INDEPENDENT DIABETES TRUST Newsletter

WINTER 2026 Newsletter, Issue 132

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Greetings for Christmas and the New Year!

This is the final Newsletter of 2026 and the Trustees and Staff would like to send all our members and readers best wishes for Christmas and 2027. During 2026, we reached out to offer help and support to more people living with diabetes, so we are also pleased to welcome all our new members who joined us during 2026.

Importantly, following our appeal for donations in March 2026, we have to say a big thank you for increased support and donations throughout the rest of 2026.

Many charities are facing difficulties in the present economic climate, so we are especially grateful for the help we have received from our members and we look forward to continuing being of help in the future.

We received requests for our booklets from people living with diabetes, but we also received requests for them from healthcare professionals to give to their patients. This is a really good way to provide people with the information they need and during 2026, we sent nearly 200,000 booklets to healthcare professionals!

One of our other major functions is to receive calls and emails from people living with diabetes, many of whom have not been receiving the care, the health checks and support they need to manage their diabetes and of course, to prevent possible future complications. We do our best to listen, so please remember that we are at the end of the phone to help where we can.

Now Christmas is coming – a time to enjoy with presents and festive food! If you or a member of your family has diabetes, it can also be a worrying and stressful time, especially if it is your first Christmas with diabetes. Our FREE booklet 'Diabetes at Christmas' offers help and advice about managing diabetes at Christmas. There is a range of recipes and ideas about food and eating, allowing you to enjoy Christmas and still manage your diabetes. For your copy, give us a call on 01604 622837 or email enquiries@iddtinternational.org



Christmas cards and 2027 Diabetes Everyday Diaries still available!

We would like to thank everyone who has already bought IDDT Christmas cards and 2027 Diaries from us and remind those who haven't that we still have Diaries available at £4.99 and Christmas cards available at £4.50, including p&p.



Calling all healthcare professionals!

See page 2...

Charity Number 1058284 Registered Number 3148360

Calling all healthcare professionals!

IDDT is pleased to supply our booklets for free to healthcare professionals to give to their patients. It forms part of our commitment to help people with diabetes to understand and learn more about their condition and so improve their blood glucose levels and reduce the risk of diabetes complications.

Do you need hard copies of IDDT's quarterly Newsletters and Type 2 & You?

We have also been sending healthcare professionals copies of our quarterly publications – the Newsletter and Type 2 & You. However, we don't know if they are read, if they are put in surgery waiting rooms or even if they are wanted. We have 2,500 healthcare professionals on our mailing list, so this is a substantial cost to IDDT, especially since the postage costs have recently increased considerably.

Both of these quarterly publications are available online at www.iddt.org and we will send emails to remind you when new issues are available.

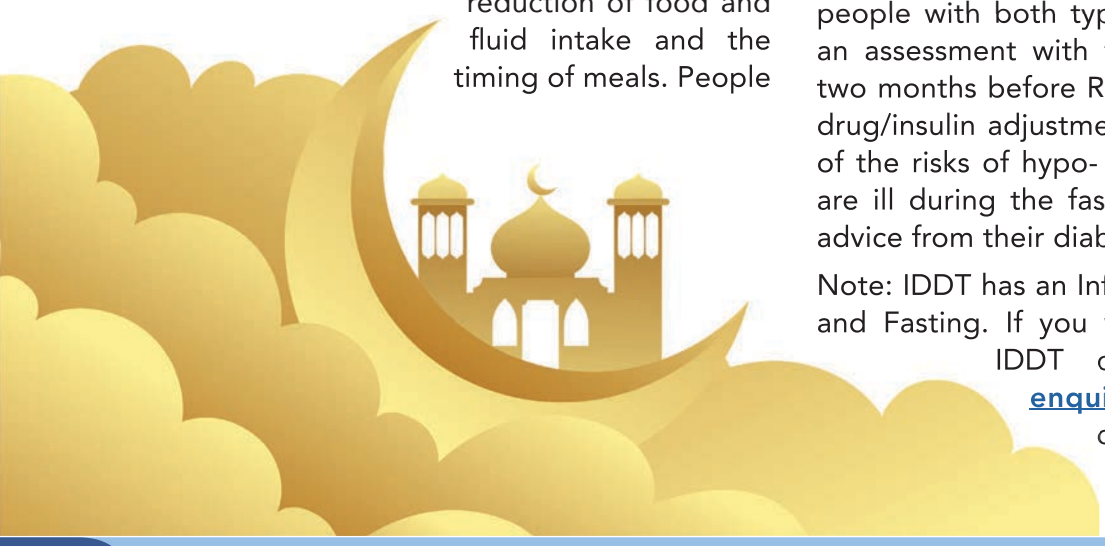
We will not be posting these publications to healthcare professionals after this issue unless hard copies are needed in which case contact us by email at enquiries@iddtinternational.org or phone us on 01604 622837.

Ramadan 2027 and fasting

In 2027, Ramadan will start on 7th February and continue until 8th March. This is before our first Newsletter of 2027, so we are reminding readers of important facts about fasting and diabetes in this issue.

During the month of Ramadan, it is expected that Muslims who participate will abstain from food, water, beverages, smoking, oral drugs and sexual intercourse from sunrise to sunset.

Fasting has special consequences for people with diabetes, especially those taking insulin. People with diabetes may be exempted from fasting but the majority do fast and therefore face increased risks of adverse health effects, such as hypoglycaemia, hyperglycaemia, diabetic ketoacidosis and dehydration, most of which are as a result of a reduction of food and fluid intake and the timing of meals. People have to rely on expert advice from doctors and their personal experiences as there are no evidence-based guidelines for fasting.



Recommendations

What studies have been done suggest that people with Type 1 and Type 2 diabetes should more actively carry out blood glucose monitoring, consider any changes in insulin/drug dosage and timing and have dietary counselling/education. One study has shown that people with Type 2 who did not have education about fasting were four times more likely to have hypos, therefore, it is recommended that those who do not normally carry out self-monitoring of blood glucose should be provided with meters.

The findings of this and other studies suggest that people with both types of diabetes should have an assessment with their diabetes team one to two months before Ramadan. This should include drug/insulin adjustments, exercise and awareness of the risks of hypo- and hyperglycaemia. If they are ill during the fasting, then they should seek advice from their diabetes team.

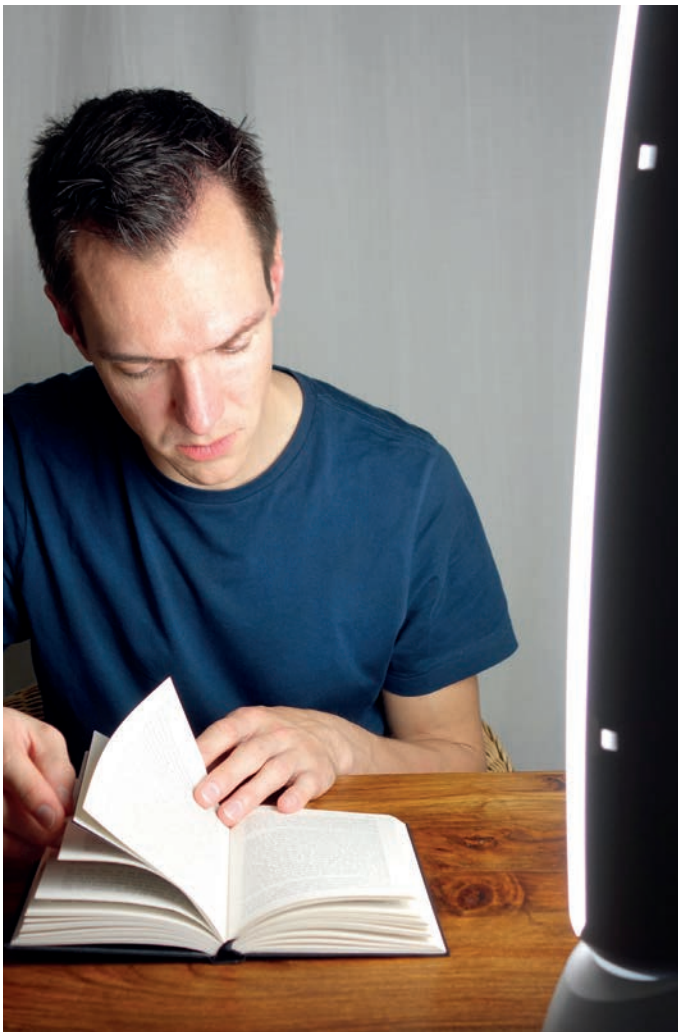
Note: IDDT has an Information Sheet on Diabetes and Fasting. If you would like a copy, just call IDDT on 01604 622837, email enquiries@iddtinternational.org or write to IDDT, PO Box 294, Northampton, NN1 4XS.

