INDEPENDENT DIABETES TRUST
Newsletter
March 2017 Newsletter, Issue 92
PO Box 294 Northampton NN1 4XS Telephone: 01604 622837

IN THIS ISSUE...

NICE guidance breached with LIMITED TEST STRIPS

One of the frequent 'complaints' that IDDT receives is the limiting of test strips to people with Type 1 diabetes. We hear many different experiences, the most common being, *'you are only allowed one tub of test strips a month',* but also older people with Type 1 diabetes are sometimes told, *'you have Type 2 diabetes and are not allowed test strips'*! Then, of course, there is the common one of the number of test strips being reduced on repeat prescriptions without telling the patient!

Some people end up buying test strips but as we all know, they are expensive and unaffordable on a regular basis for many people. People are expected to achieve blood glucose level targets, yet some are being denied the means to test and make adjustments to their insulin, their diet or their exercise levels. If this means that their control is not as good, then the chances of the development of long-term complications increases, so there is no logic in cutting costs now, only for costs to be increased in the years to come, not to mention the health and quality of life of those with Type 1 diabetes.

If you are denied the number of test strips you need, then your GP practice and local Clinical Commissioning Group (CCG) is in breach of the latest NICE guidance.

As we have said many times before, NICE guidance is just that – guidance and it is not mandatory, so it can be ignored by local decision makers. However, NICE guidance is the advised best way of managing a condition, so in the case of Type 1 diabetes, it is being ignored if the required number of test strips are not prescribed.

What does the NICE guidance say about the prescribing of test strips for people with Type 1 diabetes?

1. There should be routine self-monitoring of blood glucose levels for all adults with Type 1 diabetes and NICE recommends testing at least 4 times a day, before each meal and before bed. Clearly, this means that as a minimum, 120 test strips must be prescribed each month.

2. Support should be offered to adults with Type 1 diabetes to test at least 4 times a day and up to 10 times a day if any of the following apply:

   - The set target for HbA1c level is not being achieved.
   - Increasing numbers of hypos.
   - There is a legal requirement to test more often than 4 times a day, such as before driving to comply with the DVLA laws.
   - During illness.
   - Before, during and after sport.
   - When planning pregnancy, during pregnancy and while breast feeding.
   - If there are any other reasons, such as hypo unawareness (loss or partial loss of hypo warnings).

3. Test strips should be given for testing more than 10 times a day for adults with Type 1 diabetes if this is necessary due to the person's lifestyle eg driving for long periods, high-risk activities / occupation or travel or if the person has impaired hypo awareness.

So, testing 4 times a day means that a minimum of 120 test strips a month need to be prescribed. For people who need to test at least 10 times a day, 300 test strips a month need to be prescribed.

What action can you take?

Do not accept a reduction in the number of test strips that you need. Contact the practice manager and explain why you need the number of test strips. If this doesn't work, then quote the NICE Guidance for Type 1 diabetes, as above. If this fails, then contact your local CCG and make these same points.

MHRA WARNING

Do not change your insulin devices without medical advice

The Medicines and Healthcare products Regulatory Agency (MHRA) has been made aware that people with diabetes have been approached directly by a manufacturer or other organisation inviting them to trial a new insulin delivery system.

The MHRA warn that it is crucial that people do not suddenly stop using or change their insulin device, including pens and pumps, without first discussing it with their diabetes specialist. Stopping using or changing insulin devices can risk low or high blood glucose levels, the wrong insulin dose and risk the development of diabetic ketoacidosis (DKA), a life threatening complication of diabetes.

If you are unsure or have any questions, you should speak to your qualified healthcare professional.

Driven to Despair

This is the title of a report issued by the Parliamentary and Health Ombudsman on October 20th 2016 and the title page describes it as 'How drivers have been let down by the Driver and Vehicle Licensing Agency (DVLA)'. In the Forword from the Ombudsman, Dame Julie Mellor, OBE, says;

"The report highlights major failings in the way the DVLA makes decisions about whether people with certain medical conditions are safe to drive."

The Ombudsman goes on to say they upheld 8 separate complaints where people with complex medical conditions were unfairly prevented from driving, sometimes for several years, as a result of flawed decisions, significant delays, poor communication and complaint handling.

The DVLA has accepted these findings and recommendations for all 8 cases and in 6 of them has granted the licence applied for, so overturning its original decision. (The remaining 2 cases were still being dealt with at the time of the Report.) However, the Ombudsman outstanding concerns are:

- There will be other people who have experienced the same injustice and hardship for whom things have not yet been put right.
- That insufficient action has been taken or is planned by the DVLA to prevent the same failures being repeated and affecting many more people in the future.
- In particular, further action is needed to improve the robustness of assessments of fitness to drive for people with certain medical conditions and disabilities. Without this there are risks that some people fit to drive will be denied a licence and other people who pose a risk to themselves and others, will be allowed to continue to drive.

Ombudsman's recommendations

1. Make fitness to drive decisions in accordance with the law and guidance.
2. Operate an open and transparent decision-making process, so that the public can understand the reasons for its decisions.
3. Take relevant factors into account and discount irrelevant ones.
4. Engage with the public and stakeholders so that there is clarity about its roles and responsibilities and so that licence holders and other stakeholders properly understand what is required of them.

The Report says that investigations have shown that the above does not happen and fault has been found with the way the DMG operates. The DMG is the group within the DVLA that considers whether drivers with a medical condition are safe to drive. The report says that they have seen no evidence that proper standards or criteria are in place for the DMG to meet its required aim of road safety and that they have seen no attempt to relate medical conditions to functional ability to drive safely. In addition, there is a lack of assessment of condition specific risks and how these may affect road safety.

Department of Transport response

The Department of Transport has accepted the Ombudsman's findings about the identified failures but the Ombudsman says that she is 'deeply concerned' that it has not accepted the recommendations to put things right by providing justice for everyone who may have been affected or by improving the robustness of the criteria applied in future medical assessments. As a result, the Report was published in the public interest and put before Parliament.

IDDT comments

The report is not specific to diabetes, but IDDT receives sufficient numbers of complaints that people have with the DVLA to support the Report in all that it says. We can only hope that the Department of Transport, the DVLA and its Medical Group take notice and improve the situation.

If you have access to the internet, the Report can be found at: **www.gov.uk/government/publications/driven-to-despair**

DVLA launches new online service

Whether or not this is as a result of the Ombudsman's report, the DVLA has now made it possible to allow drivers of cars and motorcycles to notify them that they have diabetes online.

- All drivers with a medical condition that could affect their ability to drive are legally obliged to inform the DVLA. This always applies to people taking insulin but also to taking some Type 2 drugs. If you are unsure, the DVLA advise that you contact your GP or medical professional for advice.
- You can be fined up to £1,000 if you don't tell the DVLA about a medical condition that affects your ability to drive and you may be prosecuted if you are involved in an accident.
- If diabetes is under control with tablets, diet or both, then you don't have to inform the DVLA.
- If you are treated with insulin, then a licence will only be issued for a maximum of 3 years.

