InDependent Diabetes Trust

June 2013 Newsletter

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In this issue...

Passport for Diabetes in Care Settings

Over recent months there has been lots of publicity about the numbers of people with diabetes in residential care, possibly as high as 40%, and the particular set of difficulties faced by this group and those providing their care. The system is such that residential care homes, through no fault of their own, are underfunded, with high staff turnovers and with very little access to the training necessary to manage diabetes in a care setting. The result of this is that if someone has a low or a high blood sugar, then very often the first reaction of a carer is to call 999, resulting in an unnecessary hospital admission – an admission that could have been avoided had some simple steps been followed.

In order to try and remedy this situation IDDT has been working closely with the Institute of Diabetes for Older People (IDOP) and the English Community Care Association (ECCA) to produce a Passport for Diabetes

in Care Settings. The Passport draws together the essential elements of a person's care needs in relation to their diabetes, into one simple, user-friendly document. Care staff can use the Passport to familiarise themselves with a those needs quickly, easily and providing them with instruction as to what to do should problems arise.

The Passport provides basic personal information, contact details of relevant health professionals, how the individual manages their diabetes and what to do if problems occur.

If you would like a copy of the Passport, then please contact IDDT, phone 01604 22837, email martin@iddtinternational.org or write to IDDT, PO Box 294, Northampton NN1 4XS. Multiple copies are readily available to those working in the healthcare field.

Who Looks After My Feet?

The answer to this should be simple – a podiatrist, previously called a chiropodist. However, one of our members with longstanding Type 1 diabetes who recently had foot problems found the answer was not quite so simple. Initially his foot problem was not acute, so his GP gave him some cream. This did not help and in fact, the problem became worse so aware of the risks of foot problems with diabetes, he tried to obtain a second appointment with his GP but was given one over 2 weeks away. He explained the problem, that he had diabetes and that he felt that the matter had now become urgent but due to 'staff shortages' still could not get a sooner appointment. His foot became so painful that he had difficulty walking at which point he rang the GP and simply asked for a referral to a podiatrist but this was not given.

His next step was to look for a podiatrist and pay privately – bearing in mind that he lives in a rural area this was not as easy as it sounds and he was confused by the various apparent qualifications.

What is the difference between a podiatrist and a chiropodist?

In the UK podiatry is the new name for chiropody. The name was changed in 1993 because this is the internationally recognised name.

Qualifications of a podiatrist

A registered podiatrist has to complete and pass a full time honours degree in podiatry [BSc Hons]. There are also approved 4.5 year part-time courses. A podiatrist must be registered with the Health and Care Professions Council [HCPC].

So what do the letters of qualifications mean?

- **DPodM or BSc(Podiatry)** - the podiatrist has completed a full training course in podiatry at an approved institution. Originally this course was a diploma in podiatric medicine - DPodM but was later changed to a degree course - BSc. NB:DipPodMed is not the same as DPodM.
- **SRCh - State Registered Chiropodist** – since July 9th 2003 this title is defunct though it is still used by many podiatrists for the time being as the general public may still see it as a sign that the podiatrist is fully qualified.
- **MChS or FChS** - the podiatrist is a member or fellow of The Society

of Chiropodists and Podiatrists. A practicing member of this society is assured of having professional indemnity insurance cover.

- **F.C.Pod(S)** – this is a further qualification in surgery that some podiatrists may have but the qualifications above are suitable for the majority of foot problems.

So why is there confusion?
If you see a podiatrist through the NHS, then they are fully qualified because this is a requirement for employment of podiatrists in the NHS.

Registration with the Health Professional Council [HPC] ensures the practitioner meets certain minimum standards of education but it does not guarantee that the Podiatrist/Chiropodist has completed an approved course. This is because in 2003 the HPC replaced the old registration organisation and at that time it let people register who had been working privately as an unregistered podiatrist for at least 3 years - a process known as grandfathering. So not all podiatrists have completed a degree course.

So now you know who's who, you can ask if the podiatrist is HPC registered and then if they have a degree or 3 year diploma in podiatry {BSc or DPodM]. If there is a reluctance to answer or that they simply insist that they are 'fully qualified', it could mean that they are not.

Then there's a 'Foot Health Practitioner'
People who have previously used the term chiropodist or podiatrist but who have not gained HCP registration because they were not eligible have adopted the title 'Foot Health Practitioner'. This title is not protected in law which means that anyone can use it regardless of training levels. Courses are available that offer a total of only 11 days practical tuition, after which students will call themselves 'Fully trained and qualified Foot Health Practitioners' and will advertise the same medical treatments as those offered by Podiatrists. They should NOT be confused with fully qualified podiatrists.

Remember! Podiatry should be your first port of call if you have a foot problem and you do not need a referral from your GP to seek a private consultation. If your GP needs to be involved your podiatrist should contact them after your initial assessment.

Just some Facts
There are 6000 diabetes-related foot amputation a year and it is estimated that 80% of them are preventable. The reason they are not being prevented is that too many areas of the country do not have systems in place to treat foot ulcers or other foot infections within 24 hours.
A report by Diabetes UK, the Society for Chiropodists and Podiatrists and NHS Diabetes recommends:

- All hospitals should have a multi-disciplinary foot care team (MDT), which brings together different healthcare professionals to ensure good quality care for foot problems in people with diabetes. [40% of hospitals do not have this.]
- Every hospital should guarantee that people with urgent foot problems can be assessed by an MDT within 24 hours, as it is vital that foot problems are treated quickly.
- Every area should have a system for identifying and regularly reviewing people at high risk of foot ulcers and infections, including annual foot checks and foot protection teams in the community.
- People with diabetes who are at high risk of foot problems should know what to look out for and where to go in the event of a foot attack.

In Scotland
People with diabetes across Scotland are to receive new feet checks in hospital. The new checks, known as 'CPR for Feet' aim to identify patients with a foot ulcer or those at risk of developing them. The new 'CPR for Feet' programme will offer new foot care checks in hospital to everyone with a diagnosis of diabetes to determine their risk of developing foot disease, and gives them the information and support that they need to reduce that risk.

The Menopause And Diabetes

The menopause is a difficult time for women but can be an especially difficult time for women with diabetes. Despite the relationship between diabetes and the menopause being complex and known to cause difficulties, there has been limited research in this area and therefore knowledge is limited. What women with diabetes report to us about menopause is that in addition

to the classic symptoms, they have high blood sugars, not all the time but varying in an erratic manner.

Facts about the menopause

- The menopause is a natural event when spontaneous ovulation ends and therefore the reproductive function. In the western world the average age of menopause is 48 to 51 years in women without diabetes.
- Perimenopause [before menopause] is the variable length of time when there are ovarian changes and includes the first year following menopause. This is when many women start to have the classic symptoms – hot flushes, sleep disturbances, tiredness, weight gain, vaginal dryness and irregular periods until menstruation ceases altogether. .
- Postmenopause is when there is oestrogen deficiency and this adds to the menopausal symptoms.

Type 1 diabetes and menopause

AS large studies have not been conducted, the following information is based on small studies but appears to be the best information available.

- Menopause in women with Type 1 diabetes appears to occur at an average age of 41 years compared to 49 years in their non-diabetic sisters and 48 years in other non-diabetic women.
- Women with Type 1 diabetes who had menstrual irregularities before the age of 30 appear to have double the risk of early menopause.

The reasons for this early menopause are not known but there are suggestions that it could be due to times of high sugars over the years or the immune system response. It is not known whether glycaemic control has any effect on the onset of menopause.

Type 2 diabetes and menopause

There is a little more known about this.

