ISSUE 21 SPRING 2013

ABCD Newsletter

The Official Bulletin of the Association of British Clinical Diabetologists

Publishers
John Wiley & Sons Ltd

This issue of the ABCD newsletter has been supported by an unrestricted educational grant from SANOFI DIABETES

EDITORIAL

New Year – some new (and some old) challenges

Peter Winocour
Editor, ABCD newsletter

The year 2013 sees the 10th anniversary of the National Service Framework for Diabetes in England and Wales, the year for final delivery of the standards. Yet we know from the National Diabetes Audit (NDA) and the damning report on diabetes care from the Audit Commission that we are a long way off achieving the outcomes and targets that were set a decade ago. That challenge is further heightened given that 2013 will be a time of turmoil as the next reorganisation (the umpteenth in my career) gets fully underway with the abolition of the primary care trusts and the roll-out of clinical commissioning groups.

Our chairman will tell you more in his report of the important work ABCD has led on in order to try to ensure that diabetes care and services develop appropriately, and ensure service integration, effective in patient and specialist services.

There are major central changes afoot. The impending loss of NHS Diabetes, the establishment of the National Commissioning Board and the revision of the role of the National Clinical Director for Diabetes incorporating a strategic role in obesity care shifts the emphasis and sends a clear signal that obesity and type 2 diabetes is where Department of Health (DH) thinks the action is.

ABCD's commitment to ensuring adult type 1 diabetes care is supported with secure funding similar to the Best Practice Tariff for Children and Young People aged up to 19, was emphasised in the Lost Tribe campaign, which should be rolling out in all four nations. The challenge is clear when one examines the disappointing evidence from the National Diabetes Audit of the very low uptake of structured education for type 1 diabetes – apparently lower than for type 2 diabetes. The ABCD-led insulin pump service audit will also highlight insufficient and variable coverage.

The NDA and Audit Commission reports lay bare the poor coverage of basic care processes and the huge cost to the NHS from diabetes – essentially the cost of failure. Many of us work locally and nationally to remedy this and we like to think as leaders all consultants have all the answers

INSIDE

to all the problems! Yet I wonder if we could look at the whole system with a more objective perspective whether we may find better solutions.

The DH could be forgiven for looking at the 'big picture'. In fact size of the canvas for this vision is huge, ultimately affecting 1 in 10 adults and costing a fortune. Almost 90% of people with diabetes have type 2, often linked to obesity and lifestyle. The major costs from diabetes come from managing complications in type 2 diabetes, the vast majority of whom receive care from practice nurses and GPs in primary care.

Integrated care models are designed to avoid obstacles in accessing specialist care but if we focus as specialists on educating and supporting the generalists, looking after in patient DM and subspecialist clinics in eg foot, antenatal pump, transitional care we will make real improvements in these areas, but it is doubtful if the major costs of diabetes could be altered. Savings from earlier detection and management of complications and better in patient and foot care have been estimated at £170 million but the £3.9 billion estimated costs to the NHS from diabetes dwarfs this sum. Central government could therefore be expected to focus on type 2 diabetes, especially as a diabetes community we have emphasised that many adverse outcomes are potentially avoidable.

There is no suggestion that all type 2 diabetes needs specialist input, but there is a legitimate challenge to us all of how best to manage long term conditions with multiple comorbidity.

This, in essence, is what we aim to do of course with every patient with diabetes that is under specialist care given the management of complications, and the multiple vascular risk factors whose care is already intertwined.

So what is our role here? The biggest revelation for me has been through visiting primary care practices where diabetes care is usually very good. There are three consistent observations:

- The caseload is overwhelming and predominantly nurse led.
- There is an inconsistent approach to case detection among those on practice obesity registers.
- Although specialists may be referred some high risk type 2 diabetes cases with early complications or comorbid obesity, there are a further 20% of practice caseloads who remain under primary care, and who are not being escalated to specialist services or even for case discussion despite clinical need.