In addition, drivers with diabetes can use this service to renew their driving licence.

How to use this online service

- You first need to register with GOV.UK. Go to **www.gov.uk** and search on 'verify'.
- Then go to **www.gov.uk/report-driving-medical-condition**
- You can still renew your driving licence with the paper form if you prefer. More information is available at **www.gov.uk/renew-driving-licence#other-ways-to-apply**

Just a note: you must give up your licence if

- Your doctor tells you to stop driving for 3 months.
- You don't meet the required standards for driving because of your medical conditions.

A Couple of Thank Yous

Christmas Cards

We would like to say a big thank you to all of you who bought our Christmas cards last year. We sold over 750 packs and every pack sold raises funds that help us continue our work. We will be selling cards again later this year and hope you will buy your cards from us again.

Helping Developing Countries

As you may be aware IDDT acts as the UK arm of an organisation called Insulin for Life, collecting unwanted insulin and diabetes supplies and sending them out to developing countries. In 2016 we sent out over 3,800 pens, vials cartridges etc. of insulin worth over £41,000, along with over 80,000 items of various diabetes supplies – so a big thank you to all of you who donated items.

We would also like to say thank you to all of you who continue to sponsor a child looked after by the Dream Trust in India – last year you raised over £7,400!

And you!

We would like to say a big thank you to all of you who have made donations throughout 2016, your generosity and support is much appreciated. And finally, we would like to thank all the people who have been kind enough to leave IDDT legacies at what is a sad time for their families and friends. In doing so, they are helping to ensure that IDDT can continue to offer the information and support to other people with diabetes.

More help with your feet

As readers will be aware, in the absence of sufficient NHS care of the feet in people with diabetes, IDDT is trying to help through our booklet 'Looking After Your Feet'. In addition, we are letting people know of practical ways that can help them take care of their feet and avoid ulcers and amputations. Here are two more items to help you.

Diabetes-Friendly Socks

This month sees the launch of our new range of diabetes-friendly socks. Our Comfort Socks have been developed for use by people with diabetes, vascular disorders and other circulatory problems. They provide the first barrier of protection against pressure, irritation and chaffing, pressure being a potential cause of sores and ulcers. No elastic is used in the top of the sock, relying only on the gentle control of the rib for support.

We also produce a Fuller Fitting Longer Sock for people who find it difficult to wear ordinary socks. These are made with a large circumference top and are suitable for people who may be suffering from oedema, for example.

Both socks come in a range of sizes

- The Comfort Sock comes in small [4-7], medium [6 1/2-8 1/2], large [9-11] and x-large [11-13].
- The Fuller Fitting Sock comes in small [4-7], medium [61/2-81/2], large [9-12].

Both are manufactured as a unisex sock from a high quality cotton blend. They both come in a range of colours - grey, navy, white, black and beige.

The Comfort Socks retail at £8, the Fuller Fitting at £12 per pair. Both prices include p&p. To order your socks, either contact us by phone on 01604 622837, write to IDDT, PO Box 294, Northampton NN1 4XS or use our on-line shop at **http://www.iddt.org/shop**

VibraTip®

All people with diabetes are at risk of losing nerve sensation in their toes and feet. This complication can sadly lead to blisters and wounds which go unnoticed, become infected and result in ulcers and potential amputations. In England alone, there are more than 7,000 amputations every year related to 'diabetic foot'. Despite efforts made in the NHS, this number stubbornly continues to rise.

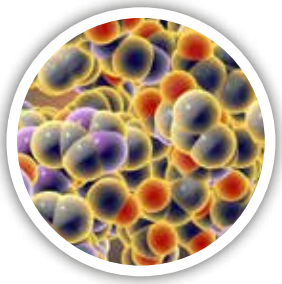
Knowing that nerves in your feet are damaged is vitally important – because this puts your feet at a higher risk of injury and requires you to be much more meticulous in your footcare.

Prof. Andrew Levy, at Bristol University Hospital NHS Foundation Trust, has invented a clever tool that helps to quickly and easily identify an early sign of a problem with the feet – the inability of the nerves to distinguish between a touch and a vibration. The VibraTip®, a small battery operated device, emits a calibrated vibration when squeezed. Only the operator knows when the VibraTip® is active because the device runs silently. If the patient cannot distinguish between a touch with vibration and a touch without vibration at the end of the big toe, nerve damage is suspected and further tests and advice are needed.

Considering the ease, speed and reliability of this test, it's not surprising that the VibraTip® is being used by more and more healthcare professionals around the world. The simplicity of the test also allows a family member or friend to check patients' feet at home, looking for those early signs of any loss in protective nerve function.

A VibraTip® costs only £14.30 and can be ordered from our website shop **http://www.iddt.org/shop** or by phoning IDDT on 01604 622837. Each device is individually blister-packed and can be used thousands of times before it needs replacing.

Education needed for ketone testing in Type 1 diabetes



This study was carried out in America but the findings do raise questions about whether they apply to children and adults with diabetes in the UK. The study found that self-monitoring for ketones was high in very young children but older adults infrequently checked their ketones, even when blood glucose levels were high.

The University of Florida carried out the study in 2,995 children aged 4 to 12 years and in adults aged 18 to 89 years with Type 1 diabetes by using an online questionnaire to find out their ketone monitoring habits.

- 62% keep ketone urine test strips at home,
- 8% had a ketone meter at home,
- 32% had no ketone testing supplies,
- 20% of the participants reported never testing and 30% reported 'rarely' testing.

When blood glucose levels were high (approx 14.5 mmols/mol),15% of all participants reported 'always' or 'most of the time' checking for ketones. Of this group of 15%, the ages were as follows:

- 53% were aged 6 years and younger,
- 33% were aged 6 to 12 years,
- 17% were aged 18 to 25 years,
- 7% were aged 26 to 49 years and
- 11% were aged at least 50 years.

Again amongst those who reported always testing for ketones when experiencing nausea and/or vomiting the findings were similar – highest in young children and lowest in adults over 50 years but 38% of all participants reported that they never checked. Nearly half of all participants reported never checking when they had a fever.

The researchers concluded that the reported rate of ketone testing is low suggesting a need for more 'robust' diabetes education for people with established Type 1 diabetes. (Diabetes Care, January 2017)

In the UK…

The #knowyourketones campaign was developed by Spirit Healthcare in the UK for World Diabetes Day in 2016 to highlight the risks and warning signs of ketoacidosis for people with diabetes.

Diabetes specialist nurse Gill Peck is quoted as saying: *"Ketones in your blood stream take less than 24 hours to cause life-threatening diabetic ketoacidosis (DKA) requiring emergency hospital treatment and it is estimated that there are more than 10,000 admissions to UK hospitals every year for DKA. This preventable condition is putting lives at risk and increasing the burden on the NHS. That's why it's so important that people with Type 1 diabetes know when to test their ketones and have the right equipment to hand, to do so."*

American Diabetes Association updates guidelines on exercise

The American Diabetes Association has issued a new Position Statement for all people with diabetes on physical activity and diabetes including those with gestational diabetes and those at risk of Type 2 diabetes with the aim of improving blood glucose control. Previously they recommended physical movement every 90 minutes of sedentary time but now they are recommending 3 or more minutes of light activity every 30 minutes of sedentary time, particularly for those with Type 2 diabetes.

