1st John Wales Memorial Lecture May 2018

Dr John Wales 1937-2017

Delivering better diabetes care – its about **Time !**

Dr Peter H Winocour

ENHIDE

Welwyn Garden City

John Wales – His Life and **Times**

CURRICULUM VITAE

PERSONAL DETAILS:

NAME:	John Kenneth Wales
DATE OF BIRTH:	16th October 1937
NATIONALITY:	British
CIVIL STATUS:	Married with 4 children
HOME ADDRESS:	
LAST FULL TIME APPOINTMENT:	Senior Lecturer in Medicine, University Of Leeds. Honorary Consultant Physician, The General Infirmary at Leeds., Leeds LS1 3EX RETIRED IN DECEMBER 2002
PART TIME APPOINTMENT:	Visiting Diabetologist and Lecturer Beijing Chaoyang Diabetes Hospital, 1 Tianshinyuan Jong Die Beijing 100025 P.R. China.

John Wales – His Life and **Times**

EDUCATION AND QUALIFICATIONS:

SCHOOL: The Grammar School, Burnley
Lancashire.
Edward Stocks-Massey Scholar

UNDERGRADUATE CAREER: School of Medicine, University of Leeds 1955-6
Half Blue (1957)
Birkett Prize (1957)
Infirmary Prize (1957)
Mayo-Robson Prize (1960)

QUALIFICATIONS: MB ChB (Leeds) 1960
Distinctions in Physiology, Public Health and Forensic Medicine

MD (Leeds) 1965
Title: "Studies on the hyperglycaemic activity of benziothiadiazine diuretics".

MRCP (London) 1968

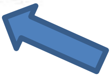
FRCP (London) 1979

AWARDS: Maccabbean Prize and Medal of the Society of Apothecaries of London (History of Medicine) 1961

William B. Peck Scientific Research Award of the Interstate Postgraduate Medical Association of North America 1966

PREVIOUS APPOINTMENTS:

From		To	Appointment
Feb 1961	-	July 1961	House Surgeon to Professorial Surgical Unit (Professor J. C. Goligher), The General Infirmary at Leeds.
Aug 1961	-	Feb 1962	House Physician to Professorial Medical Unit (Professor R.E. Tunbridge), The General Infirmary at Leeds.
Feb 1962	-	July 1962	House Physician to Professor T.Russell Fraser, Hammersmith Hospital, London W12.
Sept 1962	-	Oct 1963	Assistant Lecturer in Pharmacology, (Professor D. R. Wood), University Of Leeds.
Oct 1963	-	Feb 1965	MRC Junior Research Fellow, Department of Pharmacology, (Professor D. R. Wood), University Of Leeds.
Sept 1962	-	Feb 1965	Clinical Assistant to the Diabetic & Hypertension Clinics, The General Infirmary at Leeds.
Feb 1965	-	Oct 1965	Senior Research Assistant, Dept of Medicine, (Professor Rachmeal Levine), Division of Clinical Pharmacology (Dr F.W. Wolff), New York Medical College, New York, USA.
Oct 1965	-	Sept 1967	Assistant Professor of Medicine, George Washington University, Washington DC, U.S.A.
Oct 1967	-	Dec 1969	Registrar in General Medicine, Hammersmith Hospital, London W12 with Dr. C.L. Cope (until his retirement in October 1968) and then with Dr. Graham Neale and Dr. Gilbert Thompson).
Jan 1970	-	Oct 1972	Lecturer in Medicine, University Of Leeds.
Jan 1971	-	Dec 2002	Honorary Consultant Physician to United Leeds Hospitals, then to Leeds Area Health Authority and then The Leeds Western Health Authority and then to United Leeds Teaching Hospitals NHS Trust.



John Wales – A Man of his **Time**

Pockets on shirts fall out of style

By Caroline Gammell

IT is a question as much for men with sartorial concerns as it is for those with purely practical worries.

But shoppers are finding it increasingly difficult to buy shirts with a breast pocket.

Tailors say such a luxury ruins the line of a shirt. As a result, high street stores are selling fewer of them.

John Wales, 70, a retired doctor from Appleton Roebuck, north Yorks, who is outraged that it is increasingly difficult to buy a shirt with a pocket, said: "When you get to a certain age, you want comfort rather than fashion. Where are men supposed to put things?"

Adam Barton, of Marks & Spencer, said 90 per cent of the shirts it sold 10 years ago had pockets, compared to 25 per cent this year.

John Wales – Ahead of his **Time**

Schoolhouse
Acaster Selby

5th August 2011

Dear Ken,

I would be grateful for your views on the enclosed draft letter to the College asking for ABCD to become a permanent Council member — rather than sharing the place with the Endocrinologist and/or Diabetes UK.

As you can see I am keen not to upset John Wass and not to appear to be just wanting to cause trouble for no reason. However as you know the agenda is to avoid the next occupant on rotation from Endocrinology coming from Diabetes UK which is a charity not the specialist Society. Hence the referral to our members being Fellows, etc. to strengthen our obvious validity.