Seasonal Affective Disorder

Seasonal Affective Disorder (SAD) is a mood disorder that causes people who have normal mental health throughout the year to exhibit depressive symptoms at the same time each year. The reason for including this article is that these symptoms are most commonly associated with winter, although they can also occur in summer. Symptoms can include:

- Oversleeping or difficulty waking up
- Nausea
- Overeating often with a craving for carbohydrates

Obviously, this last symptom can have major implications for people with diabetes. Symptoms of the condition in summer can include heightened anxiety. While experts were initially sceptical about the existence of SAD it is now recognised as a common disorder. Officially called SAD it is also commonly called winter depression, winter blues, summer depression or seasonal depression.



What are the causes of SAD?

- One theory is that SAD is an evolutionary response to the lack of food during the winter months. The theory postulates that many animals, including us, reduce their levels of physical activity during winter to preserve the energy reserves they have, increase levels of sleep etc. The extreme of this is hibernation.
- On a more biological level, a second theory is that SAD is caused by reduced levels of the chemical, serotonin. Serotonin is responsible for feelings of well-being and happiness. Lowered levels of serotonin have been shown to result in depressive behaviour and treatment with anti-depressants, such as fluoxetine, can prove to be effective.
- Another theory is that SAD is caused by an excess production of the hormone, melatonin. Melatonin is produced under dim light or dark conditions.

If identified, treatment can be with artificial bright light therapy lamps (lightboxes) or by spending more time outdoors, providing you use a UV sun cream blocker.

There are several other treatments that may be suitable and used either in isolation or in conjunction with other therapies. These include:

- Physical exercise
- Vitamin D supplements

As always, speak to your health professional if you think that SAD becomes an issue for you or someone with diabetes who you support.



RSV vaccination for people over 75 years

From April 2026, people aged 75 years and older, as well as adults of any age living in a care home for older adults, will be eligible for a free vaccine to protect them from respiratory syncytial virus (RSV). It is an infectious disease of the airways and lungs and often causes symptoms similar to a cold, including:

- Cough
- Sore throat
- Sneezing
- Runny or blocked nose

It can also make you become wheezy or short of breath and lead to pneumonia and other life-threatening conditions. The RSV infection is common in young children but is most serious for small babies and for older people.

There is no specific treatment and most infections will get better by themselves but every year thousands of older adults need hospital care for RSV. It can be more severe in people with medical conditions such as heart or lung disease or a weakened immune system.

Who is eligible for the RSV vaccination?

- Everyone aged 75 years and older because they are more at risk of serious complications from RSV. There is no upper age limit
- People over 60 years but only privately and under 60 years there are more side effects
- People living in care homes for older adults as most of them will be over 75 and adults younger than 75 living in a care home for older adults
- Pregnant women to protect their babies from RSV

How RSV is spread?

RSV infections can occur all year round but peak every winter. It is spread through coughs and sneezes, so to help to prevent the spread cover your mouth and nose when you cough or sneeze and wash your hands frequently to reduce the risk of picking up the virus.

How the RSV vaccine works

Almost all older adults will have had several RSV infections during their life. A single dose of vaccine will help to boost protection as you reach an age group at highest risk of serious RSV infection. The RSV vaccine provides good protection for at least two years.

Having the RSV vaccine at the same time as other vaccines

You may be offered your COVID-19, shingles or pneumococcal vaccines at the same time as the RSV vaccine and this is safe but RSV isn't normally given at the same time as your flu vaccine.

The vaccine has been shown to reduce the chance of you getting RSV but if you do get it, it should be less severe. If you have a minor illness, you can receive the vaccine, but if you are very unwell or have a fever, you may be advised to wait until you are better.

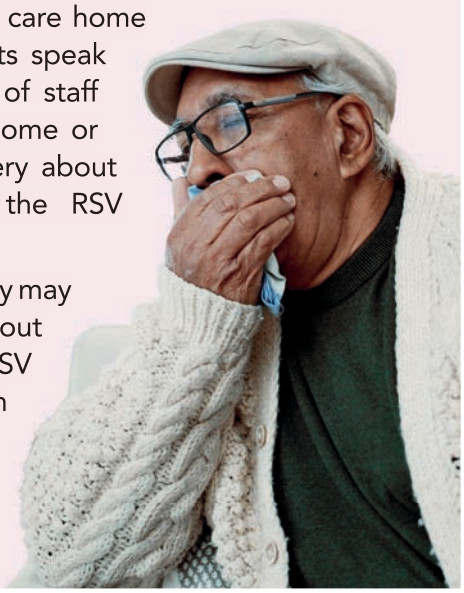
Side effects from the RSV vaccine

- You may get some soreness, redness or swelling at the site of the injection for a day or two after the vaccination
- A rare, but serious, nervous system condition known as Guillain-Barré syndrome that leads to weakness has been reported – around one case for every 40,000 to 100,000 doses given, in the six weeks after vaccination. If you have symptoms such as tingling, numbness, weakness, sharp pain or pins and needles in your hands, feet, arms or legs, you should seek immediate medical attention
- Overall, it is safer for you to have the vaccine than to risk having a potentially serious RSV infection

You can report suspected side effects to the Medicines and Healthcare products Regulatory Agency (MHRA).

What should I do now?

- If you are aged 75 years and over, contact your GP surgery to ask for your RSV vaccination
- If you live in a care home for older adults speak to a member of staff at your care home or your GP surgery about how to get the RSV vaccine
- Your GP surgery may contact you about getting the RSV vaccine which may be by letter, text, phone call or email



Availability of porcine insulin

In the UK

IDDT is very aware that many people are misinformed about the availability of pork (porcine) insulin and are told that it is no longer available.

This misunderstanding has become greater as a result of the discontinuation of pork insulin in vials.

This answer to a Parliamentary Question makes it clear that pork insulin is available and if you are denied the pork insulin you need, you can quote it:

Question, 19th January 2026:

To ask the Secretary of State for Health and Social Care, what steps he is taking to help ensure porcine insulin is available to users who are dependent on it.

Answer:

The Department is aware of the global discontinuation of insulin porcine vials, including Hypurin Porcine Isophane, Hypurin Porcine Neutral and Hypurin Porcine 30/70 Mix by Wockhardt. We have issued comprehensive management guidance to the NHS, including all general practitioners (GPs) and community pharmacists, on 23rd July 2025.

This management guidance contains information on alternative licensed medicines including Hypurin Porcine cartridges, Hypurin Porcine Isophane, Hypurin Porcine Neutral and Hypurin Porcine 30/70 Mix cartridges that remain available.

Patients and/or patient representatives should speak to their GP about the most appropriate treatment option.