- Sedentary time is not just sitting watching the TV but could be work related – sitting at a computer all day or sitting in a meeting
- Light activity is classed as walking, leg extensions or overhead arm stretches.

Studies have shown improved blood sugar management when prolonged sitting is interrupted every 30 minutes, blood glucose levels improve. This movement should be in addition to normal regular exercise but the guidelines do caution that physical activity and exercise recommendations should vary according to the person's type of diabetes, age, overall health and any diabetes-related complications. Also included are specific guidelines on blood glucose monitoring during activity and positive behaviour change strategies that doctors can use to encourage their patients to take exercise.

The statement is freely available at care.
diabetesjournals.org/content/39/11

NICE NEWS

NICE issues quality standard on coeliac disease

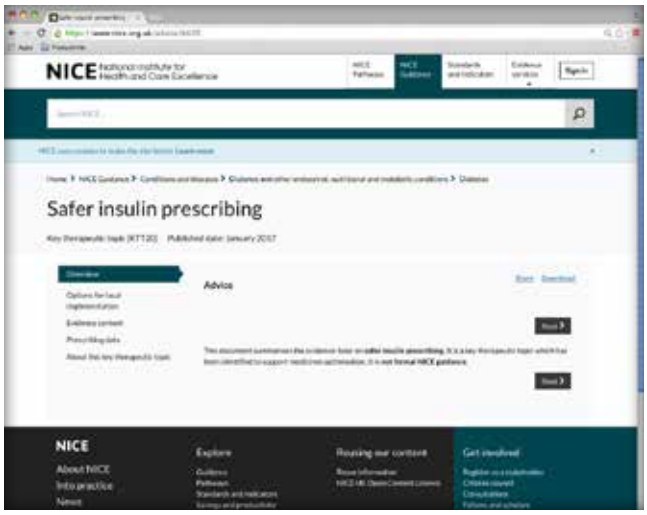
The standard sets out 5 key areas to drive measurable improvements in diagnosis, support, patients' health and quality of life. The new guidelines say that people at increased risk of coeliac disease, such as those with Type 1 diabetes, should be offered a blood test for the condition.

It also identifies areas where health inequality should be addressed by health professionals and emphasises that people with coeliac disease in economically deprived areas should be encouraged to attend annual reviews and that access to gluten-free food on prescription helps adherence to the correct diet. Perhaps CCGs that are refusing gluten-free food on prescription will take note! The full standard can be found at **www.nice.org.uk/guidance/qs134**

Dapagliflozin for Type 2 diabetes

New NICE guidance recommends dapagliflozin in triple therapy, only in combination with metformin and a sulfonylurea where two drugs are not satisfactorily controlling a person's blood sugar levels.

This final guidance means that dapagliflozin joins two other similar drugs, empagliflozin and canagliflozin, both of which are options for triple therapy. All three drugs are already recommended for use on their own if a person can't use metformin or other specific drugs, or in combination with metformin as dual therapy.



Safer insulin prescribing (January 2017)

This is not formal NICE guidance but is a new 'key therapeutic topic' and can be found at **www.nice.org.uk/guidance/ktt20**

It gives information for health and medical professionals to ensure that they and their patients can use insulin safely. Our reason for publishing in this Newsletter is so that you know what information you should be given by your doctor or health professional.

- Clinicians should ensure that people with diabetes using insulin should be given information about awareness and management of hypoglycaemia.
- Clinicians should ensure that people using insulin who drive should be made aware of the DVLA regulations for driving.
- Clinicians should be aware of 'sick-day' rules and ensure that people with diabetes using insulin should be given information about these.
- As there are new insulins on the market, including high-strength, fixed combination and biosimilar insulins, clinicians should be aware of the differences and ensure that people receive appropriate training in their use. People should be advised to only use the insulin in the way they have been trained because using it any other way could result in a dangerous overdose or underdose.
- Adults using insulin should receive a patient information booklet and an Insulin Passport.

What's new in politics?

Rt Hon Keith Vaz MP, the Chair of the All-Parliamentary Party Group for Diabetes

Diabetes Inpatients Care Bill

A Private Members Bill has been presented to parliament by the Rt Hon Keith Vaz MP calling for all people with diabetes to have their condition monitored during stays in hospitals. The Bill, called the Diabetes Inpatient Care Bill is due for a second reading on February 24th 2017 (after we go to print).

Only a minority of Private Members Bills become law but it is hoped that the publicity around this issue may have an indirect effect.

Parliamentary Question about the sugar levy

On February 2nd a Parliamentary Question asked if the Minister of Education would make it her policy to ring-fence the sugar levy to support the least active children to exercise more. The answer was that £600 million have been ring-fenced to improve PE and sport in primary schools but there is more to be done. So the government has committed to using revenue from the soft drinks industry levy to double the primary PE and sport premium to £320 million a year from September 2017 to enable schools to make further improvements to the quality and breadth of their PE and sport provision.

Inclusion of children with medical conditions at school

The Children and Families Act 2014 required all schools in England to have a medical conditions policy in place to set out the procedures and training needed for proper care. The Health Conditions Alliance has shown that 78% of schools do not have a policy in place and in 46% of those with a policy, the policies are inadequate.

Despite the law, the majority of schools are not complying which begs the question of what can be done to ensure that children with medical conditions, such as diabetes, receive the support they need to have equal access to education.

IDDT reminder:
IDDT has 2 booklets to help with this situation:

- The 'Diabetes - Parents Passport for Schools' (for parents to complete about their child's needs to give to the school) and
- 'Diabetes – what schools need to know' (for teachers and schools to understand the needs of children with diabetes)

Both of these booklets are available from IDDT, just call 01604 622837 or order on our website www.iddtinternational.org

What are we to believe?

There are various articles and reports that really do add to confusion for us, the general public. Just read on…

Obesity costs less than is commonly stated!

A new report from the Institute of Economic Affairs (IEA) has found that contrary to popular belief, the net cost of obesity to taxpayers is only 0.3% of government spending. This is less than half of the most commonly cited estimate of £16billion and only a fraction of the amount claimed by some campaigners. The cost of obesity is actually less than £2.5 billion a year.

Obesity and overweight are often blamed for being a drain on the NHS so politicians, public health bodies and campaigners blame NHS shortfalls on the 'obesity epidemic'. This justifies policies such as the sugar tax but also encourages resentment of people who are obese.

