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ABCD Newsletter

The Official Bulletin of the Association of British Clinical Diabetologists

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EDITORIAL

Call to influence CCGs

Mark Savage
Editor, ABCD newsletter

Well, the Health and Social Care Bill has been passed and of course applies to the English alone. How things will pan out is a debate that is a never ending it seems. I do wonder what our Celtic members make of the seemingly endless NHS reforms the English seem to go in for.

Nevertheless, we are where we are, and ABCD's policy is to do the best for our patients by engaging with colleagues rather than carping from the sidelines. We have known for years, since the purchaser/provider split, that commissioning is the key to service provision and this remains as true in 2012 as it did in the 1990s.

The original idea in the new Bill was for the General Practitioners to commission completely by themselves, albeit with managerial input. Now the Clinical Commissioning Groups (CCGs) are to include specialists and ABCD would urge those of you in England to consider putting yourselves forward to be considered for one of these specialist roles.

One thing that might be able to be changed is the removal of Payment By Results (PBR) for diabetes care, which, of course in reality is Payment By Activity and riddled with perverse incentives, none of which seem designed to benefit any patient with a chronic disease such as diabetes.

Liaison with your local CCG (or CCGs), even if not part of the inner core of a CCG Board, can still be effective and we might also see a revival of the Diabetes Networks, which in some areas have been allowed to wither on the vine by PCTs. This in itself will hopefully lead to more integrated care, although those of us able to remember block contracts know that they too are not perfect.

Patrick Sharp discusses another key theme for ABCD for 2012, namely the need to ensure that type 1 patients are not forgotten in the type 2 epidemic. And finally, the Insulin Passport has to be implemented before August 2012 – ABCD has had input into the multidisciplinary group working with NPSA to increase the resources available; please see http://www.diabetes.nhs.uk/safe_use_of_insulin/; most insulin companies have agreed to produce printed cards for their insulins.

INSIDE

A report from the Association of British Clinical Diabetologists (ABCD) Autumn Meeting

Russell Hotel, London, 10 November 2011

The new NHS Diabetes surgical management guidelines

Nicholas Levy (West Suffolk Hospital, Bury St Edmunds) presented the new NHS diabetes peri-operative guidelines, of which he is part author and a copy of which was given to each delegate.

People with diabetes represent 15% of the inpatient population and their length of stay is 20% longer than peers (eight days vs. five), they have a 60% higher re-admission rate and their day of surgery discharge rate is 10% less than expected. In addition to reducing complications, improving knowledge, reducing insulin-related harm and increasing patient involvement in care, the aims of the guidelines include reducing these excess lengths of hospital stay.

The guidelines propose what Dr Levy called a 'tube-map' pathway for peri-operative management and he briefly took delegates through the careful planning required at each of the 'stops': primary care referral, surgical outpatients, pre-operative assessment, hospital admission, theatre and recovery, post-operative care, and discharge. The patient should be involved in the planning for all of these stages.

Dr Levy contrasted earlier recommendations on peri-operative management with the guideline recommendations. For example, the Alberti GIK regimen was evidence based and was intrinsically safe but was labour intensive. And problems with the ambiguous sliding scales included wrong programming, wrong configuration and poor timing of establishment and discontinuation. The new guidelines recommend that the term 'variable rate insulin infusion' (VRIII) should replace 'sliding scale'.

He wondered why surgical patients with diabetes were denied day surgery. It is particularly suited for the patient with diabetes. The philosophy is to get patients eating and drinking as quickly as possible, with minimal starvation times or interference with normal diet. And it offers minimal physiological trespass or loss of autonomy.

Dr Levy's presentation was particularly well received with many compliments on the conciseness and clarity of the document.

Diabetes in the workplace – difficulties and dilemmas

Geoff Gill (Aintree University Hospital, Liverpool) outlined the continuing fight for improvement in the working lives of people with diabetes.

In the 'dark ages' before 1988, there had been no individual assessment, blanket bans and decisions taken by occupational physicians (whose assessment forms often revealed a dismal knowledge of diabetes) and virtually no input from diabetologists.

