



# ABCD Newsletter

The Official Bulletin of the Association of British Clinical Diabetologists

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**EDITORIAL**

## Divide et Impera

**Peter Daggett**  
Editor, ABCD Newsletter

I don't suppose that the words of Nicolo Machiavelli have appeared very often in the annals of diabetes. It was he who first popularised the tactic of "Divide and Conquer", presently being employed by our political masters. This has set GP against specialist and ABCD against DUK. Fortunately, the latter schism is now healing, but there is still the real danger of the two sides of the profession being pitted against each other, in a quest for diabetic patients. For that is what it is. The more patients that a GP can look after, the greater the reward. On the other hand, the fewer that specialists have on their books, the greater the difficulty convincing employers that their services are still needed. PCTs see specialist diabetes services as an un-necessary expense and are trying to remove them and their funding from hospitals. GPs who take on these patients are promised better facilities in the "community" and as a result, many practices are content to watch the destruction of long established expert departments. One of my local GPs has said at

a public meeting that he sees no reason for a "left nostril expert" and that hospital diabetic clinics should be closed at once and the money given to GPs. A PCT in another part of the country is on record as stating that the move into General Practice would "challenge the livelihood of secondary care colleagues". The powers that be have thus achieved their aim of dividing the profession. They must not be allowed to conquer it.

Let us examine why we have specialist services. Very few of us bring people back to our clinics just to say good afternoon. True, many longstanding patients are our friends and it is nice to see them, but they come because they have problems requiring expert knowledge that their GPs do not have. Our colleagues in General Practice do many things that I cannot do and would not attempt to. It must be accepted that the same applies to Specialists: we know things that GPs don't and could not be

*continued on page 2*

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**INSIDE**

<b>Editorial: Divide et Impera</b>	<b>1</b>
<b>ABCD Spring 2007 Meeting (Notice)</b>	<b>2</b>
<b>ABCD Website (Notice)</b>	<b>2</b>
<b>Charitable Fund-Raising and Specialist Diabetes Services</b>	<b>3</b>
<b>Horizon scanning and ABCD Position Statements</b>	<b>4</b>
<b>Controversy: Relatively Speaking</b>	<b>5</b>
<b>Summary of the ABCD Autumn 2006 Meeting</b>	<b>5</b>
<b>Chairman's Report</b>	<b>6</b>
<b>ABCD Membership Application Form</b>	<b>6</b>

*continued from page 1*

expected to. The two branches of the profession complement each other and should not be working in competition. We can draw an analogy with the legal profession. Although some solicitors have right of audience in the high court, the sensible majority do not attempt to enter an arena, where the judge will expect them to perform at the same level as the barristers. General Practitioners manage routine diabetic care very well. Their nurses do a lot of the work and ensure that annual reviews are performed properly and recorded. This system is excellent and means that no diabetic patient is overlooked. There are so many people with diabetes, that provision for the straightforward majority must be strengthened in General Practice. A significant number of diabetic patients, though, have problems that cannot be managed by and which sometimes are not even recognised by generalists.

Doctors are here to look after patients, not to argue with each other, or commissioning bodies about who should do the work. Hospital diabetes specialists and GPs have enjoyed a harmonious working relationship for as long as I can remember. We must urgently re-establish a *modus vivendi* and the two groups must tell the PCTs that they are wrong. It is a fact that many of these bodies are in a frankly dysfunctional relationship with their providers and unless that can be changed, our patients will continue to be used as political pawns in a game being played by central government. Specialists must stop blaming GPs for poaching their patients and GPs must stop accusing specialists of elitism.

I would suggest that there is special type of referral for patients with diabetes. The question could be “does this patient need to be seen in a specialist environment, or can he or she be managed in the community?”. The specialist would then be able to advise his colleague and make appropriate arrangements. Conversely, specialists should be considering at every visit if patients really need to attend their clinic and if the answer is no, the clinic letter should ask the GP if they would be happy to continue supervision of the diabetes themselves. That is pretty much what happens *ad hoc*, but this may need now to be formalised. Surely, this professional approach, with respect for each other and with the patients’ welfare in mind, is better than a dictat from a PCT to discharge a certain percentage of patients attending a specialist clinic?