According to this report, the reality is that the costs for the healthcare of people in their 80s and 90s are much higher than the costs of treating people who are obese because elderly people often have chronic conditions requiring long and expensive treatments or full time care. The report says that the government should be focussing on dealing with the ageing population and problems in the NHS rather than blaming people who are obese. The report finds:

- That savings on pensions, healthcare and other benefit payments have been ignored and these savings total £3.6 billion per year. Knowing this for the first time, the true net cost to the government of overweight and obesity was £2.47 billion – only 1.8% of the NHS budget and 0.3% of government spending.
- The claim that £16billion is spent on obesity related conditions is false because it includes the costs of Type 1 and Type 2 diabetes. The obvious errors are that Type 1 diabetes is not caused by obesity and nor are many cases of Type 2 diabetes! The error is made worse by adding these costs of £10billion to the estimated cost of obesity which already included obesity-related diabetes (£6billion) making the false total of £16 billion.

Obesity is not the time-bomb, it is the ageing population

More and more people are living longer and therefore require healthcare, pension payments and social care costs for longer and these are far greater than the costs of obesity. The average government spending for someone who has retired net of taxes, is £10,947 per year and average annual healthcare cost for those over 65 is £5,813 per person (obesity-related care removed), this figure increases for those aged 85 and over.

Statins again

On December 12th 2016, The Daily Telegraph published an article questioning the wide use of statins used to lower cholesterol. It points out that cholesterol has long been held as a cause of heart disease but this is increasingly being questioned and highlights cases where the adverse effects of statins have had a dramatic effect on some people - muscle pains and loss of strength, diabetes, kidney or liver dysfunction and memory loss. The people cited have stopped taking their statins and have regained their health. Equally the article cites people who are happily taking statins without any adverse effects.

The latest NICE guidelines say that anyone with a 10% increased risk of heart disease should be offered statins and in most cases, this continues for life. The risks are: raised cholesterol, blood pressure, fitness and family history of heart disease. The reason this is of interest is that people with diabetes are at risk of heart disease and so are very often prescribed statins over the age of 40. However, the NICE guidelines also mean that if followed, 17.5 million people, or around 40% of all adults in the country.

There have been critics of this policy since the outset and IDDT has always questioned how giving a drug to so many people when they are different, have different health conditions and lifestyles etc can be safe for everyone. Indeed, it was claimed that this was the biggest clinical trial ever, but it wasn't a clinical trial, statins were being prescribed to these large numbers of people without evidence of the effects on such a large population.

Clinical trials of statins have been conducted by the manufacturers of statins but the full side effects have never been published by the Oxford University Clinical Trials Unit which co-ordinates the research. Aseem Malhotra, a London cardiologist, says that biased funding of research and commercial conflicts of

interests are contributing to doctors and patients being misinformed about the use of statins.

According to the Daily Telegraph article, growing numbers of doctors are 'outraged that so many people are being exposed to what they see as statin damage.' However, in a study published in June 2016, supporters of the use of statins blamed media coverage for casting doubts on statins and encouraging people to stop taking their prescribed statins. They maintained that this led to 2,000 extra heart attacks and strokes with the likelihood of 500 deaths.

Most recently, Fiona Godlee, editor of the British Medical Journal, added her voice to the critics of statins and has called upon the chief medical officer to demand full disclosure of the information on statin side effects. She said that the risks are greater than has been stated and questioned how strong the benefits are – her answer, 'We just don't know.' She goes on to point out that people carry on taking statins because they are too frightened of their doctors to stop.

Our reasons for publishing this information are to keep you informed of the conflicting views on the safety of statins and point out that adverse effects can occur.

Screening and treating to prevent Type 2 diabetes

As readers know, IDDT does not like the term 'pre-diabetes' because it seems to be a diagnosis of a condition, when it isn't. It also upsets people because they think that they are going to get Type 2 diabetes, when actually only 10% of people with 'pre-diabetes' go on to develop Type 2 diabetes. IDDT believes that a better term is that some people are 'at risk of Type 2 diabetes' but nevertheless, we believe that it is important that people at risk of Type 2 diabetes are identified and offered the appropriate advice to prevent or delay the development of Type 2 diabetes.

However, it is important to know that screening for people at risk of Type 2 diabetes (pre-diabetes) is accurate and that the interventions of lifestyle or metformin treatment, are effective. A study published in the BMJ (British Medical Journal) looked at just these two points by carrying out two meta-analyses of trials and publications. (A meta-analysis is where all research on a topic is assessed.)

One of the difficulties of identifying people at risk of Type 2 diabetes is that there is inconsistency in how people are identified. For example, the US recommendations are different from those of the World Health Organisation, so which ones should be used to identify people at risk of Type 2 diabetes?

The final analysis of papers involved 49 studies for screening and 50 studies for treatments and the conclusions from the results were:

- HbA1c is neither sensitive nor specific for detecting pre-diabetes.
- Fasting glucose is specific but not sensitive.
- Interventions in people classified through screening as having pre-diabetes have some efficacy in preventing or delaying onset of type 2 diabetes in trial populations.
- As screening is inaccurate, many people will receive an incorrect diagnosis and be referred on for interventions while others will be falsely reassured and not offered the interventions.

These results suggest that "screen and treat" policies alone are unlikely to have substantial impact on the worsening epidemic of Type 2 diabetes. Adherence to lifestyle changes across the whole population is the key to the prevention of Type 2 diabetes. (BMJ 2017;356:i6538)

This raises questions

The UK has implemented the Diabetes Prevention Programme. In the light of this review of existing evidence, has the implementation of this Programme been premature? Are we spending money wisely?

Parents Part

Teaching assistants are called to take on more medical duties after decline in school nurses' jobs

A survey by GMB London, the union for school support staff, shows that since schools lost their nurses and the number of children needing support has increased, support staff are expected to take on more and more to support children with medical needs. They are taking on this huge responsibility, sometimes with little or no training.

The people who responded to the survey said that they are supporting children with a wide range of conditions, from Type 1 diabetes to cerebral palsy. Support staff are regularly monitoring blood glucose levels and treating the child with insulin according to the results. The survey showed that amongst those who responded:

- 40% carried out these tasks unsupervised.
- 78% said their increasing medical tasks were not included in their job descriptions and they were not paid for undertaking them.
- 20% received either inadequate or no training. Some said that the child's parents had shown them what to do and some completed online training.
- Many commented that they were just expected to take on these tasks.

GMB London are concerned that school support staff (teaching assistants) have replaced qualified medical staff, such as nurses and physios, as schools can no longer afford to pay for them. However, they state that it is time that support staff should be recognised for the invaluable work they do and they should not have things continually imposed on them. The union is demanding proper funding for schools so that support staff can do the job that they were employed to do. (December 2016)

Revolve Comics

Dr Partha Kar, Associate National Clinical Director for Diabetes, has developed a new way to help young people with Type 1 diabetes understand their condition – by turning them into comic book superheroes.

