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ABCD Newsletter

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The Atrium, Southern Gate
Chichester PO19 8SQ
Tel: 01243 770520
Email: practical_diabetes@wiley.com

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EDITORIAL

Guidelines, implementation and audit

Mark Savage
Editor, ABCD Newsletter

The English national director for diabetes has been pushing for the development and implementation of national (UK as well as English) guidelines for the management of diabetes conditions, particularly in hospitals. We all know that there are filing cabinets in our places of work, and now areas of Trust websites, where many good guidelines languish unused; some, but not all, possibly past their sell by date. The lack of guideline implementation is a major issue highlighted by audits up and down the country. How are we to get guidelines used? A two track approach is being proposed; firstly putting guidelines into Integrated Care Pathways (ICPs) and treating their none use as a Clinical Incident, and secondly, by audit. Gerry Rayman on page 3 has highlighted the main findings of the first national inpatient audit which makes frightening reading for those with diabetes, illustrating that management of diabetic patients in hospitals is not good. Things really only can get better. Funding has been secured to repeat this audit annually until 2012.

Those involved on ABCD's behalf on national committees will have seen the status of the society grow since its foundation. From initial difficulties we have seen ABCD's opinion being taken with more gravitas, we are now sought by those wishing to take things forward, although that does not mean we are always listened to!

One recent positive example has been our involvement with the Joint British Diabetes Societies (JBDS) which is an umbrella grouping incorporating Diabetes UK, Scottish, Welsh and Northern Irish societies. The JBDS' *raison dëtre* has been to develop guidelines that are easy to understand, practical for everyday use, and safe, while at the same time evidence based. The English national inpatient lead is an ABCD committee member and at the Diabetes UK APC in Liverpool guidelines on the management of diabetic ketoacidosis (DKA) were presented by two other ABCD committee members, demonstrating our commitment to be involved at a national level in improving diabetes care.

Having been involved with the original ABCD DKA guideline group I was surprised that the JBDS version was accepted with such grace, but of course this was not universal and some are concerned about the use of 10% versus 5% glucose and others about the use of 0.9% saline rather than Hartmann's solution. The one thing that is noticeable about guideline development is that the poorer and scantier the evidence, the more heat than light generated at discussion meetings. Thus it is important that we not only audit guideline implementation, but have a plan to update and review the evidence in the hope that the next version will be an improvement.

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A report from the Association of British Clinical Diabetologists (ABCD) autumn meeting

London, 20 November 2009

At the ABCD autumn meeting, chaired by Dr Peter Winocour (Welwyn Garden City), there were, as usual, many informative presentations.

Cardiovascular risk reduction in younger people

Following the welcome to members by Chair Peter Winocour (Queen Elizabeth II Hospital, Welwyn Garden City), David Dunger (Addenbrokes Hospital, Cambridge) presented evidence suggesting a role for hypolipidaemic and hypotensive therapy in preventing vascular disease in children and adolescents. He pointed out that the younger the age at diagnosis of diabetes, the greater the reduction in life expectancy, and that, as people get older, cardiovascular deaths increase as a proportion of causes. Microalbuminuria (incipient nephropathy) is highly predictive of later development of clinical proteinuria and is a risk factor for cardiovascular disease. In the Oxford Regional Prospective Study (ORPS), of 527 type 1 children recruited, 26% developed microalbuminuria (transient 39%, intermittent 13% and persistent 48%). With age, the persistent and intermittent groups increase in a linear fashion. There was a cumulative incidence of over 50% after 17 years in ORPS and Professor Dunger emphasised the importance of continual testing.
Microalbuminuria is more common in girls, is not necessarily linked to HbA1c, is linked to short stature in adults and associated with lower IGF-1 levels. It is a marker of a generalised endotheliopathy, and Professor Dunger showed data illustrating that its development causes differences in renal size and function, changes in blood pressure and lipids and, increasingly, changes in surrogate measures of cardiovascular disease during adolescence. While CVD risk is related to a family history of hypertension, hyperlipidaemia, insulin resistance, type 2 diabetes, microalbuminuria and the metabolic syndrome, a link between nephropathy and genes has not yet been fully established although further studies are underway. Environmental factors remain problematic although smoking increases the rate of progression to microalbuminuria. The DCCT had shown intensive therapy showed similar HbA1c benefits among adolescents to adults. But benefits in young people are more difficult to achieve for both behavioural and physiological reasons. The Adolescent Diabetes Intervention Trial (AdDIT) – now underway – aims to determine whether intervention with ACE inhibitors, statins or a combination of both will reduce albumin excretion and prevent decline in renal function, and reduce CVD risk in high risk type 1 youngsters. The study might also help to identify new biomarkers.