There are several factors which may explain this, but perverse incentives and demand management, limiting referrals through Payment by Results, is the most troubling. The management of type 2 diabetes is in many ways the biggest challenge to diabetes services in the UK.

The recent ADA-EASD recommendations offer an individualised approach to care. It is comprehensive and indeed requires consideration of a host of factors in treatment selection (hopefully including the evidence base of outcomes with different therapies which interestingly figured less notably than issues of cost and other factors).

If you utilise the algorithm to enable individualised second line therapy selection two observations come to mind.

Firstly, and most importantly, there is often no evidence based mandate for selection of one class of therapy over another, but an increasing need for a somewhat considered use of clinical acumen. The costs of new therapies and the expected benefits are now coming under serious scrutiny and challenge from NICE.

Secondly, in response to the very important article from Anne Kilvert and Gerry Rayman in the *BMJ* regarding the crisis in diabetes care in England, we were posed a challenge from Michael Schachter in the ensuing correspondence. He wrote 'no one, however expert, seems very confident about pathways of care. Between metformin and insulin what should we do to optimise outcomes, both microvascular and macrovascular? Insulin itself is beset by controversy. Current guidelines are not very helpful, and they really lack the evidence to be more so. In these circumstances we can assess organisational deficiencies but do we even know what to look for with respect to clinical ones?'

I suggest that we cannot treat that challenge with disdain – it may reflect an uncomfortable truth. How much of the cost attributable to diabetes is avoidable with a perfect system?

Our best hope is to actively case find trouble early – I find geological analogies helpful. Specialists may only see the tip of the iceberg. A new model integrated system should scrutinise 'what lies beneath' among the mass of the 8% of the population with diabetes under primary care. There are pre-eruptive opportunities before the volcanic eruption of

New committee member: Hermione Price

I am passionate about improving outcomes for people with diabetes and my work with both the Department of Health has allowed me to input into projects aimed at improving integrated care and reducing premature mortality. I believe that people with diabetes should receive the joined up care that they deserve and feel that this is essential if we are to improve outcomes. I am also very interested in the care that people with diabetes receive when they are in hospitals and looking at different approaches to improve safety and patient experience.

We are fortunate in diabetes to have access to large volumes of data that have exposed the variations in diabetes care that exist across the country and I am interested in exploring ways of sharing best practice.

I am a locum consultant in Oxford and currently spend the majority of my time seconded to the Diabetes Policy Team at the Department of Health and to NHS Diabetes where I am working on the CVD workstream. My clinical and research interests include the management of CVD risk in people with type 2 diabetes.

I became an ABCD committee member in 2012 and am a previous chair of the Young Diabetologists' Forum.

complications. If the system of integrated care facilitates case finding and supportive specialist input we have best hope of avoiding tragic outcomes. The challenges are that we have many balls to juggle in developing the integrated whole systems care services for DM. Many centres of excellence will major in one area at expense of another.

There has been an excellent opportunity to help find the Lost Tribe in our campaign – those with type 1 diabetes who have become disillusioned or displaced from specialist access. Traditional clinic models may not best meet their needs and new technology and models of support may deliver better outcomes. The increased DKA admission rates from NDA tell us we need to work differently here. The Best Practice Tariff for DKA admissions being introduced in April is designed to reduce readmissions.

In the midst of the potential chaos in the 'new NHS' we should look for opportunities. One such issue is the national clamour for seven day working in hospitals by senior medical staff. I worry a little when the NHS head honcho suggests that working more like Tesco is the key to salvation of the NHS. However, given virtually all consultants and trainees are still employed by acute NHS trusts it would be foolish not to determine what employers will be pushing for. The RCPL Future Hospital Commission has been addressing this and promoting the cause of generalism.

This is undoubtedly a big issue for ABCD and for consultants and trainees in diabetes. In trying to agree a consensus on this issue it is clear that it will be unhelpful to embrace one polarised perspective. An expanded service that enables integrated DM care across the primary and secondary care interface, supporting in patient diabetes and subspecialist services, while still contributing to acute-GIM might be a win-win situation we could live with.
Belated happy new year!

