INDEPENDENT DIABETES TRUST
Newsletter
September 2014 Newsletter, Issue 82
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MBE for IDDT Co-Chair

Jenny Hirst, the Co-chair of IDDT, was awarded an MBE in the Queen's Birthday Honours for her work for people with diabetes. Jenny's daughter was diagnosed with Type 1 diabetes nearly 40 years ago and she has worked voluntarily for most of those years, first as a Trustee of the British Diabetic Association (now Diabetes UK) and then for IDDT.

For many years, Jenny fought a David and Goliath battle against the pharmaceutical industry when she led the campaign for the continuation of animal insulin for the thousands of people who had adverse reactions to synthetic GE insulin. The sustained lobbying led to government intervention and people with diabetes can still use animal insulin today.

Over the years, IDDT has expanded the support it offers and developed booklets and leaflets covering many aspects of diabetes. Of course, this now includes help and support for the rising number of people with Type 2 diabetes. The publications are in much demand by people with diabetes and health professionals to give to their patients.

After the announcement of the award, Jenny said, '*I'm more thrilled about what this Award means to the charity than for me personally. Although the charity was my 'brain-child' along with my Co-Chair Dr Matthew Kiln, it is the dedication and commitment of the staff, the Trustees and members who have motivated and helped me over the past 20 years and I would like to recognise their support at this time of celebration.*'

In this issue…

- NHS Complaints Procedure
- National Inpatient Audit 2013
- Letters
- Bionic Pancreas
- Research News
- Accessing Basic NHS Care
- Diabetes and Older People

Does an MBE allow me a rant?

Don't blame the individual

During 'Diabetes Week' there was a lot of publicity about the escalating numbers of people in the UK with diabetes and 'pre-diabetes' and that this was due to the large numbers of people who are now overweight or obese as a result of their lifestyle. This was sufficient to cause one lady to telephone IDDT immediately after a news bulletin to angrily say that it was not her fault that she had Type 2 diabetes - she was not overweight and never had been but she had a strong family history of Type 2 diabetes. She felt that the publicity was blaming people for having diabetes and implying that they had brought it on themselves. Equally people with Type 1 diabetes get angry because 'diabetes' is all too often referred to as one condition when it is not and Type 1 diabetes is certainly not due to being overweight!

The implication that Type 2 diabetes is a simple matter of obesity and the fault of individuals is widely held, but it is wrong. In

addition, blaming individual people does not solve the problem and can create other problems.

When 25% of the UK population is classed obese and half as overweight, this cannot be looked at as a simple problem caused by the individual person. While we all have some responsibility to try to live healthy lifestyles, the changes that have taken place in society share the responsibility, as do successive governments of all parties.

Food production has changed, such as the refinement of grains and the use of highly processed foods. Also during Diabetes Week, there was a news item showing that some cans of drink contain the equivalent of 6 teaspoons of sugar, one even contained the equivalent of 15 teaspoons of sugar! Public Health England stated in June, '*Eating too much sugar is harming our health; excess sugar and calorie intake leads to being overweight and obese and consequently having a higher risk of developing Type 2 diabetes, heart disease and breast and colon cancer. Currently a third of our 10 and 11 year olds are overweight or obese with the majority coming from the most deprived communities, which is unacceptable.*'

It is unacceptable because it is condemning future generations to these serious, life-threatening conditions.

The government wants the food industry to voluntarily reduce sugar in food and drinks and there are various consultations to tackle obesity. How long is this going to take? Will the outcome be sufficient to help the public to make informed decisions about changing their lifestyle? The recent NICE guidelines on obesity seem a rather pathetic attempt to address the problem.

Why not put health warnings on the worst offending cans of drink? Governments, quite rightly, protect the nation's health by stamping warnings and frightening pictures all over cigarette packets, so why not do it on cans of drink loaded with sugar? As obesity has overtaken tobacco as the greatest danger to health and life, this seems like an immediate action that could be taken, even if it does offend big business!

Society has also been through huge changes in the way we work and spend out leisure time. There are no longer large numbers of people doing physical work but many of us are sitting at computer screens at work and then going home to watch TV or use our laptops and phones. What message was given out when many schools lost their playing fields? Simple - exercise is not important, when it is patently vital to the health of the nation. These are changes in society and not something that can be blamed on any one individual.

To add to the problems, we are faced with confusion about diet. As all IDDT publications point out, diet is not a choice for people with diabetes, it is an essential part of treatment alongside medication and exercise. There are many diets around but there is little evidence from independent research to tell us what does and doesn't work. National guidelines vary but in the UK, the general public and people with diabetes are still advised to eat a high carbohydrate / low fat diet. This recommendation came in during the 1980s when the emphasis was on reducing fats to prevent heart disease. However, there was little or no evidence from research to support it or to look at the long-term effects of a high carb diet. Common sense alone tells us that if we eat more carbs than we require for the energy we need, it gets stored and weight increases. For people with diabetes, this means increased medication or insulin requirements, which also increases weight.

While it may not be glamorous research, it is time for significant investment in independent research into diet for the general public and for people with Type 1, Type 2 and what is classed as 'pre-diabetes'. We need to know what is effective, what is achievable and how to change the nation's habits.

I can't leave out the drug companies who are bringing out more and more pills to treat Type 2 diabetes. Yes, this offers choice but it is too easy for people to think that if they pop a pill to treat their diabetes this will solve the problem. People need the education programme that is supposed to be given to everyone with diabetes to inform them that the treatment of both Type 1 and Type 2 diabetes is medication, diet and exercise.

Finally, I find it extremely disappointing that during Diabetes Week there was little mention of the fact that Type 1 is increasing too and that the cause of this is still unknown. This was an opportunity missed to highlight the need for research into Type 1 diabetes, especially as it largely affects children and young people who have to live with it all their lives, often from a young age.

WARNINGS!

Warning about Accu-Chek® Mobile blood glucose meters

10th June 2014

The Medicines and Healthcare products Regulatory Agency (MHRA) is asking people with diabetes who use Accu-Chek® Mobile blood glucose meters to ensure they follow the important testing instructions. This is because the meter may give false high blood glucose readings if testing instructions are not properly followed.

The manufacturer, Roche Diabetes Care, has identified a small number of people using the strip-free Accu-Chek Mobile monitoring system who have experienced falsely high blood glucose readings. This meter requires users to follow different testing instructions compared to other diabetes meters. If this procedure is not followed correctly, an incorrect reading may be given even though the meter is working properly.

Roche has issued enhanced training and handling instructions which are available online at www.accu-chek.co.uk/mobilepropertesting If you have any questions about your blood glucose readings you should speak with your diabetes care team or the Accu-Chek® customer care line on 0800 701 000.

Warning - Europe agrees with restrictions on combining different classes of blood pressure medicines

The European Medicines Agency's Committee for Medicinal Products for Human Use (CHMP) has endorsed restrictions on combining different classes of medicines that act on the renin-angiotensin system (RAS), a hormone system that controls blood pressure and the volume of fluids in the body.

These medicines (called RAS-acting agents) belong to three main classes: angiotensin-receptor blockers (ARBs, sometimes known as sartans), angiotensin-converting enzyme inhibitors (ACE-inhibitors) and direct renin inhibitors such as aliskiren. Combination of medicines from any two of these classes is not recommended and, in particular, patients with diabetes-related kidney problems (nephropathy) should not be given an ARB with an ACE-inhibitor.

Where combination of these medicines is considered absolutely necessary, it must be carried out under specialist supervision with close monitoring of kidney function, fluid and salt balance and blood pressure. This would include the licensed use of the ARBs candesartan or valsartan as add-on therapy to ACE-inhibitors in patients with heart failure who require such a combination. The combination of aliskiren with an ARB or ACE-inhibitor is strictly contraindicated in those with kidney impairment or diabetes.