Integrated care for the diabetic foot

It is estimated that up to 20% of diabetes expenditure is on neuropathic foot complications and for patients, they are among the most feared, with an enormous impact on their lives, including loss of occupation and status, disfigurement, reduced mobility, and depression. Gerry Rayman (The Ipswich Hospital) said that the key to reducing these is integrated care and coordinated procedures. He described the progress within his area of Suffolk where, with a population of over 300,000, 12,000 of whom have diabetes, a foot clinic started in 1989 on a weekly basis with joint working between podiatrist, shoe fitter, diabetes physician and surgeon in adjacent clinics. However, a review in 1996 found a number of internal problems and poor communication with primary care. Dr Rayman outlined the changes carried out by the Ipswich Diabetic Foot Clinic to provide an integrated foot care service, with a full team of experienced podiatrist, DSN, shoe fitter, diabetes physician, plaster technician, vascular surgeon and nurse, an angioplasty service, orthopaedic surgeon and microbiologist. Roles and responsibilities of all have been clearly defined and there is continual GP/practice nurse foot care education in screening and referral. He quoted studies showing how screening, fast tracking, early identification/treatment and education improve ulcer and amputation outcomes. In Ipswich, patients are screened and stratified by level of risk and education is conducted as much by patient involvement with the team as by the production of literature. Such an integrated foot care service has resulted in a 75% reduction in major amputations and a 65% reduction in bed occupancy and Dr Rayman produced evidence demonstrating that similar initiatives by other groups have produced comparable benefits.

HbA1c in the diagnosis of type 2 diabetes

Eric S. Kilpatrick (Hull Royal Infirmary) reminded delegates that, in 2009, an international expert committee report in Diabetes Care had suggested that HbA1c should be used to diagnose type 2 diabetes and that it should be diagnosed at ≥6.5% (48mmol/mol). When HbA1C is not available, traditional diagnostic methods are acceptable but the advantages in using HbA1c are that it assesses glycaemia over previous weeks or months, has a lower biological variability than FPG or HPG, there are fewer pre-analytical concerns and it is already used to guide management. And, of course, it does not require a fasting sample. But there have been criticisms of these recommendations, and Professor Kilpatrick discussed these issues in relation to both individuals and populations. HbA1c can give spurious results in haemoglobinopathies, anaemia, renal failure, HIV infection, in some ethnic groups such as African, Mediterranean, or Southeast Asian populations, and among the elderly.
Discussing cut off points, he pointed out that an HbA1c of ≥6.5% would not identify half to two thirds of patients diagnosed using current criteria. Using a 'simple' HbA1c measurement to diagnose diabetes may not be so simple after all, he felt. Individual patients might risk being wrongly diagnosed because of non-glycaemic factors and populations risk having their diagnoses delayed. Any new diagnostic criteria should be demonstrably superior to the criteria they replace and should not be just a means of obviating the need for a fasting sample, he concluded.

The ABCD debate

In the ABCD debate, chaired by Alan Sinclair (Luton and Dunstable NHS Foundation Hospital), Charles Fox (Northampton General Hospital) proposed the motion that "New therapies have added little to improve glycaemic control

compared to conventional therapies", with Mark Savage (North Manchester General Hospital) opposing.

The protagonists have published their arguments in depth in *Practical Diabetes International* (March 2010 Volume 27 Number 2). Ignoring abstentions, a pre-debate vote showed 21 in favour of the motion with 73 against. Post-debate, there was a slight shift in the vote towards Dr Fox's point of view, with 30 in favour and 69 against.

Training tomorrow's doctors in diabetes

Jyothis George (Queens Medical Research Institute, Edinburgh) and Gerry Mckay (Glasgow Royal Infirmary) gave a presentation and preliminary report on results from the ABCD Clinical Audit Award 2008/9, the TOPDOC Diabetes Study. Dr George explained the background to the study: TOPDOC (Trainees Own Perception of Delivery Of Care in Diabetes) is a national study of confidence levels among trainee doctors in the management of diabetes. Postgraduate trainee doctors have a key role in delivery of diabetes care and, as a multi-centre pilot study had demonstrated, there is a lack of confidence in diagnosing and managing aspects of diabetes. The TOPDOC study aimed to identify the specific aspects of diabetes management where this confidence is low and to use this information to inform efforts to improve training.

The authors hope to publish full results in a mainstream medical journal, but, in brief, Dr Mckay was able to report that there were 4079 starts and 2305 completions, making this possibly the largest independent survey of trainees in the UK. The responders' years of postgraduate training varied from less than one (c20%) to over 12 (c2%); the region with the largest percentage of responders was Wales and the smallest, Scotland Tayside. When it came to making a diagnosis of diabetes, only a very few were not confident, about two thirds felt satisfactory or confident and 30% were very confident. However, when it came to diagnosing impaired glucose tolerance, just under 15% were not confident while just over 15% felt very confident. Over two thirds of responders said they required further training in the diagnosis of diabetes and other glucose abnormalities, and only just over half felt that their postgraduate and undergraduate training had prepared them adequately to diagnose these conditions. And a majority wanted further training in the management of diabetic emergencies and in patient management.

