ABCD NEWS

Br J Diabetes 2016;**16**:39-45

Includes contributions from ABCD Chair

Seven-day Diabetes Service

Most diabetologists regularly see patients in different hospitals who have extended stay in the hospital because of delayed or lack of support from the Specialist Diabetes Teams. It is therefore vital that seven-day Diabetes Specialist Services are established in keeping with seven-day NHS campaign from the Department of Health. The ABCD Chair is planning to run a campaign to achieve this ambition.

All Party Parliamentary Group for Diabetes discusses inadequate care for people with diabetes

The ABCD Chair attended a round table discussion with consultants and GPs and heard from parliamentarians who were dissatisfied with the service provided by their own GP surgeries. Although there are excellent centres of care in the community for people with diabetes, generally diabetes care is delivered by a busy Practice Nurse and is far from ideal in the community. The ABCD Chair believes that new models of care for diabetes are urgently needed and hopes that NHS Vanguard sites will be addressing this.

Patients accessing results

Nephrologists in several NHS trusts share an IT system with patients so that individuals can access their results prior to appointments and prepare. ABCD has learnt that a similar system has been adapted for use by people with diabetes and is working well in Salford. If any of the members would like more information, they can contact Neil.Turner@ed.ac.uk who can send the details of the IT system and cost etc.

National Audit Office report

Department of Health or National Audit Office published its report on the management of adult diabetes services in the NHS on 21st October 2015. In the report there are positive comments on improvement in outcomes, reduction in premature mortality and the anticipated benefits of the NHS type 2 Diabetes Prevention Programme. The report, however, also highlights the lack of specialist time allocated to patients with diabetes and criticises the fact that the current funding model does not support integrated models of diabetes care. Considerable variation in the quality of care and outcomes has also been revealed in the report.

NHS Mandate 2020

ABCD largely supports the mandate and its response is on the website http://www.diabetologists-abcd.org.uk/Documents/Mandate_Reponse_ABCD.pdf ABCD is also pleased to note an investment of £8 billion from the Treasury.

DOH mandate for 2016-17

A DOH mandate to NHS England for 2016-2017 is now published. According to this mandate and included in it is commitment to improve the management and care for those living with diabetes. Additionally, there are specific targets to have 10,000 patients referred to the diabetes prevention programme in 2016-2017.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/486674/nhse-mandate16-17.pdf

What is new in the new NICE guidance?

The new NICE guidelines for the management of adults with type 2 diabetes CG28 has now been published and is likely to be less controversial than the previous version. New data on gliflozins, however, and other medications have since become available, and ABCD hopes that NICE will appoint a standing committee to regularly review data on newer agents and modify their guidance promptly.

http://www.nice.org.uk/guidance/ng28

Rowan Hillson Insulin Safety Award

Umesh Dashora, Erwin Castro and Debbie Stanisstreet are leading on the Rowan Hillson Insulin Safety Award. In the second year of this prestigious award, entries are being sought to find the best UK Inpatient Hypoglycaemia Avoidance Initiative. The last date for submissions is 1st Feb 2016. Please enter your initiatives using the link http://www.diabetologists-abcd.org.uk/JBDS/JBDS_RH_insulin_safety_competition_2015.pdf

RCP council appointments

Dinesh Nagi has completed his term on the RCP council as representative for Endocrinology and Diabetes. Professor John Wilding, Professor of Medicine at the University of Liverpool, is to succeed him. ABCD congratulates and thanks him for taking up this role.

Failings in diabetes education

In a recent report, uptake of diabetes education was found to be very poor with only 0.9% of people with new type 1 diabetes and 3.6% of people with new type 2 diabetes attending a group-based diabetes education course in 2012-2013 in England.

http://www.hscic.gov.uk/catalogue/PUB14970/nati-diab-audi-12-13-care-proc-rep.pdf

Funding for research and professional education application now open

The last date for Research Fellowship and Grant Award applications is Friday 5th February 2016 and the last date for fund awards to attend meetings is Friday 22nd April 2016.

https://www.diabetes.org.uk/Professionals/News--updates/Funding-for-research-and-professional-education/

