The ABCD Debate:

Consultant Diabetologist Expansion is best served thorough Strengthened links with General Medicine

Against the Motion

Dinesh Nagi

Wakefield

The ABCD –Debate 2013

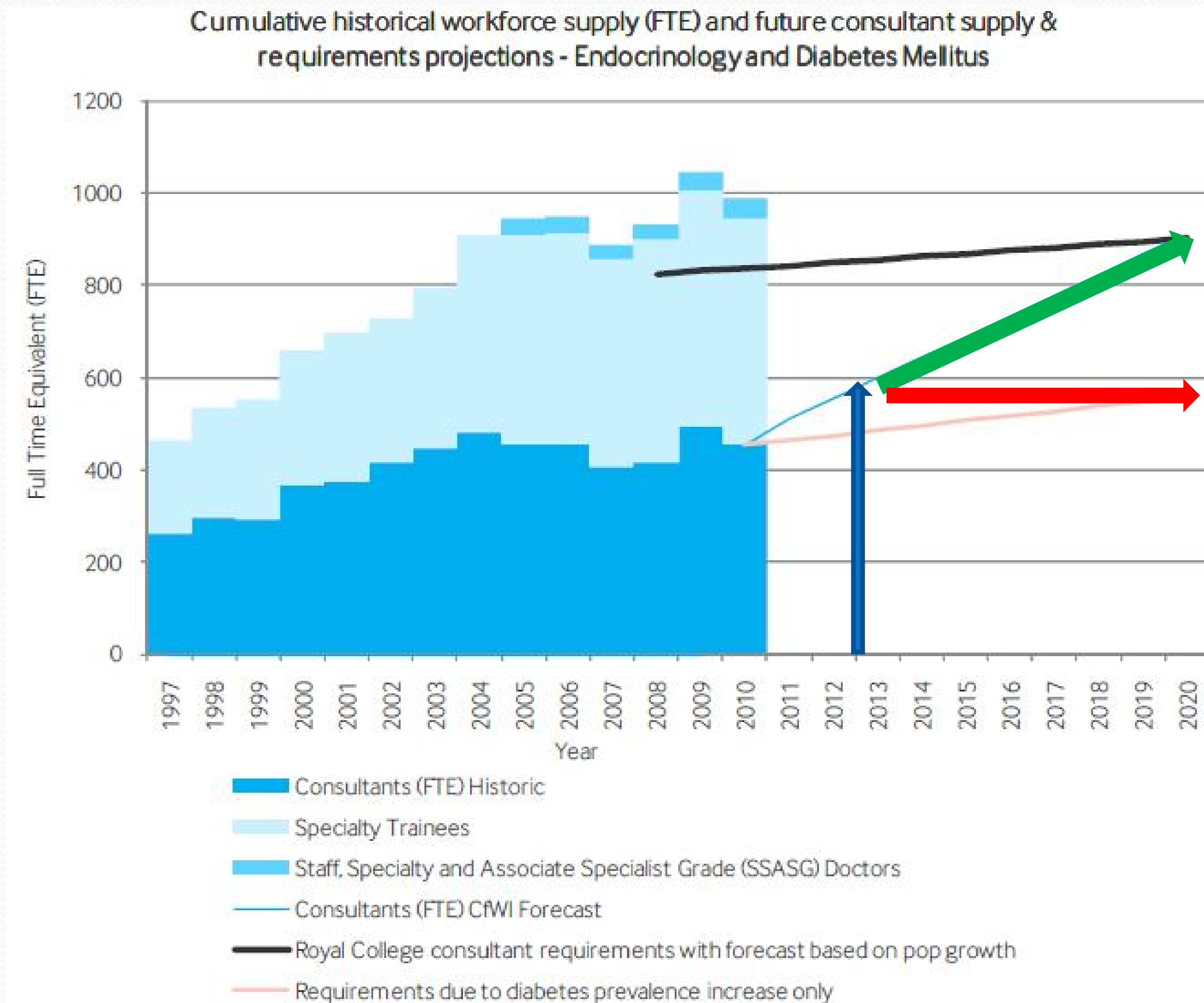
- **Peter *Vs* Dinesh**
- **Old Fart *Vs* Young Turk**
- **Hearts *Vs* Brains**