What role do professional bodies have? The Royal College of Physicians has not made any definite statement that would support hospital based specialists and that is to be regretted. DUK are certainly aware of the problems we are facing, but have not yet provided us with strong support. ABCD appears to be the only body that understands that the concept of “one size fits all” does not apply to diabetes. Within a few years, when our specialty may have been reduced to a rump, colleagues in general practice will find that there are no experts available when they encounter problems outside their experience. The majority of GPs are as worried by that prospect as we are and that fact may save the day. We must maintain close links with the GPs who work with us and ignore the posturings of organisations enthusiastically trying to dispense with a service which is self-evidently needed. Bryan Ferry and Roxy music sang “Stick Together”. We must.

## ABCD SPRING 2007 MEETING

**16 – 17th May 2007, Chester Crowne Plaza Hotel, Chester**

Lectures featuring at the conference are:

### Wednesday 16th May

7.00 – 8.00pm: Political slot

*Professor David Barnett – Chairman, NICE Technology Appraisals Programme – ‘The NICE Technology Appraisals Programme – personal reflections from the front line’*

### Thursday 17th May

9.00 – 10.00am: Preliminary results of ABCD-DUK Specialist Service Consultant Survey and review of Diabetologist Scoping Project – What is the future role of specialist diabetes physicians?  
*Dr Peter Winocour and Dr Ken MacLeod*

10.00 – 10.45am: Non-invasive assessment of CHD and its role in silent CHD in Diabetes *Dr Raj Khattar*

11.30 – 1.00am: ABCD Debate: Inhaled Insulin is an expensive waste of breath *Proposed - Dr Ian Gallen Opposed - Professor Steve Gough*

2.00 – 2.45pm: Update on driving and diabetes *Professor Brian Frier*

2.45 – 3.00pm: ABCD SpR Award 2006  
Classification of renal disease status using estimated Glomerular Filtration Rate in diabetes *Dr Varadarajan Baskar*

3.00 – 3.45pm: Psychology support in adult diabetes care – A luxury or a necessity? *Dr Andy Keen*

3.45 – 4.30pm: Hot Topic: Gliptins and Incretins  
*Invited Overseas Speaker – Professor Michael Nauck,*

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## CONTRIBUTE TO YOUR ABCD WEBSITE!

[www.diabetologists.org.uk](http://www.diabetologists.org.uk)

Keep an eye on the notice board for the latest information.



Powerpoint presentations from recent ABCD meetings can be downloaded from the members only, password protected, website. Any member can easily use the Sharepoint technology underpinning this area of the website to set up nationwide audits. There are ongoing discussions that we invite you to contribute to and new discussions can be easily be set up.

ABCD website officer, Bob Ryder, can supply user name and password for the members only website and also advise on the above.

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# Charitable Fund-Raising and Specialist Diabetes Services

**Richard Greenwood, Martin Hadley-Brown, Philip Heyburn and Philip Norton. Trustees, Norwich and Norfolk Diabetes Trust**

Diabetes has always been a “Cinderella” service. It doesn’t appear on any NHS management “must do” list and it is difficult to attract support for diabetes-related developments. Because of this we, like many others, have had to resort to charitable fund-raising to underpin and grow our service. Our charity (the Norwich and Norfolk Diabetes Trust) has been running for almost 20 years and has provided us with a range of facilities including two diabetes centres, a diabetic eye unit, a retinopathy screening programme, a diabetes research centre, an academic department of diabetes and vascular medicine and allowed us to support many smaller projects. Very little of this would have been possible without charitable funding.

The availability of charitable funding has also allowed us to do “deals” with local Trust and PCT management. When we built our first Diabetes Centre we agreed to pay all of the capital costs and also to cover any additional revenue consequences (salaries for additional staff, heating, lighting etc) for the first two years. However recently this has become more difficult and we have had to agree to provide support for up to five years in order to reach agreement with local PCTs. Nevertheless we believe that the benefits of charitable fund-raising are still substantial.

The purpose of this article is to review our experience and describe a few “tricks of the trade”, which may be useful to colleagues contemplating similar initiatives.

## What are the advantages of charitable funding?

Apart from financing and nurturing projects such as those mentioned above, there are a number of other benefits. These include:

- Giving a certain amount of control over local service delivery strategy. Availability of charitable funding obviously increases the chances of developments being supported by local Trust and PCT management.
- There are significant tax advantages available to charities, such as VAT exemption for health and education-related projects and Gift Aid, which will make your money go further.
- Running a charitable appeal is a good way of raising the profile of diabetes locally and motivating patients and relatives to support your service.
- Developments may be more secure. It is not so easy for local management to close down a facility that has been funded by a local charity.