In Canada

People in Canada who need pork insulin have had to import it from the UK through the Special Access Program (SAP) but only in vials. The withdrawal of pork insulin in vials by Wockhardt UK has caused concern because the cartridges for the pen have not been approved through the SAP. However, on 27th July 2026, a notice was issued to inform healthcare professionals that Wockhardt UK will support continued access to Hypurin Porcine Insulin cartridges through Health Canada's Special Access Program.

The instructions and warnings

- Practitioners seeking access to Hypurin may submit a patient-specific request (Form A) to the SAP. Requests must describe the patient's circumstances and provide clinical rationale in ruling out other marketed alternatives
- All requests are considered on a case-by-case basis and the submission of a request does not guarantee that authorisation for access will be granted
- Patients should be told that drugs accessed through the SAP do not undergo a benefit-risk assessment required of marketed drug products and they are exempt from the Food and Drugs Act and Food and Drug Regulations

The request forms can be found at http://www.healthcanada.gc.ca/sap.

For additional information, contact the SAP at: sapd-pasm@hc-sc.gc.ca

Wimbledon finalist is using his tennis success to raise diabetes awareness

Alexander Zverev was dealing with more than tennis when playing in this year's Wimbledon final. The 29-year-old from Germany also has Type 1 diabetes, so he has to monitor his glucose levels and, if necessary, inject insulin during matches. Zverev uses an insulin pen when needed to inject the top of his thigh during changeovers on court. He has special permission from Grand Slam tournaments to use his phone during matches to check his glucose levels so that he doesn't have to do finger prick blood tests. Prior to this, if he needed insulin during a match, he'd inject privately during bathroom breaks.

Zverev was diagnosed with Type 1 diabetes as a boy aged four and disclosed this in 2022. At the same time as declaring his diabetes, he launched his foundation to help children in particular.

He said: "There's a lot of great athletes, there's a lot of actors and musicians, who have diabetes. It shows that with diabetes there shouldn't be any limits."



Image credit: Daniel Cooper, CC BY-SA 4.0, via Wikimedia Commons

NHS News

'Summer Surge' keeps corridor care above 3,000

There was a record 2.5 million A&E attendances in the two July heatwaves. The number of patients in England being cared for in hospital corridors or makeshift areas remained above 3,000 a day in June and July 2026. The data covers patients who received corridor care for at least 45 minutes. This means care didn't take place in a clinically appropriate and safe setting where patients have privacy, access to food, water and toilets, and lights can be turned off and noise levels minimised to allow sleep. Health Secretary Yvette Cooper warned the health service must start planning for summer pressures in the same way as winter. *(13th August 2026)*

Improving the safety of hospitals in England

The Government has announced more than £1.5 billion to improve the safety and resilience of NHS hospitals in England.

- More than £200 million will fund 10 major hospital projects, including new operating theatres, children's wards, maternity facilities and improvements to mental health units
- Over £1.3 billion will support maintenance, safety and resilience work across more than 950 projects including fire safety, electrical and ventilation upgrade
- Over £32 million to specifically support cooling and overheating measures to protect patients, staff and critical equipment during heatwaves

This forms part of the Government's 10 Year Capital Plan, with the health capital budget set to rise to £15 billion by 2029-30.

UK-US pharma deal could lead to nearly 230,000 unnecessary deaths in England

A trade deal between the US and the UK could result in more than 200,000 otherwise avoidable deaths in England by diverting billions of pounds away from vital health services. In December 2025, the UK agreed with Washington DC to increase the UK's spending on new medicines from 0.3% of GDP to at least 0.6% over the next decade as part of a broader deal aimed at avoiding punitive tariffs threatened by President Donald Trump. An analysis published in The British Medical Journal said the deal is expected to cost the UK's publicly funded NHS an additional £45 billion by the end of 2036 to pay for the new medicines. *(CNN, Cable News Network, 2nd July 2026)*

Waiting list improvements

In May 2026, the Government announced that the target for its NHS 18-week waiting times had been met:

- In March, 65.3% of patients waited 18 weeks, as the waiting list fell by over 312,000 last year
- Nearly half a million fewer people waited over 18 weeks for NHS treatment in March this year
- The NHS also recorded its best year on record for elective care, with more than half a million more people starting treatment or completing care compared with last year, taking the total to over 18.6 million in the last 12 months
- The overall waiting list fell to 7.11 million, the lowest in 3.5 years and down by over half a million (515,000) since July 2024
- The number of patients facing the longest waits for NHS treatment is also at its lowest for six years (since July 20). The number of people waiting more than a year has dropped by almost half (48%) in the last 12 months and by over 69% (208,000) from the start of July 2024

Let's give credit where it is due and thank all those within the NHS who have made this happen.

Pharmacists to prescribe for more conditions

It was announced at the end of May 2026 that people in England will be able to obtain treatment for more conditions at their local pharmacy without being referred back to their GP.

The investment of £340 million will expand independent prescribing, so pharmacists with a relevant qualification will be able to make decisions and prescribe medicines on the spot. The changes will come into force in autumn 2026 and are expected to ease pressure on GPs.

This builds on the Pharmacy First scheme which currently allows patients to ask their pharmacists for advice for over-the-counter treatments and prescription-only medicines for seven common conditions:

- Sore throat, earache, sinusitis, shingles, impetigo, infected bites and urinary tract infections

People may also visit the pharmacy for eye, ear, oral and dental care and treatment for digestive problems.

Five more conditions are to be added but at the time of writing these details have not been announced. We will keep you informed.

Single patient record update

In the last Newsletter, we discussed the NHS Modernisation Bill (known formally as the Health Bill), which was introduced to parliament in May 2026. Importantly for us as patients, one of the inclusions is the establishment of a single patient record (SPR) with the overall aims of enabling (i) better joined-up and proactive care (ii) improving patient safety and experience and (iii) empowering patients.

This article aims to provide more information about the progress of these changes and the proposed SPR. At the second reading in the House of Commons, many MPs acknowledged the potential benefits of SPR but also expressed concerns about data security, privacy and controllership. Questions were also asked about the company providing the software for the platform, Palantir, which was not mentioned in the Bill.

An example of the benefits of SPR

People living with some conditions may need services from primary, secondary, community and social care settings and SPR would mean that doctors and healthcare professionals will be able to access patients' records. This could lead to better care, earlier intervention when patients need extra support and reduce emergency admissions to hospital.



How and when will the SPR be accessed?

- Clinicians will continue to access patient records through their existing clinical systems. NHS England says that staff access to the SPR will be based on their role, so staff will only be able to see patient information relevant and necessary to their role
- Patients (or those acting on their behalf) will be able to access their record via the NHS App
- According to the Department of Health and Social Care, clinicians will have improved access to linked patient data by 2027 through the connection of existing shared care records

The intention is that ultimately all patients will have access to a core set of their data via the NHS App from 2028, with access to their complete data by 2030.

Safeguards for security

The Bill includes a requirement that the secretary of state must consider safeguards to prevent the 'improper use' of data shared under the provisions of the Bill. This is not specified further, but the Government intends for this to include consideration of equivalent data security and roles-based access when sharing patient data with clinicians based outside of England but within the British Islands.

The world's first dual glucose-ketone sensing technology update

In the last Newsletter, we discussed the US approval of the Libre Duo 10 Day system, the world's first dual glucose ketone sensing technology designed to alert people with diabetes of rising ketones. Ketones can lead to diabetic ketoacidosis (DKA), a serious health complication that can lead to hospitalisation.

Libre Duo 10 Day is designed for those who may be at a higher risk of elevated ketones. This includes people with Type 1 or Type 2 diabetes who use insulin or other glucose-lowering medications, such as SGLT2s.

Abbott expects Libre Duo 10 Day to work with Beta Bionics' iLet and Sequel Med Tech's twiist AID systems by the end of this year and with devices from Insulet and Tandem in 2027.