- Past *Vs* Future
- Idealism *Vs* Realism

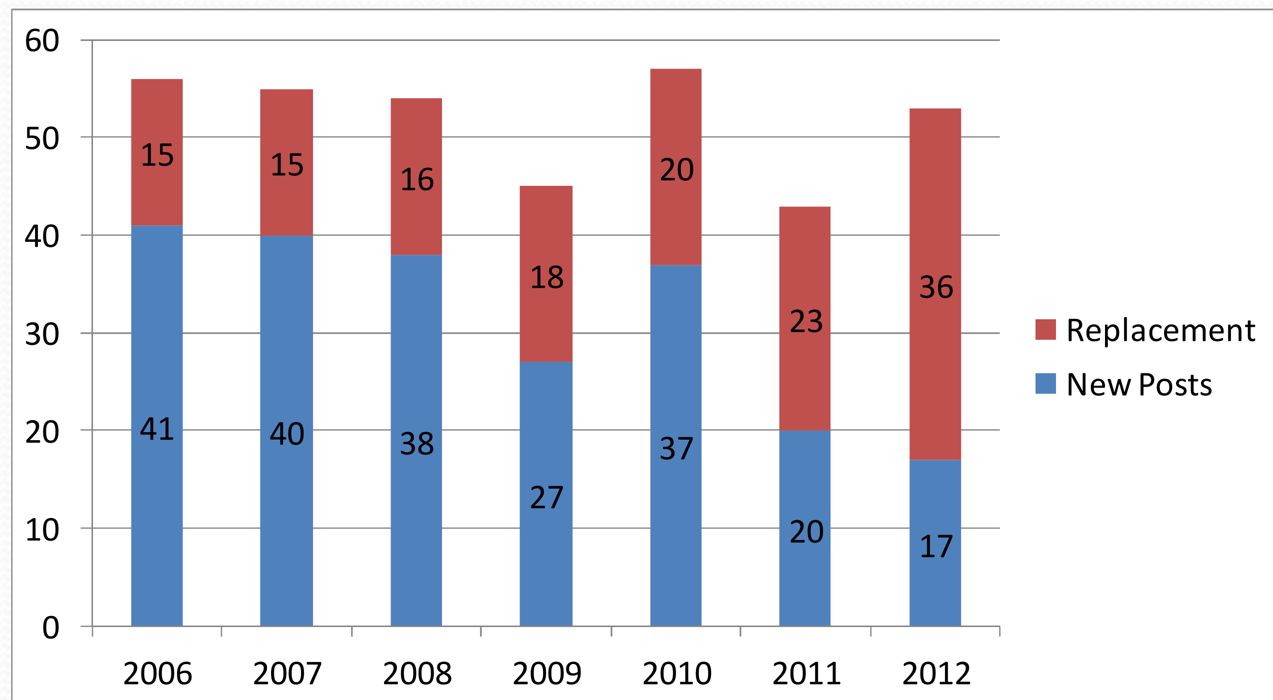
Deconstruct the debate !

"Consultant ***Diabetologist Expansion*** is best served thorough Strengthened ***links*** with ***General Medicine***"

Report from CfWi (2011)



Consultant Level Appointments New vs replacement posts



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Consultant Workforce in Diabetes

- Fourth Largest Specialty
- Largest Contribution to GIM

But

- But lowest expansion compared to other specialties – who have opted out

Why?

Hospital Workforce

Fit for the Future?