## How to go about it?

There are a number of issues to consider from the outset. First, we would recommend that you formally establish an external charitable trust. This is necessary in order to obtain the maximum tax advantages and it is also much safer to hold your funds outside the NHS endowments system, as this avoids the risk of “dawn raids” or levies imposed by cash-strapped trust finance departments.

You will need to appoint a board of trustees (there should probably be at least four and no more than twelve). It is useful to include a solicitor and someone with a financial background. There should be at least one patient representative and there should be clinical representation from both primary and secondary care. You

will then need to identify a chairman, vice chairman, secretary, and treasurer. The constitution should be widely drawn to avoid restriction of investment. For example, subject to our trustee’s agreement, we are allowed to invest in any legitimate diabetes-related project in the UK including sponsoring this edition of the ABCD Newsletter.

Once the charitable trust is in place, you can then launch a public appeal. This will have more chance of success if it is to support a specific project, e.g. building a diabetes centre. You will need to produce ‘snappy’ literature, press releases giving information about your structure and objectives. An eye-catching logo is helpful. You will need all the publicity you can get and local press contacts and support from local media personalities/celebrities is invaluable.

## Some ‘tricks of the trade’

- Make maximum use of the skills and resources of your patients. For several years before we launched our first appeal, we mentioned our project to potentially useful patients e.g. solicitors, bank managers, accountants, businessmen, media contacts. Then, when the time came, we approached them individually and received an extremely positive response.
- It is very helpful if you can identify a high profile local champion(s) to support and promote your cause. We were fortunate to attract a well-known local businesswoman, Elsie Bertram, who made a substantial donation to get us started and then applied her considerable energy to fund-raising. This was the main reason for our early success.
- Produce an attractive leaflet and mail-shot local companies, local charities in the fields of education and health and groups such as Lions, Rotary and W.I.
- Set up a website and make sure it is visible to the main search engines.
- Circularise funeral directors (for flower money) and local solicitors (for legacies). Much of our recent income has come from legacies. You may have to wait a few years for them, so the sooner you get yourself written into wills the better!
- Produce a “wedding present” list of any facilities and equipment you require starting with the most expensive (you never know your luck!). Most fundraisers and donors prefer to finance specific items rather than making general donations but don’t forget to include an element to cover any running costs for an agreed period.
- Attach acknowledgement labels to specific items – ‘Donated by.....’. Donors and fund raisers really appreciate this.
- Support local events such as coffee mornings and jumble sales even if the funds raised are small. These often generate useful publicity and may lead to larger events or donations
- Acknowledge every donation however small, preferably with a nicely printed certificate and/or a personal letter
- Apply to national charities. We obtained funding from Children in Need and the lottery is now much more kindly disposed to health-related projects than previously.

## The downside

Although charitable fundraising has many advantages it is very hard work and once you have established momentum you have to keep it going or people will rapidly lose interest. You must lead from the front, and this means personally supporting as many local charitable events as possible no matter how small. Little events often have “knock on” effects – someone in the audience may decide to do

something more significant for you. You have to grab publicity whenever possible, even if this doesn't come easily to you. Publicity is the life-blood of successful fundraising.

There are some tedious administration and due diligence issues, including preparing the accounts and an annual report for the Charity Commission. You must have a coherent strategy for managing funds raised – you cannot justify raising money if you have no object in view, and the Charity Commission will take a dim view of this. You must be prudent with your funds – your supporters will not be thrilled if you lose much of their money by injudicious speculation on the stock market. Expert advice is essential to help you manage your funds safely and effectively.

A further problem is that, if word gets around that you do have substantial charitable funds at your disposal, this may make it even less likely that you will obtain NHS funding. This is frustrating, but we have taken the view that it is unlikely that there will ever be significant local NHS funds for diabetes and if we simply sat back and waited we would achieve very little.

### Conclusions

Charitable fundraising is rewarding in more ways than one, but it is

hard work and requires energetic leadership. Nevertheless the benefits make it well worth the effort. It motivates your patients and the diabetes team and it provides facilities, which would otherwise be unobtainable. It will give you some control over the shape of your local diabetes service and should also provide some protection from 'asset-stripping' by rapacious trust finance departments and cash-strapped PCTs.