Abbott and MiniMed are collaborating on an exclusive integration between Abbott-manufactured dual glucose-ketone sensors and MiniMed smart dosing systems, which is expected in 2027. Libre Duo is not yet routinely available in the UK, although it received its European CE mark in May 2026.

Continuous glucose monitors don't tell the whole story

Continuous glucose monitors (CGMs) have transformed life for many people with Type 1 diabetes. Instead of relying on finger-prick blood tests throughout the day, users can track their blood sugar levels almost continuously. This allows them to receive alerts via a smartphone when levels become too high or too low, to spot trends in glucose levels and to have a clearer picture of how their blood sugar responds to meals, exercise, sleep and insulin.

This latest research uncovered what the researchers describe as 'a little-known blind spot'. During the most extreme high and low blood sugar events, these devices cannot tell users exactly how severe those events are and so some important information is lost when blood sugars move out of the monitor's measurement range.

CGMs can only measure blood sugars within a fixed range so if they rise or fall outside that range, the sensor cannot say exactly how high or low they are.

What the research shows

The research involved nearly 47 million publicly available CGM readings from 948 people with Type 1 diabetes across four large international clinical trials. The results showed:

- Between 93.5% and 100% of the participants experienced at least one reading that reached the upper or lower measurement limit, so this will affect almost everyone with Type 1 diabetes who uses these devices over a period of time
- The pattern was particularly marked for high glucose levels with over a third of these episodes remaining at the upper measurement limit for at least an hour and with the longest episode lasting between two and three hours
- Younger people had upper limit readings more often than older adults
- People with higher HbA1c levels were more likely to reach the monitor's measurement limits suggesting that those who struggle most to manage their diabetes are also the people most likely to encounter this hidden limitation

What needs to change?

Current smartphone apps and web-based software summarise glucose data in many different ways but they never explicitly state that a sensor has reached its limits, how often this happened or how long it lasted. Apparently, adding that information needs only a relatively small change to existing software.

CGMs remain one of the most important advances in diabetes care and the researchers say that their findings should not discourage anyone from using them. Understanding the limits helps people make better use of the information provided.

(Diabetic Medicine, 2nd July 2026)

Diabetes technology introduced new patient challenges

Diabetes technology, such as insulin pumps, continuous glucose monitors (CGMs) and automated insulin delivery systems have improved diabetes management. However, it also introduced previously under-recognised challenges as patients reported concerns about device waste, travel, device replacement and digital security that could influence long-term use.

These technologies have become increasingly integrated into routine treatment but not much is known about how they affect patients' experiences. A new study suggests the next generation of diabetes technology should be designed with greater attention to patient experience as well as therapeutic benefit.

Patients identified new technology-related burdens

Researchers analysed survey responses from 535 adults with Type 1 diabetes with an average age of 48 years. 95% were using CGMs and 69% were using automated insulin delivery technologies, including insulin pumps.

While participants acknowledged the clinical benefits of modern diabetes technology, they also described challenges which have received limited attention in previous research. These included:

- Concerns about the environmental impact of disposable device components, stress associated with travelling while carrying diabetes supplies and inconsistent airport security procedures
- The burden of premature device failures and frustration with manufacturer replacement processes
- Some expressed apprehension about digital security and the protection of personal health information as diabetes devices become increasingly connected

Conclusion

The authors suggest that future successful diabetes technologies should be evaluated not only by their ability to improve glycaemic control but also by their impact on patients' daily lives. Administrative processes, environmental sustainability, digital trust and practical usability all emerged as important determinants of long-term technology acceptance.

As diabetes care continues to evolve through connected devices and automation, the findings suggest innovation should extend beyond engineering advances alone.

Designing technologies that better reflect the realities of everyday living may be essential to ensuring that the benefits of advanced diabetes management are sustainable, accessible, and acceptable for people living with Type 1 diabetes.

(JAMA Net Open, 4th August 2026)

Diabetes distress – recommendations by the EASD

At its meeting in October 2025, the European Association for the Study of Diabetes (EASD) recommended that healthcare professionals should discuss the emotional side of diabetes at every patient visit, using open-ended questions framed around the burden or challenges of living with the condition. Here are some examples of the open questions:

- "What's challenging you the most about your diabetes?"
- "What's bothering you the most at the moment?"
- Or simply, "How can I help you?"

Diabetes distress refers to the emotional strain or burden arising from living with the daily demands of diabetes. This can include worries, fears, guilt, frustration, or sadness around management, stigma and concern about long-term complications.

The EASD will issue an evidence-based clinical practice guideline for assessing and managing diabetes distress among adults with Type 1 and Type 2 diabetes, which may be more common soon after diagnosis, a change in treatment, diagnosis of complications or other life stressors. The recommendations state:

- Recognising the emotional burden of diabetes is a critical part of care and the aim of this guideline is to standardise the assessment and management of diabetes distress among adults with Type 1 and Type 2 diabetes
- About one in three adults with Type 1 or Type 2 diabetes experience some type of diabetes distress, while up to 80% report at least one 'problem area' related to their diabetes that can lead to diabetes distress

Good Practice Statements

For addressing diabetes distress among adults with Type 1 or Type 2 diabetes, the EASD says healthcare professionals should:

- Discuss the emotional side of diabetes at every consultation as part of person-centred diabetes care
- Ask about diabetes distress using open-ended questions about the emotional burden or challenges of living with diabetes
- Assess and monitor diabetes distress using a valid and reliable tool at regular intervals as part of annual care
- When diabetes distress is identified, make a joint plan of the next steps with the person with diabetes

General and diabetes-specialist healthcare professionals should have the competency to offer psychological support to those experiencing diabetes distress and know how to enlist specialist support when it is needed. Establishing these guidelines in the real world may be challenging as this will take training, systems-level support and integration into routine care to correctly manage diabetes distress. This may require additional staff and funds but the guidelines can potentially improve the care of people with diabetes.



International News

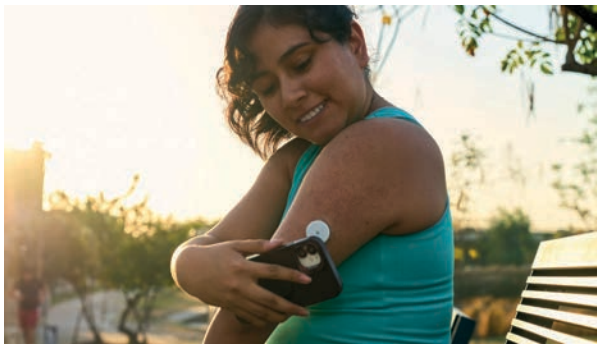
Local production of insulin cartridges in Bangladesh



Eskayef Pharmaceuticals Ltd and Novo Nordisk have announced the start of local production of modern insulin cartridges in Bangladesh through technology transfer from Denmark. Cartridges, including NovoMix and NovoRapid, will be produced locally under a contract manufacturing arrangement with the aim of improving availability and reducing costs for people with diabetes patients.

(The Financial Express, Bangladesh, 28th April 2026)

Continuous glucose monitors improve control of Type 2 diabetes



News in the US reported that people with Type 2 diabetes who wear a continuous glucose monitor (CGM) have better blood sugar control than those who rely on traditional finger-prick testing. People using a CGM had greater reductions in HbA1c levels, a marker of lower blood sugar. Using CGMs has become a standard treatment for people with Type 1 diabetes but they have not been widely adopted by people with Type 2 diabetes.

(The Lancet Diabetes and Endocrinology, 23rd April 2026)

Calls for insulin pens for those with diabetes to be covered



Advocates say that Kenyans living with diabetes could have an easier and safer way of taking insulin if the Social Health Authority (SHA) adds insulin pens and pen needles to its benefits package. The call comes as the number of people living with diabetes continues to rise and many patients still struggle to get regular treatment because of cost and limited access.