Things began to improve between 1988 and 1997 ('the breaking dawn') with the fight for individual assessment and high profile publicity in specific cases, the struggle for diabetological input, and BDA (now Diabetes UK) and political support. Professor Gill stressed the importance of patient power, and paid tribute to Tim Hoy who's well known battle on behalf of fellow fire-fighters reversed arbitrary Home Office regulations under which insulin treatment had been a bar to active service and 20 UK staff had been dismissed.

Since 1998 ('the enlightenment'), there have been further fights against discrimination, the acceptance of individual assessment and the Disability Discrimination and Equality Acts, which have made employers think hard before barring people with diabetes.

However, much remains to be done, and Professor Gill gave many examples of remaining problems, particularly in the areas of driving (taxis, the police, the armed services, the ambulance service), offshore occupations (where haircutting is allowed but 'watch keeping' still a bar!) and commercial

Launch of Quality in Care Diabetes 2012

QiC Diabetes
Quality in Care Programme

This spring sees the launch of Quality in Care (QiC) Diabetes 2012, a programme designed to recognise and share good healthcare practice in diabetes in the UK. Now in its second year the programme is organised through the publishing company PMGroup.

Supported by Diabetes UK, NHS Diabetes and Sanofi, QiC Diabetes 2012 comprises both an awards event and subsequent opportunities for finalists to explain why their efforts were successful to a wider healthcare audience.

QiC Diabetes 2012 consists of 15 award categories covering all essential aspects of diabetes care, including 'Best initiative supporting self-care', 'Best improvement programme for children and young people' and 'Best inpatient care initiative'.

Entries are invited from groups working in the NHS, industry and for patient organisations, with joint working and collaboration key to the QiC programmes.

An awards ceremony will be held at Sanofi's Guildford headquarters in October 2012.

Winners will then be able to share their work at subsequent conferences and forums, including the chance of presenting a poster or giving a talk at Diabetes UK's Annual Professional Conference next March.

Enter QiC Diabetes 2012 at http://www.qualityincare.org/enterqicdiabetes
The entry deadline is Friday 25 May 2012.

flying (although Canada recently licensed a long-haul pilot on insulin).

The ABCD debate

The motion at the ever-popular ABCD debate: This house believes that community diabetologists have little role in the management of patients with diabetes, was proposed by Niru Goenka (Countess of Chester NHS Foundation Trust) and opposed by Patrick Sharp (Southampton General Hospital).

Dr Goenka began with a semantic argument: when applied to diabetes care, the word community is not only impossible to define, but is also an unnecessary term. When applied to diabetes consultants it is actually harmful, implying a divide that ought not to exist and implying that some do not have any duty for leadership, planning services or supporting primary care across a locality.

He queried the definition of community diabetologist; there are no defined training requirements and there is no specific approved curriculum. There are no distinguishing outcomes or quality markers outside those expected in general diabetes care. He suggested that hospitals are seen as an integral part of a local community and are, therefore, community locations. Indeed, it could be argued that virtually every diabetologist is a community diabetologist.

Dr Sharp thought the motion implied that consultants in diabetes should not work in the community and that there should be no such specialty as community diabetes. His argument, replete with literary allusions, was pragmatic. He admitted that he had been initially sceptical of the concept of community diabetes, which had had an inauspicious start, arising from a growing anti-hospital and anti-consultant feeling, the growing influence of PCGs and PCTs and a loss of the medical hegemony.

He pointed out the opportunities in the community, in primary care, nursing homes and ambulance call outs for hypos. He stressed the need to see those patients who do not get sent to the clinics. Finally, he argued that "if we don't do it, someone else will... we will go wherever we need to go to do it... if we have any belief in ourselves and this Association, then we must believe that we will do it better than anybody else".

A pre-debate vote found eight delegates for the motion with 51 against and 13 abstentions. However, it seems that the force of Dr Goenka's rhetoric won the day, with a final vote of 34 in favour, 24 against and 16 abstentions.