The CHMP opinion will now be forwarded to the European Commission, which will issue a final decision valid throughout the EU in due course.

MHRA warning about buying potentially toxic herbal medicines online

May 7th 2014

The Medicines and Healthcare products Regulatory Agency (MHRA) has warned people not to use a number of herbal medicines that can be bought on the internet after they were found to contain undeclared prescription only medicines and heavy metals.

- The herbal medicine 'Shwasa Sanjeevani' contains dexamethasone, a prescription-only medicine not declared on the label.
- Some herbal slimming pills contain undeclared prescription-only medicines. The pills 'Lightning 10.0+ Reduces Weight', 'STB Summit of the 'Thin Body S Woman Degreasing Burning Pill' and 'LV Shou Reduces Fat' contain prescription-only drugs such as Sibutramine and Sildenafil.
- A number of Traditional Chinese Medicines after they were found to contain high levels of mercury or undeclared prescription-only medicines such as 'Hairgenerator' and 'Ginseng Tu chong Wan Lin Heong'.

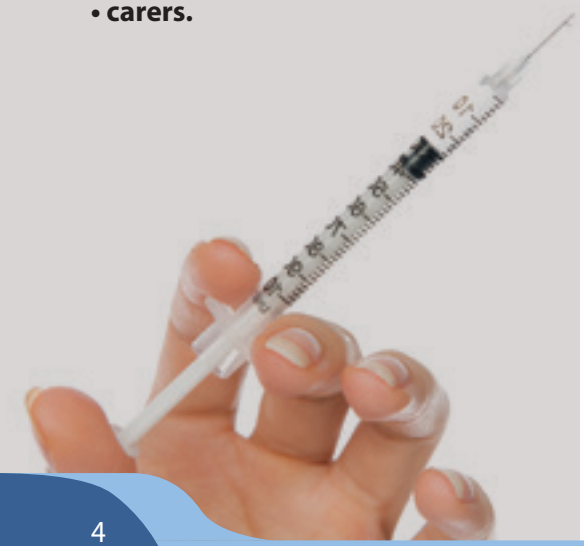
To choose a herbal medicines that has met the acceptable quality and safety standards, you should look for one that that has a Traditional Herbal Registration (THR) or a product licence on the packaging.

The flu vaccination programme starts from September 2014

People with diabetes and other long-term conditions are advised to have the annual flu jab. The national flu vaccination programme has now been expanded and the flu vaccine will be offered routinely to all children aged 2 to 4 years of age. It will also be offered to children in areas where the programme is being piloted.

The groups eligible for flu vaccination in 2014 to 2015 are:

- **those aged 65 years and over**
- **those aged 6 months to under 65 in clinical risk groups**
- **people in long stay residential homes**
- **pregnant women**
- **all 2, 3 and 4 year olds**
- **primary school-aged children, in 7 geographical pilots that started in 2013 to 2014**
- **11 to 12 year olds in around 12 new pilots schemes.**
- **carers.**



IDDT News

IDDT appoints new Chief Executive

Martin Hirst has been appointed the as Chief Executive of IDDT and took up his new role at the beginning of July. Before joining IDDT in 2008, Martin worked as a Residential Care Home Manager for people with learning difficulties.

At the time of his appointment, Martin said '*This is an important time for the charity. The number of people with Type 2 diabetes is increasing, yet our experience is that people are not receiving the information and support they need. I call on the Health Minister to get a grip on this situation and improve the diagnosis and treatment of people with diabetes, while at the same time not losing sight of the needs of people with Type 1 diabetes.*'

He added, '*I'm really happy to take on this new role and the challenges that it will no doubt produce. I'm looking forward to working with the members, Management Team and Trustees to secure the future financial stability of the charity and build on its already considerable success.*'

IDDT's Anniversary Conference

Just a reminder, that the 20th Anniversary Conference is taking place on Saturday, October 18th at the Kettering Park Hotel. Included with this Newsletter is the programme and application form. We hope that many of you will be able to join us.

IDDT's Annual General Meeting 2014

As members are aware we are obliged to hold an Annual General Meeting to comply with charity law. So we are holding an afternoon meeting on Wednesday 29th October 2014 at the Kettering Park Hotel. We hope that as many of you as possible will be able to join us – it is your opportunity to meet the Trustees, Staff and of course, each other.

If you would like to nominate someone for election to the Board of Trustees, then please send nominations to IDDT by October 10th with a letter of agreement from the person you are nominating and seconded by another member of IDDT.

The programme for the afternoon will be as follows:

2.00 - Arrival
2.30 - Annual General Meeting - presentations of the Annual Report and Accounts followed by elections to the Board of Trustees.
3.15 - Tea and biscuits
3.30 – Open Discussion
4.30 – Closing Comments

Olly's Market Harborough to Northampton £20 Challenge

As you will recall, back in June we told you about Oliver Jelley's plans to fundraise for IDDT by running from Market Harborough to Northampton along the Brampton Valley Way, a total of 14 miles. The run went ahead as planned on Saturday, 7th June, a wet and cold day. Olly was joined by his brother and fellow runner, Ben, and between them they raised an impressive £500 for IDDT!

They were supported by Oliver's father-in-law John Mayhew and Tim Newman, who both cycled alongside the pair. The team was also joined by fellow fundraisers from IDDT, Una Loughran and Caroline York who cycled to and from Northampton.

Oliver, 32, who runs PR agency Orange Juice Communications and works with the charity, said: "We were OK until the last three miles which were gruelling but we stuck at it and gritted our teeth to get to finishing line. We would like to thank everyone who supported and sponsored us. IDDT work tirelessly in the name of people with diabetes, helping to make their lives easier."

For more information about IDDT's £20 Challenge and how you can get involved, visit: www.iddt.org/news/the-20-challenge

From left to right; Una Loughran, Oliver and Ben Jelley, Tim Newman, John Mayhew and Caroline York

Confused by 'pre-diabetes'?

The term 'pre-diabetes' has crept into our language although it is not clear to some of us why this has happened and there is some debate about its use. It seems that people who are at risk of developing Type 2 diabetes are now being classed as having 'pre-diabetes' or 'borderline diabetes'. If the blood glucose levels are the high side of normal but not high enough to be classed as diabetes, then this is being classed as pre-diabetes.

There have always been people at risk of developing Type 2 diabetes but now, for whatever reason, they are being given the label of having 'pre-diabetes'. It is worth noting that 'pre-diabetes' really is what we have always known by the more familiar terms of impaired fasting glucose, when blood glucose levels are higher than normal after fasting, and impaired glucose tolerance, when blood sugars are higher than normal sugar levels after eating.

If undiagnosed or untreated, 'pre-diabetes' almost always leads to Type 2 diabetes which is not reversible. However, if 'pre-diabetes' is treated by a change in lifestyle at a stage in the development of diabetes, it can either slow down or halt the progression to Type 2 diabetes. Again this is not new.

Test results to indicate pre-diabetes

Pre-diabetes is being defined as present if the results are as follows:

- Fasting glucose levels of 5.5 mmol/l to 6.9 mmol/l
- HbA1c levels of 42 to 47 mmol/mol (between 6 and 6.5%).
- If the results are higher than those for pre-diabetes, then Type 2 diabetes may be diagnosed or a further test may be carried out.

Know the

Recommended blood glucose targets, 2014

There are varying opinions on what self-monitoring target blood glucose levels should be. Blood glucose targets must be set for the individual person because we are all different. If targets are set as standard for everyone and they are not met, the result can be feelings of failure, frustration as we are doing our best, sometimes anger and sometimes depression.