Portsmouth diabetes team wins the prestigious HSJ award

Portsmouth Hospital Trust was highly commended in the HSJ acute, community and primary care redesign category award for diabetes super six model: showing five years outcome of integration.

http://www.hsj.co.uk/more/awards/hsj-awards/hsj-awards-2015-acute-community-and/or-primary-care-services-redesign/7000264.fullarticle

Review anti-VEGF in DME after three injections

An early analysis of data presented at the American Academy of Ophthalmology shows treatment with anti-VEGF in DME should be reviewed after three injections and, if there is insufficient response, then a change in treat-

ment should be considered as non-responders are unlikely to improve. Apparently 40% of patients will exhibit insufficient response and alternative medications such as steroids might be useful for them.

A new risk scoring system for people with diabetes

A new scoring system to assess patients with diabetes for their combined risk of cardiovascular and renal disease has now been developed. This has an advantage over existing vascular risk scores in diabetes which treat macrovascular disease and renal disease separately.

http://onlinelibrary.wiley.com/doi/10.1111/dom.12614/abstract

Hospitalised patients receiving premixed insulin have higher rate of hypoglycaemia

In a study published in *Diabetes Care*, the difference between basal-bolus and pre-mixed insulin treatment for inpatients (medical and surgical) with type 2 diabetes was nearly threefold (64% vs. 24%) and the study had to be stopped early.

http://care.diabetesjournals.org/content/early/2015/10/06/dc15-0160.abstract

Which integrated model of care is the best?

In this systematic review published in the *Journal of Evaluation in Clinical Practice*, the authors could not find a single model superior to others mainly because of lack of consistent data on the comparable outcome measures among the 44 articles which met the inclusion criteria. The quest for an ideal integrated intervention continues.

http://onlinelibrary.wiley.com/doi/10.1111/jep.12478/abstract

Positive results and follow-up data for up to 8 years of a small sample of patients piloted in an integrated model in Hastings are available on this link. http://www.diabetesonthenet.com/journal-content/view/ongoing-benefit-of-improved-control-after-a-short-duration-integrated-joint-clinic-intervention-in-primary-care

Hypo-awareness week excellence awards to Basildon and East Sussex

More than 120 hospitals took part in the hypo-awareness week campaign, which took place between October 5th and 11th and saw diabetes teams across the country raising awareness of hypoglycaemia. Nine entries/case studies were submitted for the Hypo Awareness Week Excellence Award. Basildon and Thurrock University Hospitals NHS Foundation Trust was the winner and East Sussex Healthcare NHS Trust was highly commended. The winners were announced on 15th November 2015, coinciding with World Diabetes Day. http://www.novonordisk.co.uk/healthcare-professionals/diabetes/hypo-awareness-week-2015.html

OECD report on diabetes care in the UK

The OECD report shows that the UK does have one of the lowest rates of avoidable diabetes-related hospital admissions but one of the highest usages of cholesterol-lowering and antidiabetic drugs (levels over 40% and 20% higher than OECD average). The report also notes that the volume of medicine sold in the UK has been increased by sales of generics, which now accounts for about 83% of the market as opposed to 35% as an OECD average. http://www.oecd.org/els/health-systems/health-at-a-glance-19991312.htm

Interesting recent research

A rapid-fire collection of interesting recent developments in diabetes

Full fat but not low fat yogurt reduces abdominal obesity

In a study published in *Nutrition, Metabolism and Cardiovascular Disease*, the authors report that whole fat but not low fat yogurt consumption can reduce abdominal obesity and waist circumference in elderly people at high cardiovascular risk.

http://www.nmcd-journal.com/article/S0939-4753(15)30086-7/abstract

Red wine reduces total cholesterol, increases HDL and does not affect blood pressure

In a study (2-year RCT) published in the *Annals of Internal Medicine*, participants who drank red wine with dinner had a small but statistically significant increase in HDL of 0.05 mmol/L compared to those who drank water with their dinner. This was associated with a decrease in total cholesterol to HDL ratio by 0.27 in the same group. The slow alcohol metabolisers showed improvement in blood glucose control regardless of the colour of wine, but fast alcohol metabolisers did not experience this benefit with white wine. The wine did not affect LDL cholesterol, blood pressure, liver function or body fat, but the participants experienced better sleep.

http://annals.org/article.aspx?articleid=2456121.