Chairman's report

Changing times

By the time you read this the NHS Commissioning Board will officially be in place and the old order will have been swept away. At the moment it feels a bit like living in a house from which the floorboards have been removed before replacements have arrived and a degree of uncertainty that they will. ABCD has continued to express its concerns regarding the importance of preserving NHS Diabetes workstreams and more than 200 senior professionals signed a joint letter with Diabetes UK to the national commissioning board leads to express these concerns. Many thanks are due to Rowan Hillson the outgoing National Clinical Director for Diabetes and to Anna Morton Lead for NHS diabetes for their huge contributions towards building a clinical diabetes community which addresses and supports the needs of professionals in providing care for the ever growing numbers of people with diabetes.

The new 'czar' (whose name will shortly be announced) will have fewer sessions to deal with an expanded brief which now covers obesity as well as diabetes. If the new national clinical director is to achieve any success it will be essential that he/she is supported by a cohesive clinical community pulling together and ABCD is and will be working closely with Diabetes UK and other organisations to ensure that this happens.

As Peter Winocour points out in his editorial the National Commissioning Board will be focusing very heavily on those patients with multiple morbidities who consume so much of the NHS budget. We will have to fight to ensure that people with type 1 diabetes are not overlooked so the launch of the ABCD Lost Tribe campaign in November at the Royal College of Physicians was particularly timely. The message of integration of care for people with diabetes together with a call to recognise the vulnerability of those with type 1 diabetes within the current system has particular resonance at the present time and was well received. We will be looking for further opportunities to push the message of the campaign.

Championing integrated care has been a preoccupation of mine for some time and one recent pleasure was seeing younger diabetologists Hermione Price and Rustam Rea (both ABCD committee members) and Garry Tan picking up the ball and running with it while working with primary care colleagues in shaping NHS Diabetes' last major output. The feedback from CCGs is that this document (entitled 'Best practice for commissioning diabetes - An integrated care framework) is eagerly awaited and ABCD will be facilitating 10 meetings around England to ensure that the messages in the document spark the local conversations and action needed. The document will be available on both the ABCD and NHS Diabetes websites.

The Joint British Diabetes Societies (JBDS) in patient Group which will continue to be funded jointly by ABCD and Diabetes UK has fresh outputs to be released in spring on admissions avoidance and a revision of the diabetes ketoacidosis (DKA) guidance. All existing JBDS documents are downloadable from the website. Mark Savage has taken a lead role with the DKA work as well as being our newsletter editor. Mark is about to relocate 'down under' so I would like to express my thanks on behalf of the committee for all the work he has undertaken. His not always politically correct comments will be much missed!

I would also like to thank others whose term on the committee is complete including Ian Scobie who has chaired the ABCD education and training subcommittee and Susannah Rowles. Susannah has kindly agreed to continue her work in the area of transitional care for ABCD.

Last but not least one of the 'elephants in the room' for diabetologists is the relationship of the speciality to general and acute medicine. Following discussions at the Coalition of Medical Specialities about the RCP 'future hospital commission' the ABCD committee has had a vigorous virtual debate; a position statement developed from this is set out below. At the Spring meeting in Solihull the ABCD debate will be devoted to the issue of the interface with general medicine.

Chris Walton, Hull, February 2013

ABCD position statement: the Future Hospital Commission

In response to the RCP Future Hospital commission document the ABCD committee is of the view that consultants in diabetes/endocrinology have the skills that will be required to benefit patients in the future, particularly in an era where there is an epidemic not just of diabetes but of multiple long term conditions.
To ensure the maximum impact they

1. Should provide in patient diabetes care for diabetic emergencies (including diabetic ketoacidosis, hypoglycaemia, hyperosmolar hyperglycaemic syndrome and diabetic foot emergencies to which key performance indicators are attached).

2. Should contribute to the care of those in-patients throughout the hospital with diabetes or hyperglycaemia, where glycaemic issues or foot problems are not the primary reason for admission.