The reasons that some people can achieve targets and others can't, vary. The risk of hypoglycaemia is an important reason for targets to be individualised in both Type 1 and Type 2 diabetes taking insulin or tablets that can cause hypos. For instance, for people who are prone to severe hypos or night hypos, the fear of hypos can be so great that they set their own targets higher than those advised at the clinic. In others, just a tiny change in dose

NHS Complaints procedure

While we hope that you don't have to use the complaints procedure, it is good to know that there is one. However, like the rest of the NHS, the complaints procedure is no longer one single process and each NHS organisation has its own complaints procedure. If you want to complain about an NHS service, such as a hospital, GP or dentist, you have to ask that service for their complaints procedure.

You can make a complaint to either the organisation that provided your healthcare or to the organisation that commissioned that service. This will either be the local clinical commissioning group (CCG) for hospital care or NHS England for GP and dental services.

Your complaint can be in writing, by email or by speaking to them. This stage is called 'local resolution' and most cases are resolved quickly at this stage. Speaking may mean that the problem is resolved without going through the formal complaints procedure.

average targets

is often sufficient to cause a hypo but some people can increase their dose by several units without causing a hypo.

Some people are more susceptible to hypos – they are more common in children, teenagers and the elderly. However, there are other factors involved that could mean that the targets should be set a bit higher such as:

- people who live on their own,
- one parent families where the parent doesn't want the children to witness a hypo or have to deal with it,
- people who drive for a living or work shifts,
- people with additional conditions and who are taking drugs that may increase the risk of hypos.

You and your healthcare professionals should agree the target blood glucose levels that are right for you.

The recommended targets below are only a rough guide, although they are recommended by NICE

Type of diabetes	Before meals	2 hours after meals
Type 1 diabetes	4 – 7 mmols/l	Less than 9 mmols/l
Type 2 diabetes	4 – 7 mmols/l	Less than 8.5 mmols/l
Children with Type 1	4 – 8 mmols/l	Less than 10 mmols/l
People without diabetes	3.5 – 5.5 mmols/l	Less than 8 mmols/l

Target HbA1c levels

This test measures blood glucose levels over the last 6 to 8 weeks and the target HbA1c levels are as follows:

- For most adults, the aim is 48 mmol/mol (6.5%)
- For adults at risk of severe hypos, the aim is less than 58 mmol/mol (7.5%)
- For children the aim is less than 58 mmol/mol (7.5%).

HbA1c in %	HbA1c in mmol/mol
6	42
7	53
8	64
9	75
10	86
11	97
12	108
13	119

HbA1cs used to be measured in percentages but they are now measured in mol/mol. On the right is a conversion table as a reminder.

You should make your complaint as soon as possible. The time limit is normally 12 months from the date the event happened or 12 months from the date you first became aware of it.

If you are unhappy with the response to your complaint after 'local resolution', you can complain to the Parliamentary and Health Service Ombudsman. The Ombudsman carries out independent investigations into complaints about government departments, their agencies and the NHS. The Ombudsman's complaints helpline is 0345 015 4033.

You can also raise your complaints by contacting regulatory bodies, such as the Care Quality Commission (CQC) - their customer service centre can be contacted on 030000 616161.

Organisations that can help with your complaint

Patient Advice and Liaison Service (PALS) – provides confidential, support and information on health-related matters and can be found in most hospitals.

NHS Complaints Advisory Service – individual local authorities have a statutory duty to commission independent advocacy services. You should contact your local authority to find out who your advocacy provider is.

Citizens Advice Bureau – this can be a good local source of advice and support if you want to complain about the NHS, social services or local authorities.

The National Inpatient Audit 2013

The report of this audit presents the results and analysis of the changes in the care and treatment of patients with diabetes in hospital in England and Wales over the last 3 years.

The number of hospital beds occupied by people with diabetes has risen from 14.6% in 2010 to 15.8% in 2013 in line with the increase in Type 2 diabetes and the ageing population. Of these, 6.6% had Type 1 and 34.4% had Type 2 diabetes treated with insulin. 54.9% of patients in hospital completed the questionnaire. There have been some improvements but overall there has been little improvement over 3 years.

The key findings of the report are as follows:

Staffing levels

- 46.1% of diabetes consultants' time was spent on people with diabetes but only 13.9% was spent on inpatients.
- 31.7% of hospitals had no inpatients specialist nurses (DSNs).
- 71.2% had no inpatient specialist dietetic staff.
- 28.2% did not have a multidisciplinary foot care team - an improvement from 41.7% in 2011.

Medication errors

- 37% of inpatient drug charts had at least one diabetes medication error in the previous 7 days - a reduction from 39.9% in 2011. These patients were more than twice as likely to have one or more severe hypos compared to those with no medication errors.
- 21.9% of charts had at least one prescription error in the previous 7 days – a reduction from 25.2 % in 2011.
- 22.3% of charts had at least one management error in the previous 7 days.

Hypoglycaemia

- 22% of inpatients had one or more hypoglycaemic episodes over the previous 7 days.
- 20% had one or more mild hypos - down from 23.1% in 2011.
- 9.3% had one or more severe hypos – down from 10.6% in 2011.

Inpatients with Type 1 diabetes were the most likely to experience mild hypos (41.8%) or severe hypos (30.0%).

DKA after admission

Diabetic ketoacidosis (DKA) developed in 63 patients (0.4%) after their admission to hospital. This should not happen.

Insulin infusions (an insulin drip)

- 9.8% of inpatients had been on insulin infusion in the last 7 days, of which 9.7% had been on infusion for longer than 7 days.
- 7.5% of insulin infusions were classed as inappropriately long.
- 2.0% of people on infusion for longer than 24 hours received only 1 to 3 blood glucose tests in the previous 24 hours and 0.9% had no glucose monitoring in that 24 hour period.

Foot care and foot risk assessment

- 42.4% of inpatients had a foot risk examination during their stay – an increase from 25.8% in 2011.
- Of those admitted with active foot disease, 61.1% were seen by a member of the multidisciplinary team within 24 hours of admission.
- 1.4% developed a new foot lesion during their hospital stay.

Patient satisfaction

While 86% of inpatients were satisfied or very satisfied with the overall care of their diabetes in hospital, there were some important criticisms.

- 10.7% of those taking insulin were not allowed to give their own injections but they would have liked to do so.
- 15.5% were not able to test their blood glucose levels when they would have liked to do so.
- 14.7% reported that the hospital did not provide the right type of food to manage their diabetes and 15.1% said they needed food to be brought into the hospital to meet their dietary requirements and/or manage their diabetes.

Comments on the audit

The purpose of any audit is to measure what is happening now so improvements can be made where necessary and the above certainly shows where improvements need to be made.

While it is good to see that there have been some improvements, such as the increase in people having a foot risk assessment, let us not be fooled, still only 42.4% of people actually received this assessment!

It still is unbelievable that people are not allowed to inject their own insulin or test their blood glucose. Where is the logic behind this when people do it at home day in and day out?

The lack of inpatient staff trained in diabetes is a major issue. Hospital admission used to be seen as an opportunity to re-educate patients about their diabetes but this can't happen if there is not the staff to do it!

Audits are expensive to carry out and their purpose is limited if action is not taken, so let us hope that despite the NHS financial problems, the powers that be see the wisdom of making improvements now to improve the health and future health of people with diabetes, to save costs in the future.

Update on insulins

Lantus's activity level jumps overnight – the truth will out!

The long-acting insulin, Lantus, loses its patent next year, so its manufacturer, Sanofi, is bringing out a new long-acting insulin called Toujeo, which is going through the approval process in Europe and the US. Toujeo has the same active ingredient as Lantus, glargine, but in a threefold higher concentration.