Caffeinated drink consumption impairs oral glucose tolerance test in adolescents in a randomised double-blind crossover study

In a poster presented in the World Diabetes Congress, the authors from the University of Calgary showed in a study involving 10 males and 10 females aged 13–19 years that caffeinated energy drinks led to a 20% increase in blood glucose level (accompanied with a 26% increase in insulin levels) over a 2-h period compared with those who had the decaffeinated version. The results are not yet published in a journal and should be treated with caution.

http://www.medscape.com/viewarticle/855533.

Coffee consumption is associated with lower risk of death

In a study published in the *American Journal of Epidemiology*, consumption of four to five cups of coffee was associated with a lower risk of early death even for those who drank decaffeinated coffee. The reduction was seen in deaths from various causes including influenza, suicide, respiratory disease, heart disease and diabetes. The link between lower risk of cancer could not be established. The theory being that coffee may reduce mortality risk of some cancer but not others. The authors have previously reported lower risk of melanoma by 20% in association with drinking four cups of coffee.

http://aje.oxfordjournals.org/content/182/12/1010.abstract?sid=0e0ab3dd-e561-4c03-a39d-2d72ba83ee35

Drinking black tea may lower fracture risk

In an article published in the International Osteoporosis Foundation website, an Australian study looking at over 1000 older women reported that those who drank at least three cups of black tea had a 30% lower risk of having any osteoporosis-related fracture compared with women who rarely drank tea. The key ingredient thought to benefit bone health is flavinoids.

http://www.osteofound.org/news/could-drinking-black-tea-lower-fracture-risk

Standing or walking improves insulin sensitivity

In a randomised controlled trial published in *Diabetes Care*, the authors have shown that brief

periods of standing can reduce a postprandial metabolic response in postmenopausal women at high risk of type 2 diabetes. Walking for 5 min every 30 min or standing significantly reduced the glucose area under the curve after the meal. Insulin and triglyceride levels were also reduced and the effect persisted for the whole day.
http://care.diabetesjournals.org/content/early/2015/11/29/dc15-1240.full.pdf+html

Weight loss surgery can lead to neurological complications

In a study published in the *Current Neurology and Neuroscience Reports*, neurological complications of bariatric surgery have been highlighted. The primary reason appears to be micronutritional deficiency, and there is advice to follow up these patients at 6 weeks, 3 months, 6 months, 12 months and then annually after surgery. Vitamin B12, thiamine and copper are the commonest deficiencies and can lead to compressive and stretch peripheral nerve injuries, rhabdomyolysis, Wernicke's encephalopathy and inflammatory polyradiculoneuropathy. Late complications after many months may include subacute combined degeneration and hypocupric myelopathy.
http://link.springer.com/article/10.1007%2Fs11910-015-0597-2

VLCD can reverse diabetes of both short and long standing

Very low-calorie diets (600 calories) can reverse diabetes. In a previous study from Newcastle, a total of 87% of short duration (diabetes <4 years) and 50% of the long duration (diabetes >4 years) group patients achieved normal fasting plasma glucose after 8 weeks. There were also significant improvements in blood pressure and cholesterol in both groups.
http://www.ncbi.nlm.nih.gov/pubmed/25683066.

Prof Taylor says, "Earlier this year a further study was reported. This showed that up to 4 years of type 2 diabetes there was an 80% chance of reversing to normal glucose control provided that 15% weight loss or more was achieved, although most people up to 10 years were able to reverse their diabetes also. The 6 month continuation of this study has observed the effect of longer term follow up and has now been submitted for publication. In the January issue of *Diabetes Care* a paper will be published demonstrating the specific nature of the excess fat inside the pancreas. If this excess fat is removed the beta cells recover – in short to medium duration type 2 diabetes. 'Type 2 diabetes is no longer a mystery condition. It is a simple state of overnutrition'. Excitingly, the DiRECT study, funded by Diabetes UK, is steadily recruiting. This study involves general practices in Tyneside and Scotland and will show just what proportion of people can reverse their diabetes, whether this can be done by practice nurses and what happens over 2 years."