Dr McKay explained that the full implications of the study are still being teased out but the next stage in the project could be to develop educational domains in diagnosis, diabetes emergencies, inpatient diabetes management, oral diabetes medications, insulin dose adjustment, peri-operative management and the management of complications. And, he suggested, this kind of survey could well be applicable to other specialties.

In brief...

In a session devoted to endocrine topics, David Hosking (Nottingham City Hospital) updated delegates on the most common calcium disorders and Mark Vanderpump (Royal Free Hospital, London), discussing thyroid disorders, pointed out that people in the UK now appear to be iodine deficient. And finally, Malcolm Nattrass (University Hospital, Birmingham) gave an entertaining but salutary talk on the hazards which can face clinicians when "things go wrong" and they get involved in medico-legal aspects of their work. He illustrated these with a number of unfortunate case histories, many of which demonstrated the importance of accuracy in note taking and clear communication between diabetologists and other specialists who may become involved with the same patient.

Charles D Wroe, Medical Correspondent

The National Diabetes Inpatient Audit Day

A great success and a powerful tool with which to improve inpatient diabetes care. Summary of the paper presented to Diabetes UK APC March 2010

Most of you will be aware of, and indeed will have participated in, the National Diabetes Inpatient Audit Day funded and led by NHS Diabetes (England). This 'snapshot', bedside, survey of clinical care and patient experience, was undertaken on day chosen by each participating hospital's diabetes teams, in the week of 21 September 2009. Its purpose was to obtain a baseline of the level of inpatient care being received by people with diabetes, identify areas of concern, benchmark hospitals and to raise awareness amongst other health professionals including commissioners and managers.

As can be imagined organising such a large event was a considerable challenge. A steering team was engaged to design the clinical care questions, the patient experience questionnaire (titled 'Have Your Say') and to advise on delivery and analysis. Various organisations including ABCD, the Diabetes Inpatient Specialist Nurse Group, DiabetesUK (including users), and NHS Diabetes (England) were represented in this group. The organising team were very grateful to all these organisations for publicising the event and particularly to ABCD who frequently bombarded us with reminders as the day approached. We also circulated updates, letters covering 'frequently asked questions' and advice on how to organise your team to undertake the audit. Importantly, chief executives, medical directors and directors of nursing were all written to, informing them of the audit and inviting them to support their diabetes teams on the audit day.

Data from the paper based audit form and the patient questionnaire was uploaded to a database using an electronic mark reader and the analysis undertaken by the Yorkshire and Humberside Health Observatory.

So how did it go? Remarkably well; when originally devised there was uncertainty as to the potential level of interest and willingness of diabetes teams to commit a whole day to undertake the exercise, but there was enormous clinical engagement and 219 hospitals took part, far exceeding expectations. Although originally intended only for hospitals in England, there was such interest in the other UK countries it was agreed to include the12 hospitals from Northern Ireland, six from Scotland, five from Wales and three from the Channel Islands, who asked to be involved. Thus, a total of over 14,000 patients bedside records were surveyed and over 6,000 patients

completed the questionnaire on their experience, representing approximately 70% of those well enough to respond. After the event we invited the leads to meet with their teams to provide feedback on the experience. This was very encouraging. Despite the considerable work involved, diabetes teams generally found the audit interesting, informative and well organised. Many described finding worrying events and practices in their hospital that they were not previously aware of. For example, several reported finding patients with established diabetes who had been on the ward for several days but whom no one knew had diabetes. Many said that undertaking the audit as a team exercise was beneficial to the team itself and generated valuable discussion for planning the service. Following the audit, the resolve to improve inpatient care was high (4.6 of 0-6 with 53% scoring 5-6), as was the perceived value of the audit in contributing to improving future care (4.2 with 44% scoring 5-6). Perhaps the most important feedback was that 92% said that they would be willing to undertake the audit on an annual basis as a means of improving standards of care. It is of interest that several of those not willing to repeat the exercise appeared to have had to undertake the audit relatively unsupported by other team members.

So, how about the results? With over half-a million data points there was and remains a considerable amount of data-analysis to be undertaken. The key finding is that there are on average about 50% more people in hospital with diabetes than often quoted figure of 10%. Nationwide 7.5 to 28% of adult beds (excluding obstetric and paediatric beds) were occupied by people with diabetes.