Through Revolve Comics he and his team hope to increase patients' understanding of Type 1 diabetes and for those who are newly diagnosed, it is hoped that they will feel more empowered to look after themselves and see it is possible to live a long, healthy life with Type 1. Dr Kar said: "We really want to speak to children and young people receiving their diagnoses of Type1 diabetes as soon as we can to make sure they begin thinking about their condition and what it means. Educating children at young ages about taking regular medicine, needles and a life-long condition can be very scary for them but through using fun and interactive mediums and appealing to them in different ways we can tap into their imagination and begin to educate them subtly."

The comic can be found by visiting:
https://revolvecomics.files.wordpress.com/2016/09/diabetes-t1-comic-low-res1.pdf

Parenting stress in fathers and mothers of young children with Type 1 diabetes

This research was published online in December 2016 and it compared the levels of parenting stress in 56 fathers and 56 mothers of young children with Type 1 diabetes from 0 to 7 years. They used various tests to assess stress at the outset and a year later asked the parents to fill in the questionnaire again. 44 mothers and 31 fathers completed the questionnaires. Over the 12 months the results showed that within families with a young child with Type 1 diabetes, the burden of care increases in fathers and decreases in mothers. The researchers' interpretation of this was that fathers assume more responsibility for the care of their child with Type 1 diabetes as the child grows.

Transfer to adult clinics

A study has looked into the changes in glycaemic control in young people around the time of transfer from the paediatric clinic to the adult clinic. It involved 126 young people between the ages of 14 to 22 years who were followed for 2 years before leaving the paediatric clinic and the first 2 years in the adult clinic.

The researchers adjusted for gender, age at diabetes onset, age at transfer, duration of diabetes at transfer, amount of time between last paediatric and first adult visit, comorbidity, learning disability and/or mental health conditions and family structure. They also looked at associations between acute hospital admissions, the numbers of those who stopped attending the clinic and HbA1c level at the beginning of the study and later.

The results were as follows.

- The average HbA1c level was 80 mmol/mol (9.4%) before transfer to the adult clinic but decreased by an average of 3 mmol/mol (0.3%) each year after transfer.
- Young people with a learning disability and/or a mental health condition had worse glycaemic control.
- The average HbA1c of those with divorced parents was 14 mmol/mol (1.2%) higher.
- Almost a third of the young people were admitted to hospital for acute diabetes care.
- Low visit attendance rate, high baseline HbA1c level, learning disability and/or mental health conditions and divorced parents predicted acute hospital admissions.

The researchers concluded that glycaemic control improved significantly after transfer to the adult clinic but average HbA1cs remained high. They recommend that to improve HbA1cs and reduce hospitalisation rates, future research should focus on young people with divorced parents, those with a learning disability and/or mental health condition and those who do not attend clinical visits. (Diabetic Medicine, January 2017)

Jeremy Hunt Watch

More doctors and nurses in senior positions in the NHS

At the end of November, Health Secretary, Jeremy Hunt, announced that he wants more doctors and nurses to occupy senior positions within the NHS. At present only a third of NHS chief executives have a clinical background. The intention is that the NHS will recruit the UK's "brightest graduates" to train in leadership roles by expanding the NHS graduate scheme, doubling places next year to 200 with plans for up to 1,000 places by 2020. Mr Hunt said that GPs and nurses are capable of taking on senior roles of the "same standard as the best in the NHS and the private sector".

Scrapping nursing bursaries leads to student applications dropping

The change in policy of stopping bursaries for student nurses in England and replacing them with student loans has led to a drop in applications for 2017 by 20% (over 9,000). A survey by Universities UK has also shown that applications have dropped by twice that of other courses. The Royal College of Nursing (RCN) predicted this drop and advised against the change but to quote, 'their advice fell on deaf ears'. Wales is keeping the bursaries for student nurses at least until 2018.

It seems a strange decision when TV stations are advertising bursaries of up to £25,000 to people to train as teachers – did the government choose between teachers and nurses?

Plans for the future of the nursing profession

In November, Jeremy Hunt also announced his plans for the future of the nursing profession. While this may not seem to have much to do with IDDT, the number of registered nurses will affect our care within the NHS, so the plans are important to all of us. Mr Hunt's his plans include two new job roles:

Associate nurses – they are not to replace registered nurses but will support and compliment them. They will be able to administer medicines, so after pressure from the nursing profession, he has agreed that they must be regulated by the Nursing and Midwifery Council in the same way as for registered nurses.

Nursing apprenticeships - this role will be available from September this year and will be another way into nursing without attending university and getting a degree. They will compliment the associate nurses and train for 4 years in community and social care settings. Surprising - it was only in the year 2000 that it was decided that all nurses should go to university to obtain a degree!

Replacing nurses with support staff increases the risk of death

A study in BMJ Quality and safety has for the first time, shown that a higher proportion of qualified nurses is associated with a significantly lower risk of death, higher patient satisfaction and fewer reports of poor quality care. In England, where the nursing associate has just been introduced, the nursing skill mix varies and registered nurses on average make up 57% - the lowest in Europe (66%). Has Mr Hunt seen this report?

Scottish government invest £10million to improve the management of Type 1 diabetes

£10million of extra funding from the Scottish government will be used to increase the provision of insulin pumps and to provide more people with continuous glucose monitors. There are currently about 3,200 insulin pumps in use in Scotland, a 400% increase since 2010 and this further investment will further increase their use in adults with Type 1 diabetes.

Continuous glucose monitors will be made available to priority groups including people who have severe hypoglycaemia. (December 2016)

Continuous glucose monitoring for children in Northern Ireland

Mrs M O'Neill (Minister of Health) told the Northern Ireland Assembly that the Health and Social Care Board is planning to introduce Continuous Glucose Monitoring (CGM) in line with NICE guidance (NG18) from 1 January 2017 for children and young people with Type 1 diabetes who meet the NICE criteria for CGM.

Over £40 million promised to treat and care for people who already have diabetes

These plans were unveiled in the 2017-2019 NHS Operational Planning and Contracting document. CCGs will have the opportunity to bid for funding to spend in four key areas:

- Improving hospital care,
- Structured education attendance,
- Foot care treatment to reduce amputations,
- Meeting the NICE treatment targets and driving down variations between CCGs.

It has also been announced that the Healthier You: NHS Diabetes Prevention Programme is to be expanded for which there is separate national funding for the initiative, aside from this extra £40million a year. The Prevention Programme will be increased in 2017/18 and 2018/19. At the same time Public Health England announced figures showing that 3.8million adults in England have diabetes and the proportion of the adult population with diabetes is set to rise to one in ten by 2035 (4.9million people).

Sore Throat Test and Treat

There has been much publicity about the over-use of antibiotics and we are all being encouraged not to demand them unnecessarily, such as for virus infections which are not helped by antibiotics.

In November NHS England announced that a walk-in community pharmacy-based 'Sore Throat Test and Treat' will join the National Innovation Accelerator (NIA), a scheme that helps to speed up new treatments and technologies in the NHS. In this new programme people will be tested to determine whether or not they need antibiotics through a throat swab. Those who test positive for a bacterial infection will be given antibiotics and those with a viral infection will be given appropriate advice. The aim is to reduce the demand for GP appointments and decrease the over-use of antibiotics.