High intensity exercise reduces liver fat

In another study published this month, researchers have shown that high intensity intermittent exercise reduced left ventricular mass and peak torsion while improving systolic function and diastolic filling rate compared with a control group. The exercise group showed a 39% relative reduction in liver fat and improvement in HbA_{1c}. The two were co-related.
http://link.springer.com/article/10.1007/s00125-015-3741-2

Risk-based approach better than trial-based approach to guide statin treatment

In a recent article in the *Journal of American College of Cardiology*, the authors have compared the current approaches to guide statin therapy for primary prevention. They conclude that, if the statins are given according to ECC/EHA risk-based approach compared to the approach based on clinical trials or a hybrid approach, it would prevent more ASCVD events and would result in fewer people receiving treatment. More details on the link: http://content.onlinejacc.org/article.aspx?articleID=2476062.
You might like to catch up on the related NICE guidelines: http://www.nice.org.uk/Guidance/cg181

HbA_{1c} not related to PTCA outcome

In an abstract from Korea, there was no association between initial glycosylated haemoglobin level and cardiovascular outcome in people with pre-diabetes and ST segment myocardial infarction who received primary percutaneous coronary intervention.
http://journals.lww.com/coronary-artery/Abstract/2016/01000/Impact_of_initial_glycosylated_hemoglobin_level_on.8.aspx

Diabetic ketoacidosis in pregnancy may be because of pancreatitis

In a paper in *Obstetric Medicine*, the authors describe case reports in which pancreatitis was responsible for ketoacidosis in pregnancy. Pancreatitis therefore may be the missing link in non-diabetic ketoacidosis in late pregnancy and must be considered.
http://obm.sagepub.com/content/early/2015/11/30/1753495X15612330.abstract?rss=1

Metformin associated with lower risk of renal cancer in people with type 2 diabetes

In a recent article published in the *European Journal of Cancer*, the hazard ratio for ever versus never users of metformin for renal cancer was lower at 0.279. The study was on 917 ever users followed up and compared with 824 never users of metformin and the respective incidence was 80.09 compared with 190.30 per 100,000 person/years.
http://www.ejcancer.com/article/S0959-8049(15)00873-4/abstract?rss=yes

The case against metformin in overweight adolescents with type 1 diabetes

The addition of metformin in an RCT did not improve HbA_{1c} over 6 months but led to more gastrointestinal adverse events in adolescents with type 1 diabetes. Insulin dose and body mass index were, however, lower by 25% and 10% respectively in the metformin group. The authors do not recommend adding metformin in this group of patients.
http://jama.jamanetwork.com/article.aspx?articleid=2473492

Metformin improves endothelial function

Metformin was shown to have effects on soluble fms-like tyrosine kinase 1 (sFlt1) and soluble endoglin (sENG) secretion from placental endothelial cells which are thought to cause endothelial dysfunction responsible for the pathology found in pre-eclampsia. It reduced endothelial cell MRNA expression of vascular cell adhesion molecule on VCAM-1 induced by TNF-alpha (VCAM-1 is increased in pre-eclampsia). Bradykinin-induced vasodilation was also restored. Metformin also improved whole blood vessel angiogenesis impaired by sFlt-1. The effect seemed to be regulated at the level of mitochondria. Thus, metformin has the potential to prevent or treat pre-eclampsia.
http://www.ajog.org/article/S0002-9378(15)02540-5/abstract

Reduction in vascular events by manipulating gut bacteria

Researchers have shown that the cardiac events that arise from ingesting red meat, egg and high fat dairy products can be blocked by utilising a novel mechanism. Cleveland Clinic researchers had previously shown that trimethylamine N-oxide (TMAO) formed in the intestine by gut bacteria during digestion of animal fat is associated with atherosclerosis. More recently they reported that it can be blocked by a naturally occurring inhibitor, 3,3-dimethyl-1-butanol (DMB), which is found in some cold-pressed extra virgin olive oils and grape seed oils. Production of TMAO in mice fed on a diet high in choline, lecithin and carnitine (abundant in animal fat and dairy products) was blocked by DMB. This product therefore has the potential to reduce atherosclerosis and, as a result, cardiac problems and stroke.
http://www.cell.com/abstract/S0092-8674(15)01574-3