- Women with Type 2 diabetes appear to have earlier menopause than non-diabetic women – 45 years compared to 48 years respectively.
- In a larger study which excluded women with poor glycaemic control and previous menstrual irregularities, women with Type 2 diabetes had their menopause at a similar age to non-diabetic women.

The increased risk of osteoporosis and fracture

- Postmenopausal women with diabetes are at an increased risk of lower bone density [osteoporosis] and fracture compared to non-diabetic women.
- The risk of hip fracture is higher for women with Type 1 diabetes than Type 2 diabetes.

Menopause and the risk of developing diabetes

We know there has been a dramatic rise in the development of Type 2 diabetes and the number of women over the age of 45 with diabetes has increased tenfold over the last 10 years. This is because some people are genetically predisposed to develop it and environmental factors such as overweight, obesity and less active lifestyles are involved.

Menopause is associated with changes in the body composition which includes weight gain and abdominal obesity. Research has shown that postmenopausal women with abdominal obesity, although not overall weight gain, are more likely to have higher fasting insulin and triglyceride levels, higher glucose intolerance and higher systolic blood pressure [the top number], so may be more susceptible to Type 2 diabetes..

The use of HRT in women with diabetes

Hormone replacement therapy [HRT] involves replacing oestrogens and progesterones which are the two hormones that decline during menopause. It is the decline in these hormones that causes the well known symptoms of menopause. Using HRT allows women to replenish the hormone levels to reduce the symptoms but there are risks involved for women with diabetes and non-diabetic women.

- For women without diabetes, using HRT can increase the chances of developing it but there are other studies which show the opposite.
- For women with diabetes, HRT can increase blood glucose levels so it's advisable that a doctor monitors blood glucose levels regularly during hormone replacement therapy to detect any changes that may occur.
- Research published in the British Medical Journal [February 2003] showed a connection between HRT and heart disease. This risk was greater in women with diabetes and it is thought that this may be due to raised blood glucose levels.

- In 2004 a study showed that both diabetic and non-diabetic women are more likely to have a stroke when using HRT. A US study being conducted by the National Institutes of Health was halted early because the researchers found that the risks of stroke outweighed any potential benefits that women could derive from HRT. There was also an earlier US study [2002] that was stopped early due to the discovery that HRT led to increased risks of cardiovascular conditions, blood clotting conditions, and breast cancer in some women.

Currently, HRT may be used when necessary in women with diabetes, and it is thought that either low dose oral oestrogen or transdermal (patch or gel) preparations are best. If progestogen is required, either dydrogesterone or micronised progesterone seem least likely to interfere with diabetic control. Further studies are needed to find the ideal type of HRT.

These are some points to discuss with your doctor or health professional if you are going through the difficulties of the menopause.

NICE Updates

By the way, as a result of the changes in the NHS, the name has changed to the National Institute for Health and Care Excellence but it will still be referred to as 'NICE'.

NICE decision on Lucentis [ranibizumab] for diabetic macular oedema
As discussed in IDDT's February Newsletter NICE has reversed its decision and in future Lucentis will be available to treat diabetic macular oedema under certain conditions. Your eye specialist will discuss these with you.

The full guidance can be found on the NICE website:
http://guidance.nice.org.uk/TA274

The Definition Of Hypoglycaemia Has Been Raised

The European Medicines Agency has raised the level at which people are to be defined as having hypoglycaemia to equal to or less than 3.9mmol/L from 3.8mmol/L. This is in line with the American Diabetes Association definition of hypoglycaemia for adults and the International Society for Pediatric and Adolescent Diabetes [ISPAD] for children. So the new definitions are:

- **Symptomatic hypoglycaemia** is hypo during which typical symptoms of hypoglycaemia are accompanied by a blood glucose test of less than or equal to 3.9mmol/L
- **Asymptomatic hypoglycaemia** is a hypo where there are no typical symptoms of hypoglycaemia but the blood glucose test reading is less than or equal to 3.9 mmol/L. It is suggested that particularly for children, the level at which asymptomatic hypoglycaemia occurs, should be recorded especially if it is below 3.6mmol/L to prevent people being at risk of hypos without symptoms.

Those of you who have lived with diabetes a long time will remember that the definition of a hypo used to be at or below 3.9mmol/L, This is when Professor Harry Keen coined the phrase "4 is the floor", in other words any tests below 4 meant that you were hypo even if you didn't have any symptoms.

Looking back to the DCCT
In the early 1990s the results of a study, Diabetes Control and Complications Trial [DCCT] were published that changed the treatment of Type 1 diabetes. It was a large study of nearly 1500 people with Type 1 diabetes who received excellent care of their diabetes, better than in the real life situation. It compared intensive treatment with conventional treatment. Intensive treatment was actually what we now see as fairly normal – aiming for blood glucose levels that are as near 'normal' as possible or 'tight control' [blood glucose levels between 4 and 7mmols/L].

The DCCT clearly showed that tight control of blood glucose levels reduced the risks of complications but it also showed that the risk of severe hypos was three times greater with tight control.

- Of the 711 people in the DCCT who received intensive treatment, 312 [44%] had more than one severe hypo within a year.
- Of the 730 people in the conventionally treated group, 127 [17%] had more than one severe hypo within a year.

It was for this reason that in the published conclusion, the authors stated that intensive treatment, that is aiming for near-normal blood glucose, was not suitable for everyone. However, this statement was largely ignored in attempts to avoid the risk of complications. The risk of severe hypos and loss of hypo warnings were virtually ignored at the time – an approach that has come home to roost.

During this period hypo unawareness became fully recognised after the introduction of synthetic human insulin. Many people who were changed from natural animal insulin to so-called human insulin noticed that they had lost their hypo warnings or they did not notice them until their blood glucose levels were much lower. It was much later that it became accepted that the hypo warning symptoms with synthetic insulins are much more subtle in many people and therefore not noticed until blood glucose levels are dangerously low.

What are the implications for driving with the new EU regulations?

This is not rocket science! If the new EU definition is applied to the DCCT participants then:

- a third of people with Type 1 diabetes treated either with conventional or intensive treatment would lose their driving licences due to severe hypos
- 44%, nearly half of those aiming for near normal blood glucose levels would lose their driving licences due to severe hypos.

Take this further and it means that anyone with a blood glucose of less than 3.9mmol/L but does not have any symptoms, or does not recognise the symptoms, could be classed as having hypoglycaemia unawareness. This could have a serious impact for drivers because it is not legal in the UK and across Europe to drive with hypoglycaemia unawareness. So it is important to follow the DVLA advice "**Don't drive below 5**".

The potential effects of severe hypoglycaemia for those who rely on a driving licence.

An article in Diabetic Medicine [February 2013] points out the substantial impact the new EU regulations have on people with Type 1 diabetes and emphasises the need to take into account the potential effects of severe hypoglycaemia in those who rely on a driving licence.

It begs the question of whether there is a need to address the whole issue of the target blood glucose levels that are set for people with Type 1 diabetes, the majority of whom are probably drivers.

NICE guidelines set targets, doctors are paid on targets and patients are encouraged to achieve these targets to reduce the risk of complications, a very understandable reason. However, the consequences of achieving these targets with the risk of not being able to drive are very far reaching – they affect jobs, livelihoods, the whole family and the quality of life and all that this entails.

It is important that health professionals and patients discuss targets taking into account whether or not they drive.