Diabetes in England

Rowan Hillson (National Clinical Director for Diabetes) pointed out that in England in 2010 there were an estimated 3.1 million people with diabetes over 16 years of age and that this figure is estimated to rise to 4.6 million by 2030. The NSF for diabetes started in 2003, and Dr Hillson discussed the various provisions since then of the NICE Quality Standard for Diabetes, the NHS Operating Framework and the National Diabetes Audit.

These cover the whole integrated diabetes care pathway, including structured educational programmes, personalised advice on nutrition and physical activity, participation in annual care planning, agreeing documented personalised HbA1c targets and annual assessments for the risk and presence of complications, insulin, pump therapy, pregnancy advice, foot ulceration reviews and multidisciplinary treatment, hospital care, DKA and hypoglycaemia.

She explained the economic need for change and, in particular, emphasised that between £2.3 and 2.5 billion a year is spent on inpatient care for people with diabetes – 11% of the total NHS expenditure.

Improving outcomes in thyroid eye disease

In patients with Graves' disease, 5% have severe thyroid eye disease (TED), between 205 and 50% have clinical TED, and up to 90% have CT detectable TED, according to Colin M Dayan (Cardiff University School of Medicine). TED causes pain, discomfort, double vision, disfigurement and sometimes blindness, and patients have a poor quality of life and long-term psychosocial morbidity.

The condition is easily missed, but manifestations include soft tissue signs, chemosis, periobital oedema, proptosis, diplopia or abnormal EOM function and optic neuropathy, all of which can occur separately. Prevention involves treating thyrotoxicosis, avoiding Iodine-131 and stopping smoking (TED is relatively more common in men and smokers, explained Professor Dayan).

Conventional treatments are effective when used appropriately and by centres with expertise and Professor Dayan stressed the importance of early treatment. This includes selenium, steroids and immunosuppression in active disease, and rehabilitative surgery. He urged that patients should be referred promptly to specialist centres.

The management of diabetes in pregnancy

Helen Murphy (Addenbrookes Hospital, Cambridge) updated the meeting on developments in the management of diabetes in pregnancy, including the impact of continuous glucose monitoring, real-time continuous glucose monitoring and closed-loop insulin delivery. Current thinking is that closed-loop insulin delivery is as effective as conventional CSII, with less time spent in extreme hypoglycaemia.

These advances are leading to a better organisation of care in type 2 diabetes: women have better glycaemic control, fewer large-for-gestational-age infants, fewer preterm deliveries and fewer neonatal care admissions. However while there has been technological progress towards near-normoglycaemia in type 1 diabetes, improvement is still needed to reduce the rates of large for gestational age.

ABCD training award 2010

Samiul Mostafa (University of Leicester) presented his ABCD award winning study: Performance of strategies using one and two HbA1c cut-points for diagnosis of type 2 diabetes: WHO or ABCD?, which concluded that although using HbA1c ≥ 6.5% to detect type 2 diabetes was a reasonable option, the ABCD two cut-point strategy was more accurate and maintained a high diagnostic accuracy, with only some 25% subsequent testing.

The study was an analysis of the LEADER trial cohort of 8696 undiagnosed primary care individuals which compared the performance of the ABCD 'rule-out, rule-in' HbA1c strategy: 5.7% to 7.3% with the WHO 2011 strategy , namely, HbA1c ≥ 6.5% to detect OGTT defined type 2 diabetes.

Charles D Wroe
Medical Correspondent

Diabetes and endocrinology national manpower report

The manpower report is a survey conducted each year in September on behalf of ABCD and Diabetes UK. The main aim is to identify new consultant posts in the speciality and look at the trends.

The survey looks to forecast the expected number of retirements and the trainees who will complete their training leading to award of Certificate of Completion of Training (CCT).

Forty-four new appointments were identified for the year to September 2011; this was down compared to the previous year. The major proportion of this reduction would appear to be due to fewer appointments in acute medicine posts with interest in diabetes and endocrinology (six during 2011 vs 15 in 2010). The overall trend appears to have stabilised somewhat. There was only one 'single handed' Trust at the time of the survey. There continue to be a small number of hospitals with only one consultant.

