It is the case currently in England that the majority of patients with diabetes are managed in primary care. In our local area (Portsmouth and SE Hants), a major review led to patients with diabetes being discharged from specialist care to primary care unless their current condition or complications met certain criteria – the ‘Super Six’ model of inpatient diabetes, antenatal diabetes, diabetic foot care, diabetic nephropathy, insulin pumps and Type 1 diabetes (poor glycaemic control or young people). Therefore a large proportion of patients with diabetes who do not meet these criteria are exclusively being seen by primary care, which means the care offered in this setting must be optimised as best possible. With landmark studies such as UKPDS and DCCT proving that good glycaemic control is essential for better outcomes, and with the majority of diabetes care based in the community, both patients and care givers need reliable and acceptable methods of monitoring, measuring and interpreting glycaemic data in the outpatient and community setting.

HbA1c (glycated haemoglobin) has been used as a descriptor and indicator of risk for patients with diabetes based on the results of the major diabetes studies DCCT and UKPDS. However, HbA1c was not the mechanism by which therapeutic change was initiated or measured in these studies (DCCT used SMBG and UKPDS used fasting plasma glucose predominantly). Despite this, HbA1c has been adopted both in primary and specialist care as the ‘gold-standard’ marker of control that is easy for both clinician and patient to understand, as well as being largely comparable over time. It is currently the unit of measurement by which the primary care Quality and Outcomes Framework (QOF) audits glycaemic control for patients with diabetes, and it is understandable that this has become the driver behind the primary care consultation. However, HbA1c represents a retrospective averaged view of glucose control and as such is not a focussed tool by which day to day variations in glycaemic control can be appreciated, nor can it identify within a day where the glucose excursions are that require a change in therapeutics. To know this information requires a more direct way of observing changes in glucose levels on a more frequent basis. SMBG (self-monitored blood glucose) is a widely used and accepted method of observing glycaemia and offers a more personalised and timely view of the individual’s control. There have been many studies looking at the use and efficacy of SMBG as part of diabetes management and research overall has shown the benefits from both the simple act of taking SMBG as well as its effectiveness when applied for glycaemia, but traditionally there has still been the problem of access to, and thus the interpretation of and then action as a consequence of, this data. The key step has been with the healthcare provider (HCP) and incorporating data use into routine review, and applying this data to therapy change.

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Diabetes Research In Portsmouth
A flavour … and a request for help

The diabetes centre has a significant research programme undertaking relating to all aspects of diabetes care. Our studies are part of the national Diabetes Research Network portfolio. Glycaemic control and cardiovascular risk are particular areas of interest. Below you will see examples of three key studies that are being undertaken within the diabetes centre - one in patients with established diabetes, the other two in patients with impaired fasting glycaemia. We hope you find the studies of interest and it is likely you may have a number of patients that you may feel could participate. Our research team have given their contact details within each article should you have patients that might be interested. As always we are very grateful for any support you can provide through identifying suitable patients. Professor Mike Cummings
In this issue of the Solent Voice we would like to introduce a new exciting research project that is currently under development in our research centre. Its main aim is to investigate the effect of oral vitamin D supplementation on vascular function and markers of cardiovascular risk in patients with impaired fasting glycaemia (IFG).

The anticipated start of recruitment to this study is November 2014. Over the last few years there has been substantive scientific interest in Vitamin D as it was found to affect the function of multiple body systems. Although traditionally we have been mainly interested in its role in calcium metabolism and the management of osteoporosis, its effect upon insulin resistance, endothelial and pancreatic islet cells suggest other important roles.

Vitamin D deficiency has been linked to endothelial dysfunction, chronic vascular inflammation, insulin resistance and oxidative stress. However, there are several studies linking vitamin D replacement to the improvement in these markers of cardiovascular risk. The possible mechanisms linking vitamin D deficiency to cardiovascular disease include:

- Increase in blood pressure through activation of the renin-angiotensin-aldosterone system.
- Reduced levels of antioxidants and increased levels of reactive oxygen species that damage endothelial cells.
- Reduced secretion of insulin from the pancreatic beta cells and increased production of markers of chronic inflammation that are known to cause insulin resistance in various tissues.