Obituary

George Guy Dodson, born 13 January 1937; died 24 December 2012, x-ray crystallographer renowned for his work on the structure of insulin

Guy Dodson was an outstanding x-ray crystallographer. He was world-renowned for his research on the three-dimensional structure of biologically important proteins, particularly insulin. At Oxford University from 1967, he played the leading role in determining the structure of the first polypeptide hormone, insulin, and later related the hormone's chemical and biological properties to its atomic structure. His work on insulin continued following his move to York University in 1976, especially with the use of mutant and chemically modified versions of the hormone designed for analysis of its structure, assembly and action. His work showed that human insulin crystals were different from pork insulin crystals and very likely to dissolve more rapidly in solution giving a different clinical effect.

IDDT News

Thank you for your support

The Trustees and the staff would like to thank all our members and readers for their generous donations to help IDDT through these difficult financial times. We are very grateful too to those who are donating by standing order and those who now receive the Newsletters, Type 2 & You and/or the Parents Bulletin electronically, so saving us postage costs.

All of these help IDDT to be able to look forward to the future – a future where we can continue to offer help, support and up to date information to people with diabetes and their families and to the healthcare professionals who help all of us. So a big thank you to everyone for helping IDDT in these ways and if you can spare a couple of pounds a month, just give us a call on 01604 622837 for a standing order form.

We're sorry ...

As we are all only too well aware, IDDT is having to watch the pennies and after a great deal of heart searching, we are sorry but we will not be holding our usual big conference this year. Instead we will hold our Annual General Meeting, on the afternoon of Saturday, October 12th 2013 at the Hilton Hotel, Northampton, just off the M1 at Junction 15. We will provide a sandwich lunch, a discussion session and our speaker will be Dr Gary Adams. So we hope that many of you will still be able to join us for the afternoon. More details will be available in the September 2013 issue.

But 2014 is our 20th Anniversary, so we are holding a 'proper' conference and hopefully one that will be a little bit special to celebrate the formation of IDDT and some of our achievements. A date for your diary - October 11th 2014!

IDDT attended DVLA consultation

Jenny Hirst

On March 20th 2013, I, along with representatives from other charities whose members have medically restricted driving licences, attended a consultation meeting organised by the DLVA. The aim was to discuss extending the period of a medically restricted licence from 3 years up to a possible 10 years for Group 1 licences.

I stress that this was a very early meeting in the process of such possible changes, so please don't expect that changes will appear soon, it could take 2 to 3 years.

The general view was that up to 5 years would be appropriate, which is also the recommended time in the latest EU Driving Regulations. The DVLA did present some interesting statistics for people with diabetes treated with insulin – on average it is 17 years before the DVLA has to ask to be able to contact the doctors of licence applicants. So if the 5 year recommendation does come into force, then the DVLA will have to deal with fewer applications, so hopefully they will be more efficient!

This is a positive step forward for drivers with diabetes.

Note: according to an article in GP [01.04.13] the DVLA attributes 45 serous events a month and 5 fatal crashes a year to hypoglycaemia.

Adjusting Rapid-Acting Insulin Before And After Exercise

One of the problems associated with Type 1 diabetes is the avoidance of hypoglycaemia and this is particularly so with exercise. With exercise hypoglycaemia can occur during, immediately after or up to 24 hours afterwards. This raises the questions of what insulin dose to have, what and when to eat. Decisions people have to take just add to the difficulties of day to day living with Type 1 diabetes.

Recent research [Diabetes Care, April 2013] involving 11 males looked at various options of insulin doses and meals for exercise to see what effects they have glycaemic control and in particular hypoglycaemia.

1. The participants ate a standardised breakfast and gave themselves 25% of their rapid-acting insulin dose 60 minutes before carry out 45 minutes treadmill running.
2. An hour after exercise they had another meal and gave themselves a full, a 75% or a 50% dose of rapid-acting insulin.
3. Blood glucose levels were tested 3 hours after the meals and interstitial

glucose levels [glucose in the fluid in cells] measured using a continuous monitor for 20 hours after leaving the laboratory.

The results

- The glucose levels were the same for the first 60 minutes after exercise.
- After the post-exercise meal, blood glucose levels were maintained with the 50% dose and protected against hypoglycaemia for a further 4 hours under normal living conditions.
- With the full and 75% doses of rapid-acting insulin, blood glucose levels went down.
- Importantly, late evening and night time hypoglycaemia were similar with all the different doses and late onset hypoglycaemia was experienced under all conditions.

The researchers concluded, therefore, that lowering the dose rapid-acting insulin before and after exercise, does not protect against hypoglycaemia in the late evening or during the night. Perhaps something many people who live with Type 1 diabetes already know, from experience! What this study does not do is to advise on what should be done to avoid night hypos after exercise. This does not mean that night hypos are unavoidable after exercise, there are various options and your diabetes specialist nurse can discuss these with you to find out what works for you.

Apologies for error

In the March 2013 Newsletter, we gave the wrong amount of sugar in a can of cola, so please always check the can.

News For Americans Who Need Pork Insulin

People with diabetes in the USA have not been able to obtain beef or pork insulin for many years now because Novo Nordisk and Eli Lilly discontinued supplies some years go. They have been able to import from the UK but only if they could obtain a doctor's prescription and a doctor's letter to say that they could not tolerate GM human or analogue insulins. However, many people have difficulty finding a doctor who is prepared to do this.

Until fairly recently it has been possible for people in the USA to obtain Hypurin Pork insulin online from Canadian pharmacies without a doctor's prescription or letter. This service has now been stopped, therefore we have been advising that the only option left to people who need pork insulin is to import from Wockhardt UK. However, this not without problems as some people have found that on arrival the insulin has lost its potency due to the length of time it has taken to reach them in hot temperatures.

There is now more positive news from Robert Francesconi who has very recently received pork insulin from Canada Pharmacy Online. Here is how he did it...

- He phoned Canada Pharmacy Online and explained that US doctors cannot write a prescription for a drug that is not approved by the US FDA as by doing so, such a doctor could jeopardize both his/her prescribing privileges and his/her license to practice medicine.
- He then explained that instead of a prescription, he could offer:
  1. A copy of his US Department of Agriculture permit to import, VS FORM 16- 6A(MAR 95)
  2. A copy of his physician's certificate of medical necessity.
  3. A copy of his certification for personal use.

He faxed the 3 documents with payment and received his insulin within 4 days.

Robert has checked with other pharmacies in Canada and placed a further order which again was received a few days later.

For people in the US who need animal insulin, there are more details and samples of Robert's letters on our website:
http://iddt.org/here-to-help/iddt-international/iddt-united-states

Recalls And Warnings

Onetouch Verio IQ, Verio Pro and Verio Pro+ meters being recalled March 25th 2013

Johnson & Johnson, who own Lifescan, are recalling and replacing nearly 2 million blood glucose meters due to a failure to operate properly at extremely

high glucose levels. At extremely high glucose readings the meters have failed to provide a warning and will shut off potentially delaying proper treatment.
The US Food and Drug Administration [FDA] and other health regulators around the world have been notified as well as registered users and health professionals.
The affected recalled meters are as follows:

- **OneTouch Verio IQ** – about 90,000 meters in the US and 1.2 million worldwide
- **One Touch Verio Pro** – about 670,000 in Europe
- **One Touch Verio Pro+** - 4900 hospital-based meters in the Middle East, Europe and the Asia/Pacific region

The company stated that patients could continue to use the Verio IQ model until replacements arrive as long as they are aware that if the meter shuts down it could be indicative of dangerously high glucose levels.
If you have a Lifescan OneTouch Verio blood glucose meter, please telephone LifeScan on 0800 279 9118 (UK) or 1800 535 676 (Ireland) for a replacement.

The OneTouch Ultra model is not affected by the recall.

FreeStyle InsuLinx blood glucose meters recalled in the US
April 16th 2013
Abbott, the manufacturers of the FreeStyle Insulinx blood glucose meters have voluntarily recalled the above meter in the US because at extremely high blood glucose levels, the meter displays and stores incorrect test results which are much lower than the actual result.