If the letter does go to the College, I feel it would be improved if it was joint from you, Richard and me with perhaps Clive, Peter, Ian, David, Bob Ryder and other senior Fellows. However I would be worried if Clive wanted it to be seen by the Committee as I am sure it would be 'leaked' to George who will wish to scupper the idea or make sure Diabetes UK is the permanent member!!

I must stress that this is a draft. Please feel free to make changes as well as whether you think it is a good idea at all. Add any other points you think would strengthen the case. Ever onwards and upwards. I have only sent it to you and Richard.

Regards to Phillippa,

As ever

John Wales

ABCD Gang of Three – Bygone **Times**

ABCD - Founded 1997

ASSOCIATION OF BRITISH CLINICAL DIABETOLOGISTS

To be held at the Royal College of Physicians,
11 St. Andrews Place, Regents Park, London, NW1 4LE
on Friday, 13th June, 1997 at 2.00pm

(by Kind Permission of the Treasurer of the College)

Chairman: John K. Wales MD FRCP

AGENDA

1400 Welcome

Introduction and Aims of the Association (including result of the ballot)
Dr. John K. Wales, MD, FRCP

Discussion

1430 The Current Issues

(1) changes in clinical practice
(2) primary/secondary care interface
(3) quality and clinical effectiveness
(4) manpower situation
(5) ABCD relationship to endocrinology & general medicine

Dr. Richard H. Greenwood, FRCP

Discussion

1520 TEA

1550 Structure and Function of the Association

(1) constitution
(2) membership
(3) meetings
(4) relationships with other organisations

Professor Ken Shaw, MD, FRCP

Discussion

1630 General Discussion and Further Plans for the Association

1700 Close

Time for a change – John Wales and the formation of ABCD

ASSOCIATION OF BRITISH CLINICAL DIABETOLOGISTS (ABCD)

Consultant Physicians attending the Meeting at the Royal College of Physicians in London on 13th June, 1997

Name	Hospital
Dr. W. Alexander	Queen Mary's Hospital, Sidcup
Dr. A. Baksi	Isle of Wight
Dr. M.A. Baxter	St. Peter's Hospital, Chertsey
Dr. C. Baynes	Chase Farm Hospital, Enfield
Dr. S.F. Beer	Scunthorpe General Hospital
Dr. J. Bending	Eastbourne
Dr. C. Burns-Cox	Frenchay Hospital, Bristol
Dr. J. Cassar	West Middlesex Hospital
Dr. P. Coates	Staffordshire General Hospital
Dr. P.R. Daggett	Staffordshire General Hospital
Dr. H. Alban Davies	Westhill Hospital, Dartford
Dr. M. Davies	Leicester Royal Infirmary
Dr. D.J. Galton	St. Bartholomew's Hospital, London
Dr. C.J. Gibbs	Greenwich District Hospital, London
Professor P.J. Grant	Leeds General Infirmary
Dr. P. Hale	Stepping Hill Hospital, Stockport
Dr. M. Hammersley	Royal Hampshire Hospital, Winchester
Dr. C. Hardisty	Northern General Hospital, Sheffield
Dr. K. Hardy	Whiston Hospital, Prescot
Dr. R. Harvey	Dr. Gray's Hospital, Elgin
Dr. C. Kesson	Victoria Infirmary, Glasgow
Dr. I. Lewin	North Devon Hospital, Barnstaple
Dr. P. McNally	Leicester Royal Infirmary
Dr. C. McIntosh	Queen Mary's Hospital, Roehampton
Dr. A. MacCleod	Royal Shewsbury Hospital
Dr. L.E. Murchison	Royal Aberdeen Hospital
Dr. N.W. Oakley	Wimpole Street, London
Dr. S.A. Olczak	Pilgrim Hospital, Boston
Dr. C. Paton	Milton Keynes Hospital
Dr. Premawardhama	Caerphilly Hospital
Dr. G.H. Robb	Epsom Hospital
Dr. R.E.J. Ryder	City Hospital, Birmingham
Dr. R.J.M. Scott	King Edward VII Hospital, London
Dr. A.H. Al-Shaboury	Prince Charles Hospital, Merthyr Tydfil
Dr. J. Smithard	Rochdale Hospital
Dr. G.S. Spathis	St. Helier Hospital, Carshalton
Dr. A. Taylor	Horton General Hospital, Banbury
Dr. R.C. Temple	Norfolk & Norwich Hospital
Dr. P. Vice	Preston
Dr. I. Worsley	Lewisham Hospital
Dr I Gallen (handwritten)	High Wycombe (handwritten)
No name	Postmarked Swansea
No name	Postmarked Stevenage
No name	Postmarked Hemel Hempstead (x2)
No name	
No name	
Professor Shaw	Portsmouth
Dr. Greenwood	Norwich
Dr. Wales	Leeds

Handwritten additions:

Apols

Dr P. Winocour – Wel G City

Dr L Borthwick

Dr Beck – Llandough

Dr Sandler – High Wycombe

Dr Frier – Edinburgh

Dr Heyburn – Nottm

Dr Owen – Llandough

ABCD and John in Action

ABCD Chairs **Times** 6 !

