can offer clinical support, guidance and challenge to the commissioning of diabetes services.

SCNs are perhaps the obvious place for diabetologists to find a role. It has been determined that for each of the 12 regions of England there will be four SCNs:

1. A cardiovascular SCN
2. A maternity and children SCN
3. A mental health, dementia and neurological conditions SCN
4. A cancer SCN

While it is appreciated that important parts of diabetes management could sit well within a maternity and children SCN, diabetes has been nominally assigned to the cardiovascular SCN in each region. Each of the 12 cardiovascular SCNs in England can determine their own format, and we have seen four of the 12 appoint dedicated diabetes leads – London (Steve Thomas), Yorkshire and Humber (Chris Walton), East of England (Nick Morrish) and Cheshire and Merseyside (Aftab Ahmed). There will be complimentary roles played by Academic Health Science Networks, which will become clearer over the coming months.

My role as national clinical director

Twenty-five NCDs have been appointed from 1 April to work within NHS England by providing clinical leadership, policy direction and credible interfaces with healthcare professionals, third sector and professional and patient representative bodies.

While the role of NCD for diabetes had been well established over the previous 10 years by my predecessors Sue Roberts (2003–2008) and Rowan Hillson (2008–2013), there are some important differences to the role that I have taken on:

1. The role sits within NHS England rather than the Department of Health.
2. The portfolio has been expanded to include obesity. Around a quarter of the adult population are classified as obese, and while the NHS can contribute to appropriate management and prevention, a multi-agency approach is required involving public health, education, transport, environment/local council planning, and successful interactions with the food industry. The specialty of obesity management is in its infancy without a clearly defined career structure for physicians, although most currently working in the field have been trained in diabetes and endocrinology.
3. The traditional support infrastructure for the role of NCD in Diabetes, that previously involved a policy team at the Department of Health as well as NHS Diabetes, no longer exists. My goals as NCD for Obesity and Diabetes will need to be pursued through the work of all parts of NHS England and the wider system, and it is my responsibility as NCD to ensure that obesity and diabetes are well represented.
4. NCDs are actively encouraged to work together in pursuit of the successful management and service delivery of broader themes. An example would be management and service delivery for those with multiple long-term conditions/multi-morbidity, in which NCDs for obesity and diabetes, heart, stroke and kidney disease are all working under a cardiovascular umbrella. Another example would be transition from paediatric to adult services, where NCDs for children, obesity and diabetes and kidney disease, among others, are working together to address common themes, such as poor engagement and attendance, via a common template.

My priorities

Important priorities and themes for diabetes need to fit with the current NHS direction of travel if they are to be achievable. The following areas are where I think we can successfully concentrate our efforts.

1. **Prevention/early diagnosis/finding the undiagnosed.** A great deal of emphasis is now being placed on NHS Health Checks, a tool for assessing cardiovascular risk, including diabetes risk and non-diabetic hyperglycaemia, in order to treat those at high risk to prevent onset of disease.⁴ Everyone between ages 40 and 75 will be offered a health check every five years. It will also act as a potential mechanism for finding those with type 2 diabetes who are as yet undiagnosed. We also need to look at how primary care can be supported to narrow the gap between expected and observed prevalence of a number of diseases including diabetes.
2. **Managing people well** – delivery of the nine care processes and achievement of targets for HbA1c, blood pressure and cholesterol in those with diabetes remain highly relevant, and were areas at which criticism was levelled in the reports of the National Audit Office 2012⁵ and the Public Accounts Committee 2012.⁶
3. **Empowering patients** – this is an important theme in Domain 2/long-term conditions management and also relates

to better experience of care (Domain 4). Encouragingly, participation in structured education has now been included in GP pay-for-performance/QOF. The use of personalised care plans across all environments of care delivery, including specialist clinics, will continue to gain momentum.

4. Integrated care. The challenge is to design financial flows that facilitate and incentivise delivery of integrated models of care. NHS England is actively exploring ways in which the commissioning system can more effectively support delivery of high quality integrated care. This is particularly important for those with complications of diabetes and with multi-morbidity.

5. Transition services. NHS IQ is particularly focussed on a generic approach to transition from paediatric to adult services, addressing the themes that are common to young people with diabetes, kidney disease, epilepsy, disability and mental health issues, such as poor engagement and poor attendance rates.

6. Inpatient diabetes care. The focus on patient safety (Domain 5), the recent Francis Report⁷ and the subsequent Keogh Report⁸ continue to highlight the importance of high quality inpatient care. Excess inpatient mortality for those with diabetes in England has just been published⁹ and we are exploring the possibility of some diabetes specific metrics supporting Care Quality Commission hospital inspections.

7. Type 1 diabetes care. Unfortunately type 1 diabetes remains particularly vulnerable to a lack of appreciation of the specific care needs and the themes of the ABCD Lost Tribe campaign remain as relevant as ever.¹⁰ I am currently exploring ways in which we might achieve greater appreciation of these specific care needs.