Testosterone replacement improves insulin sensitivity

In a news release from the University of Buffalo, Dr Paresh Dandona and colleagues have reported further work on the link between testosterone

deficiency and type 2 diabetes. In the recent study they provide definitive evidence that testosterone replacement makes people with type 2 diabetes more sensitive to insulin. When testosterone was administered there was a 32% increase in the uptake of glucose by tissues in response to insulin. However, HbA_{1c} did not drop although fasting glucose did. It has been suggested that, with longer term studies, HbA_{1c} reduction might also be seen.
http://care.diabetesjournals.org/content/early/2015/11/24/dc15-1518.abstract

Sleep increases the risk of type 2 diabetes

The authors show that increases in sleep duration of >2 h/day were adversely associated with the risk for diabetes [hazard risk (95% confidence interval) 1.15 (1.01 to 1.30)] after adjustments for changes in diet, physical activity and body mass index.
http://link.springer.com/article/10.1007/s00125-015-3775-5

Lard but not salmon oil increases insulin resistance and cardiac dysfunction

In a study published in Diabetologia, high-fat feeding with lard increased body weight, insulin and insulin resistance along with reduced left ventricular function but high-fat feeding with salmon oil increased body weight without impairing cardiac function or insulin sensitivity in a canine model.
http://link.springer.com/article/10.1007/s00125-015-3767-5

Early diagnosis of gestational diabetes is associated with poorer pregnancy outcomes compared with late diagnosis

In this article in *Diabetes Care*, hypertensive disorders including pre-eclampsia, preterm delivery, caesarean section and neonatal jaundice were all more common in women with pre-existing and early (before 24 weeks) onset gestational diabetes. Macrosomia, large for gestational age and neonatal intensive care admission in women diagnosed before 12 weeks of gestation were comparable with the rates seen in pre-existing diabetes.
http://care.diabetesjournals.org/content/39/1/75.abstract

Basal insulin peglispro (BIP) superior to insulin glargine in patients with type 2 diabetes

In a recent RCT, a new basal insulin peglispro (BIL) was compared with insulin glargine in patients with type 2 diabetes treated with basal Insulin alone or with three or fewer glucose-lowering medications. Reduction in HbA_{1c} was superior (vs. glargine) with BIL and was maintained at 52 weeks with more patients in the BIL group achieving HbA_{1c} less than 7% at 26 and 52 weeks. Nocturnal hypoglycaemia rate was 60% lower with more patients achieving HbA_{1c} less than 7% without nocturnal hypoglycaemia at 26 and 52 weeks. The total hypoglycaemia rate was also lower at 52 weeks. Glucose variability was lower. Basal Insulin dose, triglyceride and aminotransferase levels were higher and liver fat content increased with BIL.
http://care.diabetesjournals.org/content/39/1/92.abstract

A case for treating pregnant women with HbA_{1c} >41 mmol/mol

Women with HbA_{1c} of 41–49 mmol/mol (5.9–6.6%) in early pregnancy screening or subsequent diagnosis of gestational diabetes by 75 g glucose tolerance test remain at higher risk than with lower HbA_{1c} at diagnosis of gestational diabetes. Treating these women before 24 weeks is associated with reduction in the risk of pre-eclampsia.
http://onlinelibrary.wiley.com/doi/10.1111/dme.12812/abstract

Alogliptin reduces the progression of carotid IMT in patients with type 2 diabetes

In a recent RCT published in *Diabetes Care*, alogliptin (vs. conventional treatment) achieved greater reduction in intima media thickness of the carotid artery (a surrogate marker of atherosclerosis) and blood glucose without hypoglycaemia.
http://care.diabetesjournals.org/content/39/1/139.abstract