In IFG some degree of endothelial dysfunction is already present but at a lesser degree than in diabetes and it might be potentially reversible with intervention. The endothelial dysfunction in IFG seems to be caused by mechanisms that seem to be also present in vitamin D deficiency (insulin resistance, oxidative stress, chronic inflammation) and we hypothesise that these might improve with vitamin D replacement.

If this hypothesis is proven, early intervention with vitamin D supplementation might provide an inexpensive public health opportunity to delay or reverse IFG progression to diabetes but also cardiovascular disease and any intervention that can potentially reduce this risk deserves attention. Interestingly, vitamin D deficiency is associated with a higher probability of future diagnosis of diabetes or metabolic syndrome in prospective population studies and is more prevalent in IFG and diabetes.

We chose to study the IFG population because of its rising prevalence in the general population. IFG is a risk factor not only for future diabetes but also cardiovascular disease and any intervention that can potentially reduce this risk deserves attention. Interestingly, vitamin D deficiency is associated with a higher probability of future diagnosis of diabetes or metabolic syndrome in prospective population studies and is more prevalent in IFG and diabetes.

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If this hypothesis is proven, early intervention with vitamin D supplementation might provide an inexpensive public health opportunity to delay or reverse IFG progression to diabetes and delay or reverse the cascade of events leading to atherosclerosis and macrovascular complications. This study is a randomised double blinded placebo controlled trial. The study period is 12 weeks comprising of 2 visits to the Diabetes Research Centre in Queen Alexandra Hospital. We aim to recruit around 70 participants.

Thank you,

Dr Eveleigh Nicholson
Clinical Research Fellow
Participants will be randomised to intervention with 3200 IU of vitamin D3 orally daily or placebo equivalent. The study dose of Vitamin D3 is safe and was chosen with the aim to achieve blood Vitamin D levels in sufficient range even in participants with very low levels (<20 nmol/l).

In fully Vitamin D sufficient participants this dose is extremely unlikely to cause any side effects and is well within the Upper Tolerable Daily limits of 4000 IU/day established by the European Food Safety Authority. Each visit will last approximately 3 hours and will involve blood and urine test for markers of insulin sensitivity, inflammation and oxidative stress. Endothelial function will be measured by a non-invasive technique, finger photoplethysmography, which is completely painless. We do not have direct access to the databases of patients with prediabetic states and therefore rely on primary care as a source of potential participants. Your GP practice might have already received our questionnaire investigating its ability to assist us with the recruitment process.

The SMS study is a pragmatic and scalable strategy using mobile technology to promote sustained lifestyle changes to prevent Type 2 Diabetes in India and the UK.

The population studied will be subjects with impaired glucose regulation aged between 18-74 years. The prevention strategy will employ a lifestyle modification programme delivered by text messaging. Text messaging has been successfully used to modify behaviour in other contexts. This study will assess the efficacy, acceptability and cost primary outcome will be the progression to diabetes. Secondary outcomes will be physical activity, other cardiovascular disease risk factors and quality of life.

Diabetes increases the risk of developing a wide range of foot complications including foot ulceration. Major leg amputation is almost universally preceded by foot ulceration. Every 30 seconds a lower leg is lost to diabetes somewhere in the world.

Diabetes related amputations have a dramatic effect on quality of life and life expectancy and are a huge financial burden to then NHS. Over £119 million is spent each year in England on diabetes-related amputations. The frequency of amputation is rising- from 5,700 in 2009/10 to over 6,000 in 2010/11 and the estimated diabetes related amputations is over 7000 in England by 2014/15 if urgent action is not taken. Portsmouth City was identified as having the second highest amputation rate in the country from 2007-2010 according to the data published in early 2011.