8. Psychological support for those with diabetes when required. The emphasis within the mandate and NHS Outcomes Framework on parity of esteem for mental and physical ill health affords opportunity for our patients with diabetes who require psychological support, an area of service delivery traditionally under-resourced.

Describing our goals and aspirations for diabetes care in the new language and structure of the NHS Outcomes Framework is important if we are to successfully highlight their relevance, and therefore my priorities have had to be modified to some extent since starting the role in April.

A great deal of concern has understandably been raised around the future of the seven national clinical networks for diabetes that had previously been supported through NHS Diabetes. It is clear that NHS IQ will not take on the roles of support and delivery for these disease-specific networks. However, I would want to reassure colleagues that I am doing all I can to ensure that the good work of the networks over the last few years is not lost, and that the achievements, expertise, and connections continue to be pursued through various new routes in the new system. For example, the areas of diabetic foot disease, transition services and delivery of the nine care processes/primary care are all high on the agenda in many of the cardiovascular SCNs, and the previous work of the Children and Young People Diabetes Network and the National Diabetes in Pregnancy Network we hope will sit within relevant work streams of many of the maternity and children SCNs across the country. The diabetes networks are

most likely to remain relevant where they can be described in the language of the current NHS direction of travel and where they span across disease specificity – for example, the previous work of the Older People Diabetes Network sits well within the multi-morbidity agenda, and the work of the pump network can be described as an example of national application of technologies across the NHS in England.

Although the NHS has undergone major structural reorganisation since April and we are still waiting for the dust to settle, our focus as diabetologists on high quality care for our patients of course remains. My task as National Clinical Director for Obesity and Diabetes is to ensure that this focus is carried throughout the commissioning system as a whole, and I look forward to working with colleagues to make sure that happens.

References

1. Health and Social Care Act 2012. http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf. Accessed 2 August 2013.
2. Department of Health. The mandate. A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213131/mandate.pdf. Accessed 22 July 2013.
3. Department of Health. The NHS Outcomes Framework

- 2013/2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213055/121109-NHS-Outcomes-Framework-2013-14.pdf. Accessed 22 July 2013.
4. Department of Health. NHS Health Check Programme 2009. <http://www.nhshealthcheck.nhs.uk/default.aspx?aID=9>. Accessed 2 August 2013.
5. National Audit Office. The management of adult diabetes services in the NHS. <http://www.nao.org.uk/wp-content/uploads/2012/05/121321.pdf>. Accessed 22 July 2013.
6. Department of Health: The management of adult diabetes services in the NHS 2012. <http://www.publications.parliament.uk/pa/cm201213/cmselect/cmpubacc/289/289.pdf>. Accessed 2 August 2013
7. Francis R. Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry: Executive Summary. <http://www.midstaffpublicinquiry.com/sites/default/files/report/Executive%20summary.pdf>. Accessed 22 July 2013.
8. Keogh B. Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. <http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf>. Accessed 22 July 2013.
9. Holman N, Hillson R, Young RJ. Excess mortality during hospital stays among patients with recorded diabetes compared to those without diabetes. *Diabet Med* 2013 DOI: 10.1111/dme.12282.
10. Association of British Clinical Diabetologists. The Lost Tribe Campaign 2012. http://www.diabetologists-abcd.org.uk/Type1_Campaign/Press_Release.pdf. Accessed 2 August 2013.

Introducing our committee



Rustam Rea

Rustram trained in Oxford before going to the Midlands for his SHO posts. He completed his higher specialist training in Mid-Trent which included an MD in molecular aspects of insulin resistance.

After this he was appointed as a consultant in Diabetes and Endocrinology in Derby (2007) and since then has been involved in implementing

integrated diabetes services across the city.

He hopes that he can contribute to ABCD's work in representing the importance of the work of consultants in shaping the care of diabetes patients both in the hospital and in the wider health community. The recent publication 'Best practice for commissioning diabetes services – an integrated care framework' will be an important stepping-stone in that journey.



Thozhukat Sathyapalan

Dr Thozhukat Sathyapalan ('Sathya') is a Reader and Honorary Consultant Physician in Hull. He received his specialist training initially in Aberdeen and subsequently in Yorkshire Deanery.

His postgraduate research at the University of Hull with Professor Stephen Atkin's group was in cardiovascular aspects of polycystic ovary syndrome (PCOS). He was appointed Senior Lecturer in 2009 at the University of Hull and became a Reader in 2012.

His clinical interest in diabetes includes 'diabesity', which involves working closely with bariatric surgery services. In endocrinology, his sub-specialty interests are neuroendocrine tumours and gynaecological endocrinology. He has developed the regional neuroendocrine tumour services in Hull.

The focus of his research is in understanding the cardiovascular risk in insulin resistance states such as polycystic ovary syndrome (PCOS) and the modulation of that risk by both pharmacological and nutritional intervention. He is also involved in teaching undergraduate medical students in Hull York Medical School and supervises post graduate research trainees.

He enjoys cricket and travelling; with the former, he has regressed from being a participant to being merely a spectator albeit an enthusiastic one.