November 2014

The National Service Framework 2002 and Future **Times**

National Service Framework for Diabetes:

Delivery Strategy

Vague and Focused on Process not Outcomes

'GIRFT2002'–Got It wRong in Former Times

National Service Framework for Diabetes: Delivery Strategy

Figure 2: Diabetes NSF Standards to be reached by 2013	
Prevention of Type 2 diabetes	*Standard 1* The NHS will develop, implement and monitor strategies to reduce the risk of developing Type 2 diabetes in the population as a whole and to reduce the inequalities in the risk of developing Type 2 diabetes.
Identification of people with diabetes	*Standard 2* The NHS will develop, implement and monitor strategies to identify people who do not know they have diabetes.
Empowering people with diabetes	*Standard 3* All children, young people and adults with diabetes will receive a service which encourages partnership in decision-making, supports them in managing their diabetes and helps them to adopt and maintain a healthy lifestyle. This will be reflected in an agreed and shared care plan in an appropriate format and language. Where appropriate, parents and carers should be fully engaged in this process.
Clinical care of adults with diabetes	*Standard 4* All adults with diabetes will receive high-quality care throughout their lifetime, including support to optimise the control of their blood glucose, blood pressure and other risk factors for developing the complications of diabetes.
Clinical care of children and young people with diabetes	*Standard 5* All children and young people with diabetes will receive consistently high-quality care and they, with their families and others involved in their day-to-day care, will be supported to optimise the control of their blood glucose and their physical, psychological, intellectual, educational and social development.
	Standard 6 All young people with diabetes will experience a smooth transition of care from paediatric diabetes services to adult diabetes services, whether hospital or community-based, either directly or via a young people's clinic. The transition will be organised in partnership with each individual and at an age appropriate to and agreed with them.
Management of diabetic emergencies	*Standard 7* The NHS will develop, implement and monitor agreed protocols for rapid and effective treatment of diabetic emergencies by appropriately trained health care professionals. Protocols will include the management of acute complications and procedures to minimise the risk of recurrence.
Care of people with diabetes during admission to hospital	*Standard 8* All children, young people and adults with diabetes admitted to hospital, for whatever reason, will receive effective care of their diabetes. Wherever possible, they will continue to be involved in decisions concerning the management of their diabetes.
Diabetes and pregnancy	*Standard 9* The NHS will develop, implement and monitor policies that seek to empower and support women with pre-existing diabetes and those who develop diabetes during pregnancy to optimise the outcomes of their pregnancy.
Detection and management of long-term complications	*Standard 10* All young people and adults with diabetes will receive regular surveillance for the long-term complications of diabetes.
	Standard 11 The NHS will develop, implement and monitor agreed protocols and systems of care to ensure that all people who develop long-term complications of diabetes receive timely, appropriate and effective investigation and treatment to reduce their risk of disability and premature death.
	Standard 12 All people with diabetes requiring multi-agency support will receive integrated health and social care.

Time to take stock –ABCD survey 2000

July 2002 Volume 19 Supplement 4

Diabetic Medicine

Journal of Diabetes UK

www.blackwell-science.com/dme

State of Diabetes and Diabetic Care in the UK

Association of British Clinical Diabetologists (ABCD) survey of secondary care services for diabetes in the UK, 2000. 1. Methods and major findings

P. H. Winocour*, A. Ainsworth and R. Williams† on behalf of the Association of British Clinical Diabetologists (ABCD)

East and North Herts NHS Trust, Welwyn Garden City, *Royal Free Hospital School of Medicine, London, and †Nuffield Institute for Health, University of Leeds, Leeds, UK

Accepted 16 October 2001

Abstract

Objective To examine the provision, and variations in, secondary care diabetes services in the UK.

Methodology and participants A postal survey of all 238 identified secondary care providers of diabetes services in 2000.

Results Following two reminders, a 77% response rate was achieved. Major deficiencies in core staffing levels were recorded, with 36% of services provided by only one consultant physician with an interest in diabetes. The provision of diabetes specialist nurses was less than recommended in 87% of responses, whereas podiatry and dietetic support was unavailable in 3% and 27% of responses, respectively. Diabetes registers were not present in 28%, and a co-ordinated retinopathy screening programme unavailable in 26% of responses. Key biochemical measurements were unavailable in 9% (microalbuminuria) to 18% (HDL-cholesterol) of responses. A 'Well-Resourced Service' score was devised taking account of levels of personnel, facilities and specialized clinical services. There was a significant geographical variation in this score ($P < 0.001$), with the lowest score (least well-resourced services) in the Eastern NHS Region of England, and the highest score in the North-west NHS Region of England. The 'Well-Resourced Service' score was also significantly lower ($P < 0.05$) where there were less than two whole-time consultant physicians providing diabetes services. In contrast to other aspects of service provision, availability of dieticians and a combined diabetes–ophthalmology service had declined since 1990. Of 245 recorded bids for resources and service improvements for diabetes care, the success rate overall was 44%, and lowest where bids were made for dietetic and podiatry support.