Taking this challenge of reducing the amputation rates in our area the diabetes service has identified many of the problems leading to amputation and attempted to correct them. This has led to a re-structure of the foot care pathway. Local problems identified:

• Inadequate multidisciplinary (MD) diabetic foot care clinics. One provided away from the major hospital site each week.

• A foot care pathway that directed patients with new diabetic foot ulcers and unexplained foot disease to a community-based podiatry service and only on to a specialist MD clinic when there was failure to heal or an added complication.

• A lack of dedicated foot care education for people with diabetes which was leading to a lack of self-care and awareness of foot problems.

• Low rates of referral and late referrals to specialist podiatrists (An audit of diabetic patients undergoing major amputation revealed that only 50% of patients with major amputations had seen a podiatrist and less than 5% had attended a MDT clinic).

• Low rates of foot examination in primary care and a lack of education for health care professionals around the identification and management of diabetic foot disease.

• Delayed and inadequate access to orthotic services for provision of appropriate insoles / footwear for pressure offloading.

• Poor access to Orthopaedic specialists and limited access for “gold standard” offloading by “total contact casting” for patients with troublesome diabetic foot problems.

The responses so far have been fantastic and we can’t wait to get started. Once we have all the necessary approvals in place we will approach practices that are able to help with a request for a database search for our inclusion criteria and to distribute the study information packs to potential participants.

In the interim, if you come across patients with a diagnosis of impaired fasting glycaemia between 18-74 years of age who would be interested in getting involved in this or other future IFG studies please do not hesitate to provide our contact details.

If you have any questions about this study please don’t hesitate to contact me: jana.bujanova@porthosp.nhs.uk or 02392 286260

Dr. Jana Bujanova
Clinical Research Fellow

Victoria Hunter
Diabetes Research Nurse
Service Changes

The development of a new pathway of care was established to direct every patient with a diabetic foot ulcer or suspected acute Charcot disease to a specialist MD clinic comprising an advanced diabetes podiatrist & Diabetologist.

This service incorporates the following links
- Within 24 hour Radiology reporting
- Immediate microbiology advice (Infection management)
- Immediate or early access to vascular surgery (Consultant opinion and next-day rapid access vascular clinics)
- Access to Orthopaedic opinion and contact casting through the creation of additional urgent diabetes-related orthopaedic slots
- Improved access to orthotics services through fax and email referral
- Improved links to community podiatry with access to specific diabetes foot clinics and intensive therapy clinics
- Dedicated access to specialist nurse review for glycaemic control issues.

There has also been a commissioned uplift in MD clinics from one to three per week and a relocation to the acute hospital site to enable rapid and easy access to the range of specialists required to deliver high quality foot care.

As part of a comprehensive diabetes education portfolio we have pioneered four half-day education modules around foot disease each year. These incorporate an explanation of the foot care pathway as it applies to a range of at-risk and diseased feet, a practical assessment of the foot plus education on the management of diabetic foot disease and neuropathic pain. These courses are provided free of cost to all HCPs in our locality.

Self-care is enormously important in both the identification of foot problems and the early treatment. Foot education is provided directly to patients at DESMOND courses which is an education programme for all new patients with Type 2 diabetes in our area.

Foot care issues will also be highlighted at refresher courses being set up to educate patients with pre-existing diabetes who may not have attended DESMOND or may require updates. Within Portsmouth there is a strong body of patients with diabetes who have set up an annual patient conference. This has also provided the opportunity for an update on foot care issues.

Graph: Major Amputations Performed During The Three Year

Early Results

Over a three year period the rate of major amputations in Portsmouth has fallen from 2.3 per 1000 adults with diabetes to 1.4 per 1000 compared against the national average of 1.1.

Repeat hospital admissions for diabetic foot disease are comparable to the national average for the first time.