(The Star, Kenya, 29th August 2026).

The US issues new dietary guidelines – eat more meat and whole fat dairy



This year the US issued new guidelines encouraging people to eat more protein, specifically meat and whole-fat dairy products. Using a new upside-down food pyramid, these products are at the top with a message encouraging the consumption of 'real food'. In the new 2025-2030 Dietary Guidelines for Americans, vegetables and fruits have also been placed at the top of the pyramid. The Department of Health and Human Services maintain that protein and healthy fats are essential and that previous guidelines wrongly discouraged them, stating: "We are ending the war on saturated fats." The recommendation keeps saturated fat unchanged to less than 10% of daily caloric intake and urges Americans to avoid highly processed foods, added sugars and to limit sodium intake.

Sickle Cell Trait and diabetes – the HbA1c may not be accurate

For most people with diabetes, the HbA1c is a three-month average blood glucose test which helps determine if treatment is working and the risk of complications. For people with diabetes and sickle cell trait, the HbA1c results may be inaccurate or simply wrong.

When sugar enters your blood, it sticks to a protein in your red blood cells and this creates what is called glycated haemoglobin. The more sugar in the blood, the higher the HbA1c.

Sickle cell trait is a genetic haemoglobin variant which means people carry one copy of the gene that causes sickle cell disease. People with sickle cell disease have two copies of this gene. Many people with sickle cell have no symptoms and don't even know that they have it.

Who is affected by sickle cell trait?

- It is most common in people whose ancestors come from Sub-Saharan Africa
- It also affects people with ancestry from South Asia, the Middle East, India and Mediterranean countries like Greece, Turkey, and Italy
- More than 100 million people worldwide carry the trait

The dangers of a falsely low HbA1c

A study published in JAMA found that sickle cell trait is associated with lower HbA1c readings compared to what blood sugar levels actually are. This is likely nto be because the haemoglobin variant may shorten the lifespan of red blood cells, which means glucose has less time to accumulate and so falsely gives a low HbA1c. The researchers recommended that doctors following Black people whose HbA1c levels falls within 0.3 percentage points of a diagnostic cut off should also use additional blood glucose measures.

An incorrect HbA1c reading that is falsely low, can lead you and importantly your healthcare team to think your blood sugar is better controlled than it actually is. This in turn can lead to delayed diagnoses, undertreated diabetes and a mistaken sense of safety. You could be walking around with blood sugar high enough to cause complications while your lab results say you're fine.

On the contrary, some haemoglobin variants can cause falsely high HbA1c readings. This means a person could be overtreated and given medications or insulin doses based on numbers that overstate the problem.

Both directions are dangerous and the person with diabetes is the last one to know, because the number they're being judged by doesn't reflect what's actually happening in their body.

The health impact

- People with sickle cell trait are carriers. They usually live normal, healthy lives and do not have sickle cell disease
- Under extreme conditions, such as severe dehydration, low oxygen levels or very intense physical exertion, some people can have rare complications such as muscle breakdown or pain crises
- Carriers cannot develop the disease themselves, but they can pass the gene on to their children

Alternative tests

As the HbA1c test tends to be inaccurate in people with sickle cell trait, there are other blood tests available – fructosamine and glycated albumin that measure glycated proteins instead of glycated haemoglobin. They reflect average blood sugar over the past two to three weeks rather than two to three months and importantly, they're not affected by haemoglobin variants or red blood cell lifespan. These tests aren't used as widely as HbA1c , but they're clinically validated alternatives. If your HbA1c might be unreliable, your healthcare provider can organise these tests to get a more accurate picture.

Continuous glucose monitor (CGM) data can also provide a clearer picture of actual glucose patterns than a single HbA1c result. On your CGM, your glucose management indicator (GMI), an estimated HbA1c calculated from your sensor data, may actually be more accurate than the lab test.

The message

The HbA1c is only useful if it's accurate but for too many people, and especially for people of Black, South Asian and Afro-Caribbean descent, it isn't. Better tools now exist but the bad news is that often people might not be offered them, so it is important to ask. Trust your CGM data, trust what your body tells you and don't be afraid to ask your care team for another way to measure your blood sugar.

Overweight and obesity in Type 1 diabetes

Researchers believe that the presence of obesity in people with Type 1 has an impact on their glycaemic control and long-term health so the prevention and treatment of overweight/obesity is a high priority. There have been several studies looking at the new weight loss drugs in overweight people with Type 1 diabetes but they are small studies, so more research is necessary.



Managing obesity in Type 1 diabetes

There is a rising prevalence of obesity in Type 1 diabetes and therefore discussion of whether the weight loss drugs, glucagon-like peptide 1 receptor agonists (GLP-1 RA), should be prescribed in addition to insulin.

Currently, GLP-1 drugs are approved for treating Type 2 diabetes but not for Type 1. While insulin remains essential for treating Type 1 diabetes, there is new thinking that weight loss with GLP-1 RAs would also enable insulin dose reduction and add cardio and renal benefits in people with Type 1 who are also overweight or obese.

Many of us will remember that people with Type 1 diabetes tended to be lean and thin but this is not always so anymore! Researchers believe that obesity in people with Type 1 has an impact on their glycaemic control and long-term health, so the prevention and treatment of overweight/obesity is a high priority in this group. Several studies are looking at the new weight loss drugs in overweight and Type 1 diabetes but more research is necessary.

The increase in overweight/obesity in Type 1 diabetes

Shlomit Shalitin, of Tel Aviv University, has shown that there has been an increase in adults and children with Type 1 diabetes who also have obesity in countries including the US, Finland, Sweden, Italy and Germany/Austria:

- In four registries for Type 1 diabetes, overweight/obesity ranged from 15.3% in Germany/Austria during 1995-2011 to 36.0% in the United States during 2016-2018
- A 2022 range of studies showed that children with Type 1 diabetes had higher total body fat mass than children without diabetes

The causes

It has been known for many years that there are several factors that contribute to weight gain in Type 1 diabetes:

- Administrated insulin itself causes weight gain
- Fear of hypoglycaemia can lead to eating more carbs and calories
- Lack of exercise
- Psychological factors
- Disruption of food regulation

We must also acknowledge the changes in treatment that have happened over the years can increase weight, such as:

- A change in the dose of insulin and matching this with the correct amount of carbohydrate, often referred to as the carbohydrate restricted diet
- The next change was an attitude of 'eat what you like and give an insulin dose to match'. The extra food increased weight and the extra insulin to deal with it also increased weight
- This was then followed by the popularity of insulin pump therapy making it easy to eat and insulin dose as needed or wanted. Again, this risks a weight increase

Obesity in Type 1 diabetes can make the risk of insulin resistance greater leading to poorer glycaemic control and an increased risk for both cardiovascular and microvascular complications.

There is also evidence that obesity plays a role in the development of Type 1 diabetes as obesity-induced insulin resistance increases the burden on pancreatic islets in people who are already genetically at risk, increasing insulin demands and starting or accelerating autoimmune destruction of the beta cells which produce insulin.



GLP-1 drugs linked to cardiovascular benefits in Type 1 diabetes

Researchers in Greece conducted a study to evaluate the association between GLP-1-based therapy and cardiovascular and renal outcomes in adults with Type 1 diabetes.

Among adults with Type 1 diabetes, the initiation of GLP-1-based drugs (weight loss drugs) was associated with a lower risk for all-cause death, several cardiovascular outcomes, all-cause hospitalisations and hypoglycaemia without a higher risk of diabetic ketoacidosis (DKA).