However, Pharmacy Voice CEO Rob Darracott pointed out when the announcement was made, the new NHS service is not yet available but is an opportunity to test how it can be scaled-up and rolled out to provide greater patient benefit and improve health outcomes.

Emergency prescriptions

NHS England has plans for a new pharmacy service which will allow emergency prescriptions to be requested by phone. It appears that at present a large number of out of hours calls to GPs are from people who have run out of their regular medication. However, Dr Richard Vautrey, BMA GP committee deputy chair commented that it is important that this system focuses on providing emergency medication only and does not become the fall back position for repeat prescriptions which need to be supplied in the normal way so the necessary checks are carried out.

The National Diabetes Audit 2015/16

More CCGs (Clinical Commissioning Groups) and GP practices have taken place in this latest National Diabetes Audit in England and Wales than in previous years, providing a bigger picture of what is going on with diabetes care around the country. The most striking issue is just how great the variation in care / treatment is across areas, so your level of care and ultimately your health, is very dependent on where you live.

Key findings

- The 2013/14 drop in BMI checks and the 2014/15 drop in urine albumin checks have not recovered during 2015/16.
- Fewer people with Type 1 than with Type 2 and other forms of diabetes receive their annual checks.
- Young people with Type 1 or Type 2 diabetes are less likely to receive their annual checks than older people.

The NICE 3 key treatment targets

The following are the 3 key treatment targets set out by NICE and achievement of these was measured in the Audit.

HbA1cs - 58mmol/mol (7.5%)
Blood pressure - 140/80
Cholesterol -less than 5mmols/L

- For people with Type 1 diabetes achieving the NICE recommended treatment targets for glucose control, blood pressure and cholesterol varied from 11% in some CCGs and Local Health Boards (LHBs) to 34% in others.
- Glucose control and cholesterol targets were less often achieved by people with Type 1 diabetes.
- More people with Type 2 diabetes achieved treatment targets but there is still a wide variation of 16% from 33% in some CCGs/LHBs to 49% in others.
- Younger people with both Type 1 and Type 2 were less likely to achieve the targets than older people, mainly due to poorer glucose and cholesterol control in people under 65 years.
- People with learning difficulties whether with Type 1 or Type 2 diabetes are more likely to achieve their targets than their peers.
- Similar variations occur between GP practices within CCGs and between specialist services (such as hospitals) and GP practices and are not due to patient demographics.

The devil is in the detail

- In the last 6 years there have been improvements nationally in achievement of all three treatment targets, in both Type 1 (1.6%) and Type 2 (5.1%) diabetes.
- People with Type 2 diabetes are more likely to achieve all 3 treatment targets than people with Type 1 diabetes - 40% of people with Type 2 compared to only 18% of people with Type 1 diabetes.
- Older people are more likely than younger ones to achieve all 3 treatment targets; the difference for those with Type 2 diabetes is 46% of people aged 65 to 79 achieved all 3 treatment targets compared with 27% of people under 40. For people with Type 1 diabetes only 24% of people aged 65 to 79 achieved the targets compared with 18% for those aged under 40.
- The percentage of people with Type 1 diabetes receiving all the NICE care processes has fallen 8%, from 45% in 2013/14 to 37% in 2015/16. For people with Type 2 diabetes, the decline is greater - from 68% in 2013/14 to 54% in 2015/16. These declines are almost entirely due to reductions in the urine albumin checks for the detection of early kidney disease.
- The percentage of people with Type 2 diabetes who have been offered structured education within a year of diagnosis has increased, from 10% in 2009 to 82% in 2014 and for people with Type 1 diabetes the increase has been 5% to 39% during the same period.

The notable recommendations for improvements in the Report are:

The variations in care must be reduced.

- The services for young people with both Type 1 and Type 2 diabetes must improve.
- The services for people with Type 1 diabetes must improve.
- The services for people with Type 2 and learning disabilities must improve.

There are two particularly interesting comments in the Report which are good to see!

- ***The NHS sometimes underestimates or undervalues structured education for people with diabetes.***
- ***Both forms of diabetes are lifelong conditions and people with diabetes only spend 2 to 3 hours a year with a healthcare professional, so they need the knowledge and skills to manage their diabetes.***

How true these comments are and we have to hope that they do not fall on stony ground! While providing readers with these facts, it is easy to see the question that arises; what if you live in an area where care is not good and you have never been offered an education programme?

– big variations in care, again!

You are the person with diabetes and poor services may mean that your health and quality of life is not as good as it could be. There are no easy answers, but we can only advise that you have as much information about your diabetes as you can and that the NICE recommendations for treatment and education are carried out. This may not be easy but it does mean making sure that the 9 key NICE recommendations are carried out at least annually and if they are not, ask why not.

Reminder...

People 12 years and over should receive an education programme when diagnosed and the following 9 NICE recommendations should be carried out at your annual check

1. HbA1c
2. Blood pressure
3. Cholesterol
4. Urine albumin/creatinine ratio (for kidney function)
5. Creatinine levels (for kidney function)
6. Foot risks
7. BMI (body mass index)
8. Smoking history
9. Retinal screening

All Party Parliamentary Group for Diabetes Report

Levelling Up: Tackling Variation in Diabetes Care

All Party Parliamentary Groups (APPGs) are made up of MPs of all political parties who have a special interest in a topic, in this case diabetes. In November 2016 prior to the publication of the above Audit, the APPG for diabetes published a report on the variation of diabetes care across the country and made recommendations for action to try to alleviate this problem. Their key recommendations are as follows.

Care and support planning

(i) Local areas need to implement training for healthcare professionals so that patient centred care and support involving the patient becomes routine.
(ii) Sharing of expertise in managing diabetes between specialists and primary care professionals so there is recognition of when to refer people to a specialist.
(iii) Integrated IT systems to allow better communication between healthcare professionals in different organisations.

Support for self-management

(i) CCGs need to meet NICE guidelines by expanding structured education to ensure people have attended an education course within a year of diagnosis.
(ii) Other options should be developed so people have a better access to ongoing learning opportunities.
(iii) There should be a national standard of diabetes education for children and young people under 18.

Access to key technologies

Although NICE recommends continuous glucose monitoring (CGM) for people with Type 1 diabetes with serious problems with hypo- and hyperglycaemia, the APPG found muddled funding processes making access to CGM difficult.

Flash glucose monitoring, the Freestyle Libra being the only one available in the UK, enables people to test as many times as they want without finger pricks. However, it is not available on the NHS to adults with Type 1 diabetes and is costing about £120 per month so is only available to those able to pay, adding to the inequalities in care.

(i) People with diabetes and healthcare professionals need to be much more aware of funding availability of new technologies and healthcare professionals need to have access to training to use the devices.
(ii) More staff need to be available in specialist care to support people using the new technologies.