<table>
<thead>
<tr>
<th>Major Amputations Performed During The Three Year</th>
<th>Annual amputations per 1,000 Adults with diabetes</th>
<th>Episodes of care where an amputation is performed on those with diabetes</th>
<th>Episodes Of Care For Diabetic Foot Disease</th>
<th>Annual episodes of care for diabetic foot disease per 1,000 Adults with diabetes</th>
</tr>
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<tr>
<td>---</td>
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</tr>
<tr>
<td>August 2011</td>
<td>2.3</td>
<td>1.08</td>
<td>5.7</td>
<td>2.7</td>
</tr>
<tr>
<td>January 2012</td>
<td>2</td>
<td>1.01</td>
<td>5.2</td>
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<tr>
<td>January 2013</td>
<td>1.4</td>
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<td>4.3</td>
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<tr>
<td>January 2014</td>
<td>1.3</td>
<td>0.9</td>
<td>4.3</td>
<td>2.6</td>
</tr>
</tbody>
</table>
Discussion
The majority of the diabetes related amputations are preceded by foot ulceration. Amputations may be prevented by the early discovery and appropriate intervention during the at risk stage.
Comprehensive education of all patients about diabetic foot problems to improve self-care is important. Regular appropriate assessment in primary care to identify a person’s foot risk with onward referral to a foot ulcer prevention team.
Once a foot ulcer has occurred early and appropriate intervention by a wide range of health care professionals (podiatrist, orthotist, tissue viability nurse, Diabetologist, vascular surgeon, orthopaedic surgeon, radiologist, microbiologist, community nurse and general practitioner) contribute to the reduction in amputation rates.
Improvements in some of these areas may have contributed to this dramatic reduction in amputation but much work remains to be done if we are to best serve our diabetes population locally.
All patients with diabetes and a foot ulcer or with suspected acute Charcot disease should be referred directly to the MDT via the Diabetes Centre.

DIABETES FOOT REFERRAL PATHWAY
Portsmouth and South East Hampshire v1 2013

Foot assessed as AT INCREASED or HIGH RISK NICE 2004 Diabetes Foot Assessment Score >10

DIABETIC FOOT ULCER
If mild to moderate infection
• Initiate Empirical antibiotics
• Deep wound swab
• Review response
(Foot ulcer = below malleoli)

SEVERE INFECTION
• Patient systemically unwell
• Spreading infection despite antibiotics
• Deep abscess

References
1. www.idf.org/webdata/docs/T2A_Introduction.pdf

Dr Malik Humayun
Dr Darryl Meeking

Solent Podiatry Service
Referral by letter or fax
The Adelaide Health Centre
Western Community Hospital Campus
William Macleod Way, Southampton, SO16 4XE
Fax: 023 80538746
Tel: 023 80608800

Diabetes Multidisciplinary Foot Clinic QAH
Referral by letter / fax / phone as indicated by patients’ condition to Dr Meeking at the Diabetes Centre, Queen Alexandra Hospital
Tel: 023 92286260
Fax: 023 92286791
Clinical advice from Podiatrist available on: 07810 656019 or 07770 581507
Referral form on PIP or by GP Summary + letter with details incl. foot neuro/vasc/infection status

Admission via Surgical Assessment Unit
Queen Alexandra Hospital
Contact SAU Coordinator for admission to SAU
Tel: 023 92286000 Bleep:0050
ACUTE CRITICAL ISCHAEMIA
Features include the following:
- Discoloration of toes (pale, dusky, black)
- Signs of necrosis
- Pain at rest (often at night)
- Cold
- Diminished / absent pulses

HOT SWOLLEN NEUROPATHIC FOOT
(Suspect CHARCOT)
Features may include:
- Pain on walking when usually neuropathic
- Adequate blood supply
- Recent minor trauma