Studies showed that in Type 1 diabetes rates of hypoglycaemia and blood glucose control were similar to Lantus but people with Type 2 were 31% less likely to have night time hypos than those taking Lantus. Interestingly, the lead researcher told the American Diabetes Association conference in San Francisco, "Its activity level does not jump overnight, as is the case with Lantus."

When Lantus was marketed we were told that it was a 'peakless' insulin and it was largely on this basis that Lantus became one of the most widely used insulins. Now with an imminent marketing campaign for their new insulin, we are told the truth - the activity levels of Lantus jump overnight with the risk of potentially dangerous hypoglycaemia! It's all in the marketing!

Eli Lilly developing new long-acting insulin

Lilly and its partner, Boehringer Ingelheim, are developing a long-acting insulin which is made of glargine for people with Type 1 and Type 2 diabetes. Studies have shown that it is just as safe and effective and has similar levels of hypoglycaemia as Lantus.

Lilly is also developing its own new basal insulin, peglispro, which in clinical trials proved more effective than Lantus in reducing blood sugar levels for people with Type 2 diabetes and also caused significantly fewer episodes of overnight hypoglycaemia. However, people taking peglispro had significant increased liver enzymes, a sign of liver toxicity.

US approves inhaled insulin

The US Food and Drugs Agency (FDA) has approved Afrezza, a rapid-acting inhaled insulin that is to be given before each meal. Its safety and effectiveness were evaluated in 3,017 participants –1,026 people with Type 1 and 1,991 people with Type 2 diabetes. In adults with Type 1 diabetes, Afrezza was given in combination with a basal insulin and in adults with Type 2 diabetes it was given in combination with oral antidiabetic drugs.

Afrezza is not a substitute for long-acting insulin and must be used in combination with long-acting insulin in people with Type 1 diabetes.

It is not recommended for the treatment of diabetic ketoacidosis, or in people who smoke.

Acute bronchospasm has been observed in people with asthma and chronic obstructive pulmonary disease (COPD) and should not be used in people with chronic lung disease.

The most common adverse reactions associated with Afrezza in clinical trials were hypoglycaemia, cough and throat pain or irritation.

The FDA requires post-marketing studies to be carried out. In the UK NICE is carrying out an appraisal of Afrezza.

Updated statement on animal insulin from Canada, July 2014

IDDT still receives calls from people who either want to change to animal insulin or who are already using animal insulin but they are being refused this choice by their doctor or health professional. The refusal is usually on grounds that are not supported by evidence from research.

A paper, whose lead author is Agnes Klein from Health Canada, has the following conclusion and oh, how we wish that its messages could be listened to!

"*Despite the shift towards biosynthetic insulin in the treatment of type 1 diabetes in Canada, the need for animal-sourced insulin remains. There is some evidence to suggest that some patients have better metabolic and symptomatic control when receiving animal-sourced insulin and can therefore manage their diabetes more effectively. As a result, animal-sourced insulin remains available in Canada as a treatment option for health care professionals and patients. Given the need for animal-sourced insulin, Health Canada will continue to monitor the situation and work with stakeholders and manufacturers on the place in therapy and the availability of animal-sourced insulin in Canada.*" (Chronic Diseases and Injuries in Canada, Vol 34, No 2-3, July 2014)

From our own correspondents

Animal insulin - IDDT's reasons for forming are still important

Dear IDDT,

Thank you for saving my life! I recently switched from analogue insulin to pork insulin. The results have been great so far. My quality of life is gradually improving every day. I can apply my knowledge of diabetes and see the true effects.

My suffering has ended after 15 years of nausea, fatigue, diarrhoea, mood changes, and erratic glycaemia, similar symptoms to asthma, cold hands and feet, fast heart rate, depressive state, weight loss. I thought I was dying and was treated for what appeared to be clinical depression.

In the past five days since changing to pork insuin, these symptoms are slowly vanishing, although I can feel some damage will take longer to heal. I am confident I will get better and better with time.

- Hunger is back
- I feel my lows and high,
- My thoughts are coherent, coordinated and stable
- My overall self-esteem and anxiety seems to improve as I worry less about my diabetes.
- Energy and stamina are progressively improving. I even caught myself jumping up and down as I did when I played basketball in High-School. I want to stretch and move and get my muscles working. I regrettably thought I was finished.

I've always been on human insulin and I changed to new analogues 10 years ago (Lantus/ Novorapid). At that point I was seeking better control than from Humulin S and I as those insulins were also making me ill. I even thought the pump was the answer, well it might have been if it wasn't for the Novorapid used during the treatment. Clearly, it was impossible to regulate my glycaemia on these GM insulins, not to mention all the horrible symptoms.

If the choice was given to me, I would have at least tried the animal sourced insulin a long time ago. I got a condescending look from my endocrinologist when I requested animal insulin but I was well prepared from the information I got from the IDDT website. I even allowed myself to complete my doctor's sentence when debating with him… Doctor: "No scientific studies suggest that…Me: "One insulin is better then the other"!

Sent by email from outside the UK
Name withheld

Recycling doesn't cost you anything

Hi all at IDDT,

Thanks for all you do for ALL people with diabetes, no matter what type of diabetes. I still continue to send mobile phones and empty printer cartridges with the hope the Trust gets some money!

Being retired I can't do much these days but if we all did the above the Trust would benefit further. It cost members NOTHING.

By email

Note: if you have used printer cartridges or unwanted mobile phones, just call IDDT for a recycle envelope to send them off to recycle4charity and IDDT receives a donation.

Overuse of carbs in hospital

Dear Jenny,

I have had Type 2 diabetes for 35 years and insulin dependent for the last 8 years. I fully support the comment in the last Newsletter about the need for diabetes specialist nurses (DSNs). My doctor is good, along with his nurses, but it is obvious that their workload is very heavy. I would welcome the occasional extra help from a DSN, which would help to save the NHS in the long run.

I have been very conscious of the need to reduce carbohydrates after a recent 9 week stay in hospital, after a broken hip. This exposed me to the overuse of carbohydrates, such as bread, potatoes, rice and pasta etc. This contributes to the increase nationally in the use of insulin and means higher doses of insulin have to be used.

Mr H.W
East Mids

Driving and disability

Dear Jenny,

I have neuropathy and although I have never been told not to drive, I was feeling unsure about my ability to drive safely. I did not know about being assessed or whether I needed a car adapted to my particular needs, so I searched for the details.

There may be other members in a similar situation so I thought they might find the information useful.

There are Regional Assessment Centres all over the country. They can be contacted by telephone on 0845 337 1540 or you can visit their website www.rdad.co.uk. Assessments are made in dual control cars and cost £80.00.

By email

My experience of an insulin pump

Dear Jenny,

I read with interest the article in the June 2014 Newsletter about insulin pumps and thought I would share my experiences with other readers.

My diabetes specialist nurse, a full time diabetes nurse not a practice nurse, recommended that I try a pump as my control is not good enough and referred me to my local hospital. After a while I received a telephone call from a very officious person asking a lot of questions. She then told me that if I had a pump, I had to sign a contract to say that I would use it for at least 4 years and that I could not try it and stop. When I said that I was on animal insulin she said that I could not stay on animal and would have to go on synthetic - they would not consider allowing me to have a pump with animal insulin.

I went back to my nurse with this information and discovered that the next nearest hospital won't do pumps with animal insulin either, so she referred me to the large hospital in the centre of town.