Specialist contact at diagnosis is better for patients with complex conditions

In an article published in *Diabetic Medicine*, the study reports that an early specialist diabetes contact in people newly diagnosed with diabetes is associated with a lower incidence of cardiovascular events and death among medically complex patients with newly diagnosed diabetes. In contrast, non-complex patients fare equally well with primary care support alone.
http://onlinelibrary.wiley.com/doi/10.1111/dme.12801/abstract

Diary 2016

24 February
DAFNE Doctor Programme (DDP)
London. http://www.dafne.uk.com

21 April
Insulin Pump Network UK Inaugural Conference
Manchester

21-22 April
ABCD Spring Meeting, Manchester
http://www.diabetologists-abcd.org.uk/home.htm

18-20 May
16th Malvern Diabetic Foot Conference,
Malvern, Worcestershire
http://www.malverndiabeticfoot.org

10-14 June
American Diabete Association 76th Scientific Sessions, New Orleans, LA, USA
http://professional.diabetes.org/Congress_Display.aspx?TYP=9&CID=97963

12-16 September
European Association for the Study of Diabetes, Munich, Germany
http://www.easd.org/index.php?option=com_content&view=article&id=69&Itemid=509

22 September
DAFNE Doctor Programme (DDP)
Sheffield. http://www.dafne.uk.com

If you are looking for a specific date, sub-specialty or place for conference, one of the following sites might help –

http://www.doctorsreview.com/meetings
http://www.endocrinology.org/meetings/world.aspx
http://www.continuingeducation.net/schedule.php?profession=Physicians
http://www.ese-hormones.org/meetings/World.aspx
http://www.medical.theconferencewebsite.com/conferences/endocrinology-and-diabetes

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YDEF NEWS

YOUNG DIABETOLOGISTS & ENDOCRINOLOGISTS
EDUCATION • REPRESENTATION • COMMUNICATION

The Junior Doctor Contract Dispute – The YDEF Position

January 8th saw the first junior doctors strike since the mid-1970s. The whole of the debate regarding the contract has signalled a breakdown in communication, a loss of trust and the perceived denigration of our profession. On the positive front, we have never been more united and the support of our patients is heartening.[1] The threat of contract imposition and the threat of continued strike action hang over us. In this article we consider the main issues around the new contract and the history of the dispute. The key events in the dispute are highlighted in Figure 1.[2]

Figure 1. Key events in the Junior Doctor Contract Dispute[2]

July 2013	BMA Junior Doctors Committee agree to enter formal talks with the government
October 2013	The Department of Health gives NHS employers a mandate to negotiate with the BMA, and negotiations start
October 2014	Failure of talks to progress because of difficulty agreeing safeguards for doctor and patient wellfare
December 2014	BMA submits evidence to the DDRB
July 2015	DDRB submits final report to the government
August 2015	The BMA decides not to re-enter contract negotiations
September 2015	The BMA ballots members on industrial action
November 2015	Junior doctors vote for industrial action with a majority of 76.2%
December 2015	Strike action postponed as talks with the government and the BMA commence through conciliatory service ACAS
January 2016	Talks end with no resolution

The DDRB report

The Doctors' and Dentists' Review Body (DDRB) produces a report annually containing recommendations on pay for doctors. They were given a remit by the UK government, the Welsh Assembly, and the Northern Ireland Executive to make recommendations on changes to the contract, including a new system of pay progression. This report is separate from their annual recommendation. To quote their report "their remit was linked to a desire to facilitate healthcare services, in a financially sustainable way".[3] To aid making their report, they include evidence from various bodies including the BMA.

Following this remit, they produced a list of recommendations which were felt by the BMA to lack an understanding of how junior doctors work. Among the recommendations were the extension of plain time working from 60 to 90 hours a week, the end of the banding system, and the loss of pay protection if you change specialty. The DDRB highlighted that pay progression should be linked to taking up a position of greater responsibility rather than accounting for number of years served. By many, this was felt to potentially disadvantage clinical academics and those who take maternity or extended paternity leave. As a safeguard for this, trusts would be able to use flexible pay premia for clinical academics undertaking a higher degree where their work may improve patient care. One of the main concerns from the BMA was how these changes may cause a widening gender pay gap and a disincentive to undertake research.[3]

What is the drive for change in the Junior Doctor Contract?