Vascular Team
Mr Gibbs, Mr Payne, Mr Pemberton, GC Whitbread, Mr Grewal
Rapid Access clinic runs weekly for urgent cases
Referral by letter / fax / telephone as indicated by the patient’s condition
Tel: 023 92286400
Fax: 023 92286263

Diabetes Foot MDT Clinic
Referral by letter / fax to Dr Meeking at the Diabetes Centre, Queen Alexandra Hospital
Tel: 023 92286260
Fax: 023 92286791

Why refer to an MDT?
- The risk of a lower extremity amputation in a person with diabetes is more than 20 x that of a person without diabetes
- 95% of all non-traumatic amputations start with a foot ulcer

DIABETES AND DEPRESSION

According to NICE, people diagnosed with a chronic physical health problem such as diabetes are three times more likely to suffer from depression than people without. Depression not only affects your brain and behaviour, it affects your entire body. Dealing with more than one health problem can be difficult. Therefore correct treatment for depression is extremely important holistically.

Studies show that diabetes and depression are linked, but scientists are yet to know if depression increases risks of diabetes or diabetes increases risk of depression. Current research would suggest both cases are possible. The stress of managing diabetes every day and the effects of diabetes upon the brain may contribute to depression. At the same time symptoms of depression may reduce overall physical activity, increasing risk of weight gain and possible diabetes and if diabetes is pre-existing this could make glycaemic control worse (2).

Evidence suggests depression has a significant impact upon the development and subsequent management of Type 2 diabetes, as well as showing an increase in morbidity and mortality in those with CHD (4). This may be due to self-care issues but is also being recognised affecting vascular health via activation of counter regulatory stress hormones over time.

People with diabetes suffering from depression are at a greater risk of diabetes burnout which collectively can have adverse effects on physical health and potentially lead towards long term complications of diabetes.

The concept of diabetes burnout has been described as the state of disillusion, frustration and submission to diabetes. Diabetes burnout is often reached after numerous years of dealing with the condition and often highlighted due to disregarding blood glucose levels and neglecting their diet.

Research has found that people who suffer from both diabetes and depression have poorer metabolic and glycaemic control, in turn, which has been found to intensify symptoms of depression. Anti-depressants have also been found to have adverse glycaemic effects causing multiple problems for self-management.

Blood glucose monitoring therefore is a useful tool to enable appropriate OHA/insulin titration. Some antidepressants also cause weight gain as a side effect such as:
1. Tricyclic Antidepressants
2. Monoamine oxidase inhibitors (MAOIs)
3. Paroxetine
4. Mirtazapine

If a patient has Type 2 diabetes this may cause further problems when trying to gain good glycaemic control.

It has previously been reported that depressed people with diabetes are less likely to adhere to medication and diet regimens and subsequently have a reduction in quality of life and increased health care expenditure (3). Research has shown by addressing depression, glycaemic control is enhanced, mood and quality of life is significantly improved.
Identifying diabetes burnout using the PAID (Problem areas in diabetes) scale can assist a clinician to help the person review their diabetes self-management problems and provide a basis for discussion to aid reduction in the burden of these areas (1). 7 quick questions that may help understand diabetes burnout:

1. Consider what particular areas of diabetes are causing you problems – usually it is not all of it! Then develop steps for sorting these areas. Get help if needed.
2. What else is happening in your life that might be conflicting with diabetes care, or making it harder?
3. How might you address these things?
4. What are your expectations for your diabetes management? Do you need to lower or increase your expectations?
5. What sorts of thoughts and feelings are you having about diabetes.
6. How are you managing these and are these strategies working? What have you tried?
7. Do you have any support? Is it the right support? Is it enough support? If not, how can you get this?