They warn that although extremely high results may be very rare, if they do occur, there is a serious health risk and immediate medical attention is required. As the FreeStyle InsuLinx meter can display an inaccurate low result at very high blood glucose levels, there may be a delay in the identification and treatment of severe hyperglycemia, or incorrect treatment may be given, with serious consequences.

Outside the US, there have been no patient incidents reported related to this specific problem. The FreeStyle InsuLinx meter is available in many countries including the UK. Abbott have notified the US FDA and all relevant healthcare authorities in other countries. In the meantime, Abbott says that people can continue to use the meters but if they have unexpected, suspicious results, then they should contact the company.

If you have an InsuLinx meter, call Abbott on 0800 088 5521 to obtain a replacement.

ANIMAS 2020 insulin pump recalled
In the US, the FDA has recalled the Anima 2020 insulin infusion pump due to false alarms that may trigger or stop functioning and cause serious adverse events. The affected pumps are those manufactured between March 1st and November 30th 2012.

Just a warning about test strips
Recently one of our members was having problems with his blood glucose test strips – he was getting high results when he knew that he wasn't high [he had two meters so could check]. He believed that his results were inflated by between 15 and 100% - dangerous!

He tried new batches of strips but still had the same problems but then he noticed that instead of the packs having the usual Abbott logo on them, they had 'distributed by MPT Pharma Ltd' on them. He contacted Abbott who explained that these particular strips are a parallel import product which while legal and still an Abbott product, they are imported without Abbott's permission.

Abbot also explained that the problems with the strips could be because during importation they had been stored at the wrong temperature or damaged in some other way. They also told our member that he is entitled to ask his pharmacy for non-parallel imported products.

Disability Living Allowance replaced by PIP scheme

Understandably many people have expressed their concerns and worries about the changes to Disability Living Allowance [DLA], so we are covering these changes to provide a better understanding of what is happening.

Personal Independence Payment (PIP) started to replace DLA from 8 April 2013 for people aged 16 to 64 with a health condition or disability.

PIP helps with some of the extra costs caused by long-term ill-health or a disability. What you receive is not based on your condition but how your condition affects you.

The Department for Work and Pensions [DWP] will carry out assessments so that they can work out the level of help you receive. There will then be regular assessments.

Most people will not be affected by PIP until 2015 or later

The details of if or when PIP affects your DLA or when you can claim PIP, can be found on the following website www.gov.uk/pip This site advises you who to contact to get help if you don't understand PIP, or presumably if you don't use the internet.

What you will receive

Personal Independence Payment (PIP) is usually paid every 4 weeks. It's tax free and can be paid if you're in or out of work. It is made up of 2 parts and whether you get 1 or both of these depends on how your condition affects you. The payments are as follows:

Daily Living component	*Weekly rate*	*Mobility component*	*Weekly rate*
Standard	*£53.00*	*Standard*	*£21.00*
Enhanced	*£79.15*	*Enhanced*	*£55.25*

Who is eligible for PIP?

To qualify for PIP, you must have a long-term health problem or disability related to daily living and/or mobility. You must have these for at least 3 months and expect them to last for 9 months.

Daily living difficulties include: preparing or eating food, washing and bathing, dressing and undressing, reading, using the toilet, communicating, managing your medicines or treatments and making decisions about money.

Mobility difficulties

You may get the mobility component of PIP if you need help with going out or moving around.

Health assessments

You may get a letter telling you to go for an assessment to work out the level of help you need. The letter explains why and where you must go.

The DWP makes the decision about your claim based on the results of this assessment, your application and any supporting evidence you include.

How to claim

If you get DLA you don't need to contact the Department for Work and Pensions (DWP) about PIP now. You'll have received a letter in early 2013 to tell you more about PIP and when you might be affected.

Most people getting DLA won't be affected until 2015 or later. You may be affected earlier if your care or mobility needs change, or you reach the end of your existing DLA award. You can find out when your DLA will be affected by using a 'PIP checker' on the website **www.gov.uk/pip**

You do need to apply for PIP when asked even if you get an indefinite or lifetime DLA. When you apply, your DLA will continue until DWP makes a decision about your claim. If you decide not to apply, your DLA will end.

The change from DLA to PIP only affects you if you are aged 16 to 64 from April 8th 2013. You should use the 'PIP checker' to find out what happens to

your DLA when you turn either 16 or 65.

New claims
PIP was introduced for new claims in parts of the north of England from 8 April 2013. It will be introduced nationwide from 10 June 2013.
To make a new claim you have to phone the DWP who will then send you a form to fill in about how your long-term health condition or disability affects you. You can describe your condition on both good and bad days.

Appeals
If you are not satisfied with the DWP decision you can appeal. Before going to a Tribunal you should ask the DWP to look at the decision again – this is called 'mandatory reconsideration'.

If you are still unhappy with the decision you can appeal by filing out a form called the SSCS1, available online at:
https://www.gov.uk/government/publications/notice-of-appeal-against-a-decision-of-the-department-for-work-and-pensions-sscs1

Contact numbers – available 8.00am to 6.00pm Monday to Friday

New claims
Telephone: 0800 917 2222
General information (if you already get DLA)
Telephone: 08457 123 456
General information (if you don't get DLA)
Telephone: 0845 850 3322

We hope this will be of some help!

Nine key checks for diabetes health – are you getting yours?

PRAXIS DIABETES

www.praxisdiabetes.co.uk

I am pleased to announce that Catherine Brant has agreed to write for IDDT Newsletters on a regular basis and I am sure that you will welcome her articles.

Catherine is head of a new organisation which provides support and advice to people with diabetes and in her first article she tells us more about the nine key processes to improve care for people with diabetes.

The National Service Framework for Diabetes was established in 2001 as a 10 year plan to improve care in diabetes. Together with NICE a set of 9 key processes were set out which aimed to improve the care provided for people with diabetes. Everyone with diabetes should receive all of these checks at least once a year. The head of the National Audit Office stated in May 2012 that "**The Department of Health has failed to deliver diabetes care to the standard it set out as long ago as 2001**" (Amyas Morse, head of the National Audit Office (NAO), 23 May 2012) and the latest figures from 2009-10 have found that only half of people with diabetes are receiving all nine checks (NAO 2012). In addition, there is still significant variation in the quality of care received by people with diabetes.

The purpose of the nine checks is to reduce your risks of diabetes-related complications such as blindness, amputation, kidney disease and cardiovascular disease all of which impact on quality of life as well as life expectancy.

Most checks will take place in your GP surgery and you will usually be invited to attend for your 'annual diabetes review'. If for some reason you do not receive an invitation, organise the review yourself. If you feel you would like to see someone before your annual review date make an appointment

and do not wait to be called. Remember, it is your diabetes and if you need advice and support at any time throughout the year, see your diabetes healthcare professional.

The nine checks are outlined below – ideally you will receive written results of your tests including the target ranges, together with any agreed plans to address individual areas and importantly, review dates.

1. **Microalbuminuria** – this is when the kidneys start to leak tiny amounts of albumin into the urine which can be a sign of early kidney damage. Microalbuminuria can also be associated with cardiovascular disease, both in people with and without diabetes. The test is also known as albumin:creatinine ratio (ACR). Ideally this sample should be collected early morning. The aim of treatment of microalbuminuria is to slow the progression of kidney damage and this can be helped by taking certain antihypertensive drugs such as ACE inhibitors or Angiotensin Receptor Blockers (ARB's). Tight control of blood pressure is also essential to reduce kidney damage and the target blood pressure in this case is 130/80.