The Conservatives pledged in their 2015 manifesto their commitment to a truly 7-day NHS.[4] The "weekend effect" has become a key point for debate and a focus point for change. There is evidence that patients admitted on a Saturday and Sunday are more unwell and that they have a higher 30-day mortality. However, patients who are already in hospital at the weekend do not have a higher mortality. What is clear from the original paper is that it is not possible to be clear what proportion of this is preventable or reversible.[5] Key to arguments on the other side is that patients admitted at the weekend are more unwell – so you may expect them to have a higher mortality. The interpretation of the article has been widely questioned. The authors themselves did not claim causality for the weekend effect. The Secretary of State of Health, the Rt Hon Jeremy Hunt, however on many occasions claimed both to the public and to Parliament that the cause of these 11,000 excess deaths was reduced staffing at the weekend.[6]

It is important to consider the other evidence of the "weekend effect", but it is equally important to note that each statistic on this matter has both supporters and opponents. Other studies have illustrated a raised mortality for emergency admissions at the weekend.[7,8] In addition to these reports there are a number of government reports that highlight staffing at the weekend. The Academy of Medical Royal Colleges (AoMRC) highlight that there is less senior review and a reduction in the progress of a patient's care when they leave acute areas.[9] The question remains, however, whether simply increasing the number of doctors would solve the problem.

What is broadly supported across the evidence is that there is a difference in

acuity of patients admitted at the weekend and a proposal that a person's threshold to attend hospital may be higher at the weekend – a time when they may not have access to their usual GP.[5,8] This suggests that the reasons for a weekend effect are complex and multi-factorial – and should be solved by greater accumulation of evidence and discussion to bring about strategies to address this.

The NHS mandate – a missed opportunity for setting the direction of the NHS?

The NHS mandate sets the direction for the NHS in the coming year. It not only outlines the objectives for the NHS over the coming 2 years, but also its budget. In line with the Conservative pledge on a 7-day NHS, the NHS mandate for 2016/2017 sets out to tackle the variation in care received at the weekend and to "transform the provision of urgent and emergency care at the weekend".[10] The consultation on the NHS mandate passed in October with some disagreement over whether there had been sufficient advertisement to enable patient engagement.[11] The Department of Health had to enlarge its inbox after a surge of late replies to the consultation after the issue was highlighted in the media.[11] With the controversy, it is difficult to be certain that there has been sufficient patient group involvement in these initiatives to make a 7-day service a key performance marker for the NHS.

The drive for an equitable service across all seven days of the week is a shared aim of both the BMA and the Government, although the BMA is committed that we need to get acute care right before focusing on elective care.

As trainees, or consultants in diabetes we will spend a large portion of our time managing long-term conditions. The drive, however, for improved acute care is competing with resources at the same time as the five year forward view. The five year forward view highlights the increasing burden of "multi-morbidity" and increasing demand on hospitals, as well as identifying the "care gap" between specialists and GPs. Patient centred care is at the core of the five year forward view, and a key to this is flexible, responsive and integrated services. 70% of the NHS budget is spent on the management of long-term conditions.[12] It feels like an additional challenge to marry the drive for a 7-day NHS with a proposed restructuring of care to meet the needs of our patients.

What issues stand in the way of resolving the conflict?

The current proposal from NHS employers resulted in strike action in January. The main differences that remain are highlighted in Figure 2.

Figure 2. Issues to resolve to reach contract agreement

1. Removal of safeguards on hours worked
2. Pay no longer matching a junior doctor's experience in training
3. Extension of standard time

To distill these into three bullet points is difficult, and must not undermine their importance. The BMA have been clear that both the extension of standard time and the removal of safeguards on the number of hours worked present a direct threat to patient safety, and that the Government's proposals do not go far enough to address these concerns.[2]

Although the BMA have been clear that this is not an argument about pay, pay is clearly an issue in this debate. Up to now, if you switched careers your experience in another specialty would be recognised by a continued move up the pay scales. This would be lost, and instead may be replaced by flexible pay premia which would be under review and discretionary. This is likely to put people off changing careers. Discretionary payments for people entering shortage specialisms are an area of debate. As professionals we choose our career in the safety of the knowledge that we will be renumerated the same whatever career we choose. As a profession we want committed colleagues, not those forced to make a choice for financial reasons.