Too few people with diabetes in the UK are entered into trials which answer fundamental clinical issues. As a committee member, he intends to work with the academic sub-committee to promote research in diabetes by empowering the clinical community to generate ideas and define clinically important research questions which need answering.



Chairman's report

Challenges for integrated care

After nearly six months of the new NHS England how is diabetes care shaping up in England? I suspect that readers in Scotland, Ireland and Wales must be slightly bemused by all the chatter about changes; and if you are a diabetologist in England you would be forgiven for having retreated into a bunker wondering apprehensively as to how the new system will look once the dust has settled and how all the new bodies and structures will interrelate.

Certainly the attainment of integrated care as espoused by 'Best Practice in Commissioning Diabetes Services – an integrated care framework' the commissioning document produced just before the demise of NHS Diabetes, to which ABCD had major input, looks vastly more difficult to deliver given the spaghetti junction like map of the NHS in England. In Wales, in contrast, a diagram of the services is divinely simple with local health boards at the centre of everything and few other structures.

On a personal level I have dipped my toe into the waters of NHS England after being appointed as a diabetes specific lead within the Yorkshire and Humber Cardiovascular Strategic Clinical Network where I hope the lessons learnt while working for ABCD can be put to good use.

Role of the ABCD in the new world

How is ABCD as an organisation responding to the new world? As Chair I meet and talk regularly with Jonathan Valabji, National Clinical Director for Diabetes and with Barbara Young and Bridget Turner, Chief Executive and Director of Policy at Diabetes UK respectively, to discuss the evolving picture and how we can mutually and individually support the development of high quality care. Bridget and myself recently did a joint presentation at the commissioning show highlighting the challenges of commissioning for diabetes and promoting the 'Best Practice In Commissioning...' document and the ABCD type 1 campaign.

Productive collaborations for ABCD

One important collaboration between ABCD and Diabetes UK continues to be the Joint British Diabetes Societies (JBDS) Inpatient Group which is co-funded by the two organisations. Autumn will see the publishing of the Admissions Avoidance document which will provide a comprehensive review of admissions avoidance strategies for diabetes and include recommendations for commissioners.

On 4 September I was accompanied by Prof Mike Sampson, Chair of the Joint British Diabetes Societies Inpatient Group to a meeting with the chief executive of the Care Quality Commission to discuss inpatient care. Also present were Professor Alan Sinclair to raise the findings of the National Diabetes in Care Homes Audit, a project co-chaired by the Institute of Diabetes in Older People (IDOP) and ABCD, which will be published in the autumn.

Wearing a different hat Alan Sinclair as Chair of the ABCD Academic Committee, Richard Greenwood Chair of Trustees and myself have had discussions with JDRF. Included

in those discussions, among other issues relating to promoting research, was the opportunity that is presented by the network of diabetologists that is ABCD working with JDRF on JDRF funded type 1 projects.

Current ABCD projects

There are many others to thank for their work on ABCD projects but I will mention a few. Dev Singh for his work on the mentorship scheme which is bearing fruit as the project is now oversubscribed. Bob Ryder's work with the website committee has transformed the website, and Andy Macklin is enthusiastically developing our social media activities. The work of the ABCD research fellow Piya Sen Gupta with Bob Ryder has seen the DIABESITY study enroll its first subject with the insertion of an Endobarrier. I would also like to welcome new committee members Ali Chakera (who represents YDEF on the committee), Umesh Dashora, Stella George, and Thozhurath Sathyapalan (academic within 10 years of appointment).

Active role required from ABCD members

In many ways ABCD is currently at a crossroads. We have developed an effective platform from which to speak and act as diabetologists but the activity generated is barely supportable by our current infrastructure and is still growing. The executive will therefore be looking at proposals in the autumn to beef up the infrastructure of support for the executive and committee.

Meanwhile ABCD needs the support of its membership to deliver the various workstreams. For those of you struggling to find time to work national projects I think it is worth repeating to your Trusts the words of Sir Bruce Keogh taken from his recent review into the quality of care and treatment provided by 14 hospital trusts in England: 'Ambition 5. No hospital, however big, small or remote, will be an island unto itself. Professional, academic and managerial isolation will be a thing of the past. The trusts reviewed tended to be isolated in terms of access to the latest clinical, academic and management thinking. We found many examples of clinical staff not following the latest best practice and being 'behind the curve'. They – and other trusts not included in this process – need to be helped to develop a culture of professional and academic ambition.

- NHS England should ensure that the 14 hospitals covered by this review are incorporated early into the emerging Academic Health Science Networks. We know that the best treatment is delivered by those clinicians who are engaged in research and innovation.
- Providers should actively release staff to support improvement across the wider NHS, including future hospital inspections, peer review and education and training activities, including those of the Royal Colleges. Leading hospitals recognise the benefits this will bring to improving quality in their own organisations. Monitor and the NHS Trust Development Authority should consider how they can facilitate this.'

Chris Walton, Chairman

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