2. **Blood Pressure** – raised blood pressure increases the risk of kidney, eye, feet or cardiovascular problems. The target blood pressure is 140/80 or 130/80 for people who already have these complications. Many people with diabetes have high blood pressure (hypertension) and are likely to require one or several drugs to control it to the target level.

3. **Body mass index** – this is a way of assessing healthy body weight. It is known that BMI is not always an accurate predictor of overall health and other factors such as abdominal girth can sometimes be better predictors of health risks. Research has shown however that even modest weight losses of 5-10% can significantly reduce risks of developing cardiovascular disease and improve HbA1c (Wing et al 2011)

4. **Cholesterol** – raised cholesterol is a known marker for cardiovascular disease. Being overweight, drinking too much alcohol, a high fat diet and genetics are all risk factors for high cholesterol. LDL is the 'bad cholesterol' and this is carried in the blood and deposited in the body and in blood vessels. HDL is the 'good cholesterol' and this takes excess cholesterol out of the body and carries it back to the liver. Targets in diabetes are:
   Total cholesterol: 4 mmols/l or less
   LDL cholesterol: 2 mmols/l or less
   HDL cholesterol: 1 mmol/l or more
   Triglycerides are fats carried in the blood from the food we eat. Excess calories, alcohol or sugar are converted into triglycerides and stored in fat cells throughout the body. They can be temporarily raised when sugar levels in diabetes are high, for example at diagnosis or during periods of deteriorating control. Ideally the level of triglycerides in the blood should be 1.7mmols/l or less. Treatment of high cholesterol is usually with a statin which prevents the liver from producing so much LDL and thereby reducing the total cholesterol levels.

5. **Creatinine** – the levels of this are measured in the blood and a rise in creatinine indicates some damage to the kidney. Creatinine levels can also be used together with other factors such as age, gender, weight, to estimate how efficient the kidneys are at filtering waste products into the urine and this is known as the glomerular filtration rate (GFR). This is used in practice to look for early signs of kidney problems and this test should be taken at least annually.

6. **Retinal screening** – this is usually undertaken by a specialist team either in a hospital or a mobile unit. A photograph is taken of the back of the eye to look for very early signs of damage in the tiny blood vessels which supply blood to the eyes. Early signs of deterioration are checked more frequently, usually every 6 months but otherwise screening annually is sufficient.

7. **Foot examination** – your feet should be checked annually by someone trained in diabetes footcare. This might be a specialist podiatrist or a diabetes trained Practice Nurse or a GP with an interest in diabetes. They will assess your skin condition, nerve and circulation to your feet and early recognition of risk will help to prevent

problems in the future such as ulcers and potentially amputations. Checking your feet daily is important for picking up problems early and having them assessed before they lead to complications.

8. **HbA1c** – sugar is carried around the blood as glucose attached to red blood cells. As red blood cells have a life cycle of around 8-10 weeks, measuring the number of glucose molecules attached to red blood cells in a sample of blood can provide an estimate of blood sugar control over the preceding 8-10 weeks. NICE recommends this test is carried out every 2-6 months when making changes to improve diabetes control and once stable, every 6 months. You may need to request this test yourselves from your GP / diabetes Practice Nurse as often a formal review process by your GP surgery is only initiated once a year. NICE recommends a general target of 48mmols/mol (6.5%) but individual targets are often set higher than this as very tight control is often difficult to achieve without regular hypoglycaemia for people taking insulin or hypo-inducing medication. A reasonable target in practice for many people is 53mmols/mol (7%) or less but some may have higher targets than this for valid reasons. If you are not sure what your HbA1c is or you are not happy with your current level you need to speak with your GP or diabetes practice nurse.

9. **Smoking** – if you are still smoking, being able to quit will reduce your risk of developing heart problems and complications from your diabetes. Lots of support is available to help you to successfully stop smoking.

Make sure you are having all nine of these checks every year. Be involved in your care and agree health goals and decisions about targets for improved health together with your diabetes healthcare professional.

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National audit office (2012) The Management of adult diabetes in the NHS. May 2012

Wing et al (2011) Benefits of modest weight loss in improving cardiovascular risk factors in overweight and obese individuals with type 2 diabetes. Diabetes Care July 2011 34(7) pages 1481-6

Holidays

This time of year many of us are planning holidays, although in this economic climate this is not always possible. Whether it's a holiday abroad in the sun...

Or a holiday at home...

Maybe we should look at holidays in the light of their health benefit. It is worth noting that as many as a third of workers do not take their full holiday entitlement each year, yet it is important that people have a break to rest and recuperate.

Recent research has supported the long-held belief that holidays have an actual health benefit rather than just giving us a feel good factor. The research divided participants into a travel group and a non-travel group and they all had a stress resilience test [the ability to recover from stress], a

year's health assessment in addition to psychotherapeutic tests.

The results

- The average blood pressure of the holidaymakers dropped by 6% while the average for the non-holidaymakers went up by 3% over the same period.
- The sleep quality of the holidaymakers improved by 17% while that of the non-holidaymakers deteriorated by 14%.
- The ability to recover from stress saw an average improvement of 29% among holidaymakers compared to a 71% fall in stress resilience scores among the non- holidaymakers.
- There were decreases in blood glucose levels, reducing risk of diabetes.
- There were improvements in energy levels and mood.

So it does seem that holidays have real benefits but we have to warn that the study was small and was conducted by tour operator Kuoni and Nuffield Health, the UK's largest healthcare charity.

Holiday Tips for people with diabetes

IDDT has a Holiday Pack for people with Type 1 and Type 2 diabetes. There are useful tips wherever you are going but it is particularly useful for those going abroad who need to carry insulin, injection pens and testing devices. If you would like a copy, call IDDT on 01604 622837, email **enquiries@iddtinternational.org**
or write to IDDT, PO Box 294, Northampton NN1 4XS

Ramadan – Fasting and Diabetes

Ramadan is based on the ninth month of the lunar calendar, so this year it is expected that the fast of Ramadan will commence at the sunset on July 9th 2013 and will last for 30 days.

During this month it is expected that Muslims who participate will abstain from food, water, beverages, smoking, oral drugs and sexual intercourse from sunrise to sunset. Ramadan moves forward each year by about 11 days which means the length of fasting is greater at certain times of year than others. The length of fasting has special consequences for people with diabetes, especially those taking insulin and the risk of complications increases with longer periods of fasting.

People with diabetes who fast during Ramadan can have acute complications, such as hypoglycaemia, hyperglycaemia, diabetic ketoacidosis and dehydration, most of which are as a result of a reduction of food and fluid intake.

There are no evidence-based guidelines for safe fasting so people have to rely on expert advice from doctors and their personal experiences. However, a recent study in people with Type 1 and Type 2 diabetes carried out in Pakistan, has shown that with active glucose monitoring, alteration of drug dosage and timing, dietary counselling and patient education, the majority of patients did not have any serious acute complications during Ramadan. [Diab. Med. 29, 709-715 (2012)

Two educational sessions were given to patients, one about drug dosage and timing and one about dietary and lifestyle modifications. Patients were asked to test their blood glucose levels twice daily for at least 15 fasting days with one test being during the fasting period. Following these education sessions and the advice given the researchers found that the majority of people did not have any serious acute complications – none developed diabetic ketoacidosis and the highest frequency of hypo- and hyperglycaemia occurred before dawn.

The findings of this and other studies suggest that people with Type 1 and Type 2 diabetes should have an assessment before Ramadan with their diabetes team about drug/insulin adjustments, exercise and awareness of the risks of hypo- and hyperglycaemia.