Conclusions There is presently a major shortfall in provision of secondary care diabetes services throughout the UK, with evidence that there is significant regional variation and less facilities and resources where there are less than two consultants providing specialized diabetes services. On average bids for service improvements were only successful in < 50% of cases, most usually where the service was relatively better provided for. Considerable development and investment are required nationally to ensure equitable access to specialized diabetes services, a vital component in reducing adverse diabetes outcomes.

Diabet. Med. 19, 327–333 (2002)

Keywords diabetes services, physicians, diabetes specialist nurses, dieticians, podiatrists

Correspondence to: Dr P. Winocour, Consultant Physician, Department of Diabetes and Endocrinology, Queen Elizabeth II Hospital, Howlands, Welwyn Garden City, Herts AL7 4HQ, UK. E-mail: peter.winocour@qeii.enherts-tr.nhs.uk

© 2002 Diabetes UK.

17 years on .. The passage of **Time** and the 2017 ABCD Workforce Survey

- Definite increase in consultant workforce
- FTE/100K population was 0.67 and now 1.43
- The significant geographical variation in resourcing of services persists
- Well resourced service score in 2000 - lowest in Eastern and highest in North West of England
- Consultant variation in 2017 from 0.9 in Wessex to 1.9 in Scotland FTE/per 100K

My 15 Minutes of Fame

Effective diabetes care: a need for realistic targets

Peter H Winocour

The research based metabolic and blood pressure targets that the national service framework for diabetes in England and Wales will set in the implementation document will be impractical for use in routine clinical care: targets need to be tailored to the individual patient, according to Peter Winocour

The publication of the national service framework for diabetes in England and Wales will raise public awareness of diabetes throughout the United Kingdom. Its recommendations are influenced by evidence that adverse vascular outcomes may be reduced by tight control of blood sugar and blood pressure[1-3] and that secondary prevention of macrovascular disease is feasible through modification of dyslipidaemia and use of antiplatelet agents[4-7 w1]; and by the recognition of an estimated doubling in incidence of diabetes over the next 10 years.[8]

This has led to the production of guidelines for optimal care that may be incorporated into a nationally recommended standardised approach, with targets for metabolic and vascular variables and recommendations for certain therapies.[9-11 w2] The effectiveness and quality of healthcare systems are increasingly being measured by how well such standards are adhered to, and it is therefore vital that the targets are appropriate. The following discussion focuses on type 2 diabetes, since this is much more common than type 1 diabetes.

Summary points

Aggressive treatment of hyperglycaemia, dyslipidaemia, and hypertension and regular use of antiplatelet agents has been advocated in type 2 diabetes

Current targets for glycaemia, lipids, and blood pressure are attainable in only 50-70% of individuals in research studies

The targets are often impractical and involve taking too many drugs, with which patients often will not comply

Individually tailored targets are needed, and their effectiveness will be shown by improvement in the range of metabolic and blood pressure measurements in diabetic clinics

Department of Diabetes and Endocrinology, Queen Elizabeth II Hospital, Welwyn Garden City, Herts AL7 4HQ
Peter H Winocour
consultant physician

peter.winocour@qeii.enherts-tr.nhs.uk

BMJ 2002;324:1577–80

Targets for glycaemia, lipids and BP attainable only in 50-70%

DOING THE ROUNDS

Swallow that

THE revelation, courtesy of the Commission for Social Care Inspection, that the elderly are given the wrong drugs in half of all care homes could be seen as progress.

When left to their own devices, only a third of patients take their tablets properly. This long-standing problem has been compounded of late by the absurd number of pills elderly patients have to pop so GPs can hit the government's targets and send their children to public school.

Targets do at least concentrate the mind; but as Peter Winocour, a consultant NHS diabetologist, puts it[1]: "Targets are often impractical and involve taking too many drugs… 10% of type 2 diabetics could require two or three hypoglycaemic agents (ultimately including insulin), at least three antihypertensive agents, two hypolipidaemic agents, and aspirin. A high proportion will also require treatment for coexistent cardiovascular disease and coincidental unrelated chronic disease. It is difficult to see how we can realistically expect patients to comply for long with such a draconian regimen requiring so many separate drugs."