The evaluated drugs included liraglutide, dulaglutide, lixisenatide, albiglutide, exenatide, semaglutide and tirzepatide. The results were as follows:

- Compared with no GLP-1-based therapy, GLP-1-based therapy was linked to a 33% lower risk for all-cause death, a 39% lower risk for adapted major cardiovascular events and a 62% lower risk for heart failure
- GLP-1-based therapy was also associated with a 30% lower risk for all-cause hospitalisation, no significant differences were observed for myocardial infarction, ischaemic stroke and chronic kidney disease
- The risk for hypoglycaemia was lower with GLP-1-based therapy, however, the risk for DKA did not differ significantly between the two groups. Fewer than 10 pancreatitis events occurred in each group

The researchers recommend that further trials need to take place to confirm the cardio-renal benefits in Type 1 diabetes.

(Diabetes, Obesity and Metabolism, May 2026)

The Unpaid Carers Action Plan

The Government has published a new cross-government Unpaid Carers Action Plan aimed at improving support for England's millions of unpaid carers as part of its plans for a National Care Service.

The plan has three key points: (i) recognising carers (ii) referring them to appropriate support and (iii) helping them reach their potential. The plan aims to:

- Identify unpaid carers earlier, especially young carers
- Ensure they can access financial assistance, employment support, health and social care services and educational opportunities

There are 42 measures which recognise that unpaid carers often face challenges balancing caring responsibilities with work or education, maintaining their own health and wellbeing and avoiding social isolation. These include:

- Enabling unpaid carers to register their status on the NHS App which will enable healthcare professionals to identify them more easily, involve them in care planning and direct them to relevant support
- A new GOV.UK carers hub will consolidate information on benefits, employment rights and health and care services, while a forthcoming Carers' Charter will outline carers' rights and entitlements

From spring 2027, employers with 250 or more employees will be required to improve support for unpaid carers, helping them balance employment with caring responsibilities. Collectively, the measures aim to improve recognition of unpaid carers, reduce barriers to support and enable them to maintain fulfilling lives alongside their caring roles.



New report urges better diabetes support across England

Children and young adults with diabetes continue to experience marked variation in care across England. Now, a new national report outlines practical steps to improve outcomes, expand access to technology and standardise services for people aged 0 to 25 years.

The report emphasises that effective diabetes management during childhood and early adulthood is critical for long-term health, independence and emotional wellbeing.

There are around 56,000 children and young adults in England living with Type 1 diabetes, and a further 9,000 have early onset Type 2 diabetes.

The report from Getting It Right First Time (GIRFT) was produced with the NHS Diabetes Programme. It made an assessment of the services provided by all 42 Integrated Care Boards (ICBs) looking into how services are organised, unwarranted variation in care and sets out recommendations to support more equitable, evidence-based care.

What variations were found?

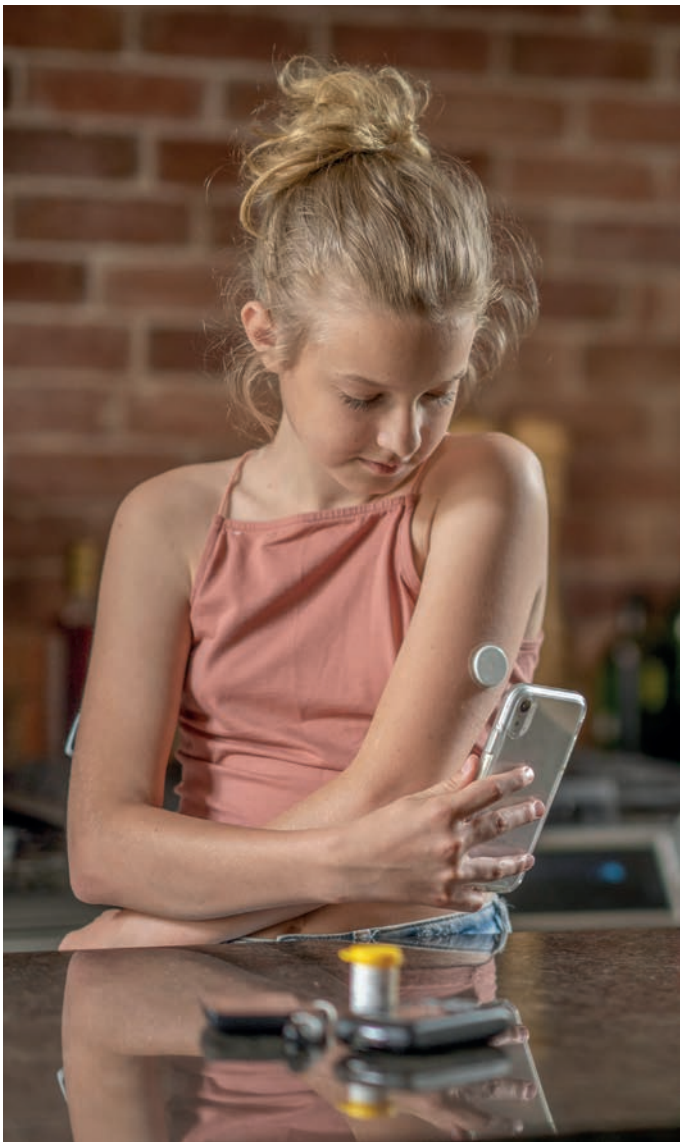
- Average HbA1c values across paediatric diabetes units ranged from 54.8 mmol/mol to 70.5 mmol/mol, suggesting considerable variation in care delivery
- Essential diabetes health checks also varied widely – some paediatric diabetes units completed all six recommended annual health checks for 98% of eligible young people with Type 1 diabetes but others only completed 6%
- There was inconsistent access to psychological professionals with diabetes expertise, as well as variations in treatment pathways and specialist therapies
- There were variations in hospital emergency admissions for diabetic ketoacidosis (DKA) and severe hypoglycaemia, with variation in implementation of inpatient protocols
- Access to hybrid closed loop technology varied despite it being recommended by the National Institute for Health and Care Excellence (NICE) and financially supported by NHS England. Uptake among children aged 0 to 18 years ranged from 37% to 79% across ICBs

The report calls for stronger clinical leadership, integrated data systems and nationally agreed minimum standards for children and young adults with diabetes, with the aim of ensuring consistent, high-quality care regardless of where patients live. (Getting It Right First Time report, August 2026)

Note from the Editor...

As editor of this Newsletter, I feel that this report cannot go without a comment! Over many years, governments have changed the NHS so that different NHS areas of England (ICBs) decide on what patients in their area can be allowed to have.

We are told that the justification for this policy is that each area can answer the specific needs of its local people. However, this report shows that it doesn't really work otherwise all children and young people with diabetes would receive the six diabetes health checks wherever they live – there would not be a difference of between 98% and 6%! Obviously, this is a postcode lottery but the report doesn't mention 'postcode lottery' but instead refers to 'variations'.



New physical activity guidelines

The UK Chief Medical Officers have published revised physical activity guidelines which reaffirm that the current recommended activity levels remain appropriate. However, they do highlight new evidence showing that even small increases in physical activity can deliver significant physical and mental health benefits.

The updated guidance places greater emphasis on the following:

- Reducing prolonged periods of sitting
- Increasing light-intensity activity
- Incorporating strength and balance exercises throughout life

The guidelines cover all stages of life, including children and young people, adults, older adults, disabled people and women during pregnancy and after birth. They also highlight that physical activity does not need to involve structured exercise but all the following contribute to better health: everyday activities such as walking, wheeling, climbing stairs, gardening, dancing, active play and household tasks.