A strong local diabetes system

(i) There needs to be effective local networks to share information, reduce financial barriers between organisations and undertake regular quality improvement.
(ii) Leadership needs to be supported to drive effective change.

Health Education England

(i) Health Education England should recognise the increase in diabetes in training so that non-diabetes specialists are able to look after people with diabetes well.
(ii) They need to ensure that there are enough healthcare professionals trained in various services that people with diabetes need: dietitians, podiatrists, pharmacists, optometrists and nurses.

IDDT comments

There is nothing in the report with which we would disagree and its recommendations would help to improve the variations in care highlighted in this latest Audit. What we need to see is that the Secretary of State for Health, Jeremy Hunt, NHS England and Public Health England actually take notice and if necessary, force CCGs to implement the recommendations!

From our own

Leaking cartridges - should we be scared?

Dear Jenny,

I'm writing further to the article on page 8 of your December 2016 newsletter – MHRA warning: Accu-Chek Insight pump and leaking cartridges.

That MHRA Medical Device Alert was triggered in part by the death of my son from diabetic ketoacidosis on 22 January this year. He used an Accu-Chek Insight pump and did not receive sufficient (if any) insulin when the insulin from the cartridge leaked into the pump instead of going into him. At the time, my son was away at university so we are not clear how he felt, but within 24 hours of the cartridge being changed and starting to leak he went to bed and never to our knowledge awoke. He had tested his blood sugar levels during the day and they were high enough that he should have tested ketones and taken preventative action but tragically he did not.

The alert from the MHRA states that the under-delivery of insulin "may lead to rapid deterioration of health, diabetic ketoacidosis or death". Your article, similarly to letters issued by our local diabetes care team, refers only to "serious health implications". I feel it is really important that patients and their families understand just how quickly failure of the pump to deliver insulin can result in death.

Patients should be forcefully encouraged to take action even if they don't feel particularly unwell and they should be told that they must not leave taking action until the next morning. By not explicitly talking about the risk of death, I feel that we are doing them a disservice, possibly a fatal one – if my son had been educated in that way he may still be alive. I do not accept that it is wrong to scare patients – I would rather that my son and the family had been scared if it would have meant that he had not died.

Given the wording of your article I thought it important to get in touch and inform you about my son's death as this issue with the Accu-Chek Insight pump has had a more devastating impact than one of your members being admitted to hospital.

By email anonymous

IDDT comment: our sympathies go to the whole family for the loss of their son and we appreciate our attention being drawn to the possible dangers of pump failure. Unlike multi-dose regimes, with a pump there is no background insulin in the system, so blood glucose levels can rise much faster.

Cheap needles follow up

Dear Jenny,

I read the letter from Mr G.H about being him being given cheap, poorer quality needles than the Novo Nordisk pen needles he has used for many years. I also had this problem with my GP practice, apparently a directive from the local CCG. The first needle I was offered I found to be awful – they hurt and left several bruises on my injection sites.

However I had a meeting at the practice with a pharmacist from the CCG who said I could try different fine needles and I find these are the equal to Novo Nordisk needles.

Mr W.A

Response from Mr G.H.

I am now back on Novopen needles... long may it last!

correspondents

I can't drive the scouts any more

Dear Jenny,

Just a few notes which may help others with Type 1 diabetes like myself.

I have been diabetic since I was 7 years old, had it for 52 years. I passed my driving test in 1976 and had motorcycle, car, minibus and several other types of vehicles on my licence.

In 1997 the DVLA took D1 off of our licences, but the good news is you can still drive "not for hire or reward". I have carried on driving the Scout minibus until now.

The bus is now worn out, so I went to hire one from our local agent. The problem is no D1 on my licence. Although I went armed with a wad of letters and information from the DVLA saying I can drive for the Scouts, the hire companies computer says "NO" because D1 does not show on my licence. Several companies say the same.

You can apply to have it put back at a cost of £70+ for a medical from a doctor and £50+ for report from an optician. I am not willing to pay this for a once a year camp trip and outings for something I had and the DVLA took away.

I don't think there is any way round this and am wondering if I should carry on as a Scout leader - with more rules and regulations we may have to stay indoors!

Mr S.T. by email

The **WINNERS** of IDDT's lottery draws!

We are delighted to announce the winners of the draw of our monthly lottery for November 2016. They are as follows:

1st prize of £357.60
goes to Anon. from Uttoxeter
2nd prize of £268.20
goes to Anon. from Tredegar
3rd prize of £178.80
goes to Ronald from PontyPridd
4th prize of £89.40
goes to Anon. from Seaton

Winners of the December 2016 draw are:

1st prize of £358.56
goes to Anon from New Addington
2nd prize of £268.92
goes to Anne from Doncaster
3rd prize of £179.28
goes to Barbara from Hope Valley
4th prize of £89.64
goes to Frederick from York

Winners of the January 2017 draw are:

1st prize of £381.60
goes to Elizabeth from Shrewsbury
2nd prize of £286.20
goes to Bob from Hereford
3rd prize of £190.80
goes to Anne from Bromyard
4th prize of £95.40
goes to Anon from Belfast

Note: the winners of the draws for February, March and April will be announced in our June 2017 Newsletter and will be available on our website.

THANK YOU TO EVERYONE WHO JOINED IN IDDT'S LOTTERY.

If you would like to join in for just £2.00 per month, then give us a call on 01604 622837 or email tim@iddtinternational.org

PHARMACEUTICAL NEWS

Fiasp® (fast-acting insulin aspart) approved in Europe

On January 10th 2017 Novo Nordisk announced approval from the European Commission for a new insulin called Fiasp® for the treatment of adults with Type 1 and Type 2 diabetes. Fiasp® will be available in vial, Penfill® and FlexTouch® pen as well as for pumps. The authorisation covers all 28 member states and it is expected to be available in the first European countries in the first half of 2017. It has also been approved in Canada.

Fiasp® is a faster-acting version of rapid-acting insulin aspart (NovoRapid) and the press release says, "Fiasp® provides improved mealtime and overall glucose control with a similar safety profile versus NovoRapid." It has two new excipients to provide earlier insulin action greater, and faster absorption. The review was based on 4 trials of over 2,100 people with Type 1 and Type 2 diabetes.

FreeStyle Libre glucose monitoring system is safe to use in children with diabetes

In the UK a trial of Abbott Diabetes Care's FreeStyle Libre glucose monitoring system was conducted in 89 children with Type 1 diabetes aged between 4 and 17 years. The sensor detected hyperglycaemia and hypoglycaemia 85% and 70% of the time respectively, rising to 94% and 84% respectively, when pending alerts were considered. The study also showed that 5 participants had 5 device-related adverse events, all of which were resolved by the end of the study. (The Archives of Disease in Childhood, February 2017)

Novo Nordisk to invest in Type 2 diabetes

Insulin manufacturer, Novo Nordisk, is investing £115 million over 10 years in a joint venture with Oxford University to build a research centre to develop new treatments for Type 2 diabetes and its complications. One hundred researchers will be based at the centre including academic and industrial scientists.