To illustrate the point, a GP has written to the *Eye* about an elderly woman who was expected to take 20 tablets of 16 different drugs spaced out over four different time intervals. "One of the

and swa
figuring
Give
(as we tr
Switzerl
need mo
they nee
else all d

Not al

**GP tar
prescript
expensive
states tha
coronary
ventricul
should ha**

Unsurp
ordering f
interesting
chief exec
primary ca
unnecessar
which are
satisfy the

off

NOW MA
HAVE Y

Time after Time

Time Series

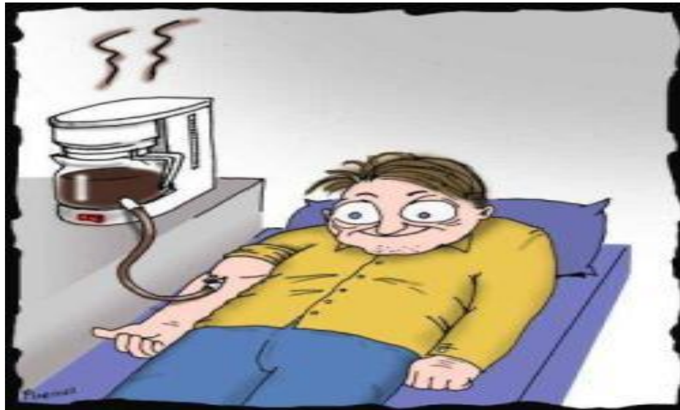
Table 2: Percentage of people with diabetes achieving their treatment targets by diabetes type and audit year

	Type 1					Type 2 and other				
	2012-13	2013-14	2014-15	2015-16	2016-17	2012-13	2013-14	2014-15	2015-16	2016-17
$HbA1_c$ ≤ 58 mmol/mol	27.2	29.4	29.9	29.2	30.2	64.9	66.8	66.1	65.7	66.8
Blood pressure ≤ 140/80	73.4	76.4	76.4	74.2	75.8	68.6	73.6	74.2	73.6	74.2
Cholesterol < 5mmol/L	70.2	71.5	71.3	70.8	69.4	76.7	77.8	77.5	77.1	76.0
Meeting all three treatment targets	**16.1**	**18.6**	**18.9**	**18.1**	**18.9**	**37.3**	**41.4**	**41.0**	**40.2**	**40.8**

Time Costs Money – No **Time** Toulouse

- In 2014 ‘cost of DM’ estimated at £10 billion
- 10% of NHS budget with DM 6% prevalence
- 80% of cost on managing complications
- In 2018 - 4.5 million DM in UK (T2 90% and 10% T1-other)
- Projected cost £17 billion by 2035 with increasing DM incidence

Time to wake up and smell the coffee



ISSUE 15 AUTUMN 2009

ABCD Newsletter

The Official Bulletin of the Association of British Clinical Diabetologists

Editor of ABCD Newsletter
Dr M Savage
North Manchester Diabetes Centre
Tel: 0161 7204723
Fax: 0161 7202029
Email: mark.savage@pat.nhs.uk

Chairman of ABCD
Dr P Winocour
Queen Elizabeth II Hospital
Tel: 01707 365156
Fax: 01707 365366
Email: pwinocourabcd@hotmail.com or peter.winocour@nhs.net

Hon. Treasurer of ABCD
Dr C Walton
Hull Royal Infirmary
Tel: 01482 675368
Email: chris.walton@hey.nhs.uk

General Secretary
Dr I Gallen
Wycombe Hospital
Tel: 01494 526161
Email: ian.gallen@sbucks.nhs.uk

Meetings Secretary
Dr Dinesh Nagi
Pinderfields General Hospital
Tel: 01924 201688
Email: dinesh.nagi@midyorks.nhs.uk

Dr S Boardman
Warwick Hospital
Tel: 01926 495321 Ext: 4098
Email: shirine.boardman@swh.nhs.uk

Dr N Goenka
Countess of Chester Hospital
Tel: 01244 36500
Email: niru.goenka@coch.nhs.uk

Dr R Gregory
Leicester General Hospital
Tel: 0116 258 8017
Email: rob.gregory@uhl-tr.nhs.uk

Dr K Dhatariya
Elsie Bertram Diabetes Centre
Tel: 01603 288170
Email: KETAN.DHATARIYA@nnuh.nhs.uk

Dr N Morrish
North Bedfordshire Diabetes Centre
Tel: 01234 792264
Email: Nick.Morrish@bedfordhospital.nhs.uk

Dr J A Kilvert
Northampton General Hospital
Tel: 01604545576
Email: Anne.Kilvert@ngh.nhs.uk

Dr G Rayman
The Ipswich Hospital
Tel: 01473 704183

Reality checks

Peter Winocour, Chairman

I have just 'celebrated'? 30 years working in the NHS and have been experiencing a little battle fatigue. Apart from being startled at the youthfulness of policemen and FYPs you know you have been round the block a few times when you recognise 'new' NHS schemes as rehashed initiatives from a previous generation. My prediction for the next government's 'big idea' – GP fund holding revisited.