Guidelines for physical activity by age group

Under-5s

- Infants (under 1 year) should be physically active several times every day in various ways, including interactive floor-based activity, such as crawling. Movements for infants who are not yet mobile include at least 30 minutes of 'tummy time' spread throughout the day while awake and movements such as reaching and grasping, pushing and pulling themselves independently or rolling over
- Toddlers (1 to 2 years) should spend at least three hours taking part in physical activities at any intensity each day, including active and outdoor play, spread throughout the day – more is better
- Pre-schoolers (3 to 4 years) should spend at least three hours taking part in a variety of physical activities throughout each day, including active and outdoor play. The three hours should include at least 60 minutes of moderate-to-vigorous intensity physical activity

Children and young people – 5 to 18 years

Children and young people should engage in moderate-to-vigorous intensity physical activity for an average of at least 60 minutes a day throughout the week. This can include physical education, after-school activities, play and sports. They also need physical activity to develop movement skills, muscular fitness and bone strength.

This age group should minimise the amount of time spent being sedentary and when possible, should break up long sedentary periods with at least light physical activity.

Adults – 19 to 64 years

For good physical and mental health, adults should aim to be physically active every day with activities to develop or maintain strength in the major muscle groups, which could include resistance exercises. Muscle strengthening activities should be done on at least two days a week, but any strengthening activity is better than none.

Each week, adults should have:

- At least 150 minutes of moderate intensity activity, such as brisk walking or cycling or 75 minutes of vigorous intensity activity, such as running
- Or even shorter durations of very vigorous intensity activity, such as sprinting or stair climbing or a combination of moderate, vigorous and very vigorous intensity activity
- Adults should aim to minimise the time spent being sedentary and again, when possible, should break up long periods of inactivity with at least light physical activity

Older adults – 65 years and over

Older adults should participate in daily physical activity to gain health benefits, including maintenance of good physical and mental health, wellbeing and social functioning. Some physical activity is better than none. Even light activity brings some health benefits compared to being sedentary, while more daily physical activity provides greater health and social benefits.

- Older adults should maintain or improve their physical function by activities to improve or maintain muscle strength, balance and flexibility on at least two days a week, which could be combined with sessions of moderate aerobic activity
- Each week older adults should aim to have 150 minutes of moderate intensity aerobic activity or 75 minutes of vigorous intensity activity, or a combination of moderate and vigorous activity, to achieve greater benefits

Research

Duration and age linked to risks of different complications in Type 1 diabetes

Researchers in Sweden conducted the study looking at the link between age at diabetes onset and glycaemic control on the development of microvascular complications in people who had childhood onset Type 1 diabetes. The outcome measures were diabetic retinopathy (any retinopathy and proliferative diabetic retinopathy) and diabetic nephropathy (defined as the presence of albuminuria, microalbuminuria or macroalbuminuria).

Results

- 85% of patients developed diabetic retinopathy with 19% progressing to proliferative diabetic retinopathy
- Albuminuria occurred in 45% and 12% developed macroalbuminuria
- The duration of diabetes was a significant predictor of diabetic retinopathy and also proliferative diabetic retinopathy, and chronological age predicted albuminuria
- Higher average HbA1c levels were associated with a greater risk for microvascular complications
- Female sex was independently associated with about a threefold higher risk for proliferative diabetic retinopathy but no sex-based differences were observed for albuminuria or a decline in kidney function
- Prior retinopathy doubled the risk for subsequent albuminuria and prior albuminuria increased the risk for later diabetic retinopathy

Conclusions

Researchers suggest that treatment could be planned to individual patient characteristics, especially sex and age of diabetes onset, to reduce the risk of long-term microvascular complications.

(Journal of Diabetes and Its Complications, August 2026)

Double diabetes

Insulin resistance has been independently linked to metabolic dysfunction-associated steatotic liver disease (MASLD) in adults with Type 1 diabetes. MASLD is a condition of excess fat accumulation in the liver.

Research suggests that there is a distinct, higher-risk metabolic phenotype with MASLD affecting about a quarter of the global population, however, it is estimated to affect 16% to 20% of people with Type 1 diabetes. Historically, people with Type 1 diabetes have shown lower susceptibility to insulin resistance but there is a subgroup of people who may develop insulin resistance. This is sometimes known as 'double diabetes' which is where Type 1 diabetes co-exists with insulin resistance.

Insulin resistance in MASLD

It is well known that insulin resistance is the driver of MASLD in the general population but its role in Type 1 diabetes has remained less clear. A recent study investigated this gap to assess both liver fat content and insulin sensitivity. Research analysed 39 adults with Type 1 diabetes and relatively controlled blood glucose levels and the findings were as follows:

- Participants with MASLD had markedly higher liver fat content and significantly lower insulin sensitivity
- The average glucose disposal rate was less than half in the MASLD group compared with those without liver disease

A strong inverse correlation (when two variables move in opposite directions – as one variable increases, the other decreases) was seen between liver fat content and insulin sensitivity which remained significant after adjusting for body mass index, waist circumference, age, lipid levels, insulin dose and genetic predisposition. Additional measures of insulin sensitivity reinforced these findings.

Patients with MASLD also displayed features of metabolic syndrome, including higher body mass index, elevated triglycerides, lower HDL cholesterol and increased systolic blood pressure as well as poorer glycaemic control despite higher insulin dosing.

As this was a small study, further research is needed to assess whether improving insulin sensitivity could reduce liver fat content and improve future health in this group of people.

(EMJ, May 2026)

From our own correspondents

We like to hear from you, so do get in touch by writing to: IDDT, PO Box 294, Northampton, NN1 4XS or emailing ***enquiries@iddtinternational.org****.*

So nice to hear!

Hi There,

This isn't an enquiry, I just wanted to thank you for helping me to make some sort of sense of what I can eat as a confused newly diagnosed Type 2 diabetic. I have been told to control my blood sugars with diet but came out of a meeting with a dietitian no wiser as to how I was to do this. Enter a Google search and I'm so pleased to have found you and printed off your excellent information on diabetic eating. I'm surprised and relieved to find that I don't have to starve myself or do without everything I like.

Thanks again.

By email

Looking forward to learning more!

Dear IDDT Team,

Thank you very much for sharing your Summer Newsletters and the valuable information you provide to people with diabetes and healthcare professionals around the world.

I am a Physical Education and Sports educator from Burundi and I am currently implementing a community-based diabetes prevention project which promotes physical activity, diabetes awareness and early screening among vulnerable populations.

The educational resources and updates you share are very useful for my work and will help me improve the quality of diabetes prevention activities in my community. I appreciate your commitment to supporting people affected by diabetes and advancing diabetes education. Thank you once again for your valuable work. I look forward to learning more from your publications and staying connected with your organisation.

By email

Needles and needle clippers

Dear Jenny

I noted with interest the item in Newsletter 131 regarding GlucoRx needles. My surgery switched me, and probably all other insulin pen-users, to these needles after a visit by a company rep. Like your correspondent, I have had multiple failures of the 4mm / 31gauge needles, it seems that some are manufactured badly and are blocked internally, possibly by "swarf" particles. I have also had occasions where the tip has been badly formed and is a barb not a smooth point. I have just entered a case on the "Yellow Card" system and suggest that anyone else finding the similar problems does the same – the reporting system is quite convoluted but I got there in the end.

A second point, I had the B-D "Safeclip" needle clipping device on my prescription but it seems that despite still being listed on the NHSBA drug tariff part.iXa, B-D have ceased production.

I have found a suitable alternative – the Novofine needle remover, it pushes over a used pen needle gripping the body. It can then be unscrewed and the needle ejected directly into a sharps bin with no danger of contact with your fingers. Check the internet – priced as low as £2.75 plus pp (Express Chemist) although another company want £62.12 plus £8.90 pp!

Another item of interest is a pocket-sized yellow box is another item still listed on the part.iXA drug tariff but comes back as "not available" from my pharmacy. It was very handy for needles / lancets when on holiday or simply out for an evening meal. NHS price 39p each – web price ranges from £6.50 (+pp) for qty.3 to near £50 (= £8 pp!) for qty.10 black / blue coloured ones.