Only six posts had locums in place in 2011 while 14 posts had locums in 2010. There did not appear to be any long term vacancies.

The mean age at retirement and numbers of those approaching retirement show no change.

Recent and predicted CCT dates

The number of CCTs awarded is to be around 70 and has remained constant over the last five years. The number of trainees enrolling in the specialty varies as they register with the JRCPTB at different times in relation to their training. Hence accurate prediction about how many CCT will be awarded in coming years is difficult.

The plan is to move to an electronic survey for the 2011–12 survey and collect relevant information which will help inform the societies of manpower issues and any significant changes in working patterns for consultant workforce.

Dinesh Nagi
Pinderfields Hospital
MYT, Wakefield

ABCD and Renal Association inaugural meeting

On 23 February ABCD, together with the Renal Association, hosted the first joint meeting on diabetes and kidney disease. Entitled 'Advances and Controversies' it aimed to discuss some of the hot topics in this rapidly advancing field. Several officers of both associations were involved in the day, which was attended by over 100 delegates.

We were delighted to hear Professor Peter Rossing from the Steno Diabetes Centre in Denmark, who spoke eloquently about the field of tubular disease, and in particular focused on the early markers that change using proteomic techniques. The hope being that as this technology becomes more widely available, detection of early markers of tubular damage would allow earlier intervention thus preventing or delaying the progression of tubular disease.

Professor John Wilding from Aintree then gave an excellent overview of the newer agents that diabetes teams are familiar with, but the renal physicians less so. In particular he focused on sites of action and also modes of action. He mentioned the incretin therapies, but then moved on to the next class of drugs likely to appear in the next few months, the SGLT-2 inhibitors. Acting predominantly on the kidney, this class of drugs proved to be of great interest to the renal specialists in the audience, as well as those of the diabetes teams who were not familiar with them.

We then heard a talk by Dr Mel Lobo, from Barts and the London Hospitals, giving a fascinating insight into the trials involving renal artery denervation for the treatment of resistant hypertension. He described the techniques used and then showed the excellent results his team, and others, had achieved. It looks as though it may be a promising treatment option if the technology becomes more widely available.

After lunch we heard a masterclass from Professor John Cunningham from the Royal Free Hospital, on vitamin D metabolism and in particular the pathophysiology of bone mineral disease in relation to kidney disease. He took the audience with him on a journey from basic physiology to quite complex pathology in gentle steps that even those who did not have a particular interest in the subject could follow.

The discussion on vascular calcification then led nicely into the session given by Dr Fran Game from Derby on preventing amputations and foot disease in those people with diabetes-related kidney disease. The talk highlighted several factors that were present on the 'stairway to amputation' that could and should be addressed individually to prevent what was described as the 'stairway to heaven' – given the very high mortality associated with this group of patients.

Finally, to round off the day, we heard from Dr Richard Smith from Bristol, who spoke enthusiastically about New Onset Diabetes After Transplantation (NODAT). Dr Smith gave the audience an insight into this emerging problem, and some of his thoughts on how best to prevent it, and also on therapeutic strategies.

Overall, the day was met with great enthusiasm, and feedback was excellent. I'd also like to acknowledge the sponsors (Abbott, AstraZeneca/BMS Alliance, Boehringer-Ingelheim/Lilly Alliance, MSD, Novartis, NovoNordisk and Sanofi), without whom we would not have been able to hold the event. We hope to run the meeting again.

As always, I am very grateful for ideas for future meetings – subjects that members would like to hear about, and wherever possible, maybe suggest names of speakers. The last few meetings have been made up exclusively of suggestions from the membership.