In view of the severe difficulties currently being experienced by many diabetes services we believe that charitable fund-raising is even more important than in the past and would encourage colleagues to embrace it enthusiastically, if they are not already doing so.

### Acknowledgement

We are indebted to the late Elsie Bertram MBE, her family and our numerous other supporters for their contributions to our charitable fund-raising efforts.

### Reference

The Charity Commission ([www.charity-commission.gov.uk](http://www.charity-commission.gov.uk))

## Horizon scanning and ABCD Position Statements

**Ian Lewin**  
**Consultant Physician, North Devon District Hospital**

Horizon scanning is all about the appropriate introduction of new and worthwhile treatments into clinical practice. Hugely conflicting pressures require this process to be handled effectively at national and local levels. For the prescriber there are masses of data to be assimilated in a field of healthcare increasingly invaded by politics, finance and law.

Some of the pressures emanate from the drug industry. At a time when the rate of true therapeutic innovation is waning there is a surfeit of me-too drugs presented as something new and sexy. To promote rapid uptake of new treatments, disease mongering is not uncommon and the industry has polarised more than its fair share of self-help groups and professional organisations. Disease awareness campaigns have preceded the launch of new treatments to heighten public and professional demand and to increase sales as soon as they receive their licence.

Sitting in the weekly journal club one gets the impression that there's a lot of marketing out there masquerading as science. The true pedigree of a me-too drug may not be apparent from the trials. It might be compared with placebo or, rather unhelpfully, with a therapy one would not instinctively wish to use. Rarely is there a comparison which makes good clinical sense. Abstracts are often more upbeat on outcomes than the definitive peer reviewed paper which eventually follows. Not surprisingly it is the abstract which gets undue publicity, sometimes from sponsored meetings addressed by favourably disposed experts. Even the methodology of the double blind trial is not sufficient to correct for the positive spin of sponsorship. One is left wondering why, if an SHO working for the Membership can see through all of this, so many trials are designed with basic intrinsic flaws. Perhaps an answer lies in the commentaries of the financial analysts. The drug industry is typically a hard-nosed business picking off soft targets.

As ever, marketing strategies pitch the price of a new drug at a level the market will bear. Increasingly, there is an incentive to pay a high price for a new treatment on the supposition that it will lead to big savings in the future, perhaps from some adversity which will now be prevented. Yet so often there are surrogate rather than real clinical endpoints, and the economic model does not seem to stack up. It would not be unusual for a calculation of numbers needed to treat to indicate marginal benefits, if any, without any useful data being available on numbers needed to harm. The idea of horizon scanning is to begin a process which unscrambles this sort of stuff so that prescribers get reliable and useful information at a time when they need it.

Various bodies, including the National Prescribing Centre and the National Horizon Scanning Centre, attempt to track promising therapies through Phase 2 and Phase 3 trials to the point of launch. Information from any source can be useful at these stages. This is especially the case if the drug industry is sparing with details of trial results whilst weighing up the prospect of licensing a therapy to exploit a niche market. Although new treatments used to be visualised as typically low cost-high volume, or high cost-low volume, increasing numbers are now likely to be high cost-high volume. Because this applies to diabetes as much as any other field, finite local healthcare budgets are likely to feel the pressure. The true total cost of an innovation needs to be understood. Potential patient numbers, rates of uptake, and additional services needed to provide the treatment or deal with side effects, all need to be estimated as accurately as possible. Horizon scanning tools are now available to do these calculations and ours in Devon has found increasing use.

Those therapies which rise above a certain therapeutic or financial threshold become contenders for technological appraisal by bodies like NICE. Those which form part of the NICE work programme eventually come on-stream as formal guidance. The problem remains of how to manage therapeutic innovations not dealt with by NICE or the NPC, especially if they are targeted at inexpert practitioners in primary care. Perhaps this is where the combined insights and early position statements from ABCD might be most welcome.