The median age of the patients was 72 years with approximately one third over the age of 80. Only 6% have type 1 diabetes but more than a third are insulin treated. Of these, more than one third had an error on their insulin/glucose chart. Insulin infusions were considered to be inappropriately used in a fifth and in more that a quarter the transfer back to subcutaneous insulin not appropriately managed. More than a quarter of all patients experienced a hypoglycaemic episode whist in hospital and approximately one in thirty required rescuing with intravenous glucose or glucagon. Less that one third of the patients recalled a foot examination but one in thirty acquired a foot lesion whilst in hospital. One in six patients described the hospital experience as being negative. Care planning, involvement in their own management and timing of and meal selection were areas of particular concern for patients.

What next? By the end of April, each hospital will have been sent a report which benchmarks them against others (you may have already received yours by the time you receive this newsletter). The report is intended to help teams identify areas of their service that are good and those that need addressing. These are not being sent to hospital managers but we would encourage diabetes teams to share the results as they should help support business cases for service development where needed. Indeed, we have already had feedback from several hospitals that have analysed their own data and have used the results successfully support inpatient DSN appointments. A complete report is currently being prepared which will be presented in June/July at a conference to be organised by NHS Diabetes and to which all the leads will be invited (date and venue to be announced). We will ask participants to share what they have done to improve any problems identified by the audit in their hospital. This meeting will provide an opportunity for others to have input into the design of the 2010 audit and in particular to the methodologies to be used for data collection such that the process becomes easier and less time consuming. The conference will be a very valuable platform for discussing developments in inpatient diabetes care and for show casing innovative practices. A complete report is currently being prepared which will be presented in June/July at a conference to be organised by NHS Diabetes and to which all the leads will be invited (date and venue to be announced). This will also provide an opportunity for others to have input into the design of the 2010 audit and in particular to the methodologies to be used for data collection such that the process becomes easier and less time consuming. Furthermore, the conference will be a very valuable platform for discussing developments in inpatient diabetes care and for show casing innovative practices.

In summary, the National Diabetes Inpatient Audit Day was a resounding success. It has further raised the awareness of inpatient diabetes care and has demonstrated a clear need for this to improve. It has already been used by many teams to improve their services. We believe the process of annual re-auditing and benchmarking will prove to be a powerful tool with which to drive up the standards of inpatient care. I would like to thank everyone who took part and encourage everyone else to join in this year.

Gerry Rayman

ABCD WEBSITE AND NATIONWIDE AUDIT

Message to all liraglutide users: please contribute your patients to the ABCD prospective nationwide liraglutide audit. A useful tool is provided free which will allow you to monitor and analyse data on your own patients and also easily contribute them to the nationwide audit: http://www.diabetologists.org.uk/liraglutide.htm

Website (www.diabetologists.org.uk): Keep an eye on the noticeboard for the latest information. Powerpoint presentations from ABCD meetings can be downloaded from the members only, password-protected, website. A complete database of ABCD members is held there. Please check your details are up to date. Any member can easily use the Sharepoint technology to set up a nationwide audit. ABCD website officer, Bob Ryder, can supply user name and password for the members-only website and advise on the above. Tel: 0121 507 4591 Email: bob.ryder@swbh.nhs.uk

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
Website: www.diabetologists.org.uk

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

Chairman's report

Now that the noughties are over...

So, how was it for you? It remains to be seen whether we have unwittingly lived through a (rather tarnished) golden age of diabetes with some of the increased NHS spend devoted to diabetes care – although predominantly through QuOF, registers and retinal screening enhancing primary care of diabetes.

What will the next decade hold for diabetes care in Britain? – theoretically there are opportunities with a wealth of data from NHS Diabetes and the National Diabetes Information Service (NDIS) advising commissioners how to assess needs and ensure provision of integrated diabetes services through the 'Commissioning Diabetes Without Walls' toolkit.

However this will be balanced by public service funding cuts. The impact of the possible change in government is more difficult to predict. I think it is likely that cost cutting for chronic diseases including diabetes will take place. It is vital that we ensure this does not lead to 'disintegrated' diabetes care.

Driving service changes

It is our role as leaders and specialists to drive service changes through our acute trusts, and by engagement with GPs-PBC and PCTs-SHAs. The challenge is whether they want to listen and work consensually or whether they will find it easier to employ simple minded dogma. A focus on new to follow up ratios can probably be viewed as a surrogate marker that the PCT conforms to the one dimensional stereotype.

PCT pharmacists are an interesting breed. I often wonder if they operate a bonus scheme for successful denied introduction of new therapies. An example is the challenge in accessing liraglutide, and we may need to await final NICE guidance. ABCD are keen to carefully manage the entry of GLP-1 analogues with our national independent database. Our inaugural ABCD clinical research fellow took up his post with Bob Ryder in February, and already we have accumulated extensive data looking at Exenatide use alongside insulin.