The Medical Exemption Certificate

Free prescriptions for certain medical conditions

One of our members recently became aware that his Medical Exemption Certificate was out of date by over a year and unfortunately was wrongly informed that he would have to pay for the prescriptions he had had during that time. He was eventually given the correct information and of course he did not have to pay!

There are many conditions requiring regular medication but only the following qualify for a Medical Exemption Certificate:

- Treatment for cancer - this includes treatment for the effects of cancer, or treatment for the effects of a current or previous cancer treatment.
- A permanent fistula requiring dressing.
- Forms of hypoadrenalism such as Addison's disease.
- Diabetes insipidus and other forms of hypopituitarism.
- Diabetes mellitus except where treatment is by diet alone.
- Hypoparathyroidism.
- Myxoedema (underactive thyroid) or other conditions where thyroid hormone replacement is necessary.
- Myasthenia gravis.
- Epilepsy requiring continuous anticonvulsive medication.
- A continuing physical disability which means you cannot go out without help from another person.

So people with diabetes are entitled to free prescriptions except if they have Type 2 diabetes treated with diet only.

- If you have a Medical Exemption Certificate all your prescriptions are free.
- You may be asked to produce your Certificate when collecting your medication.
- If you are over 60 years old, you are entitled to free prescriptions so a Medical Exemption Certificate is not necessary.
- If you have a medical condition which may entitle you to a Medical Exemption Certificate, you must also inform the Drivers Medical Group of the Driver and Vehicle Licensing Agency [DVLA] of your condition, as it may affect your fitness to drive.

How to obtain a Medical Exemption Certificate

- Ask your doctor's surgery for an application form [FP92A].
- You fill it in and your doctor, or an authorised person at your doctor's surgery will sign it to confirm the information you have given is correct.
- Your doctor's surgery will then send the form to the appropriate office and the Exemption Certificate will then be sent to you.

Renewing your Medical Exemption Certificate

The certificate is valid for 5 years after which, you will be [or should be] sent a letter with a renewal form for you to re-apply about a month before your old one expires.

Our member referred to at the beginning of the article is not the only person to not receive a renewal letter, so it is as well to check from time to time that your Certificate is up to date. If you do not receive a renewal letter, call 0300 330 1341.

IDDT T-Shirts Go To Help Children In Uganda

IDDT is in regular contact with the Diabetes Consultation Association in Uganda. We supply our information booklets and in March 2013 we sent IDDT T-shirts to help the children with diabetes in need.

Robert and his colleague receiving IDDT T-shirts and the children wearing them!

Robert Masereka, Director of the Association, sent us this message:
"We thank you Jenny and your staff of *IDDT*, yesterday we received three

packets of T-shirts. I have attached some of pictures for you. I am holding them and I am standing with my staff at our head office. So I will supply all of them to children and adults soon. God Richly Bless You All and we thank you for your support."

Pilot Licences For People With Diabetes Short-Lived!

As we reported last year, in August 2012 the Civil Aviation Authority [CAA] approved licences for people with insulin treated diabetes to fly commercial and private aircraft following passing stringent medicals. However, at the end of October the new European Aviation Safety Agency [EASA] requested that the CAA halt all further medicals.

After formal requests for more information, it was then understood that in January 2013 the CAA resumed issuing medicals but in February the European Aviation Safety Agency again challenged the CAA about issuing medicals to pilots with insulin-treated diabetes. This is the present position but the group, Pilots With Diabetes, vow to continue their campaigning to be able to fly.

Note: Canada allows insulin treated people to fly commercial aircraft and the US allows them to fly private aeroplanes.

From Our Own Correspondents

A result - weight loss and my insulin levels!

Dear Jenny,
I feel that I must write to let you know what effect weight loss has made to my daily insulin levels. I have been a Type 2 diabetic for some 20 years and over the last 10 have been treated with insulin and metaformin. Up until about 7 months ago I was taking 50 units in the morning and 80 in the evening.

However, my G.P. decided that I was extremely overweight at 19 ½ stone and 5'11" and my blood pressure was far too high even though I was taking medication to help reduce it. As a result she referred me to visit my local gym with a view to losing weight.

As of this week I have managed to loose some 56 pounds. As a result I feel far better and my blood pressure is now normal. But as far as I am concerned the most important result is that I now only take 10 units of insulin in the morning and 20 in the evening.

Mr W.G.
By email

Reduction in carbohydrates, reduction in insulin dose and weight loss! MR M.B.'s update from the Newsletter March 2013

Readers may remember the update the last Newsletter from Mr M.B. He has Type 2 diabetes treated with insulin and after reading an article in a previous Newsletter, he tried reducing his carbohydrates to reduce his dose of insulin with the aim of losing weight [insulin itself tends to increase weight].

In the March Newsletter, he wrote that by reducing his carbs he had lost 10lbs in a month from 12st 9lbs to 11st 13lbs, his daily Lantus dose had dropped from 50 units a day to 38 units and his Humalog from 26 units to 16 units 3 times a day and his average blood sugars were 7.4.

Now his results are: weight 11st 11lbs, his dose of Lantus has dropped to 34 units [from 50 units] and his Humalog with each meal is now only 12 units [from 26 units]. He's just had an HbA1c test and it is 7.6% [60mmol/mol].

Mr M.B. says "Thank you for help, I hope my results will be of help to some of your other members."

Keep Moving

Dear Jenny,
Having suffered from cheiroarthropathy for 15yrs now, I was very interested to read Connective Tissue Disorders in the March Newsletter. I would like to point out that this can be a very painful condition especially in the hands and feet. My best advice is keep moving as your hands and feet are trying to make a claw. Use anti-inflammatory gel such as Brufen, keep at a constant temperature by using 'breathable' socks and don't over do it when the weather warms up and you loosen up. Hope this helps.

P.R.
By email

I had to fight for this, which shouldn't be the case.

Dear Jenny,
For two years I was an outpatient at my local hospital but then the consultant unilaterally decided that I was "too well" (his words) to necessitate having hospital consultancy support and I was to be referred back to my GP for care for my diabetes, against from my strongly voiced concerns. My thoughts at the time were: I may be well now, but what about the future, where would my specialist support come from?

So when my diabetes decided to 'play up', I called my "Specialist GP" who told me to go back to hospital care because he couldn't help. This referral took six weeks!

When I eventually got an appointment, the advice I got from the outpatient clinic only made my diabetes worse, so I ended sorting out my control myself anyway.

This was so stressful as I felt little support or help was available to me. After this debacle I decided I needed to completely change hospitals and have a new consultant, preferably one who wasn't going to chuck me out of the hospital system any time soon.

It took some strong discussions to get a new referral from the GP. He suggested that I first see the "Specialist Diabetes GP" but I explained the back history and got my referral, stating more than a few times what I wanted was proper specialist hospital care for a specialist condition.

Happily I am now under the care of the wonderful team at a different hospital and I know that I have the support I need. My diabetes has returned to its happy and stable state and this is because I know I have the support of the proper system for my Type 1 diabetes by specialists.

I wanted to highlight my experience on the following points:
GPs now hold a lot of budget and decision making power through Patient Based Commissioning. If they refer patients to hospital it comes out of their budgets. If they do diabetes reviews they get paid for every patient they see. Conversely hospitals get money for referrals, so if they can get more referrals they get more funds. It's a case of different sides squabbling over the same funds. (I previously worked in the PBC sector of the NHS.)

I now have a great consultant who listens and asks what I need/want and then makes suggestions. It's a team effort, which is great. I also know how lucky I am – although this should be the norm rather than the exception for us all. I had to fight for this, which shouldn't be the case. I used the NICE guidelines for T1s, the (obvious) need for specialist support and the evidence that I wasn't getting the proper support.