**CONTROVERSY**

**Relatively Speaking**

**Peter Daggett**

Its 5.30 and I have just got back from the clinic. The telephone rings and a Health Care Support Worker – there are no nurses on my ward – informs me that there are 8 relatives of Mrs Treacle who want to see me. This lady was born when the Prime Minister was Herbert Asquith and she had been admitted because she was confused. The admitting Physician was a geriatrician and she therefore had a CT brain scan, MRI (twice) and more blood tests in 3 days than an endocrinologist’s patients normally have in a life-time. The scans showed the usual “atrophy consistent with the patient’s age, with areas of sub-cortical ischaemia”. Every one of the blood test results came back red, because they are 1% outside the reference range that is based upon 21 year old male medical students. Some cretin has told the family, who are outraged that Mrs Treacle has not been sent for a liver biopsy and considered for dialysis. I trudge up-stairs, knowing that the relatives will have a list of complaints and I am not disappointed. The four alarming female relatives refuse to shake hands, to indicate how displeased they are. The husbands are more civil, but give the impression that they have been brought along just to make up the numbers. I know what is coming: “don’t you think that an old lady who has lived through 2 world wars deserves better?” I try to point out that at the age of 97, people wear out and that is Mrs Treacle’s problem. “But the Queen Mother (God bless her) had a new hip when she was 97” comes the retort, which I have only heard three times that week. Next comes the matter of the corn-flakes being soggy, the cocoa being too hot, the ward being filthy and none of the staff understanding what

the relatives are saying. The last of these is hardly surprising, since they speak with such a thick midlands accent that even Professor Henry Higgins would have had difficulty interpreting their utterances. The list of course continues and I find myself apologising amongst other things, for the fact that the ward is painted green, a colour that Mrs Treacle particularly dislikes. Next I am told that the family have been doing some “research” on the internet and had I considered floppy brain syndrome? Apparently, it’s caused by deficiency of vitamin G and can be diagnosed by measuring the faecal molybdenum excretion. I realise that the battle is lost and after 45 minutes, I am told, “we are not satisfied and shall be taking this further”. Once, that would have worried me, but I am now desensitised and I will just wait for a message from “PALS”. That comes the next morning and I am told that I must attend another meeting with the family and a “patient’s friend”. By now, I am fed up with relatives demanding the impossible and junior managers making sure that they can in no way be blamed for the mess over which they preside. I therefore politely decline.

How have we allowed ourselves to be put into the position of having to accept responsibility for something that is not our fault, nor indeed anyone’s fault? Old people do get sick. Patients with one failing system often go on to develop failure of another and not infrequently, treatment for one make the other worse. Diabetologists are in particular difficulties, because after a few years of hyperglycaemia, everything is a bit ropey and it doesn’t take much to tip aging diabetics into multi-organ failure. These are the heart sink cases with notes 6 inches thick and often in 2 or 3 volumes. We must somehow teach relatives to accept that death is inevitable and that, usually, it is no-one’s fault. The absurd over-investigation that is now fashionable, compounded by poly-pharmacy on an industrial scale convinces people that no-one should die. Diabetologists must use their experience to instil some common sense into the therapeutic enthusiasts and to let the great British population know that death with dignity is not such a bad thing.

**SUMMARY OF THE AUTUMN 2006 MEETING OF ABCD (November 2006)**

**THE ABCD LECTURE**

**The contribution of specialist services to integrated diabetes care – the GP perspective**

*Dr Martin Hadley-Brown, GP, Thetford, Norfolk, and PCDS*  
 What do people with diabetes want, asked Dr Hadley-Brown? The answer was accessibility, continuity of care, expertise, research and well planned and delivered services. Primary care (PC) was good at providing the first two, plus teamwork, holistic care and an input to local planning. It had breadth of experience, good records and IT systems, an understanding of the hospital service - and common sense! The specialist service (SC) had more detailed expertise and depth of experience, knowledge of rare conditions, the skills for carrying out and interpreting research and access to the specialist diabetes team, eg the Diabetes Specialist Nurse (DSN), and other specialists. It provided teaching, leadership and input to strategic planning. The answer, surely, was for GPs and specialists to combine their talents. There are however obstacles (Table).

Dr Hadley-Brown explained that under PBC consortia of general practices within a locality would define required diabetes services. These consortia would be accountable for budgets but in general the services would continue to be commissioned by Primary Care Trusts (PCTs). The Primary Care Diabetes Society (PCDS), of which he was Chair, had been involved in producing guidelines for these commissioners. He acknowledged that there was considerable uncertainty about the level of fixed costs per hospital case under PBC and as to what these would cover.

