THE PATIENT GROUP (PPG)

of Queen Edith Medical Practice (QEMP): Complementing the Work of the Practice

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Welcome to our first Newsletter of 2019.

Important Announcement

After 16 superb journals, our Editor, Roger Crabtree, has hung up his quill pen as heralded during the last year. So, this esteemed journal is under new management. My instinct is to change little of the style and approach (why change a success?) and to allow the Newsletter to evolve slowly. Even just thinking about this edition has created a long list of articles that we might do this year and even next year. In addition, I am keen that we should start (in the next edition for example) to give an opportunity to one or two other members to make contributions; if you are willing to take part in this way, please let me know.

Content

1. Our main feature in this edition will be an overview of Type 2 diabetes which can have a potentially shocking effect on people and on the Health Service.
2. We have an update on Addenbrooke's
3. Practice News – very brief this quarter
4. We have indicated some subjects that we may address in other editions this year
5. Our first Talk for 2019 is due soon and is announced here.

Requests To You

Please do not hesitate to pass this Newsletter on to friends and neighbours. Anyone registered at QEMP may become a member of the Patients Group and a (very short) form giving name, e-mail, phone number and signature is all we ask for (please note that the only reason we request a phone number is that a name or an e-mail address might not be sufficiently clear and we would use the phone number just to check this).

Additionally, please note that our Talks are public events. We post notices about them and cannot realistically object to patients from other practices coming along; nor do we want to.

Diabetes

Diabetes, and especially Type 2 (the most common form), may well be the greatest scourge of modern times, especially in the more developed nations of which UK is one. Almost four

million people have been diagnosed and Diabetes UK estimates that about one million more have the condition but have not yet been diagnosed; it also estimates that about twelve million are at risk of developing it.

The fact that diabetes is linked to the pancreas was only clarified in 1899 and that diabetes results from a deficiency of a single chemical (it was called insulin) from the pancreas was demonstrated in 1910. The first treatment, insulin derived from an ox, was given to a patient in 1922. Insulin from animals is slightly different from human insulin and was the only available treatment for many years.

In 1935, a researcher called Himsworth demonstrated that there are two forms of diabetes. We now know that Type 1 diabetes (*sometimes called juvenile diabetes*) is caused by an inability to make insulin because of destruction of the key cells in the pancreas. It has to be treated with an injection of insulin and, since 1982, human insulin produced in fermenters by modified bacteria has been used. Type 2 diabetes (*sometimes called adult-onset diabetes*) occurs in people who make insulin but it is inefficiently used in their bodies. The role of insulin (in all patients) is to transfer sugar that is circulating in the bloodstream into the cells of the body to provide energy for them to function (blood sugar comes from sugar itself in the diet or in drinks or is derived from carbohydrates including starchy foods). Excess sugar (more than is needed to survive) is stored as fat.

Disclosure: I make no secret of the fact that I am a Type 1 diabetic testing my blood sugar three to five times a day (stabbing my fingers to get drops of blood for analysis in a hand-held device) and injecting insulin two/three times each day. The odd thing is that I developed the condition long after childhood - just 16 years ago; this is relatively rare and mostly it is diagnosed in childhood. There are suggestions that it can be triggered by keeping out of the sun (a possible link therefore to levels of Vitamin D which is synthesised in the skin) and some viruses have also been suggested as causes.

According to Diabetes UK, Type 1 diabetics account for around 8% of all diabetics in developed countries like the UK. Type I diabetes is caused by an autoimmune attack on insulin producing pancreatic cells and is not caused by excess sugar consumption (autoimmune implies a malfunction of the immune system and a few quite common diseases are caused by this phenomenon).

In contrast, Type 2 diabetics make up 92% of diabetics in the UK. It is stated in all the relevant literature that Type 2 diabetes is closely associated with being overweight (Body Mass Index over 30) and even more so with morbid obesity (Body Mass Index above 40).

Calculating your BMI

First weigh yourself in kg and measure your height in metres; then divide your weight by the square of your height. For example, if your weight is 78 kg (12st 4lb) and your height is 1.75 m (5ft 9in) your BMI ($78/1.75^2$) is a smidgeon above 25.

But note that it is possible to have a high BMI and be superfit – like international rugby forwards who are extremely lean and muscular rather than carrying a great excess of fat – but have to be careful when they retire! An even simpler approach is one's waist measurement; more than 31 inches in women and 37 inches in men is considered to increase the risk of several health issues including Type 2 diabetes. It typically used to appear in middle age but is becoming increasingly common among younger people and some children as young as ten years old are being observed with the condition in UK.