The difference in attitude couldn't be greater, the consultant said that I was the patient and if I wanted to be on animal insulin that was my choice and they were quite happy with me trying it. Also he could not believe the attitude regarding the 4 year contract, after all the main cost is the control unit (I am on the bluetooth pump) and if I decided that the pump wasn't for me, I could give it back and someone else on the waiting list could have it.

Since going on the pump I have had a lot of ups and downs but it seems to be heading in the right direction.

Mr C.P.
North West

Note: The names of the hospitals were supplied.

An experience of electronic prescriptions

Dear Jenny,

Following your article in the June Newsletter, please publish a word of warning - if members are unfortunate enough to have a doctor's surgery similar to ours, they would be advised very strongly not to use the system of electronic prescriptions. Every 4 weeks my wife and I have the same items on our repeat prescriptions and nearly every time there are mistakes and/or omissions.

Two days ago I handed in our lists and waited 48 hours, as requested. I have just been to collect them, by a minor miracle mine was correct, I was given a form with 1 item on for my wife, the other 11 (yes. eleven!!!) drugs were missing. There followed a rather "interesting" discussion with a receptionist who eventually went to see a doctor and she returned with the missing requested and required items prescribed.

I feel members must be warned to use this system with great caution unless they 100% certain that their surgery staff can be relied upon to get the repeats correct.

Mr B.B. J.
West Midlands

Can you help?

Dear Jenny,

For some time I have had a very sore tongue. My doctor has checked for the obvious possible cause, thrush, but tests for this are negative so I am left with the problem and no treatment. I wondered if any of your readers have experienced this problem.

Mrs O.D
S Yorks

Note: If you can offer any help to Mrs O.D., please give Jenny a call on 01604 622837.

Disability Living Allowance (DLA) to Personal Independence Payment (PIP) – delays

We know that some of our members have experienced problems with the new system following the change in benefits from the Disability Living Allowance to Personal Independence Payments (PIP). The Department for Work and Pensions (DWP) outsourced the payments to a private company called Atos Healthcare and Capita Business in contracts worth £1 billion.

New claims for the Personal Independence Payment (PIP) began in April 2013 and are worth between £21 and £134 a week. Most people applying for PIP have a face-to-face assessment with Atos to assess their eligibility.

A report by the Public Accounts Committee (June 2014) into the handling of PIPs showed that many claims have been delayed by more than 6 months, with some claimants taken to hospital due to the stress of the process and due to an inability to afford medically prescribed diets for gastric problems and diabetes. By October 2013, the DWP had only made 16% of the decisions for the 1.7 million claimants it had expected to make by that time. So this could account for why your payments are or were delayed.

According to the Committee Chairman, the DWP's failure to pilot the scheme meant that the most basic assumptions, such as how long assessments would take and how many would require face-to-face consultations, had not been fully tested and they proved to be wrong. The DWP expected 75% of assessments would be face-to-face rather than on paper and they would take 75 minutes to carry out. In fact, over 97% of assessments have been face-to-face, taking about 120 minutes.

Also exposed was that Atos stated in its tender for the work that it had 'contractual agreements' in place to provide the assessments with 56 NHS hospitals, 25 private hospitals and over 650 physiotherapy practices. This was found not to be true, although Atos deny that they misled the government.

Leaked government documents suggest Atos's PIP assessment backlog would not be cleared until March next year. However, an additional £27 million has been paid by the government, so the backlog is expected to be cleared by the end of November. Watch this space…

Bionic

In a small study, people with Type 1 diabetes who used a 'bionic' pancreas were better able to control their blood sugar levels than those who monitored their levels manually.

The artificial systems aren't transplanted inside the body. Instead, the experimental system consists of three devices worn or carried outside the body. There are two pager-sized hormone pumps connected to the body with thin tubes inserted under the skin and what the researchers describe as a small "brick," combining an iPhone and continuous glucose monitor, to coordinate when each hormone should be delivered. One pump delivers insulin to lower blood glucose levels and the other pump delivers glucagon, a hormone that raises blood sugar, both of which are produced by the pancreas in people without Type 1 diabetes.

The researchers' aim in producing the 'bionic' pump was to reduce the daily difficulties of calculating the insulin doses which is still necessary whether people are using a pump or injections.

Duty of candour to be introduced

Health Secretary, Jeremy Hunt's ambition is to reduce avoidable harm in the NHS over the next 3 years, cut costs and save up to 6,000 lives. NHS organisations are to be asked to sign 'Sign up to Safety' and to publicly set out their plans to reduce avoidable harm, such as medication errors, blood clots and bed sores.

The government is introducing a 'duty of candour' which will mean that NHS organisations must tell patients about incidents where 'significant harm' has occurred and they must apologise. From June, NHS Choices is to have a section called 'How safe is my hospital' so that everyone in England can compare hospitals.

Should doctors have consent before communicating electronically with patients?

There is much debate about sharing patient information and the medical defence organisation, MDDUS, is advising that doctors must have consent and agree levels of disclosure with patients before

pancreas
for Type 1 diabetes

In this new study, involving 20 adults and 32 adolescents, doctors compared participants' blood sugars using the pump for five days, with the bionic pancreas for 5 days, which provides round-the-clock glucose monitoring. The results were as follows:

- In adults glucose levels using the bionic pancreas averaged 7.38% compared with 8.83% on the pump.
- Importantly, adults had low blood glucose levels about 4.1% of the time spent on the bionic pancreas compared to 7.3% of the time spent on the pump.
- In adolescents blood glucose levels averaged 7.66% on the bionic pancreas compared to 8.72% on the pump.
- In adolescents the amount of time spent with low blood glucose levels was the same with the bionic pancreas and the pump.

Researchers are starting a larger study and also working on a system that will include a single pump capable of providing both insulin and glucagon.

(Presented at the American Diabetes Association Conference, May 2014 and published in the New England Journal of Medicine)

NHS News

communicating electronically. Patients must be asked to opt-in before receiving electronic communications from their doctors. Not all patients wish to receive emails or texts from their medical practice because others may have access to their email accounts or mobile phones.

Clamp down after NHS expenses 'scandal'

Simon Stevens, recently appointed Chief Executive of NHS England, has ordered a ban on first class travel and a clamp down on the use of taxis by the organisation's 6,000 staff. This came after official disclosures revealed that the 9 board members of NHS England claimed nearly £200,000 between them in expenses during 2013/14.

The highest claim was made by Tim Kelsey, national director for patients and information, who claimed more than £46,000 in expenses on top of his £180,000 salary. The claims included 130 nights in hotels costing up to £370 a night, £20.00 a day meals allowance and 39 journeys between NHS England's offices to his home in Taunton. It appears that these terms were agreed when Mr Kelsey was recruited, so not really his fault!

The report also discloses that officials claimed 170 train journeys which cost more than £200 each during 2013/14. This included 70 journeys between NHS England's offices in Leeds and London for which officials claimed more than £240 each when return tickets can be purchased for as little as £45.20.

NHS England was launched as part of the Government's promises to streamline the bureaucracy in the NHS, but more than 280 of its executives earn six figure salaries with 45 of them earning more than the Prime Minister.

This is taxpayers' money and for this, we are getting an NHS that can't afford enough GPs and nurses, frontline NHS staff is denied a 1% cost of living rise and patient services are being cut back. To really put it into perspective, Mr Kelsey's expenses alone would pay for over 3000 packs of blood glucose test strips!

Research News

New stem cell study for Type 1 diabetes

Early days but scientists at the New York Stem Cell Foundation have created insulin-producing cells using a new process that could bring a cure for Type 1 diabetes a little nearer. They used skin cells from a woman with Type 1 diabetes to make stem cells and then showed that they could turn these stem cells into beta cells (cells that produce insulin).