I am undoubtedly a little more pensive given the recent tragic news of the deaths of two valued colleagues and friends – Trevor Blair and Ken MacLeod. Apart from the undoubted sadness for their families, I know we all valued Trevor and Ken for their sound clinical judgement and the good company they offered, and their passing represents a real loss for diabetes in the UK.

Since my first Chairman's report, the last six months have been busy ones. ABCD recruited a public communications company in line with our strategy outlined at the May AGM. Our first serious independent foray was to promote our recent position statement on gliptins and exenatide – this went well but the press interpretation of our measured approach was misinterpreted as protectionism by specialists. One positive outcome was that our summary guidance was published

- The 'Super Six' is just one part of specialist diabetes care (Inpatients, Foot Care, T1 DM (including adolescents and insulin pump services), Renal - Low eGFR or dialysis, AnteNatal Care
- 80%+ of DM care takes place in primary care
- The majority of care costs reflects T2DM GP care

Time for leadership

- Diabetologists serving whole communities and health systems
- Fully integrated MDT care led by consultant diabetologists
- ABCD NDCMP AND Clinical Leadership programmes

Time to reappraise and challenge dogma

- Pioglitazone and bladder cancer
- SUs and CVD safety
- HbA1c targets in CKD
- Statins in NAFLD

The difficulty lies not so much in developing new ideas as in escaping from old ones.

John Maynard Keynes
British economist
1883 - 1946
QUOTEHD.COM

Time - the 4th Dimension:
Tempo of DM: slow, slow, quick, quick, crash

- Duration of Diabetes and Therapeutic Inertia

- Acute and Chronic metabolic and vascular events
- Retinopathy – from BDR to vitreous bleed
- CVD – silent atheroma to acute thrombosis
- Feet – stable at risk foot with trivial injury triggering acute foot attack

The Best of **Times**, the Worst of **Times**

- Potential reduction in CVD and Renal Disease with gliflozins –GLP1
- The failure of the NHS health care model ?

DAILY Mirror
250MPH
jet stream storm to batter Britain
HOSPITALS GO INTO MELTDOWN
OUR NHS IS DYING
'Nurses are crying, doctors are quitting and we don't have beds for patients...'
TERRIFYING REPORT FROM A TOP DOCTOR ON THE FRONT LINE

THE Sun
£98bn NHS BUDGET BUT...
THIRD WORLD A&E
10 hospitals in crisis
Worst wait in 10yrs
Car park care tent
£9.50
BOOKING FORM INSIDE

Ultimate 5:2 diet for her – and HIM
Daily Mail
Most inspiring Fast Diet success stories ever
A&E CRISIS WORST FOR TEN YEARS
Casualty units turning away sick
Patients treated in car park tents
Chaos blamed on Labour's GP contract
Cameron Diaz weds tattoo covered rocker

DAILY EXPRESS
PAMPERED SPORTS STARS WHO DON'T KNOW HOW TO MAKE A CUP OF COFFEE
NATURAL CAUSE BY JAMES OSWALD FOR £1
HOSPITALS JUST CAN'T COPE
A&E crisis is the worst in a decade

It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair, we had everything before us, we had nothing before us, we were all going direct to heaven, we were all going direct the other way - in short, the period was so far like the present period, that some of its noisiest authorities insisted on its being received, for good or for evil, in the superlative degree of comparison only.

(Charles Dickens)

izquotes.com

The **times** they are a changin

- Ageing population – DM prevalence > 10% aged 75+yrs
- More complexity in DM therapy selection
- Multimorbidity in DM

61%

increase in the number of over 65s in the UK by 2032

Britain's over 65s already outnumber its under 16s

? Just in **Time** – NHS Transformation Funds (and GIRFT 2018 ?)

- £40M in England from NHSE recurrent for 2 years for IPDM , Foot care , Care Process-Target Attainment , Patient Education
- Clinician led England survey of DM services
- ABCD T1 Collaborative