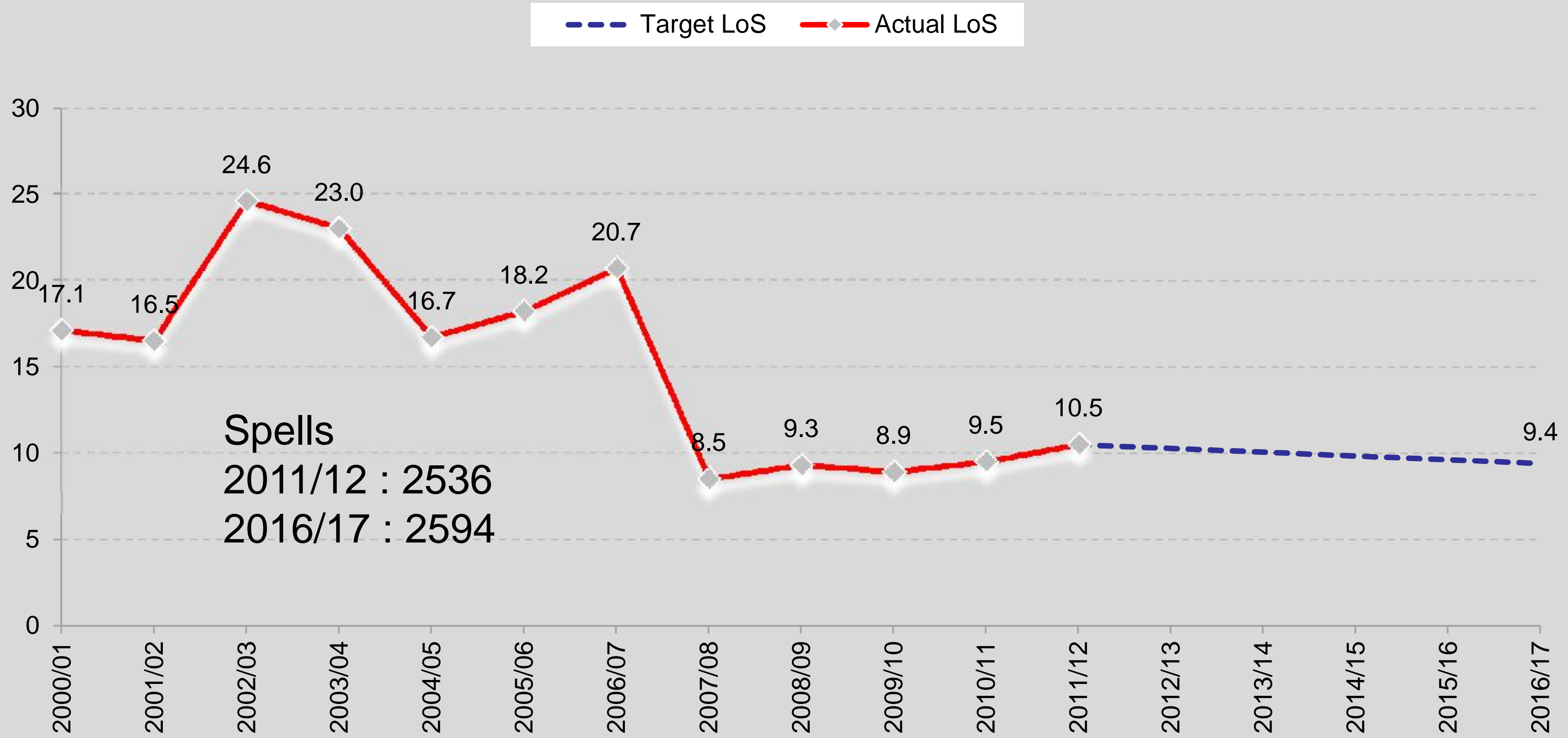
A report by the Royal College of Physicians
March 2013

- We are going to need more Consultants with skills in “acute general” and “geriatric medicine” to be able to cope with ageing population