3. Should provide the specialist medical direct care for diabetic patients with complex needs as part of a locally-agreed integrated model of care.

4. Should provide specialist leadership for the local health economy in designing a high quality and cost-effective integrated model of diabetes care.

5. Should provide, as part of a broader endocrine team an endocrinology, lipid and metabolic service, both within the hospital and for outpatients.

6. Will usually contribute to the Acute/GIM rota for being on call.

7. Can make an important contribution by having a GIM bed base depending upon local arrangement of services/resources available. Wherever possible these beds should be used for patients with diabetes-related problems. ABCD would be happy to support Consultant appointments which had joint diabetes/GIM job descriptions provided adequate time is allocated to speciality work.

In making this statement consideration has been taken of the professional duty of care responsibilities of diabetes physicians. Only a Consultant trained in diabetes and endocrinology can fulfill the first five functions However, the committee understands that as part of a broader group of physicians trained in GIM there is a collective responsibility to provide a high quality modern GIM service in a hospital. *Too often the pool of physicians involved in GIM care and the acute take has been diminished by deals between trusts and individual specialist groups who have negotiated withdrawal from involvement in general medicine without adequately rewarding those specialties who continue to contribute. Either this trend must be reversed or new jointly accredited posts must be created involving those specialties who remain within GIM in any hospital.*

Mindful of the above trainees in diabetes/endocrinology should continue towards dual accreditation, but their contribution to GIM on call should not be at the expense of specialty training, as only properly trained diabetes specialists can ensure that the health care needs arising from the diabetes epidemic are fully serviced. Ensuring that specialist training is not compromised and revitalising the role of RMO may require all specialties contributing one year of training to GIM with consequent extension of speciality training programmes.

LATE BREAKING NEWS

ABCD wishes to welcome and congratulate Dr Jonathan Valabhji on his appointment as National Clinical Director for Diabetes and Obesity. Dr Valabhji is a consultant at Imperial College Healthcare NHS Trust, has been an ABCD committee member over the last two years and has contributed leadership in North West London around integrated diabetes care provision.

He suggests that while there are obvious needs to address the increasing prevalence of diabetes, to make earlier diagnoses of diabetes, and to promote the timely uptake of structured education for those with diabetes, a major priority must be to cause the financial flows and incentives within the new NHS to promote delivery of integrated care across provider institutional boundaries. With a big emphasis now around reducing premature mortality in England, there is a need to tailor healthcare delivery to take account of the fact that many elderly people with diabetes often have multiple long-term conditions. A more holistic approach to those with multi-morbidity could therefore see returns for our patients in terms of reduced mortality and improved quality of life in a reasonable time frame, but must not divert resources from younger people with diabetes, especially those with type 1 diabetes, whose higher morbidity and mortality risks will not be realised for several decades.

With the greater emphasis on clinical leadership, one hopes that the huge energy, enthusiasm and passion for diabetes care delivery that diabetologists bring can be more effectively harnessed within the new structures of the NHS.

Diabetes care in England and Wales: the 2010/2011 National Diabetes Audit (NDA)

The NDA scope is expanding. The very successful National Diabetes Inpatient Audit (NaDIA) will be reporting again at Diabetes UK APC in March. New National Pregnancy in Diabetes (NPID) and Patient Experience audits will be starting up this year to be followed by a National Diabetic Foot Audit. Meanwhile the Core NDA which started in 2004 has published for 2010/11 in two main reports; report 1 on care processes and treatment targets June 2012, and report 2 on complications, chronic kidney disease and mortality December 2012.[1] The audit dataset was extracted from primary and secondary care electronic records for the period 1 January 2011 to 31 March 2012 then linked using the NHS number to hospital episode statistics (HES) and mortality (MRIS) data, thereby overcoming deficiencies of recording diabetes as a co-morbidity in discharge summaries or on death certificates.

The 2010/11 participants included 83% of general practices in England, 49% in Wales and 75 specialist services. There are data on 2.15 million people with diabetes; overall prevalence 4.57%; 9% type 1 diabetes and 91% type 2 diabetes.