Since my autumn report I attended the IDF meeting in Montréal. The trip exceeded my expectations with plenty of high quality clinical research. There are many benefits from attending such meetings – mainly curricular, although I did attend an excellent jazz session with Ian Scobie as company after a hard day's conventioning.

Networking is a real bonus of our own ABCD clinical meetings, but a wider international perspective offers its own rewards and an opportunity for reflective thinking time away from base. I personally also value a natter with colleagues.

I returned from the IDF enthused and brimming with ideas how to change the world, but then inevitably met the inertia that characterises the NHS, the trust priority of cost savings, and delivery of acute medicine. As the old stalwart US Senator Tip O'Neil once said – 'In politics ultimately everything is local' – and I think the same applies to diabetes.

Analyses from our 2006 ABCD specialist survey with Diabetes UK is reaching completion. The issues raised in our survey of retinal screening have been brought to the attention of the Chair of the National Screening Committee on Diabetic Retinopathy. Most importantly was the disconnect of the screening process from holistic diabetes care and failure to enable urgent access to specialist ophthalmology and diabetes care for sight threatening retinopathy. Our earlier qualitative analyses of consultants documented frustration that I am sure remains as we try to direct our restless energy to improve services. Never mind pushing through metaphorical glass ceilings – we have brick walls to contend with.

The Kings Fund Diabetologist Leadership Course was recently reconvened in Blenheim Palace and rekindled in me the enthusiasm I came away with two years previously. It was invigorating to see that many delegates had undoubtedly benefited in grappling with 'the system', and ABCD fully support this training opportunity for consultants. At present we already fund the SpR course.

We heard about a pilot study where the independent sector helped community matrons avoid hospital admissions, which seemed of value. The majority of us carry out unselected medical take – how often do we have to manage frail elderly patients admitted unnecessarily to hospital and languishing for weeks awaiting the unrealistic verdicts of the therapists as to when they can leave hospital?

Given the choice I would see a future role for hospital based consultant diabetologists doing what we were put on this earth for – delivering specialist diabetes care. Historically the number of hospital beds a consultant was responsible for used to be almost viewed as a 'virility symbol'. I personally would prefer a modest number of perhaps 10 for in patient specific diabetes and endocrine care, with our commitment to in patient care for the 15-20% with diabetes throughout the hospital.

I am hopeful that the National Diabetes In Patient Audit day co-ordinated by Gerry Rayman will provide the evidence to compel SHAs, commissioners and acute trusts to ensure effective hospital wide consultant led in patient diabetes care.

Training SpRs to a high standard remains a core objective of ABCD. A recent ABCD survey found inconsistencies in regional training programmes. Our last committee meeting agreed that we progress ABCD-badged input to these sessions and ensure coverage of service development and preparation for the Specialty Certificate Exam (SCE). However I have to say that this is a two-way street and the trainees need to make their own efforts to seize such opportunities. As a forward thinking proactive chairman I arranged our own regional programme with a high calibre programme and a renowned international speaker who shall remain nameless! It was more than a little embarrassing that the audience turned out to be the equivalent of 'three men and a dog'. Next time perhaps more stick and less carrot?

ABCD incorporated

You will be pleased to know that at our November EGM in London we agreed to become an incorporated organisation, which makes our organisation more tax efficient and offers other benefits. Perhaps most importantly for the executive and committee it limits our own individual liability in the event that we are sued. Whereas this possibility might at one time have been fanciful, you only need to read the papers to see that Britain is currently a favoured centre for libel actions involving clinicians and scientists.

Following the EGM we had another top-notch ABCD meeting in London organised by Dinesh Nagi, attended by well over 100 delegates. As ever I feel the meeting provided a unique atmosphere – proven by your feedback. I hope to see many of you in Gateshead in May.

We continue to actively engage with Diabetes UK and its new chairman George Alberti. Together the organisations have

defined specialist diabetes services to support commissioning, and are assessing the status of community specialist services, and the opportunities for training within them. We have been better able to input to the NICE technology programme through coordinated nominations of experts and are working together to update the diabetes section of JBS3 guidelines on CVD.

We have met with the executive of the Primary Care Diabetes Society (PCDS) and had a fruitful meeting. We agreed to formulate an update of our joint position statement on integrating diabetes care and opportunities for training, joint operational research and audit.

I have just completed my term as our representative for diabetes and endocrinology on RCPL College Council. I am concerned that the current arrangement of alternating with endocrinology means that over the next two years we may not have college access at a critical time.