There are many very successful treatments for depression available but each case needs individual assessment. The following methods may be used to treat depression caused by diabetes:

1. Exercise
2. Talking therapies/ counselling
3. Self help/ support groups
4. Antidepressant medication
5. Combination therapy
6. Mental health teams

In treating depression or burnout in patients with diabetes, help to manage their condition and improve their overall health. Raising mood levels will improve motivation and in turn improve blood glucose control. All kinds of treatment will take time but will be effective in improving their overall diabetes management.
Health care providers can guide their patients in the art of setting individualised and realistic targets and goals and ultimately lead to supporting on-going improved health. Just remember even a small improvement in blood glucose levels can improve long term outcome, keep goals and targets realistic.

In Portsmouth we offer numerous education programmes for those patients feeling the burden of diabetes, these include JIGSAW (Juggling insulin goals for success and wellbeing) for patients with Type 1 diabetes as well as a Type 1 day for those diagnosed within a year. Future developments as part of the best practice tariff we will be offering support to those patients admitted with hypoglycaemia or diabetic ketoacidosis as this may help highlight some ongoing problems.

References:

CARBOHYDRATE AWARENESS AND COUNTING GROUPS

Who are these groups for?
All people with Type 1 or 2 diabetes who wish to understand more about which foods affect their blood glucose levels and how to balance their carbohydrate intake with their lifestyle and/or diabetes medications.

What format are the groups?
Groups last up to 3 hours. They are run by Specialist Diabetes Dietitians along with a Specialist Diabetes Nurse. They are informal and group discussion and interaction is encouraged. Those people who have attended these groups have found them enjoyable, informative and helpful.

When and where do the groups run?
Group dates and venues for the next few months are as follows:
- 22.7.14  9.30am  QAH
- 10.9.14   9.30am  Southsea Medical Centre
- 14.10.14  9.30am  QAH
- 25.11.14  9.30am  Gosport War Memorial

How do my patients get on to these groups?
You or your patient simply need to call the Diabetes Centre on 023 92286260 to book on to the most convenient course. A patient information sheet is available on PIP.

Participants had improved understanding and confidence after the groups:
- Knowledge of which groups of foods contain carbohydrate increased from 25% to 70%.
- Confidence in knowing how much carbohydrate they are eating at different meals increased from 4.5/10 to 8.7/10.
- 100% of participants felt that the group was helpful in helping them to manage their diabetes (72% very helpful).

Do the groups benefit patients?
What our participants have said ...

An excellent morning. Learned a lot.

Very interesting. I have learnt a lot more to help me manage my diabetes.

First Class!

Sue Beaden, Jeanette Head Specialist Dieticians
<table>
<thead>
<tr>
<th>COURSE TITLE</th>
<th>COURSE DATES</th>
<th>TIME</th>
<th>VENUE</th>
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</thead>
</table>
| **Diabetic FOOT DISEASE**  
Half-day course  
Sponsored by Pfizer and Lilly Pharmaceuticals | Monday 7 July 2014  
Monday 6 October 2014  
Monday 15 December 2014  
Monday 23 February 2015 | 13.30 – 17.00 | QAH |
| **EFFECTIVE MONITORING in Diabetes**  
Half-day course | Dates to be announced |  |  |
| **Diabetes Care for the HOUSEBOUND/RESIDENTIAL & REST HOME PATIENT**  
One-day course | Thursday 3 July 2014  
Thursday 20 November 2014 | 09.00 – 16.30 | SJH |
| **Diabetes in HOSPITAL INPATIENTS**  
1 ½-day course, attendance required on both days | Tuesday 7 October & Wednesday 8 October | 09.00 – 18.00  
09.00 – 13.00 | SJH |
| **Diabetes for NON-REGISTERED HEALTHCARE PROFESSIONALS**  
Half-day course | Tuesday 21 October 2014 | 09.00 – 13.00 | QAH |
| **Diabetes PHARMACOLOGY**  
Half-day course | Tuesday 2 September 2014  
Tuesday 2 December 2014  
Thursday 5 March 2015  
Thursday 4 June 2015 | 09.00 – 12.30 | QAH |
| **Diabetes in PREGNANCY**  
Half-day course | Friday 23 January 2015 | 14.00 – 17.00 | TBA |
| **NINE CARE PROCESSES for Diabetes**  
Half-day course | Thursday 14 August 2014  
Thursday 9 October 2014  
Thursday 13 November 2014  
Tuesday 3 February 2015 | 09.00 – 12.30 | QAH  
SJH  
SJH  
TBA |
| **IMIT - 2D (Initiating & Managing Injectable Therapies)**  
Two-day course, attendance required on both days | Fri 26 Sept & Thurs 2 Oct 2014  
Wed 26 Nov & Tues 2 Dec 2014  
Wed 25 March & Wed 1 April 2015 | 09.00 – 17.00 | QAH  
CFP  
TBA |
| **IMIT - 2D Update**  
Half-day course | Thursday 31 July 2014  
Wednesday 4 February 2015  
Wednesday 3 June 2015 | 12.30 – 17.30 | QAH  
TBA  
TBA |