Ketan Dhatariya
Please contact Ketan directly with ideas at:
ketan.dhatariya@nnuh.nhs.uk

Call to recognise the right of people with type 1 diabetes to have ready access to specialist care

ABCD calls upon those commissioning services for people with diabetes to recognise the right of people with type 1 diabetes to have ready access to the consultant-led multiprofessional diabetes team

The recent results from the National Diabetes Audit (NDA) have demonstrated increased death rates among people with type 1 diabetes, increased complication rates, poor control of the condition and poor screening processes. As a result of these figures, ABCD is planning to call on those who commission services for people with type 1 diabetes to enable ready access to the multiprofessional diabetes team to bring about improvement in clinical outcomes.

Not receiving best care

Type 1 diabetes affects approximately 0.4% of the population of the UK. However, the figures from the NDA indicate that those with type 1 diabetes are not receiving best care. People with type 1 diabetes are particularly vulnerable because:

- They are usually diagnosed at a young age when they are ill-equipped to deal with the stresses of managing a long-term condition.
- They are, by definition, fully dependent on insulin, resulting in medical emergencies at times of insulin deprivation or insulin excess.
- The early age at diagnosis results in long-term disease exposure with resultant complications.
- Long-term disease exposure renders good glucose control at an early stage of paramount importance to avoid long-term complications.
- Life events, which are routine for the non-diabetic population, such as pregnancy or elective surgery, acquire a layer of complexity which requires input from the specialist team.

Drift away from specialist care

In view of the considerations above, ABCD is asking that people with type 1 diabetes have ready access to the specialist team if they wish it. It is true to say that across the UK, the proportion of people with type 1 diabetes who are under the supervision of the specialist diabetes team will vary greatly. However, it is also true that over recent years, there has been a gradual drift of people away from the specialist team. This comes about, perhaps unintentionally, due to a variety of policy changes.

- The generic use of the term 'diabetes' without reference to the subtype.
- Payment of primary care through QOF to manage diabetes within the practice.
- The setting of financial tariffs for referral to specialist teams leading to a financial disincentive to referral.
- The setting of financial tariffs for the follow up of patients within the hospital service leading commissioners to discourage continued engagement with the specialist team and limiting the amount of contact that an individual can have with the specialist team.

Increase death rates

The National Diabetes Audit, an annual analysis of processes and outcomes in diabetes has highlighted increased death rates amongst people with type 1 diabetes, particularly young women and those who are socially deprived. It has also pointed out that many routine screening tests which would pick up early problems are not being carried out. It also demonstrated increasing hospital admission rates for the diabetes emergency associated with lack of insulin, DKA.

The reasoning behind the call for all patients with type 1 diabetes to have unrestricted access to the multiprofessional diabetes team is made in recognition of the fact that the current laissez faire attitude to the management of this condition is no longer tenable. A more managed approach is clearly called for, and this would most logically be provided through the local diabetes team.

Simple adjustments needed

The changes needed to allow access of people with type 1 diabetes to the specialist team would be relatively minor, but would require a change in the way in which services for long-term conditions such as diabetes are commissioned. The principle change would be to move away from the idea of a fixed cost for each clinical visit, instead moving toward a payment for a service, regardless of the number of contacts. Breaking down the boundaries between 'hospital based' and 'GP' care would also be useful, allowing the specialist team to come to the patient with type 1 diabetes. We are not pushing the notion of hospital based care.

Such changes would not generate any additional costs for the NHS, but would involve a change in the way we organise services for long-term conditions such as diabetes. The person with diabetes should not be restricted in who they can see. They should be able to seek advice from the most appropriate group of healthcare professionals at a time when they need them.

ABCD is currently planning to use the recently published figures to highlight the issues outlined above. We are in discussion with various partners to investigate the possibility of a multi-agency campaign, and will keep the membership informed through the website.

Patrick Sharp
General Secretary
ABCD

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. 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, Red Hot Irons Ltd, PO Box 2927, Malmesbury SN16 0WZ
Tel: 01666 840 589 email: eliseharvey@redhotirons.com
When your application has been approved, you will be sent a Standing Order form for your annual subscription.