It is important to remember that there are two aspects to finding a cure for Type 1 diabetes (i) to produce cells that can make insulin and (ii) to control the autoimmune system so that it does not kill off the insulin-producing cells.

Intensive glucose control versus conventional glucose control for Type 1 diabetes

We are all aware that clinical guidelines differ regarding recommended blood glucose targets for people with Type 1 diabetes. In addition, recent studies on people with Type 2 diabetes suggest that aiming at very low targets can increase the risk of mortality. This study was designed to look into the effects of intensive (tight) versus conventional glycaemic targets in people with Type 1 diabetes in terms of long-term complications and find out whether very low, normal blood glucose levels are of additional benefit.

Results

Tight blood sugar control reduced the risk of developing microvascular diabetes complications.

- The evidence of benefit was mainly from studies in younger people at early stages of the disease. The authors suggest that these benefits need to be weighed against risks, including severe hypoglycaemia which we know is trebled with tight control, so they say that patient training is important.
- The effects of tight blood sugar control seem to become weaker once complications are present. There is a lack of evidence on the effects of tight control in older people with Type 1 or in those with macrovascular disease.
- The study concludes that as there is no firm evidence for specific blood glucose targets, treatment goals need to be individualised taking into account age, disease progression, macrovascular risk, as well as the patient's lifestyle and disease management capabilities.

Once again, this study confirms that blood glucose targets should not be the same for everyone.

http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD009122.pub2/abstract

According a study by Imperial College London and reported in GP News (7th July 2014), 5.77 million people attended A&E in 2012/13 because they could not obtain an appointment with their GP practice. In addition an analysis by the Royal College of GPs showed some staggering, if not surprising, figures that demonstrate the delays people experience when accessing basic NHS care.

47 million GP appointments in 2013 involved a wait of at least 7 days compared with 40 million in 2012. If this trend continues, it is projected that next year 57 million appointments will take a week or more.

Experts said that some patients were forced to wait even longer than a week, with delays up to a month for appointments at some GP surgeries.

Senior GPs say that patients are being put at risk because family doctors are overloaded which results in long waits and rushed appointments. A poll of GPs carried out by the College found that 8 out of 10 GPs fear missing a serious illness because of their heavy workload.

In 2010, the government scrapped the target which promised patients a GP appointment within 48 hours largely due to concerns that seriously ill patients were not being seen because less serious cases had to be seen just as quickly.

On June 13th 2014, the government announced that £650 million was being allocated to tackle the crisis in A&E departments, £400 million of which came from diverting money from other things. There is to be a £50 million fund to help surgeries stay open for longer and a promise to give elderly patients a "named GP". Further cash injections are expected. This seems like patching up a system that is nearly broken!

Shortage of GPs

Further recent figures show a fall in the number of GPs since the government coalition came to power, with warnings that the take-up of GP training places is the worst since 2007. Information analysed by the House of Commons Library shows:

- The number of GPs has dropped by 356 compared with its level in 2009/10.
- The proportion of GPs serving every 100,000 people has dropped from 70 in 2009/10 to 66.5 now.
- The take-up of GP training places has fallen, especially in the East Midlands and large parts of the north of England suggesting that there could be different standards of care across the country.
- The government has promised to train 3,250 new GPs a year by 2016, but this goal has already fallen behind by a year.

And there is a shortage of nurses in the NHS

A survey by a Health Education England steering group has found that 83% of NHS organisations have a shortage of nurses. Over 40 different specialties of nursing were reported to be hard to fill and many organisations (45%) have tried to recruit from outside the UK.

What does IDDT hear?

- Not able to get a GP appointment for 2 weeks is common.
- I asked for a podiatry appointment because of foot problems and was told to contact Age Concern.
- I tried to get an appointment with my GP but I was told that as I have diabetes, I will be called when the doctor wants to see me. (What about the patient wanting to see the doctor?)
- I really am unsure about managing my diabetes. I was diagnosed with Type 2 diabetes 9 months ago and I haven't seen a doctor or nurse since then.
- I have not been given any information about diabetes except to eat healthily.
- I used the new 111 service one night and was told that a doctor would ring me back but he/she never did. I went to the local walk-in centre the next morning and was told that they could not access my notes because the doctors were employed by a private company. (Unbelievable on all counts!)

Some are the old chestnuts but just because they happen frequently does not make them less problematic

- I have Type 1 diabetes and my doctor has refused to prescribe the number of test strips I need.
- As I have Type 2 diabetes, my GP surgery is refusing to prescribe test strips despite the fact that I have been testing for the last 5 years.
- I have received a letter saying that my surgery will no longer prescribe the test strips for the meter I use (and purchased myself) and they will change me to a different meter when my next prescription is due. What about patient choice?

Unfortunately, IDDT's response to most of these problems is that as individuals, we have to be assertive - one of the people who shout the loudest! We recognise some people don't feel able to do this and also that by shouting the loudest, other people are missing out on appointments but it seems that as patients, we have been put in a position where we really do have to look after our own health. It's not the fault of the GPs, nurses or other health professionals working in the NHS, many of whom are overworked and demoralised by the new system. However, we must ensure that we receive the care and treatment we need at the appropriate time – it's our health and our lives that are important.

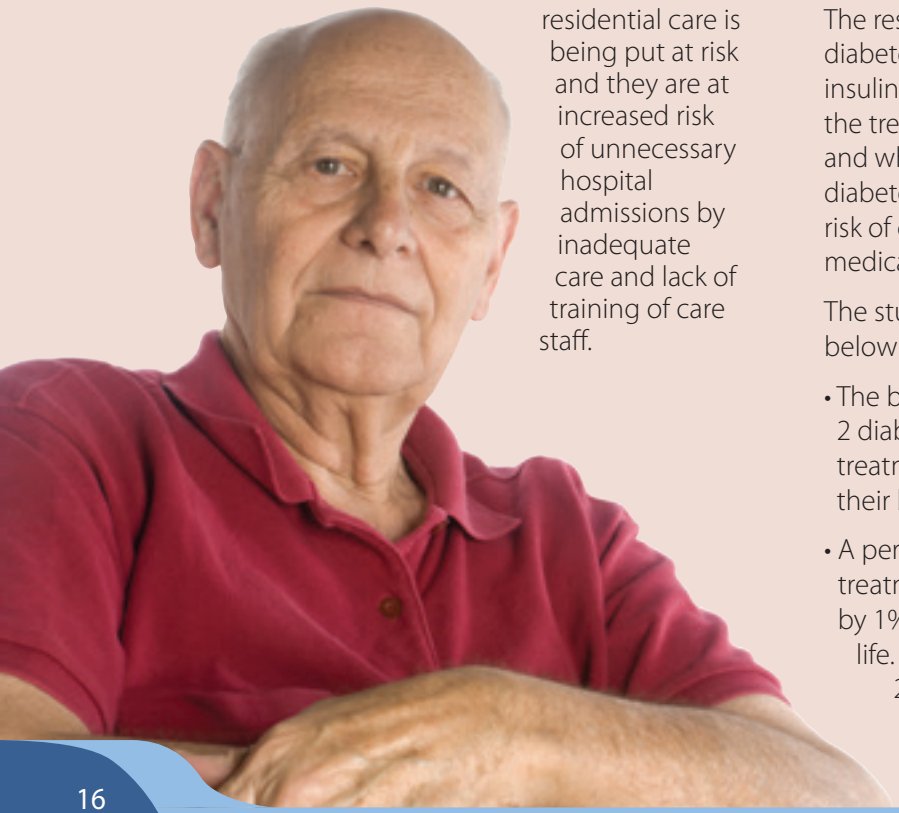
Diabetes and Older people

England's first care home audit

The audit was carried out by the Institute of Diabetes For Older People (IDOP), the organisation which worked with IDDT to publish the Passport for Diabetes in Care Settings. The audit shows that despite an estimated 37,625 people with diagnosed diabetes living in care homes, the care home sector is ill equipped to look after them. The audit showed that:

- **homes have far too many unqualified carers due to a lack of training,**
- **the links with NHS services, such as foot care, are ineffective,**
- **17% of homes had no systems in place to check whether or not people who administer their own medication had done so,**
- **over a third of homes reported that they did not assess whether the residents know about the signs and symptoms of hypoglycaemia,**
- **36.7% of homes had no policy for screening for Type 2 diabetes, which means that people could be living in care homes with undiagnosed diabetes,**
- **63.2% of homes had no designated staff member with responsibility for diabetes management.**

Only 23% of care homes responded to the audit, so the situation is likely to be even worse than the above results. The health of people with diabetes in residential care is being put at risk and they are at increased risk of unnecessary hospital admissions by inadequate care and lack of training of care staff.