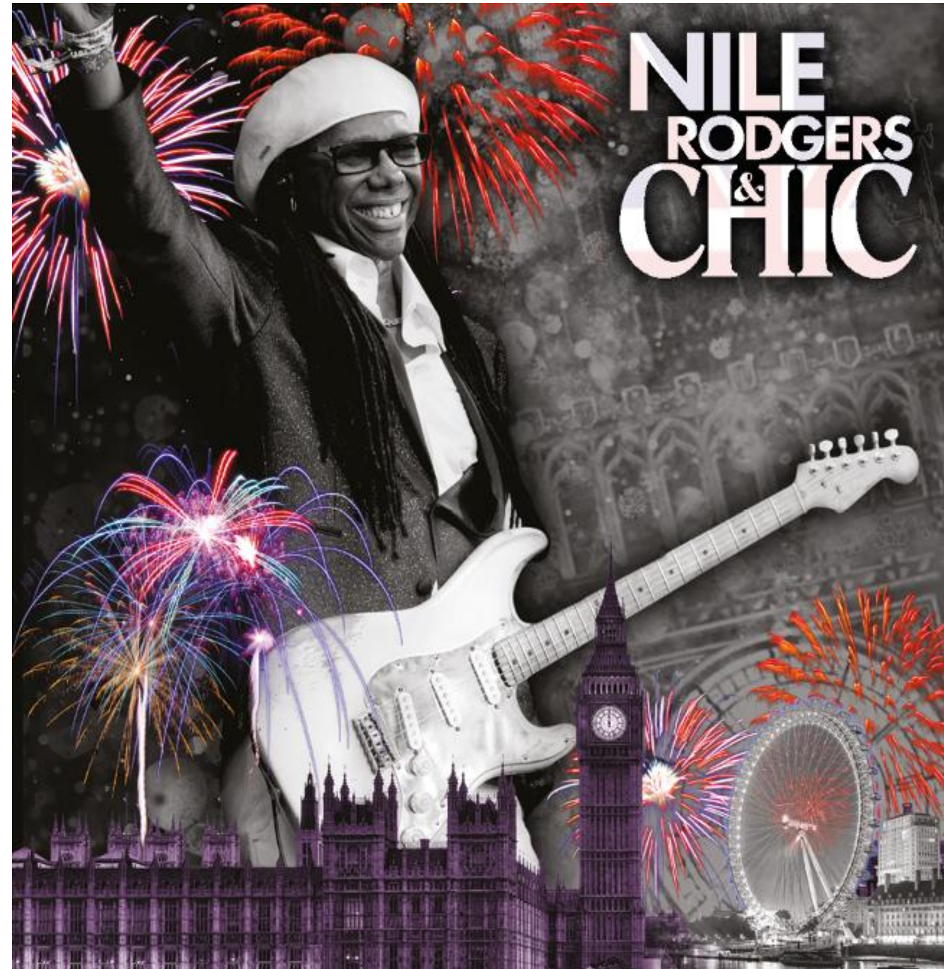
One Step at a **Time**?

ENHIDE
East and North Hertfordshire NHS Trust
East and North Herts Institute of Diabetes and Endocrinology

- Service development in a DGH - East and North Herts over 25 years
- From single consultant + 2 DSNs to a team of 50
- 7 day IP care
- MDT Foot care
- MODY Service
- Joint DM Eye Care
- Close GP collaboration
- Single CYP-Adult IT-ethos

Good **Times**… Ahead

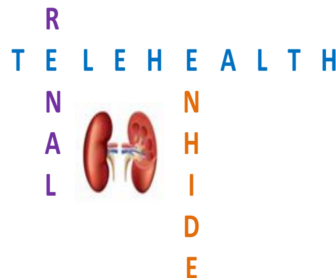
- Using Expertise and Technology for DM population health and surveillance to complement tailored individual ambulatory and acute in patient care

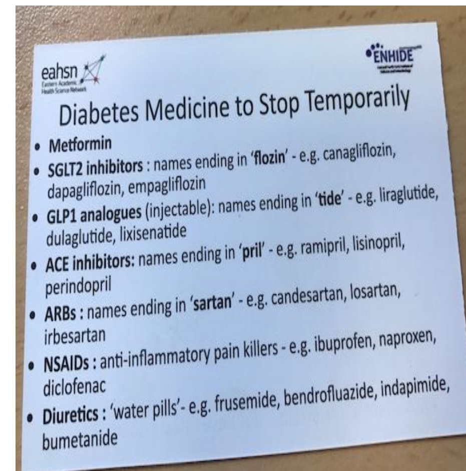


ENHIDE Telehealth – Better use of **Time**

- Managing disengaged T1DM Young Adults

- Manging DM with CKD in primary care





eahsn Eastern Academic Health Science Network

ENHIDE

Diabetes Medicine to Stop Temporarily

- **Metformin**
- **SGLT2 inhibitors** : names ending in **'flozin'** - e.g. canagliflozin, dapagliflozin, empagliflozin
- **GLP1 analogues** (injectable): names ending in **'tide'** - e.g. liraglutide, dulaglutide, lixisenatide
- **ACE inhibitors:** names ending in **'pril'** - e.g. ramipril, lisinopril, perindopril
- **ARBs :** names ending in **'sartan'** - e.g. candesartan, losartan, irbesartan
- **NSAIDs :** anti-inflammatory pain killers - e.g. ibuprofen, naproxen, diclofenac
- **Diuretics :** 'water pills'- e.g. frusemide, bendrofluazide, indapimide, bumetanide

Your contact details:

Name: ____________________

Address: ____________________

____

____

Home telephone number: ____________________

Mobile number: ____________________

E-mail address: ____________________

Please check the above contact details that we have for you. If they are wrong, please let us know.

If they are correct but you do not wish us to make contact with you for an initial discussion, please phone or text us on **07585 328751** or **07585 328754** within the next five working days of receiving this leaflet.

We very much hope we can support you going forward!