One area I feel strongly about is the interface between acute-general medicine and specialist work and our increasing commitment to acute medicine as other specialities opt out 'of the take'. Our 2006 ABCD survey recorded this and I reckon the situation has got worse. The College Manpower survey confirms we make the greatest contribution but suggests that some other specialities are in the same boat. The opt out of cardiologists etc. of course does not imply their intensity of work is any less but the point I put across when I tabled this item at RCPL Council was that our increased on call commitment is at the expense of specialist work and service development in contrast to those who opted out. I am not sure where this issue is going but we need to keep the momentum going. My solution – more diabetologists sharing the load.

The Specialty Certificate Exam (SCE) board for 2010-11 met in December. I think we agreed a fair but testing examination for May 2010.This is a vital educational exercise and I am positive we are engaged in a well organised project.

The wisdom of elderly statesmen

ABCD is a founder member of the Coalition of UK Specialist Medical Societies, which have together addressed areas of common interest including the acute medical-specialty interface, SCE, revalidation, academic training, finances, and education.

The Coalition meeting has enabled ABCD to share ideas and learn from other more established organisations. One helpful suggestion from the British Geriatric Society was to invite senior members to critique output from DH, NICE or write position statements. We had already exploited such an 'asset' in the form of Ken Shaw who produced an excellent practical paper on helping localities plan for the potential impact of swine flu on diabetes services.

By the time this newsletter is with you, winter will have passed and we will see whether the guidance came into play with Sir Liam's Doomsday scenario. Regardless, Ken's document sets a benchmark for future major events where contingency planning for diabetes care is necessary. Ken also continues to play an active role in supporting our input to ACCEA where our members continue to have a high success rate. I consider Ken my 'consigliere' – a bit like Robert Duvall supporting Al Pacino in the Godfather but with less pasta and gunfire!

Over the winter holidays I came across smiling shop assistants with the 'How Am I Doing' badge on their lapels and thought I should tempt fate by asking this question of myself 18 months into my chairmanship. I am sure you will let me know!

My main priorities were to increase our membership, improve our financial status and enhance our profile nationally.

I have of course benefited enormously from the great support from the other members of executive and the committee but to offer you progress to date:

We have around 400 consultant members, an increase of just 3.6% over past 18 months, way short of the 500 we need to ensure the loudest voice in all circles. We have by contrast been very successful in attracting a 40% increase in SpR members over that time.

Supported projects and new opportunities

I am extremely appreciative of the support of corporate sponsors who enabled ABCD to carry out national NHS–ABCD priority work. At present we have agreed to support a project reviewing current specialist provision and training in 'community diabetes', upgrading the educational section of our website and supporting our input to the writing of JBS3 CVD guidance. We are still looking to identify one additional project that could free up a consultant for a day a week over a year, so if you have a national project that you would like to take on behalf of ABCD please let me or Ian Gallen know.

Our efforts to raise our profile through a public communications company has delivered some returns and I expect this to continue – our upcoming position statements on HbA1c and the treatment of male hypogonadism in DM should prove cases in point.

There are many 'big tasks' for 2010. We will be looking to expand the portfolio of ABCD position papers under Ian Gallen's direction and updating our views on insulin pumps and gliptins-GLP-1 analogues over the next 12-18 months. A revalidation sub-group led by Patrick Sharp will be a priority to ensure the process is fair, meaningful and effective for diabetologists. Our input to diabetes information strategies is being led by Anne Kilvert. I am keen we progress the concept of core group work within the committee and financial and academic sub-structures have also been created.

2010 will also bring important output from the Joint British Diabetes Societies (JBDS) In Patient Group with the publication of guidelines on hypoglycaemia and diabetic ketoacidosis. JBDS are also pushing ahead to promote auditable standards for in patient diabetes care, derived in part from the findings of the National Diabetes In Patient audit day. Our joint meeting with RCPL in January on in patient diabetes was well attended and a testament to the importance of this area.

I want to pay tribute to our valued friend Jeff Goulder, who died earlier this year. Jeff was absolutely irreplaceable as a colleague from the pharmaceutical industry who was unswervingly dedicated to improving professional care for those living with diabetes, and who ABCD remains indebted to. I will miss him as will many of you.

Let me conclude with some lyrics from a classic Hollies number that emphasise the spirit of co-operation that will be needed in the year ahead, and which most of you are probably too young to recognise:

The road is long
With many a winding turn
That leads us to who knows where
Who knows where
But I'm strong
Strong enough to carry him
He ain't heavy, he's my brother

Peter H Winocour, Chairman

Revalidation: the way ahead

The ABCD is broadly in agreement with the principles laid out in the document 'Revalidation: the way ahead'. As a main stream medical specialty, we have been working with the Royal College of Physicians in formulating the generic and specialty components of the revalidation process. In general, we feel that diabetes as a specialty will largely follow the generic framework but would wish to develop targeted audit and open book learning particular to those wishing to remain on the specialist register for diabetes.