**IMIT is aimed at** HCPs, GPs, Drs and nurses who have already completed some diabetes training and are going to be managing and initiating insulin and other injectable therapies.

**Venues:**  
QAH (Queen Alexandra Hospital)  
SJH (St James’ Hospital)  
CFP (Cowplain Family Practice)

**Visit our website at:**  

**To register, complete and return the Registration Form on our website**

**Queries? Contact Caroline Parnell via email:**  
caroline.parnell@porthosp.nhs.uk
**Diabetes Winter Conference**

‘*Diabetes Through the Ages*’

**Friday 28th November 2014**

at the Hotel Marriott, Portsmouth

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**Annual Diabetes Patient Conference**

Each autumn with the invaluable help of the local diabetes groups, we organise a Patient Conference held in the large entertainments hall at St James’ Hospital. This is a popular event for all those who regularly attend and we would like to make sure that all people with diabetes have this opportunity.

The purpose of the conference is to provide lay people with an interest in diabetes to meet others and exchange experiences and stories whilst having the opportunity to gain more national and local diabetic related knowledge and information.

The content of the conference is planned around feedback from last year. By popular demand we will again include the ‘speed dating (questioning) drawing on the experience of Consultants, GP’s, Diabetes Specialist Nurses, Podiatrists, Dentists and Dietitians. We have invited Dr Lorraine Albon, Diabetologist to discuss Diabesity and treatments. We have dietitians who are able to provide the latest information on diet, plus much more. Professor Ken Shaw has always been a wholehearted supporter of this event and is hoping to join us again to meet popular demand.

This years Diabetes Patient Conference will be held on **Thursday November 6th** at **St James Hospital** in the Entertainments Hall.

We are dependant on you as Health care Professionals to promote and advertise this event within your surgeries and Health Centres. We will be sending you posters (with details of how to book a place) to display within your waiting areas.

**Sarah Moutter DSN**
Diabetes Specialist Nurse PHT

**Jane Egerton DSN**
Diabetes Specialist Nurse Southern Health Care

**Debbie Fishwick DSN**
Diabetes Specialist Nurse Southern Health Care

**Alison Tier DSN**
Diabetes Specialist Nurse Solent Health Care

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**EDITORIAL TEAM**

*Academic Department of Diabetes & Endocrinology*

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Portsmouth PO6 3LY

[www.portsmouthdiabetes.com](http://www.portsmouthdiabetes.com)

Tel: 023 9228 6260

email: davina.irish@porthosp.nhs.uk

**Professor Mike Cummings**

Consultant, Diabetes & Endocrinology

**Dee Irish**

Diabetes Centre Administrator

**Jo Buchanan**

Diabetes Specialist Nurse

**Dr Lina Chong**

Research Registrar
### Basal Bolus Insulin Conversion Groups

For people with type 1 and type 2 diabetes who wish to change their insulin to a basal bolus regimen. Goals based programme with dietetic and nursing input focussing on carbohydrate counting. Accessed by proforma.