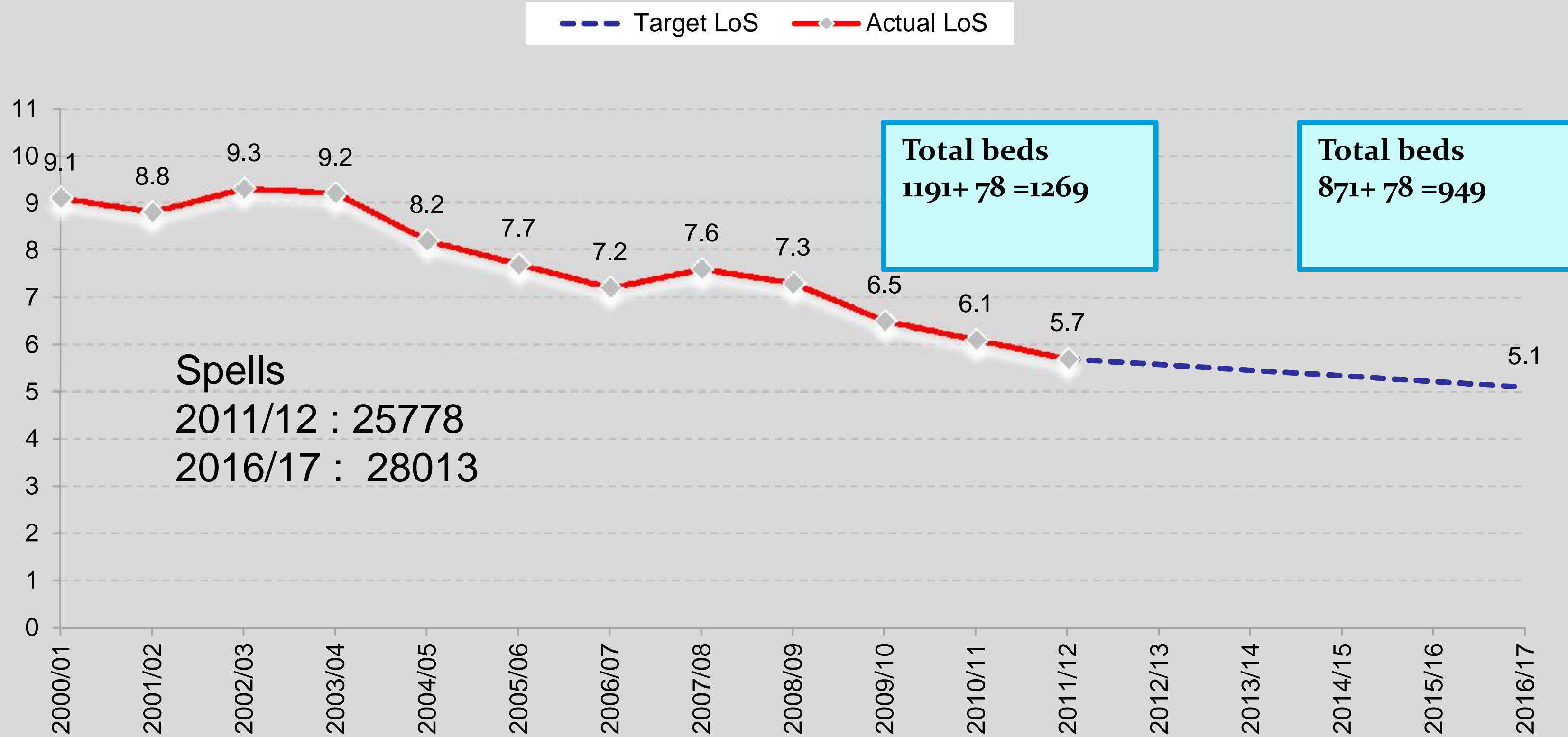
Current State of the NHS - Reality

- Financial Challenge and Target driven care
- Acute and GIM is a loss making service and will remain so
- Reduced Length of Stay: LOS has gone down markedly and needs to continue
- Ever Shrinking bed base served by “Ologies” including Acute Medicine.
- No such thing as “General Medicine”
- **“Shape of Training”- Define Generalism**

Length of Stay Trends



Length of Stay Trends



- A look into the Past
- A look into the Present
- A look into the Future

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- A look into the Past- Yes Peter was there and he Influenced it!

This is what Leo said to Peter!

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- A look into the Present- Hope that we can drag Peter out of his Illustrious Past

My Own Perspective

Consultant for 17 years

First Phase

- 1996-2001: General medical ward (28 beds)
- 2002-2010: Medical SSU- turnover of upto 200 discharges/week

Second Phase

- May 2010: Innovative Model to support Primary Care
- Nov 2010: Pilot of MDT Style Diabetes In-reach
- Reflection –of strengthening links with Acute Medicine
- 2011- to date: No SSU or in-patient GIM beds
- Jan 2011-12: Implementation of Diabetes In-reach

Oct 2009-Dec 2012: Associate Medical Director with Responsible for H@N and Consultant Recruitment

What has our Strong Links with GIM Achieved?

- Diabetologists are sucked more and more into AIM-
- Frustration and Anger
- No or little support or acknowledgement from the management
- No rewards in terms of consultant Expansion
- Implications
  - Less time for innovative service developments
  - Less time for proper in-patient diabetes
  - Less time to support primary Care
  - Less time for Education and training

ST3 Recruitment for 2012 round

Specialty	Posts Available (NTN + LATS)	Posts Filled % Total (NTN)
Diab & Endo	41 (25 + 16)	53.7 (88)
AIM	67 (49 + 18)	22.8 (30.6)
Geriatrics	73 (44 + 29)	15.1 (25)
Dermatology	18 (12 + 6)	100 (100)
Respiratory	41 (16 + 25)	46.3 (100)
Cardiology	25 (11 + 14)	44.0 (100)

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- A look into the Future: A journey into Dinesh’s world with Peter on Board!