Other useful contact details:

Young Adult Support Worker, Lister Hospital ☎ 07585 328750

Date of publication: January 2017
Author: Diabetes/Enhide
Reference: Version: 01
Review Date: January 2020
© East and North Hertfordshire NHS Trust

www.enherts-tr.nhs.uk

You can request this information in a different format or another language.

East and North Hertfordshire NHS
NHS Trust

Patient Information

Helping you live better with diabetes

TeleHealth Young Adult Service

ENHIDE
East and North Herts Institute of Diabetes and Endocrinology

Diabetes TeleHealth Team

'Here to support **you**'

Dear ____________________

Thanks for picking up your insulin prescription.

We wanted to let you know that we are providing a new service for those aged **16-30** who need a more flexible way of supporting diabetes self-care. We will tailor this support to **your** individual needs.

Are you struggling with your diabetes?

We recognise how difficult it can be sometimes to live with diabetes and manage it in your day to day educational or working life, as well as your social life. You might need specific diabetes related advice to deal with working hours, exams, sport, stress, eating out, holidays and many other issues that may arise.

New methods to contact you regarding your diabetes

The ENHIDE (East and North Herts Institute of Diabetes and Endocrinology) TeleHealth team are here to help in a way that suits you, without clinic appointments if you prefer. We'll be looking to use **Skype, text** and **phone call** support, and to find times and settings for contact that work for you and us.

The team providing this service is led by two consultants with the support of a 'young adult support worker' and a dedicated 'diabetes specialist nurse' that you can have regular contact with.

We have a range of new support systems in place to help you better self-care for diabetes. We can direct you to a range of local health and social services, if necessary, regarding work and available resources such as claiming relevant benefits and accessing mental health support if required.

All young people being offered this new support have been identified from GP records as we want to provide this service alongside your primary care team.

We feel that this service could be of particular benefit to you as:

- ☐ you have been admitted to hospital with a diabetes emergency within the past two years.
- ☐ you have not been able to attend the diabetes eye check for over 12 months.
- ☐ you have not had a blood and urine diabetes health check in the past 12 months.
- ☐ you have been unable to attend your last two appointments for diabetes clinics and have been discharged in line with the Trust policy.
- ☐ your last measure of diabetes control (HbA1c) has been high and we want to provide additional help to reduce the risk of development and progression of complications.
- ☐ we feel you would benefit from a more flexible means of support with your diabetes self-care.

Managing Complex DM takes **Time**

DIABETICMedicine

DOI: 10.1111/dme.13564

Review Article

Diabetes and chronic kidney disease: an increasingly common multi-morbid disease in need of a paradigm shift in care

P. H. Winocour

East and North Herts Institute of Diabetes and Endocrinology (ENHIDE), Howlands Clinic, QEII Hospital, Welwyn Garden City, UK

Accepted 12 December 2017

Abstract

Diabetes is considered the commonest cause of end-stage renal disease. The increasing incidence of obesity and an ageing population, together, will lead to a greater number of people with diabetes associated with chronic kidney disease that could either be secondary to diabetic nephropathy or of different aetiology. Ageing and obesity influence approaches to the management of diabetes and accurate assessment of kidney disease. People with diabetes and chronic kidney disease consume a disproportionate component of expenditure on medical care. Guidelines on managing diabetes and kidney disease do not recognize the complex multi-morbid nature of the process. In addition to managing glycaemia and monitoring renal function, the assessment and management of cardiovascular disease risk factors and cardiovascular disease itself need to be factored into care. People with diabetes and diabetic nephropathy are more vulnerable to retinopathy and foot complications requiring coordinated care. People with diabetes and chronic kidney disease are more prone to anaemia and metabolic bone disease than those without diabetes at similar stages of chronic kidney disease, further increasing their vulnerability to acute complications from cardiovascular disease, foot emergencies and fractures. People with diabetes and chronic kidney disease are also more prone to hospitalization with infections and acute kidney injury. Given the 30–40% prevalence of kidney disease amongst people with diabetes, potentially >2% of the adult population would fit into this category, making it vital that new surveillance models of supported care are provided for those living with diabetes and kidney disease and for primary care teams who manage the vast majority of such people.

Diabet. Med. 35, 300–305 (2018)

- **15 Pillars of Care**
- Changing GFR and ACR
- HbA1c – Anaemia
- Hypo risk – DM Rx
- Sick Day Rules- IP risk
- CVD - Risk factors
- Feet and Retinal comps
- Metabolic Bone
- Obesity and Smoking

Time for Some Home Truths?

- What can optimal DM care really achieve ?
- DM remission
- Managing established complications – damage limitation ? Fixed Trajectory
- Managing metabolic and CVD risk in obesity

The treachery of images- Magritte

John Wales – his Spirit and Legacy

- Some Confucian tips:
- ‘Flowers may bloom again, but a person never has the chance to be young again’
- ‘The spectators see more of the game than the players ‘

謝謝

Thank You