Audits are expensive to carry out and are only of value, if they result in action to improve the highlighted inadequacies. With the increasing numbers of people living longer and the increase in Type 2 diabetes, standards need to be set and must be monitored. This is the case with dementia care where there are mandatory requirements to provide care, including a minimum number of staff being trained, and should be the case with diabetes.

Note: IDDT's 'Passport for Diabetes in Care Settings' is designed to help care home staff and residents and is available by contacting IDDT on 01604 622837 or email martin@iddtinternational.org

Insulin treatment in older people with Type 2 diabetes may do more harm than good

A study by researchers from University College London has shown that for older people with Type 2 diabetes, the benefits of taking insulin are so small that they are outweighed by the harms or risks.

Co-author of the paper, Professor John S Yudkin said: "*In many cases, insulin treatment may not do anything to add to the person's quality life expectancy. If people feel that insulin therapy reduces their quality of life by anything more than around 3%-4%, this will outweigh any potential benefits gained by treatment in almost anyone with Type 2 diabetes over around 50 years old.*"

The researchers assessed 5,102 UK people with Type 2 diabetes who managed their condition with tablets or insulin. Over a 20-year follow-up, they looked at how the treatments affected people's overall quality of life and whether they were effective in reducing their risk of diabetes complications. They then compared the reduced risk of complications with the burden of using diabetes medications and the side effects associated with them.

The study showed the following in people with HbA1cs below 8.5%.

- The benefits of insulin treatment for people with Type 2 diabetes are dependent on their age at the start of treatment and the potential side effects, rather than their blood sugar levels.
- A person with Type 2 diabetes who begins insulin treatment at the age of 45 and lowers their HbA1c levels by 1% may experience an extra 10 months of healthy life. However, a person who starts treatment for Type 2 diabetes at the age of 75 may only gain them an additional 3 weeks of healthy life.

Note: people with HbA1cs above 8.5% may have greater benefits from insulin treatment, as they are at greater risk of diabetes complications.

Professor Yudkin commented, "*Ultimately, the aim of a treatment is not to lower blood sugar for its own sake but to prevent debilitating or deadly complications. If the risk of these complications is suitably low and the burden of treatment correspondingly high, treatment will do more harm than good. The balance between the two can never be defined by a simple figure like blood sugar level.*"

The researchers' conclusion

- Using HbA1c levels alone to judge whether people with Type 2 diabetes will benefit from insulin therapy is a fundamentally flawed strategy.
- Each treatment decision should be individualised, mostly on the basis of the patients' views of the burdens of treatment with age and initial level of glycaemic control important secondary considerations.

(JAMA Internal Medicine June 2014)

Insulin use in Type 2 diabetes increases sevenfold

In view of the above study, research carried out at Bristol University is particularly interesting. It found that the use of insulin to treat Type 2 diabetes has risen sevenfold over the last 20 years.

- The total use of insulin for Type 1 and Type 2 diabetes trebled from 136,800 to 421,300 between 1991 and 2010, largely due to a rise in the number of people with Type 2 diabetes.
- The number of people with Type 2 diabetes using insulin increased from 37,000 to 277,400.
- The estimated cost of insulin to the NHS has risen from £156 million in 2000 to £359 million in 2009.

The researcher suggested that most insulin use in Type 2 diabetes was unrelated to clinical need. He also said that insulin is very expensive and there is a belief that it involves too many serious side effects in people with Type 2 diabetes. (Diabetes, Obesity and Metabolism online, February 2014)

Parents Part

Statutory guidance for schools

In May 2014, the Government launched new statutory guidance for schools on the support they should give children with medical conditions such as Type 1 diabetes, asthma, epilepsy and heart conditions. The new guidance will comes into effect in September 2014 – the beginning of this term. There are statutory requirements that governing bodies have to put in place and there are advisory requirements. The key statutory requirements that governing bodies must put in place are as follows.

- They must ensure that arrangements are in place to support pupils with medical conditions and they must ensure that children with medical conditions can access and enjoy the same opportunities as other children.
- In terms of disabled children, governing bodies must comply with the Equalities Act 2010.
- They must ensure that staff are properly trained to ensure that they are competent to look after children with medical needs.
- Governing bodies should ensure that school leaders consult with health and social care professionals to ensure that the needs of children with medical conditions are effectively supported.
- Each child should have an individual care plan developed with parents. The care plan must be reviewed annually or earlier if there is evidence that the child's needs have changed.
- Schools must develop a policy for children with medical conditions and appoint a named person responsible for implementing the policy. It must also set out what to do in emergency.
- Governing bodies must ensure that the school's policy covers arrangements for children competent to manage their own health needs.
- School staff must not issue prescription medications or undertake healthcare procedures without appropriate training. Schools must only accept medications that are in-date and in the original container, the exception to this being insulin in pens or pumps.
- Governing bodies must ensure arrangements are clear and unambiguous about the need to actively support pupils with medical conditions to participate in school trips and visits and NOT prevent them from doing so.

Complaints

If there are problems and it is necessary to make a complaint, then formal complaints must be made via the school's complaints procedure. If this does not resolve the complaint, then a final complaint should be made to the Department of Education once all other avenues have been exhausted.

Perhaps one of the important statements for parents is:

"*Governing bodies must not require parents (or make them feel obliged) to attend school to administer medications or provide medical support to their child. No parent should have to give up working because the school is failing to support the child's medical needs.*"

The full statutory guidance is available on the Department of Education's website.

Children and young people with Type 1 diabetes not even close to meeting targets

According to results of the TEENs Registry Study (American Diabetes Association 2014 Scientific Sessions) 75% of young people living with Type 1 diabetes are not meeting the recommended glycaemic targets.

The TEENs Study, funded by insulin manufacturer Sanofi, was one of the largest studies to ever assess Type 1 diabetes management and the factors that affect it. The information was collected from 5,960 young people between the ages of 8 and 25 from 219 diabetes centres in 20 developing and developed countries. The average age was 15 and the average duration of Type 1 diabetes 7 years.

The results were as follows:

- Average HbA1c levels were 8.3% (around 67mmol/mol) for the 8 to 12 year olds, 8.6% for the 13 to 18 year olds and 8.4% for those aged between 19 and 25.
- Overall 72% of participants were not meeting recommended HbA1c targets of less than 7.5% for those 18 or younger and less than 7% for those between 19 and 25.

Rates of DKA and severe hypoglycaemia were higher among the young adults than either the teens or the children.