Mrs P.L.
Email

Success with the DVLA for the first time but it took 21 weeks!

Dear Jenny,
At last I have good news to report from DVLA. The ordeal of having to renew my licence every 3 years has been successful for the very first time.

I first came under Swansea's attention 10 or 11 years ago. I failed on the grounds of having had laser treatment on my eyes some years earlier and had my licence revoked but won it back on appeal. The same happened 3

years later. On the 3rd renewal I was only given a 1 year licence but after sending a very stern, pithy, hand written letter, 3 months later they agreed their decision was inconsistent and increased it to 3 years.

The renewal process this time became a saga! I received a renewal notice on 31st August 2012 and not until 16th January 2013 did I receive my driving licence and this was after two field check with one being 30 miles away fro where I live.

It took 21 weeks to renew my licence and we all know only too well the implications of this. I think things can only get worse after the decision to close satellite DVLA offices and concentrate everyone's driving details in Swansea.

Mr S.C.
Nottingham

But here's a more positive experience!

Hi Jenny,
I have just renewed my 3 year driving licence and I would like to share what happened. I am in no way saying people should do it, it's just what I did.

I have had Type 1 diabetes for 41 years and my 3 year driving licence ran out on the 17th March. The form was new so had changed in the 3 years since my last application. What I normally do when it is due to expire is to schedule an appointment with my diabetes consultant about a month before, and one for the eye clinic and my optometrist. I ask my consultant (if it applies and you have been good!) to say he has no problems with me renewing my licence, and to put my HbA1c (54.1) and eye status in the clinic letter he sends to me and my GP. I enclosed this together with a letter from my optometrist giving my eye test and vision results, also mentioning whether or not I had cataracts.

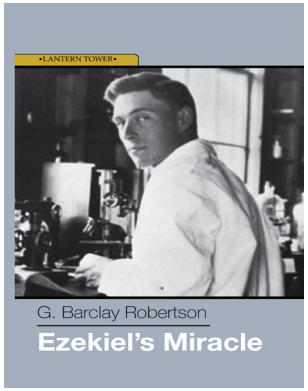
I enclosed it all with the application (I was late in sending it back, I only left 7 days before it was due to expire). I contacted Jenny to see what the view was on driving while you are renewing the licence, as mine had expired, and she kindly said that it is ok to drive if you are waiting for a reply from the DVLA, unless they have written to you to say you cannot drive. Today I received a new licence (23/3/13) and did not have to play space invaders in the field of vision test. It would also seem they did not need to contact my GP, or write to my diabetes consultant to confirm what he had written. I am not saying this will work for everyone, just that it worked for me. I had 2 vitrectomies at aged 30, and my eyes have been lasered to death, but not since the 2 vitrectomies, 17 years ago.

Thank you, Jenny.

F.C.
By email

Ezekial's Miracle

By Barclay 'Barry' Robertson



Long standing member of IDDT, Barry Robertson was diagnosed with Type 1 diabetes in 1948. He wanted a career in journalism but at that time was discouraged by doctors from doing so. He had an apprenticeship as an ironmonger and then a career in architectural ironmongery. By the time he was 57 complications of his diabetes meant that he lost his driving licence so he retired to live in Uplawmoor in East Renfrewshire.

Barry returned to writing articles and short stories and then started writing about the discovery of insulin and Frederick Banting's work at the University of Toronto. While some of the episodes in the book are imaginary, most of the book is factual about the discovery of insulin and the tensions between Banting and Macleod, his fellow Nobel prize winner.

Where does the title come from? Dr Elliott Joslin met one of the earliest patients to receive insulin and three month's later, she happily ran up to

him. Dr Joslin whose father was called Ezekiel saw the transformation as a miracle, hence the title of Barry's book. Ezekiel's Miracle is published by Melrose Books and is available through online booksellers for £7.99.

How NHS Services Are Being Provided

The diagrams below sets out how are services have been provided until April 2013 and the way they are being provided from now on. Basically, the Department of Health was and still is responsible for the provision of the health services we receive from NHS Trusts in hospitals and the primary care services from GPs as shown in both charts in turquoise and pink respectively.

The way our health services have been provided

The way our health services are now provided from April 2013

As we can see, it is the part in the middle layers that have changed – the organisation of how those services reach us, the patients. The changes in the middle are 'market-based' which means they increase competition between the providers of services. The providers can be NHS based or private companies, hence the concerns about backdoor privatisation of the NHS.

The government thinking appears to be:

- that as Clinical Commissioning Groups [CCGs] are made up of clinicians, this should mean that better services are purchased,
- that opening up the market to any willing provider means there will be more providers of services, which should create more competition which in turn should improve the quality of care purchased by the CCGs which ultimately we receive.

Other changes that have taken place

- PALS [Patient Advice Liaison Services] for patients to seek advice and/or help with complaints will no longer exist, nor will Local Involvement Networks. These will be replaced by Local HealthWatch. HealthWatch England will gather information at local level about the views and experiences of people who use health and social care services and they will report to NHS England [which was the NHS Commissioning Board] and to the Secretary of State.
- Care Quality Commission [CQC] registers ALL health and social care services and inspects them. It also responds to complaints.
- Monitor has two functions, firstly it regulates NHS Foundation Trusts [hospitals] and secondly, it has the role of promoting competition within the NHS.

NOTE: It is difficult to find the complaints procedure for patients in all this.

Do the changes mean that the services will improve?

We have to wait and see. Presumably the government believes that they will, but there are many differences of opinion not just between the political parties but also amongst doctors, health professionals and of course us, the patients.

In terms of diabetes, there are sufficient documents around to tell professionals and purchasers what care people with diabetes have a right to expect – the 9 key checks that everyone should have, so the new organisations should have no difficulty knowing what they should do. Let us see if they do just that and improve on past performances.

If you would like a copy of our booklet 'Know Your Rights' to ensure you are looked after properly, contact IDDT on 01604 622837 or email enquiries@iddtinternational.org and we will be happy to send you a copy.

People With Type 2 Diabetes Not Reporting Hypoglycaemia

The results of a survey presented at the Diabetes UK Professional Conference in March 2013, showed that more than a third of people with Type 2 diabetes not treated with insulin are unaware of the side effects of their medication and most of them do not report hypoglycaemia to their doctor.

Metformin is the only drug for Type 2 diabetes that does not increase the risk of hypoglycaemia, so the survey looked at 1012 people collecting a prescription for a sulfonylurea and found:

- 38% were unaware of the side effects of their treatment,
- Half had experienced a hypo but only 38% reported this to their GP.
- Only 3% said they checked their blood sugars before driving [not surprising if they are not prescribed test strips or sufficient as so often is the case!]

The following month, research was published in Diabetes Care that showed that people with non-insulin treated Type 2 diabetes who experienced hypos, whether mild or severe, were at greater risk of cardiovascular problems and all-cause hospitalisation along with risk of the serious consequences of these. The researchers recommend that healthcare professionals pay more attention to hypoglycaemic in people with Type 2 diabetes.

What are the lessons to be learned for people with Type 2 diabetes?

- It is important to report any hypos to your doctor because it may mean that an adjustment of your medication could help to prevent them.
- Remember to ask what the possible adverse effects of your medication are.
- Regardless of the fact that you don't have to inform the DVLA that you have Type 2 diabetes treated with tablets, if you experience hypos, then it is important to test before driving and every 2 hours on long journeys, so point this out to your doctor and 'request' a blood sugar meter, test strips and help with how to test and how to interpret the results.