Diabetes in Northern Ireland

Ireland is the land of saints and scholars, and an apt description also some would say of its diabetologists. However one might describe them, Northern Ireland has long been recognised as a centre for diabetes activity. This was largely through the visionary work of Professor Desmond Montgomery with the establishment of the Metabolic Unit in the Royal Victoria Hospital, Belfast in 1957. This was a purpose-built resource with both inpatient and outpatient facilities in addition to an attached laboratory. This centre was soon to become highly regarded in terms of its innovative patient care, being one of the first in the UK, for example, to institute a joint antenatal diabetes clinic and also to offer near patient HbA1c testing. While the original Metabolic Unit building has succumbed to redevelopment and rebuilding, the Royal Victoria Hospital Diabetes service continues with the same ethos with regards to patient care envisaged by its founders half a century ago.

In the intervening years, however, diabetes care has obviously spread well beyond the Royal Victoria in Belfast. Large and busy diabetes centres are now present in all fourteen hospitals in Northern Ireland led by approximately 25 consultant diabetologists. A broad range of typical diabetes services are provided in most centres, including pumps, specialist clinics (such as foot, prepregnancy and then joint antenatal), carbohydrate counting/self management courses such as DAFNE or BERTIE and supervision of inpatient diabetes care. An extensive number of other professionals are obviously required to help provide these services and the Diabetes Specialist Nurses in particular have organised into an effective and forward thinking group. The size of Northern Ireland permits close contact between diabetologists throughout the province and good camaraderie results with many opportunities to meet both for education and socialising! The chance to air mutual concerns is also given at the regular Northern Ireland Diabetes Consultants' Group meetings.

The nature of diabetes care delivery is continuing to change and involvement and interaction with our colleagues in primary care is obviously increasing. Primary Care Trusts have not been part of the Northern Irish healthcare system, and so perhaps we have been spared some of the recent commissioning challenges faced by colleagues in England. However, significant uncertainty exists as to what management and commissioning structures will imminently be in place, and therefore as elsewhere, there are concerns about the future shape of diabetes services. On the positive side, several new initiatives have recently commenced including significant investment in prepregnancy and adolescent diabetic health through the European funded cross-border CAWT (Co-operation And Working Together) project.

Education and research have also played a large role in the diabetes community in Northern Ireland. Many of the local hospitals are centres for Specialist Registrars training locally and there is a well established University of Ulster Diabetes Specialist Nursing course. There is long history of excellent clinical research at the Royal Victoria Hospital and more latterly at some of the other local hospitals particularly through the Northern Ireland Diabetes Clinical Research Network. Furthermore highly-regarded diabetes focussed research is also performed at Queen's University Belfast and at the University of Ulster.

So while others may judge whether we live up to our 'saints and scholars' reputation, diabetologists in Northern Ireland are a busy, yet generally contented, group! Visitors are of course always welcome, if nothing else to attest the truth of the aphorism: 'You know it's summer in Ireland when the rain gets warmer.'

Hamish Courtney
Northern Ireland Representative

UPGRADE OF ABCD WEBSITE

Phase 1 of the upgrading of the ABCD website is scheduled to be live before the end of April 2012. The upgrade project has been led by myself supported by a project development board consisting of ABCD members from across the nation and to whom I am extremely grateful for the crucial guidance given.

Phase 1 includes greatly improved navigation, current notices on the homepage, free online access to *Practical Diabetes*, RSS feeds from all the major diabetes journals, ready access to key publications in diabetes and endocrinology, and education and position papers sections both of which are set to expand in the near future. The website will be undergoing relentless enhancement over the months ahead with migration to a different platform planned in due course as phase 2 of the upgrade.

For the time being the website continues on the current Sharepoint platform which means the members only area continues and within this the access to the members database (which is now within an encryted protection layer i.e. https). All historic online material will continue to be available and any previously created bookmarks will work as before. Also members may still set up online nationwide audits or surveys.

An e-mail to the membership will announce the launch of the website upgrade.

Dr Bob Ryder
ABCD website coordinator and clinical lead ABCD nationwide audits