### Rapid Access (URGENT)

Urgent cases eg new onset type 1 diabetes, mild DKA may be discussed with any member of the diabetes team to decide the best course of action.

**Provided By:**
- Rotational basis via specialty DSN team.

### Pregnancy

Usually seen within one week of referral. Please refer ASAP 9228 6000 x4553 or 4584 since early review is essential. The service also provides pre-pregnancy counselling for all diabetic women of child bearing age.

**Provided By:**
- Prof. Mike Cummings
- Sarah Moutter
- Anita Thynne
- Jeannette Head

### Foot Clinic

Patients can be referred by any member of the community diabetes team, usually via podiatry. Urgent slots will be kept for urgent cases.

**Provided By:**
- Dr. Darryl Meeking
- Sharon Steele

### Type 1 Diabetes Intensified Insulin Education Service (JIGSAW)

Goals-based 22-hour intensive insulin education package open for patients with type 1 diabetes using multiple daily dose insulin therapy, but who are unhappy with their achieved control. Access either by DSN referral or patient self referral (both by proforma to Caroline Parnell).

**Provided By:**
- Dr. Iain Cranston
- Lisa Skinner
- Anita Thynne
- Sue Beaden
- Jeanette Head

### Young Persons

STYLE (Safe Transition to Young Adult Life) is a multidisciplinary transition clinic held monthly at QAH and tri-annually at Gosport War Memorial Hospital. Weekly nurse-led clinics are also held at QAH and six-weekly at Portsmouth University Surgery. SARB (Safe Approach to Risky Behaviour) educational sessions may be accessed at QAH and Portsmouth University to educate on safety measures that can be taken while indulging in behaviours such as drinking alcohol, attending festivals, body tattoos and piercings etc.

**Provided By:**
- Dr Partha Kar
- Dr Lorraine Albon
- Anita Thynne
- Jeanette Head

### Low Renal Clearance Clinic

Assessment and follow-up for optimised metabolic management of patients with diabetes and renal impairment (eGFR 20-40) with liaison to renal services in-clinic.

**Provided By:**
- Dr. Iain Cranston
- Joanne Buchanan

### Insulin Pump Service

Assessment / initiation and follow-up service (as per NICE guidelines) for patients wishing to consider pump therapy (after education through the JIGSAW service).

**Provided By:**
- Dr. Iain Cranston
- Lisa Skinner
- Sue Beaden

### Cardiovascular Clinics

For diabetic patients with established CVS disease or who are at high CVS risk who require specialist advice (including patients with microalbuminuria)

**Provided By:**
- Prof. Mike Cummings

### Erectile Dysfunction Clinic

For any diabetic patient that has not responded to oral therapy.

**Provided By:**
- Prof. Mike Cummings
- Sarah Moutter

### Painful Peripheral Neuropathy Groups

One off group sessions examining the causes of and available treatments for painful peripheral neuropathy. Focus also on foot care and risks associated with sensory loss.

**Provided By:**
- Mandy Morcombe DSN

### Desmond (Type 2) Education Sessions

Whole day group education sessions for people newly diagnosed with type 2 diabetes. Booked through the Diabetes Centre:
- 02392 286260 Portsmouth City, Tuesday – Friday.
- 01329 224548 Fareham & Gosport, & East Hampshire. Zoe / Caron.

**Provided By:**
- Sharon Allard
- Sarah Moutter

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**THE FOLLOWING SERVICES ARE ALSO AVAILABLE FOLLOWING INITIAL ASSESSMENT / REVIEW BY THE SPECIALIST NURSING TEAM**

### Basal Bolus Insulin Conversion Groups

For people with type 1 and type 2 diabetes who wish to change their insulin to a basal bolus regimen. Goals based programme with dietetic and nursing input focussing on carbohydrate counting. Accessed by proforma.

**Provided By:**
- Anita Thynne
- Sarah Moutter
- Jeanette Head