It would be easier to ensure the continuation of a vibrant specialist diabetes service, which PCDS certainly wanted, if SC concentrated on its strengths and both SC and PC tried to promote an atmosphere of

- The DoH dividing to rule
- Communication (until NPfIT)
- Perception of PCTs as primary care-focused
- Perception of hospital care as expensive/inefficient
- Practice-based commissioning (PBC)
- Misunderstanding of QOF
- Payment by Results (PBR)
- Increasing prevalence of diabetes

**Table.** Obstacles to good relations between primary and secondary care

mutual respect and worked together. Dr Hadley-Brown maintained that QOF, by focusing attention on fundamental targets, had delivered the greatest single improvement in diabetes care of the decade.

**THE ABCD DEBATE**

“This House believes that diagnosis of the Metabolic Syndrome adds nothing to the care of patients with or at risk of type 2 diabetes and CVD”  
 Proposing the motion: Professor Edwin Gale (Professor of Diabetes, University of Bristol) Opposing the motion: Professor Sir George Alberti (Senior Research Fellow, Imperial College, London).

**OTHER PRESENTATIONS**

- Androgen replacement therapy should be considered in management of men with type 2 diabetes: Professor Hugh Jones
- All you ever wanted to know about Coeliac disease but were afraid to ask: Dr Peter Watson
- Screening for diabetes – who, when, how and if?: Dr Simon Griffin
- Impact of medical therapies on diabetic retinopathy: Dr Paul Dodson



## Chairman's Report

Turbulence is never a particularly pleasant experience, but that is the term so commonly applied to what is happening in our current specialist world of diabetes these days. We can but hope for an eventual smooth landing, although the journey through these uncertain times requires continued determination with a destination that will be almost certainly different to that which many of us have cherished in the past. The strength of ABCD is through its membership (now over 65% UK Diabetologists), and this enables our views to be made known through a number of advisory and partnership roles. From our website dialogue it is evident that concerns in respect of specialist diabetes services are prevalent across the country, and these have been made known to Diabetes UK whom we feel should be well placed to champion the expert care people with diabetes should expect.

The autonomy of ABCD has enabled us to make strong representations in several ways. The ABCD – Diabetes UK Liaison Group is important and proving productive, and from this partnership the review of specialist diabetes services will be derived. More recently ABCD has met with the Society for Endocrinology and Diabetes UK to discuss issues around education, training and recruitment of young doctors, particularly in the light of Partha Kar's SpR Survey, highlighting the current uncertainties for young doctors considering a future career in diabetes and endocrinology. Ways of improving the speciality profile through educational initiatives and incentives do need to be identified. It is a continued privilege to publish ABCD position papers, recently including guidance on insulin pumps (Practical Diabetes International November/December 2006) led by our experts Peter Hammond, Shirine Boardman, and Richard Greenwood; whilst a paper on "Screening for Gestational Diabetes" prepared by Stephen Robinson and Anne Dornhorst is now in press. Thanks to everyone who contributed. The accumulating series of position papers is looking impressive.

Other ABCD activities continue to increase. Those attending the last Autumn Meeting will know of Maggie Hammersley's commitment to inpatient diabetes care, and on behalf of ABCD along with David Kerr she will be linking with Mike Sampson's overall inpatient project under the direction of the NDST. Mike's ABCD audit paper has been accepted by Diabetic Medicine. ABCD is also often asked to provide endorsement of new guidelines. To do so for the "Minimum Skills Framework for Commissioning of Footcare Services for People with Diabetes" provided no problem; it has been a different matter for guidelines on "Boxing with Type 1 Diabetes", where the membership clearly does not wish to be seen encouraging this particular sport.

As many of you will know this is the time of year when consultant minds focus on Higher Awards. Members supported by ABCD did quite well in 2006 (2 gold, 1 silver, 5 bronze) and a number of other members who had not requested support were successful nonetheless. It just shows the quality within the membership! Good luck to all those who are submitting for 2007.

Our last Autumn Meeting in London was informative, encouraging and above all enjoyable. Peter Winocour looks to

have put together yet another excellent programme for Chester, 16/17 May. ABCD needs to provide strong clinical leadership and promote high quality research and innovation. I believe these meetings provide the forum to take these forward. See you in Chester.

*Ken Shaw, Chairman, ABCD*

### MEMBERSHIP APPLICATION FORM FOR ABCD

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 fill in the application form below and return it to the ABCD Membership Secretariat at the following address:

**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.*

### 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