Quality of care

The National Audit Office (NAO) published its report on diabetes for the public accounts committee of the House of Commons in June 2012. It used as one of its main measures of the quality of diabetes care in England the proportion of patients with diabetes completing all of the nine annual care processes recommended by NICE. This 'bundle' measurement of the nine care processes (BP, HBA1c, blood creatinine, cholesterol, BMI, smoking review, foot examination, eye screening, and urinary albumin) has been recorded by the NDA since 2004. It has risen from around 5% then, to 54% in this latest report. But this conceals huge ongoing variation even at health economy level (<20% to >70%).

Similar variation is seen for treatment target achievement rates; on average there has been a very modest improvement of around 0.8% since the previous report. Yet some health economies and providers do so much better than others (eg HbA1c <58mmol/mol (7.5%) max 73%, min 53%; BP <140/80 max 68%, min 48%).

Also notable, as in the previous report was the finding that for people with either type 1 or type 2 diabetes the likelihood of getting all the nine care processes completed or achieving NICE treatment targets was appreciably less if you were younger (age threshold around 55 years). Because they have high risk characteristics and will live longest with diabetes it is inevitable that these younger diabetic patients will develop a high proportion of the future complications of diabetes. Services for younger people with diabetes that were more effective in delivering the full 'care process bundle' and achieving treatment targets would yield particularly large health and health economic benefits.

The NDA reports on 10 complications: angina, myocardial infarction, heart failure, stroke, minor and major amputation, chronic kidney disease, retinopathy treatment, diabetic ketoacidosis (DKA) and premature death. Much improved statistical standardisation and multivariate analysis has considerably improved the confidence with which conclusions can be drawn from the national and local reports. The high overall risk but marked geographical variation in amputation rates and mortality was reconfirmed. In addition three particular impacts stand out.

Diabetic ketoacidosis rates continue to rise. This parallels the findings of the National Paediatric Diabetes Audit[2]. Among people with type 1 diabetes, the one year prevalence of one or more hospital admission for DKA was 3.32% (6141 people). Multivariate analysis showed that young females and those living in deprived areas had the highest rates. The 150% variation and statistically significant differences observed between health economies suggests that this should not be inevitable.

Heart failure (HF) in people with diabetes has a much greater impact than myocardial infarction (MI) or stroke. From April 2010 to March 2011, 45 001 (2.27%) people with diabetes were admitted at least once for HF meaning they were 64.9% more likely to be admitted to hospital with HF than the general population, a greater additional risk than for myocardial infarction (+48.0%) or stroke (+25%). Because the NDA uses hospital admission data to identify HF, people with HF who were managed solely on an outpatient basis will not be included, so the numbers reported probably underestimate the true burden of HF in diabetes. In addition: HF is the complication that confers the highest risk of death in the short term (261% greater risk of dying in the next year); admission to hospital with HF is 60% more likely for someone living in the most deprived quintile than for the least deprived quintile; HF is most prevalent in people from South Asian ethnic groups and least common in those from Black ethnic groups.

For CKD3-5 and renal replacement treatment there were some quite striking associations in multivariate analysis that may have implications for targeting secondary prevention effort. Higher rates were found with: socioeconomic deprivation; type 1 diabetes; female sex; Black and Asian ethnicities; and morbid obesity.

At every level and for every measure (key processes, treatment targets and disease outcomes) there are significant variations which persist even after influences such as age and social deprivation are taken into account. Overall younger people with diabetes do less well than their older counterparts. Variation of this magnitude is surely unwarranted in a National Health Service; I believe it should trigger healthcare professionals everywhere to critically review and lead the improvement of services.

Bob Young, Salford

References

1. http://www.ic.nhs.uk/searchcatalogue?productid=7331&q=%22National+diabetes+audit%22&sort=Relevance&size=10&page=1#top.
2. http://www.rcpch.ac.uk/npda.