With respect to specialist areas of practice it is clearly vital to develop, where necessary, national clinical audit tools and ensure there are appropriate mechanisms to evaluate subspecialist areas of care which are likely to develop further in the years ahead. ABCD believes that it should play an active role in this process, setting appropriate standards.

ABCD has concerns about the time and costs involved in ensuring the different facets of revalidation can be met, especially in the current financial climate for the NHS, when it is likely that costs would have to be met within existing budgets.

ABCD believes that there are important and challenging considerations in applying revalidation tools to individuals in many areas of specialist care carried out by multidisciplinary teams, especially where services are considered to be under resourced. The opportunity for specialist societies, working with other agencies, to carry out service peer reviews may need to be considered as an active component of revalidation but of course raises issues of cost in respect of finance and time. Importing revalidation tools from other countries with different health care structures is potentially fraught with difficulty, and if revamped for UK use will again take time and effort through specialist organisations.

ABCD has serious concerns about the ability of senior responsible officers in acute trusts to be in a position to evaluate areas of specialist practice without clear standards established by specialist societies and the College of Physicians. Specialist societies have an important role in ensuring that the revalidation methods meet the needs in terms of knowledge, skills and professionalism of the respective specialty and subspecialty areas.

There is also a potential for a serious conflict of interest in the process of revalidation being sanctioned by the SRO as medical director within trusts.

The document 'The Way Ahead' spells out a number of questions relating to revalidation, and the consultation period is open until the beginning of June. Some thoughts on the answers to the questions are given below. Many of these questions represent a simple ratification of the obvious, but some are contentious.

Have your say If you have any strong feelings, please feel free to respond direct to the GMC in their online consultation, or if you have any views on the role of ABCD in the process, contact Patrick Sharp (patrick.sharp@nhs.net).

Question 1 'Revalidation should be a single process'. Yes, we would agree with that principle. Separating relicensing and recertification would add an unecessary layer of complexity.

Question 2 'Revalidation should be based upon an assessment of a doctor's performance in the workplace'. Yes, we would agree with that principle but would welcome development of standardised tools relevant to consultant practice to facilitate this process.

Question 3 'Do you agree with the suggestions for dealing with the common situations where the responsible officer is not able to make a recommendation'. Yes, we would agree that in those instances, referral to the GMC or NCAS would be appropriate.

Question 4 The colleges and faculties should not be directly involved in the recommendations of the RO to the GMC'. We would agree with this statement in that colleges setting up their own independent boards would only add complexity.

Question 5 'Involvement of the colleges in revalidation'. We welcome the involvement of the colleges in revalidation in relation to specialty work. In particular, we would agree with the colleges being involved in agreeing specialty specific supporting information and advising appraisers and ROs. Audit of the recommendation process might require a little more clarification as this would require some resource allocation to the specialist societies to carry out this role.

Question 6 'Successful completion of training should be the vehicle for revalidation'. We would support the view that completion of training should be the vehicle for first revalidation. However, a subsequent revalidation might be appropriate in two to three years as this is often a key point in a newly appointed consultant's career.

Question 7 'Revalidation of doctors with no clinical practice'. Requiring such doctors to sit PLAB or equivalent is contentious. We would prefer to treat such cases on an individual basis, examining why such an individual wishes to revalidate rather than imposing a blanket solution. There are many reasons why this situation may occur which can be dealt with in other ways.

Question 8 'That the register should record the specialty on which revalidation is based'. Yes, we would agree with this principle.

Question 9 'Use of good medical practice as a basis for revalidation. This document has long been the basis for appraisal and is fit for practice in revalidation.

Question 10 Any further comments on 9. It will be the role of the specialties to fit their specialty specific work into this as a framework.

Question 11 and 12 'Is the general approach to developing supporting information reasonable and the output practical? The work so far has been useful, although as the deadlines approach, it is not clear that we will have the work completed by the deadlines.

Question 13 CPD and revalidation. The principles laid out are sound. The current Royal College of Physicians CPD diary is excellent and covers the areas proposed. It does not cover the detail of whether the content is appropriate to an individual's practice, but this should be picked up at appraisal.

Question 14 Patient involvement in the process. We would agree with the process, but would welcome clarification on the qualifications required for a GMC affiliate. These would be influential roles, and there should therefore be clarity as to who is able to take up these posts.

Queston 15 and 16 Patient and colleague questionnaires. We would agree with the principles. Some clarity is required on patient and colleague selection for these processes. A balance is required between the appraisee selecting their own assessors and an outside agency selecting random names.

Question 17 Questionnaires should be validated. However, there should be some generic questionnaires to avoid each organisation setting up their own.

Question 18 19 and 20 Should revalidation be rolled out only in areas where the organisation is in a state of readiness. The danger of this approach is that such delay will result in some organisations delaying their readiness. It would be better to suggest that each organisation revalidates 20% of their workforce per year from 2011 recognising that this will be a learning process for all. Even if the process is imperfect, it is not replacing any other process, and could not therefore cause any worsening of the situation.