Health Professionals – Be Part Of Something New

East Midlands Diabetes Study Day
Tuesday 12th November, 2013, Kettering Park Hotel, Northants NN15 6XT

This is the first in a brand new series of Diabetes Study Days which aim to inform, inspire and educate the healthcare community.

The speakers confirmed so far
Dr Charles Fox, Consultant Physician,
Dr Mabel Blades, Consultant Dietitian and Nutritionist,
Julian Backhouse, Director, the Institute of Diabetes for Older People (IDOP)
Helen Adkins, Diabetes Specialist Nurse at Leicester University Hospital.

Benefits to you

- Refresh your diabetes knowledge
- Learn about new developments
- Share good practice
- Pick up CPD points

For further information contact events@iddtinternational.org

A Petition Worth Signing!

If you have access to the internet, you may be aware that you can organise or simply sign petitions on issues that are important to you and if they receive enough signatures, the government has to take notice. There is a new one online from Dorothy Cartwright which is worth your consideration. Here it is the petition:

"Putting the patient first"

2010 election for new NHS changes were promised by the Conservatives to "PUT PATIENTS FIRST".

This promise has been broken by Jeremy Hunt MP before its introduction 1.04.2013 by altering a sentence in the original new NHS document to "ASPIRE" to put patients first. This means to many, probably or not at all.

Broken promises by the Tories again. I am appalled about this change and wish the sentence to be put back to PUTTING PATIENTS FIRST.

There's a great deal of difference between aspirations and promises – aspirations are merely hopes but promises mean that you have to do what you promised.

To sign the petition go to http://epetitions.direct.gov.uk/petitions/48555

Pharmaceutical Industry News

Tresiba [degludec] approved in the EU but refused in the US

In January 2013, the European Commission approved a new long-acting insulin made by Novo Nordisk called Tresiba [insulin degludec] for people with Type 1 and Type 2 diabetes. Also approved was Ryzodeg which is a pre-mix of insulin degludec and insulin aspart which can be given once or twice daily.

Tresiba is now being marketed in the UK with Ryzodeg expected later in the year. They are both for use with the FlexTouch pen.

Warning Notes:

- **There is a warning that "a minimum of 8 hours between injections must be ensured".**
- **Tresiba will be available in two concentrations 100 units/ml and 200 units /ml which will allow maximum doses of 80 and 160 units per injection, respectively.**

Approval was granted on the basis that the manufacturers provide educational materials to healthcare professionals and to patients, particularly to raise awareness of the higher strength of Tresiba. Two strengths could easily lead to dangerous confusion if the wrong dose is given. Indeed, this is why in the 1980s the regulations changed to allow only one strength of insulin, 100units/ml to avoid the errors from the use of different strengths of insulin, especially when people were in hospital. Will we see this again?

Authorisation was granted on the basis that Tresiba and Ryzodeg are generally safe and the side effects are comparable to those of other insulin analogues with no unexpected side effects being reported. The most commonly reported adverse effect was hypoglycaemia although it was noted that Tresiba and Ryzodeg reduced the risk of hypoglycaemia during the night in people with Type 1 and Type 2 diabetes. Their report does not mention any studies or assessment of any other possible risks but the same has not applied in the United States.

Despite approval in Europe and Japan, the US Food and Drug Administration [FDA] has not granted approval and has unanimously requested a dedicated safety study of cardiovascular outcomes – effects of the use of Tresiba and Ryzodeg on the heart and vascular system. The results from these studies must be available for review before the FDA will complete the new drug applications.

Should Europe be requesting similar studies?

As the regulatory authorities are looking at the same evidence, it is surprising that they do not come to the same conclusions. The FDA is showing caution

which is to be appreciated, especially when from a patient perspective, there is no desperate need for a new insulin on the market. It is also worth remembering that when any new drug or insulin comes on the market, adverse effects show up when the product is used on the wider population and not the highly selected patients used in pre-marketing trials.

Snippets

Eggs and cardiovascular disease
A study published in the British Medical Journal [January 2013] found no link between egg consumption and the risk for stroke or coronary heart disease overall. However, in the subgroup of people with diabetes who had the highest egg consumption 54% had an increased risk of developing coronary heart disease compared with those who had the lowest intake.

NHS Employment figures
The NHS currently employs one in 18 of the population and according to a report by the King's Fund by 2060 it could be employing as many as one in 8 of the population if spending on the NHS continues to rise at the same rate as it has over the last 50 years.

Liquid diet for severely obese people
A new low calories liquid diet has been developed to help people who are severely obese. A UK study carried out through GP practices showed that this group of people lost more than 2 stones [15kg] within a year on the diet. They estimated that the liquid diet would cost the NHS £2,611 for each person who lost 15kg or more compared to £12,500 for bariatric surgery.

Good sleep coincides with nutritious diet
A study published online in 'Appetite' [20.02.13] has shown that participants who slept seven to eight hours a night ate a greater variety of food which indicates a healthy diet, compared with those who slept for shorter or longer period.

Minty chewing gums may not help people lose weight
A US study in Eating Behaviors found that people who chewed minty gum before every meal ate fewer meals but were less likely to eat fruits and vegetables compared with when they did not chew gum. Researchers said the menthol in chewing gum can make fruits and vegetables taste bitter and this may lead people to opting for less health choices.

NHS Updates And What We Need To Know

As we have already said, there are many changes in the NHS, some of which we may not notice, but there are some changes that we do need to know about because they affect us.

NHS 111
NHS 111 is a new telephone service that was introduced in some areas on April 1st 2013. It is available 24 hours a day, 365 days a year. Calls are free from landlines and mobile phones. It is staffed by a team of trained advisers, supported by experienced nurses. They ask a series of questions [what appears to be a standard crib sheet] then advise you, direct you to local services or call an ambulance for you.

According to the Department of Health, you should call 111 if:

- you need medical help fast but it's not a 999 emergency
- you think you need to go to A&E or need another NHS urgent care service
- you don't know who to call or you don't have a GP to call
- you need health information or reassurance about what to do next.

GPs are calling for a halt to NHS 111
In the first week of its introduction NHS 111 struggled to cope with the incoming calls with telephone queues of up to 100 patients in some areas. GP out-of-hours services and NHS Direct had to step in to sort out the problems.

From the outset GPs have said that NHS 111 would put patients' safety at risk and now they are calling for it to be delayed indefinitely. As a result of

the fiasco, MPs will investigate the rollout of NHS 111 in a parliamentary review into NHS 111 and emergency services by the House of Commons Health Committee. A report on NHS 111 and the structure of emergency services will be put to Parliament before mid-July.

Just a note: what is the difference between 'needing medical help fast' and a 999 emergency? It requires us, the public with no medical training, to take responsibility for a judgment between what is a life-threatening emergency and what is 'needing medical help fast' at a time when we may be frightened, worried or in a panic.

Friends and family test rolled out to hospitals

From April the Friends and Family Test is being introduced in A&E and hospitals by NHS England. This test involves patients who stay overnight in hospital or visit an A&E and they will be asked whether they would recommend the service to their friends and family members.

There will be six choices of answer, ranging from "extremely likely" to "extremely unlikely". The patients will then be invited to answer follow-up questions to give more detail on their answer. The results will then be published on NHS Choices, allowing the public to compare patient feedback and "make choices about their care", NHS England will manage and oversee the rollout of the Friends and Family Test to all NHS-funded services over the next few years.

If you would like to join IDDT, or know of someone who would, please fill in the form (block letters) and return it to:

IDDT
PO Box 294
Northampton
NN1 4XS

Name: ——————————————————————————

Address: ——————————————————————————

——————————————————————————

Postcode: ——————————————————————————

Tel No: ——————————————————————————

From Your Editor – Jenny Hirst

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