Group 2 (HGV) driving licence application for insulin treated diabetes

Recent changes enable some insulin treated patients to apply for a group 2 licence to drive a lorry, bus, medium sized lorries between 3.5 and 7.5 tonnes and minibuses. There is a three stage procedure in this process.

Initially on request, a form is sent to the driver (VDIAB1I) and consent to medical enquiry. The applicant is asked to complete a validated visual analogue scale to assess awareness of hypoglycaemia and any driver who has scored four or more on this will not proceed further in the application process. There may be other responses on this form which also stop further progress.

The applicant is then required to have an examination by their clinician (hospital doctor or GP) who will be asked to complete the DIAB2IG/C form. The questions relate to the driver's diabetes management and diabetic complications, including hypoglycaemia, and must be completed at interview with the patient. The clinician is not being asked to make a judgement as to whether or not a licence should be issued, but to answer questions about the driver's knowledge of his or her diabetes and self-management, particularly in relation to driving. Again there may be responses in this form which stop further progress in the process.

The main risks associated with insulin-treated diabetes and driving is the risk of hypoglycaemia and it is essential that the clinician establishes that the patient has a clear understanding of these risks and undertakes appropriate blood glucose monitoring in relation to driving. The driver is required to test at least twice daily and within 30 minutes of the start of the first journey and at two-hourly intervals while driving. If the driver has missed a day or more of blood glucose readings, it must be established why the data is not available as he or she may be required to collect the data again. Drivers using more than one meter will be advised to bring all meters to the interview. If more than one meter is used and only one is brought to the interview the driver cannot fulfill the necessary criteria. The meter date and time must be set. I would advise that a proforma letter is sent out with explicit instructions on the blood glucose recording requirements prior to the interview. The clinician will also be asked about complication screening and whether the patient has any significant eye or foot problems.

The final stage is an examination by an independent consultant diabetologist who will be asked to complete form VDIAB3IEX. Approximately 40 individuals are identified for this process, and will be trained appropriately. These diabetologists will contract with the DVLA to provide this service, and the DVLA will pay for the examinations.

At this interview, the diabetologist will review the information submitted by the driver and their doctor. A detailed history of the driver's lifetime exposure to severe hypoglycaemia, self-monitoring, and awareness of hypoglycaemia must be taken. It is required to ensure that the driver has a clear understanding of the risks associated with hypoglycaemia while driving and that they undertake appropriate self-management to reduce these risks.

The driver should have already provided three complete months of blood glucose readings using a memory meter(s). If the meter(s) contain(s) readings of less than 3mol/l the diabetologists must question the driver about these, establish at what level of blood glucose they experience warning symptoms of hypoglycaemia, and that as far as the driver can recall if they were fully aware of hypoglycaemia on these occasions. Readings of less than 3mol/l do not exclude a driver as they may be the result of appropriate testing to confirm hypoglycaemia. Clinical interpretation is required when reviewing this data with the driver as the circumstances surrounding each episode may not be recalled with accuracy.

Any other medical condition should have already been identified on the previous questionnaires and examinations but it is the responsibility of the diabetologists to document any condition which would preclude safe driving.

In most cases the answers to all the questions should establish whether the driver is at increased risk of hypoglycaemia. The final question asks the diabetologists to make a clinical judgement and also gives an opportunity to expand on any of the information provided.

The process to enable issue of a group 2 licence to an insulin treated diabetic is arduous, and will require both clinical expertise, and considerable communication skills and tact. Good Luck!

Ian Gallen

G'day

I have handed over the editorial responsibility for this organ to Peter Winocour as I am to depart for the Antipodes around the time of the next ABCD conference (visas and medicals permitting). Peter has written an editorial by way of (re)introduction and I am sure you will agree that he has his finger on the political diabetes pulse, as always.

ABCD hopes to develop and expand the newsletter further and we would be delighted to receive correspondence from members and others for inclusion in future editions that we intend to produce before each conference.

I wish all of you and ABCD continuing success. See you at the IDF in Melbourne?

Mark W Savage
Manchester, February 2013