- 5.6% of patients in the 8 to 12 age group reported at least 1 episode of DKA in the previous 3 months compared to 6.6% of those between19 to 25.
- Severe hypoglycemia was similar at 2.2% compared to 4.1% for the teens and young adults, respectively.
- DKA was more common among those whose HbA1c levels were consistently above the target. Hypoglycaemia was also more common in those groups above their target.

Treatment factors that predicted target achievement were:

- performing 5 or more glucose tests a day versus less than 3 tests,
- carbohydrate counting versus avoiding sugar,
- pump versus injection,
- no DKA versus DKA in the past 3 months,
- having glucagon in the home versus not.

The study also showed that there were psychosocial factors that influence achieving HbA1c targets and these include family conflict, diabetes related financial burden and living with 2 parents in the home versus not.

Some of these factors cannot be changed but some may be helped by family meetings with a psychologist to work through the issues. However, the fact still remains that despite modern advances, the majority of children and young people are not meeting the recommended targets and many experience severe hypos and DKA.

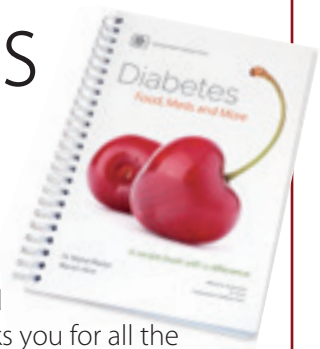
This study leaves some unanswered questions.

- If only 75% of children and young people are able to achieve the target HbA1c levels, despite all the modern advances, are the targets being set at too high?
- Does setting the targets at this level increase the number of hypos, which therefore impairs control?
- Do this 75% feel they are failing, so some of them simply give up trying?
- Does failing to meet the targets cause harm and stress to the young person and their parents, which in turn makes diabetes control even harder?

Physical Activity is associated with lower HbA1c levels in children and adolescents with Type 1 diabetes

Information from the Swedish paediatric diabetes quality registry involved a large group of 4,655 children and young people with Type 1 diabetes looked at the associations between physical activity and metabolic control as measured by HbA1c levels. It was found that HbA1cs were higher in the least physically active groups than in the most physically active groups. The researchers recommend that in clinical practice, daily physical exercise should be part of the treatment of children and adolescents with Type 1 diabetes.

Diabetes
Food, Meds and More



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News from Scotland

Podiatry services in Scotland

In answer to a Parliamentary Question about nail cutting services for older people with diabetes (May 2014), a statement was made on behalf of the Scottish Government.

- **Everyone with diagnosed with diabetes should be assessed or screened using the traffic light foot risk stratification and triage system. This system identifies people who are at risk of developing foot problems due to diabetes. It helps to identify people who can and can't self-manage their foot care, including nail cutting.**
- **People who can self-manage will be given advice on how best to look after their feet. Those who are at risk or who can't self-manage should receive a suitable level of podiatric care and advice as part of their management or care plan.**

According to the Scottish Government, this system ensures that valuable podiatry resources are used more effectively by focussing on giving the best possible, appropriate care to those who need it.

Availability of insulin pumps in Scotland

The Scottish Government was asked which NHS boards did not meet the 2013-14 targets for the provision of insulin pumps in children and adults. NHS organisations in Fife, Forth Valley, Grampian, Highlands and Lanarkshire did not meet the ministerial commitment to ensure 25% of under 18s with Type 1 diabetes are on insulin pumps by March 2014. The insulin improvement team will continue to support these boards to meet the commitment in the shortest possible safe timescale. The adult commitment deadline is March 2015.

Availability of blood glucose strips

The MP for North East Fife asked the Scottish Government what guidance it provides to the NHS boards on the prescribing of blood glucose test strips. The answer was the standard answer!

It is for clinicians to determine the treatment regime that is best for each individual patient, taking into account the relevant local and national clinical guidelines, which make it clear that people with diabetes who are treated with insulin should be provided with blood glucose test strips. However, current guidance suggests that, for people with diabetes who do not use insulin, self-monitoring of blood glucose may lack significant benefit, with little or no effect on glycaemic control, and is unlikely to be clinically effective or cost effective in addition to the usual care.

Foody Bits & Pieces

Avacados

There are many reasons to eat avacados regularly, either in meals or as a snack. They are nutrient dense fruits as they contribute nearly 20 vitamins, minerals and phytonutrients to the diet.

They help to increase fruit and vegetable intake for healthy eating, are cholesterol-free and a whole food source of naturally good fats.

It's the jam making season

For people with diabetes who make jam at this time of year, consultant dietitian Dr Mabel Blades, has some advice.

Firstly, jam is not usually eaten in excess and a teaspoonful is only 5gms of carbohydrate. This is enough for a slice of bread or toast, so my inclination is to keep on making jam as you always have. If you want to make sugar free jam or sugar reduced jam, there are various ways to do this:

Cook and puree the fruit and freeze it, defrost and add just enough sweetener to give a sweet taste. This is lovely with plums as they are often quite sweet.

A small amount of a sweetener that can be used for cooking can be added to the fruit which is then cooked in the normal way.

Some recipes recommend pectin to give firmness while others use gelatine.

The low sugar jams do not keep so well and need to be refrigerated or even frozen. It is also a good idea to freeze some fruit to use for puddings or to make toppings.

INDEPENDENT DIABETES TRUST
SNIPPETS

NICE
more people to use statins

NICE has issued guidance on the prescribing of statins. The new proposal is that the threshold for treating people to prevent cardiovascular disease is being lowered from the existing level to treat people who have a 20% risk of cardiovascular disease to people who have a 10% or greater risk. Having said this, there is much debate in the medical world about this guidance, which leaves us, the public, confused.

Risk is to be measured by a tool (QRISK2) in people aged 40-74 but some experts are questioning the use of this tool as they maintain that crucial evidence for its use is still missing. [The Lancet, Feb 22, 2014] The tool is not recommended for people with diabetes, chronic kidney failure, existing cardiovascular disease or various other conditions.

For prevention the recommendation is 20mg daily of atorvastatin but for people with Type 1 and Type 2 diabetes or established cardiovascular disease in general the dose should be 80mg daily.

At the time of writing there is no estimate of how many people may be prescribed statins but it will be a significant increase on the present 7 million users which currently costs the NHS of £450million.

Cities to become 'diabetes aware'

Launching World Diabetes Day, Nov 14th 2014, the International Diabetes Federation [FDA] and the European Connected Health Alliance are challenging cities around the world to become officially labelled as 'diabetes aware'. They have to show they offer and encourage healthy lifestyles for people with diabetes and those at risk of it.

EU GPs to have English language checks

European doctors coming to work in the UK will face checks on their English language skills from this summer. Under current laws, the General Medical Council can test language skills of overseas doctors but not those of EU doctors.

Prescriptions for fruit and vegetables in New York

Two New York hospitals are joining a programme in which doctors can write prescriptions for low-income families at risk of obesity for fruit and vegetables. The Fruit and Vegetables Prescription Programme enables this group of people to use coupons to obtain fruit and vegetables once a week at farmers markets.

Antidepressant use in the UK

New research by the Nuffield Trust and Health Foundation has shown that from 1998 to 2012 the number of antidepressants prescribed in England increased by 25 million. Over half of this, increase was between 2008 when the recession began, and 2012.

Pride and optimism in the NHS

A survey by the Kings Fund showed that only 20% of nurses and 23% of doctors feel optimism and pride about the NHS compared with 63% of executive directors. It also showed that many NHS employees did not think that swift and effective action is taken to handle inappropriate behaviour and performance.

Apologies for error!

The article about prescription charges in the June Newsletter referred to the increase in charges being from £7.85 to £8.05 and from £8.05 to £8.25 being 20% when it should have been 20pence. Our apologies.

From your editor – Jenny Hirst

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