Consultant in Diabetes & Endocrinology-

- Spend most time in outpatients
  - Funding of Hospital rewards Outpatient and Elective activity
  - This activity must continue and consultants are best placed to provide this service
  - Taking consultants away to spend substantial time away from this (on GIM) will be counterintuitive and counterproductive

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Peters Proposal!

- Continue to the Same!
- No Innovative thinking!
- Stay in Your "Comfort zone"

*"If You keep doing the things the same way-
The end result is always the same"*

My World!

- Time to be Innovative
- Time to be Brave
- Radical shift
- Focus on the Needs of People with Diabetes
- Not the Needs of Individuals or Organisations

Way Forward? Some Blue sky thinking

- De-link from GIM Bedbase

The Net Impact:

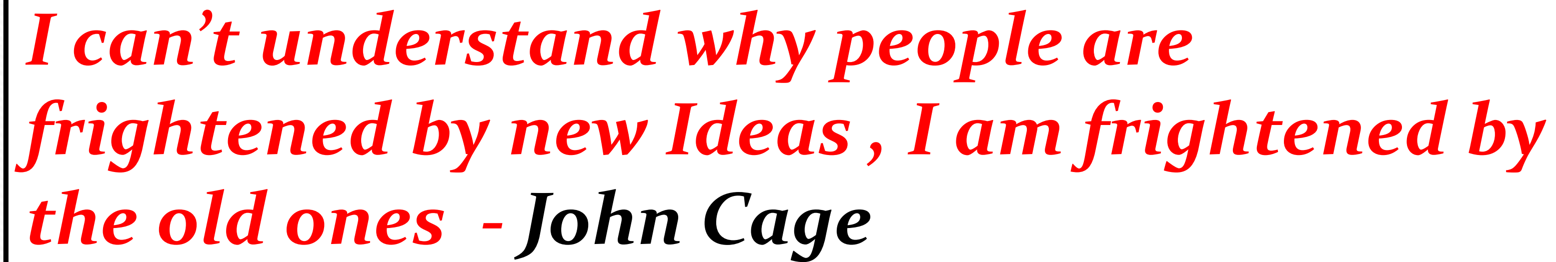
- Pull out of GIM bed base ⟶ Allows immediate implementation of high quality in-patient diabetes services
- Release consultant resource to implement other much needed services
- Feeling that this may attract more Trainees ?

A Diabetologist in MY new world!

- Provide Level 5 Services
- High Quality – In patient diabetes Care
- Early Input to those admitted with diabetic emergencies
- Supporting Primary Care to- provide high quality Care and help deal with sea of unmet need
- Education and Training
- Leadership for service development
  - Specialist Obesity Service
  - Diabetes prevention?
  - Sharing best practice

Can we Challenge ourselves – and do what is needed?

- Out of hours- Diabetes support for patients/Health professionals- Helpline ?
- How about 7 days working – to review patients in timely manner and provide specialist input?
- Working in community setting - using whatever model suits your local requirement ?



So, I can't understand why You should be frightened by my new Ideas , I am paralysed by Peter's old ones- ***Dinesh Nagi***

To use your imagination and courage in order to seize the oppurtunities there are to transform the provision of Diabetes care in the NHS

So- Colleagues & Friends

- Be Brave: Join me in my Journey into the future- and vote to de-link Diabetologist from General Medicine
  - Release time and resource to Provide in-patient care
  - Move into primary care where your contribution is much valued and ....
  - Where your presence will allow you to deliver that promise land of HIGH QUALITY CARE WITH BEST OUTCOMES FOR YOUR PATIENTS
  - Adopt this Mantra: and It will radically change your Life

The greatest danger for most of us is not that our aim is too high and that we will miss it, but it is too low and we reach it!

Michaelangelo

Why Poor Consultant Expansion?

- Lack of any targets for Acute Trusts in Diabetes
- Perception- that diabetes care can be delivered mostly in Primary Care by
  - GPWSi
  - Practice Nurses
  - Community DSNs

Way Forward!

- De-link from GIM Bedbase
- Focus on Inpatient Diabetes Care (MDT Style)
- Responsible for only acute Diabetes Specific Admissions – requires a very small bed base