The YDEF position on contract reform

We have been clear that any contract change should be safe for doctors and safe for patients. We co-signed a letter to the Secretary of State from a number of junior doctor organisations stating our concern about the contract offer.

Amongst all of the conflicted evidence regarding the weekend effect – it is clear that we need more evidence and more ideas on how to tackle this. Most poignantly it is clear that NHS reform for patients with long-term conditions will still fall short of the patient desire to have support 7 days a week. We need a greater understanding and a clearer consultation on what the NHS can offer with the current financial pressures.

We understand that for all our members the decision to take strike action was a difficult and very personal one, and one not taken lightly. We have kept our website updated with the latest developments to help our members make a decision.

The coming months may bring no more certainty and even more anxiety about what may happen in August 2016. We are certain that the outcome of these talks will be fundamental in building a sustainable and valued workforce. We are pleased that the latest strike action has been delayed whilst talks continue and we hope that there is a true desire to negotiate on the concerns of junior doctors by NHS employers. We support on-going negotiation and hope that this leads to a contract that is fit for purpose and protects both patients, and doctors alike in the future.

There has been a great loss of trust between doctors and the Government in this argument, and it is important that, as we move on from this, we work together to rebuild this. Perhaps, what is most important is that we continue to stand together to deal with the challenges that lie ahead.

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Book review

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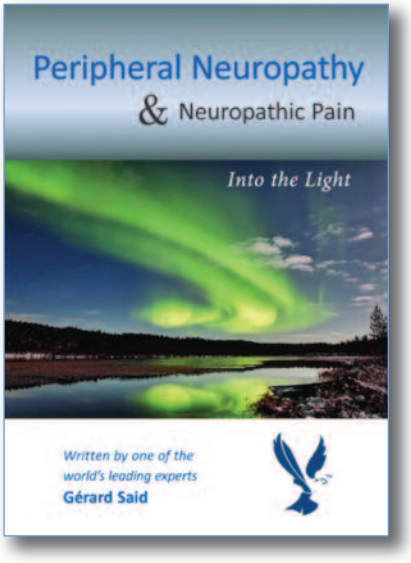
Title: Peripheral Neuropathy & Neuropathic Pain, Into the Light

Author: Gérard Said

Publisher: TFM Publishing 2015

ISBN: 1908986999



Professor Gérard Said, President of the European Neurological Society, one of the leading experts in peripheral neuropathy, has written this book in a clear and concise way, to act as a "*handy reference book for doctors, nurses and patients as well*".

It aims to present the basics of peripheral neuropathy, focusing on its main causes and presentations. The glossary, at the start of the book, consists of the main terminology that the reader will come across, along with a brief explanation; the reader will find this useful when going through the book. Also, each chapter has a short introduction and a few summary points which comprise the main take-home messages. The first three chapters introduce the reader to the basic anatomy of the peripheral nervous system (PNS), the basic pathophysiological processes relating to neuropathy as well as an overview of the main manifestations of PNS disorders.

More relevant to the diabetes specialist, diabetic neuropathy is discussed extensively. The different types of peripheral diabetic neuropathy, including autonomic neuropathy, their main signs, symptoms and consequences (e.g. ulceration) are discussed. Furthermore, the differential diagnosis and management of these conditions is also described, which is particularly useful for the practising clinician keen to ensure that they are not missing something weird and wonderful. The different diagnostic modalities and the various treatments available are detailed at length.

Helpfully, case studies are included which highlight some of the challenges in the diagnosis and management of these individuals – some of whom can suffer with chronic excruciating pain – sometimes with suicide being the only way out.

Finally, neuropathic pain, one of the main challenges for patients and physicians, is reviewed. Particular emphasis is put on its management with pharmacological and non-pharmacological measures.

In summary, this is a well-structured book, which can act as a useful guide in everyday clinical practice and a reference for the clinician focusing on a topic that has a significant impact on our patients' quality of life.

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