SugarBEAT

There is a new device on the way called SugarBEAT. It is a reusable sensor containing a daily disposable adhesive skin patch and is a needle-free method of measuring glucose levels developed by Nemaura Medical Inc.

The information from the patch can be read on a standalone reader or a pre-loaded App on a smart device (phone, watch or tablet) can receive information from the patch via Bluetooth and display glucose levels. This information can be sent to the doctor for him/her to provide tailored advice. SugarBEAT can be worn every day or on an adhoc basis and is expected to be available in Europe during 2017.

Adults at risk of Type 2 diabetes treated with pioglitazone (Actos) more likely to have a fracture

Research has been carried out on 3,876 adults at risk of Type 2 diabetes (so called pre-diabetes) who had an ischemic stroke or a transient ischemic attack (TIA). The participants were randomly selected to take Actos (pioglitazone) or a placebo (dummy pill) and those taking Actos were more likely to have a bone fracture at any site than those taking a placebo. (Journal of Clinical Endocrinology & Metabolism December 2016)

Actos and the risk of bladder cancer

In the US in 2011, the FDA added a warning to the label of Actos that it may cause bladder cancer but studies carried out in 2014 and 2015 contradicted this claim. However, the FDA has again concluded that Actos may cause bladder cancer after a 2016 study published in The British Medical Journal showed that the drug causes a 63% higher risk of bladder cancer. (Medscape, December 2016)

Acute cystitis

Acute cystitis, also referred to as a Urinary Tract infection or UTI, is an inflammation of the mucous membranes lining the bladder. It usually develops when bacteria get into the urethra and move up into the bladder where they multiply. It is a common problem and it is much more likely to affect women than men because their urethra is shorter making it easier for the bacteria to reach the bladder.

More than half of all women have cystitis at least once in their lifetime and half of all women who have had acute cystitis develop it again within a year.

Causes of uncomplicated cystitis

- Sexual intercourse increases the risk of getting cystitis because it increases the risk of bacteria getting into the urethra.
- Spermicides and contraceptive diaphragms can also increase the risk.
- Pregnant women are more likely to get cystitis.
- Other risk factors include people with diabetes, multiple sclerosis or a urological disease.
- It is also more common after the menopause.

Symptoms

- Urine is passed more frequently and this can be accompanied by a stinging and burning pain. The pain may be worse when the bladder is almost or completely empty.
- The urge to pass urine often comes on very suddenly but in most cases only a small amount of urine is passed. Some women have difficulty holding back the urine.
- The urine may be cloudy, have an unusual colour and smell.
- The pain sometimes spreads into the abdomen or the back.
- Severe cystitis can make you feel unwell, sluggish and irritable.

Uncomplicated cystitis is easy to treat with antibiotics and usually goes away quickly and without any problems. Sometimes drinking plenty of fluids may help or applying heat but these are not proven.

However, the cystitis is classed as more complicated if the usual treatment with antibiotics is not sufficient or if there is a risk of the infection spreading to the kidneys. People at risk of complicated cystitis include people with a weakened immune system or a kidney condition.

The signs that the inflammation has spread to the kidneys are:

- Pain in the area of the kidneys.
- Fever.
- Sometimes nausea and vomiting.

Diagnosis

Doctors assess whether or not it is uncomplicated cystitis based on symptoms and medical history. A urine sample can also be tested for bacteria, white and red blood cells, proteins and a salt called nitrite but this is not usually needed if the symptoms are clear.

Ultrasound can be used to check the bladder and kidneys but this is usually only used if the cystitis is complicated. Cystoscopies or x-rays are also done in very rare cases, such as when a woman has severe cystitis that keeps coming back.

Prevention

There is no reliable way to prevent cystitis. Sometimes it appears suddenly without any clear causes but many women notice certain factors in their lives that increase their chances of getting cystitis and so avoid them. If this isn't sufficient to avoid recurring cystitis, then medication may be given.

APOLOGIES FOR ERROR!

Our apologies for an error in the December Newsletter article: **'Batches of GlucaGen HypoKits for severe hypoglycaemia are being recalled' We** printed one batch as FSX590 when it should have been FS6X590. Our apologies too for the article on cholesterol not being in the December Newsletter, it is in this edition!

SNIPPETS

A public health campaign to reduce sugary drink consumption led to a significant drop in sales of the beverages in a Maryland County, USA

In 2012, several community partners launched a programme of public education and policy measures to get people in Howard County to cut back on sugary sodas, sports drinks, energy drinks, fruit drinks and flavoured water/teas. These included reducing availability of sugary drinks in schools and child care facilities and making healthier beverages and foods more widely available on local government property.

The effects were that between 2012 and 2015, sales of sugar-sweetened drinks fell nearly 20% by volume and sales of fruit-flavoured beverages with added sugars fell about 15%.

New trend – clean eating

Mental health experts are warning of the risks associated with an increasingly popular dietary trend of 'clean eating'. It is a psychological condition known as orthorexia nervosa. It affects young people, especially girls and leaves them very thin and in a dangerous position if taken to extremes.

The condition starts out innocently as an attempt to eat more healthily but experts think some of the young people become fixated on food quality and purity. Some examples are: not drinking water from a tap, not eating while walking because they think food can only be processed while sitting down and at the top of most people's list of bad foods is gluten and dairy. All this interferes with life and can become an obsession and having strict rules means some young people will worry all day about eating a biscuit.

Clean eating is promoted by bloggers who can be unqualified and offer dangerous advice with no scientific basis. Some experts suggest that a lot of younger people don't think they need therapy and that the solution to bulimia and anorexia is to eat clean.

Bertie Online

The Royal Bournemouth Hospital has updated Bertie Online, an education course for people with Type 1 diabetes. It now also includes a new online resource for young adults with Type 1 including a 'Streetwise' section which deals with issues that are important to young people such as exam stress, moving out of home, relationships and alcohol. There is also a 'Lifewise' section for adults. The site is free for anyone, just register at www.bertieonline.org.uk

Insufficient sleep tied to elevated gestational diabetes risk

A study in the journal Sleep found pregnant women who got less than six hours of sleep per night had a higher risk of developing gestational diabetes, compared with those who got seven to eight hours of sleep. The findings were based on glucose levels of 686 women in Singapore at 26 to 28 weeks of gestation.

Increase in use of artificial sweeteners

A study in the Journal of the Academy of Nutrition and Dietetics found that from 1999 to 2012 the number of children consuming artificial sweeteners increased from less than 9% to about 25%. Researchers reported 44% of adults and 20% of children consumed low-calorie sweeteners more than once per day, and the likelihood of using them increased with BMI levels.

Nurses the most trusted profession in the UK

A Mori poll has found that nurses are the most trusted profession nationally, ahead of judges, doctors and teachers with 93% of the public trusting nurses to be truthful and informative. This was closely followed by doctors at 91%.

www.iddtinternational.org enquiries@iddtinternational.org