General secretary's report

ABCD and ABCD Trust constitution/deeds

The constitutional changes to ABCD and Diabetes Care Trust are now complete and in operation.

Membership update

The ABCD membership is currently 600.

Elections to the committee

This year there is a requirement to seek election of five positions on the committee. Replacements are required for representative from Wales and Scotland, two general posts, one for a colleague under five years from appointment. We have also decided to have a junior academic representative, to strengthen representation of our profession. The results of these elections will be announced at the AGM.

NICE

ABCD is a key partner with NICE for diabetes and technology appraisals. To maintain this position it is essential that we continue to provide prompt and high quality submissions. We are collaborating where relevant with Diabetes UK, and with RCP London to co-ordinate response with ABCD usually leading these submissions. These combined submissions represent a very significant body of opinion.

Members of ABCD have contributed to Liraglutide, long acting Exenatide, Clopidrogel and buccal insulin and will contribute to Ranibizumab in macular oedema technology appraisals. Members of ABCD have also contributed to foot management guideline, and ABCD is seeking to overturn NICE decision not to review type 1 diabetes guidelines. ABCD thanks Alan Jaap, Patrick Sharp, Stephen Bain and Sudhesh Kumar, Roy Taylor, Vinod Patel, David Hopkins, Ian Cranston, Shanaz Rambotola, Satyan Rajbhandari, and Paul Dobson for their contributions in this important work.

Further NICE appraisals are on the horizon, notably on strategies to reduce progression to T2DM, and we will be seeking further excellent contributions from our membership. If individuals feel that they have a specific area of expertise, please can let me know and I can direct future appraisals.

Publicity

The committee was aware that the membership felt that the profile of ABCD needed to be raised. ABCD has recruited a public relationship company (Different PR) to assist ABCD in promoting the association's views. The aim of the press releases is to highlight the vital role of the diabetologist in providing specialist care for people with diabetes. This is in the climate when it is frequently reported that people with diabetes are, and can be, "cared for in the community".

ABCD has given guidance to the public during the Swine Flu epidemic, and released press statements on the limitation of blood glucose monitoring, and on the progress in diabetes care following the national service framework for diabetes. ABCD has released statement following publication of new research on close loop insulin delivery systems (the artificial pancreas), and responding to three studies which suggested that rates of cancer may be increased in people treated with glargine. We have also responded to an inflammatory report from the think tank Reform on the suggestion that there are large numbers of hospital bed closures as a result of greater care of diabetes in the community.

These releases have had widespread uptake in the media, although not all are attributed to ABCD. This collaboration with Different PR has a significant cost to ABCD, and this programme will need to be reviewed by the committee this year to determine whether it is felt to be good value.

Regional network

The network of regional leads or "champions", (one for each of the nations and within England one for each large region) is delivering improvements in the core activities of ABCD, being the local eyes and ears of ABCD, and the conduit for information and communication from the committee to each region. Further work is required in our global membership and retention efforts. ABCD also want a SpR champions to work with the leads in each region to assist with any educational support (eg speakers) for regional training meetings, and is recruiting for these posts. It was with great sadness to learn that one of our champions, Ken Mcleod, passed away last year. He will be much missed. Patrick English is much welcomed to take over this role in the South-West.

Region	Champion	Mail
Scotland	Pending election	
Wales	Pending election	
Northern Ireland	Kate Ritchie	kate.ritchie@southerntrust.hscni.net
England		
East	Gerry Rayman	Gerry.Rayman@ipswichhospital.nhs.uk
East Midlands	Robert Gregory	rob.gregory@uhl-tr.nhs.uk
North West (1)	Mark Savage	Mark.Savage@pat.nhs.uk
North West (2)	Susannah Rowles	Susannah.Rowles@pat.nhs.uk
Merseyside	Niru Goenka	Niru.Goenka@coch.nhs.uk
South Central	Partha Kar	drparthakar@googlemail.com
South East	Ian Scobie	ian.scobie@kcl.ac.uk
South West	Patrick English	patrick.english@phnt.swest.nhs.uk
West	Eluned Higgs	Eluned.Higgs@ruh-bath.swest.nhs.uk
West Midlands	Bob Ryder	bob.ryder@swbh.nhs.uk
Yorkshire	Vijay Jayagopal	Vijay.Jayagopal@york.nhs.uk
London	Vacant	

ABCD clinical audit awards

This years ABCD audit award was won by John McKnight and will be an audit of inpatient diabetes care.

ABCD position statements

We have released and published further position statements on exercise in diabetes and on continuous glucose monitoring this year. Topics and authors for further position statements are welcomed.