By email



From our own correspondents

Catching up!

Dear Jenny,

I have finally caught up with reading the Summer Newsletter and as always, it was full of items of interest. How I empathised with the diabetes tech distress article and stress fatigue.

Annoyingly but in some cases humorously, why does my Freestyle Libre 2 sensor always alarm when I am either visiting the loo or up ladders? Does it sense that I am unable to cancel the alarm and decides to annoy me by continuously sounding? Hey, ho, far better than not receiving any alarm at all!

What I have experienced quite frequently, is the script when 'swiping' for a reading stating: 'Reading currently unavailable, try again in 10 minutes'. Ten minutes can sometimes run to half an hour! I have not contacted Abbott about this as I assume in the former case my blood sugars may be possibly moving very rapidly but in the latter case, I do not know. It does however, show a break in the daily graphs line on the reading device. The 'tech stress' issue with this is that it always seems to happen when a reading is a real necessity, i.e. insulin taken prior to a meal and should the meal now be eaten or delayed?

The Foot & Ankle Show article is of course of paramount interest to people with diabetes, especially the postcode lottery for podiatry. It is the reference to ankles and my experience which may be of interest to readers.

I am now in my fortieth year of Type 1 diabetes and my HbA1c tests show very good overall control. My wife's views may however differ! Five years ago I started experiencing difficulty and pain in my right ankle and I was referred to a consultant. The consultant's view aligned with mine and surgery was discussed, namely fusion of the joint or a complete ankle joint replacement. I was made aware that the latter option was unusual for someone with a history of diabetes, especially those of post op healing and infection risk were detailed to me. Being generally a busy person, at surgery time sixty eight years of age, climbing steps and ladders at home and coastal path walking, albeit struggling, I favoured the complete joint replacement and ten months later climbing ladders and coastal path walking again, without struggling! A salient point in all of this was good diabetes control, as without this my consultant would not have undertaken such a complex area of orthopaedic surgery.

I hope my experiences assist those who may be suffering with all manner of non-diabetes related issues, to emphasise the additional problems associated with diabetes are not necessarily a precursor of reluctance to undertake particular procedures. Evidence of good diabetes control may however negate such reluctance.

By email

Note: it certainly seems that the B-D Safeclip is no longer made, but it can technically be prescribed on the NHS for diabetes, however they are often difficult to source through high street pharmacies and availability varies significantly by local NHS ICB policies.

When research meets hope: the DREAM Trust way

In the past, many of our members have supported children and young people with Type 1 diabetes from underprivileged backgrounds. They are cared for at DREAM Trust in Nagpur in India. Dr Sanket Pendsey has reported that DREAM Trust is committed to undertaking research that can make a meaningful difference in the lives of children and young people living with Type 1 diabetes. He has announced that they are delighted to be collaborating with Dr Steven James from the University of the Sunshine Coast, Australia. Dr James visited DREAM Trust in August as part of the project.





IDDT Lottery Results

WINNERS OF THE JULY 2026 DRAW ARE:

1st prize of £452.16 goes to Jane from East Letchworth
2nd prize of £339.12 goes to Anon from Harefield
3rd prize of £226.08 goes to Anon from Worcester
4th prize of £113.04 goes to Ruth from Colchester

WINNERS OF THE AUGUST 2026 DRAW ARE:

1st prize of £454.08 goes to Anon from Chester
2nd prize of £340.56 goes to Frederick from Driffield
3rd prize of £227.04 goes to Kenneth from Porth
4th prize of £113.52 goes to John from Rochdale

WINNERS OF THE SEPTEMBER 2026 DRAW ARE:

1st prize of £461.28 goes to Anon from Cardiff
2nd prize of £345.96 goes to Ken from Luton
3rd prize of £230.64 goes to Anon from Abergavenny
4th prize of £115.32 goes to Jane from Oxted

Note: The winners of the draws for **October, November and December 2026** will be announced in our **Spring 2027 Newsletter** and on our website.

A huge 'Thank You' to everyone who supports IDDT through the lottery.

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

SNIPPETS

'Digital' NHS spends £240m a year on storing paper medical records

An article in The Times (August 2026) claimed that a think tank has discovered that more than 200 healthcare sites are entirely reliant on paper records but do not have space to store them. This is costing £240 million a year.

Weekly insulin injection to cut injections from 365 a year to just 52 for people with Type 2 diabetes

On August 20th 2026, NICE announced a recommendation which could see hundreds of thousands of people with Type 2 diabetes swapping daily insulin injections for a once-a-week jab. This change could cut the number of injections each patient needs by 85% and reduce the number of injections from 365 to 52 a year.

Insulin efsitora alfa, also known as Onswik and made by Eli Lilly, is a weekly insulin which can be used alone or alongside other treatments for Type 2 diabetes.

Four in 10 doctors struggle to give sufficient care weekly

A survey of over 4,600 doctors by the General Medical Council found that more than four in 10 doctors and six in 10 GPs said that at least weekly, they found it difficult to provide the level of care they would like.

The findings were said to be linked to "clear emotional strains for doctors, including guilt, frustration, a reduced sense of purpose and feelings of moral injury." Pressures in the working environment were to blame including inadequate staffing, heavy workloads, time spent on bureaucracy and administrative tasks and poor co-ordination between primary and secondary care.

53% said delays to providing care, treatment or

tests were the main barriers to patient care in the last year, rising to 73% among GPs. Only one in five doctors said co-ordination was currently effective and growing cases and complex systems were making things worse.

Wasted medicines could fill up 75 swimming pools!

In August 2026, the National Pharmacy Association (NPA) reported that medicines wasted in England last year could have filled up 75 swimming pools. The NPA estimated that just under 3,400 tonnes worth of partially used medicines were disposed of last year in England alone, costing the NHS over £480 million. This is equivalent to the weight of 3,000 2015 Ford Fiestas (Freedom of Information requests from local NHS Integrated Care Boards).

The NPA represent about 6,000 independent community pharmacies in the UK and have called for more regular medicine reviews for those with several repeat prescriptions to identify medicines that are no longer needed.

In addition, they have urged patients to not over order medication and instead only to order a repeat prescription when they need it.

Banning high-caffeine energy drinks to under-16s

The Government is going to introduce legislation to ban the sale of high-caffeine energy drinks (those containing more than 150mg of caffeine per litre) to children under the age of 16 in England. This follows a public consultation that received 1,095 responses.

The policy aims to improve children's health and reduce health inequalities by addressing evidence linking high-caffeine energy drink consumption to poor sleep, anxiety, reduced concentration, behavioural issues and worse educational outcomes.

Children in more deprived communities are disproportionately affected.

Retailers will be responsible for preventing underage sales and local authorities will be responsible for enforcement through civil penalties. This replaces current voluntary restrictions operated by many major supermarkets.

The ban is expected to come into force from April 2027 and will apply to sales in shops, vending machines and online but tea- and coffee-based drinks are exempt.

GLP-1 drugs – interaction risks with oral medications

Weight loss drugs, GLP-1 receptor agonists (RAs), provide benefits beyond glycaemic control and weight reduction but they are associated with gastrointestinal adverse events, including nausea, vomiting, abdominal pain, diarrhoea, constipation, bloating, belching and flatulence. Concerns also include hypoglycaemia in people receiving antidiabetic meds, rare pancreatitis, loss of muscle and bone mass, treatment discontinuation rates of 4% to 8%, weight regain after discontinuation and high cost.

GLP-1 receptor agonists may alter absorption of oral medications due to delayed gastric emptying, affecting drug levels and efficacy, a notable interaction is with oral contraceptives. Long-term information on benefits and risks remain limited and research is necessary for strategies that improve access, adherence and safety with GLP-1 RAs.



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