People with BMI over 30 used to be quite rare in the days when there was no central heating, houses were not well insulated and few had cars so that walking, biking and buses were the common means of movement and many jobs were manual. Additionally, fast food and home delivery of prepared meals (in large or jumbo portion sizes) washed down with very sugary drinks are relatively new developments.
Healthcare professionals are nervous about the explosion of obesity and type 2 diabetes because the consequences for health are very serious. Excess blood sugar (which can easily be measured by a nurse – it takes a few seconds) can cause damage to the narrower blood vessels in the body. These are found particularly in the eyes, brain, kidneys and lower legs. When they are blocked the consequences can be blindness (eye), strokes (brain not getting enough blood), transplant or dialysis (kidneys) and amputation (feet or below the knee). These issues have enormously costly medical treatment implications and great distress for the sufferer and her/his loved ones.

But, every healthcare professional tackling Type 2 diabetes faces the same issue (lack of recognition of the risk). There is a sub-set of the population with some increase in blood sugar who are called pre-diabetic and they receive dietary advice. People with high blood sugar levels are actually diabetic but may experience no overt symptoms for many years and do not realise the growing risk they are exposed to *"but, I feel fine nurse"* is frequently heard from them. They are treated with dietary advice, or pills or (in some cases) insulin. So what can be done?

The task is educational. Listen to people interviewed in a major article in the Sunday Times recently:

- Colin was diagnosed with Type 2 at 31 years old *"I didn't understand it, I didn't want to understand it. So I ignored it."* At his heaviest he was 30 stone and 20 years after diagnosis the lower half of one leg was amputated. Colin says *"I'm entirely responsible for my own downfall. I had a terrible attitude. My attitude to sugar was as bad as a junkie's to heroin".*
- Yian Jones was diagnosed at the age of 21 *"It didn't sound serious and it didn't feel serious"*. His weakened bones resulting from nerve damage in his leg resulted in Charcot foot. *"My life is a succession of hospital visits, dealing with infections and fractures, I've just had another big operation. The bone in my left foot had twisted and broken through the skin."* He faces amputation. *"I can't work … I can't get out of the house."*
- Yian also said his life has been ruined by a disease he didn't take seriously enough. He is now determined to warn others of the dangers. *"but they haven't got a clue*," he says.

According to the article, there are now (nationally) a record 169 amputations every single week.

Further information can be found in many places on the internet but perhaps one of the most comprehensive and reliable is www.diabetes.org.uk/guide-to-diabetes/

We intended to publish the numbers of patients with diabetes but, unfortunately, the Practice was not able to prepare the data in time for this edition. Hopefully, we can report these numbers next time.

If you know someone with diabetes or a weight problem or both, you might wish to show them this article or recommend having a quick test done.

Addenbrooke's

Cambridge University Hospitals NHS Foundation Trust (to give it its full and official title) includes Addenbrooke's itself, the Rosie and a range of additional services in the community. There are upwards of 10,000 employees in the Trust and of course many more in research and business organisations on the Biomedical Campus.

Apart from providing a service to Cambridge and the surrounding areas (covering an estimated population close to 600,000) the Trust is a major trauma centre for the East of England, a leading national centre for specialist treatment for rare or complex conditions and also a university teaching hospital.

The Care Quality Commission (CQC) carried out an inspection in November 2018 and its report was issued on 26th February 2019. Ratings were given under the headings Safe, Effective, Caring, Responsive and Well-led. Two (Caring and Well-led) were deemed to be Outstanding, two (Safe and Effective) received the grade Good while one (Responsive) was considered as Requires Improvement. The overall rating was Good (the same as in the previous inspection).

Eight specific services were rated Good and one (End-of-life care) as Outstanding. So, overall, that looks like a pretty good performance and it is worth noting that Outstanding is quite a rare accolade.

Any readers wishing to learn more about this report can find the full details at: https://www.cqc.org.uk/sites/default/files/new_reports/AAAJ0418.pdf

Quite separately, we should comment on issues arising through the winter season (mostly after the Inspection mentioned above).

One area in which Addenbrooke's has regularly found it difficult to meet national targets has been A&E where the target is for 95% to have been treated within 4 hours of entry. July 2017 is the last month in which that target was achieved by "our" hospital and it fell below 90% as far back as November 2017. In January of this year the level achieved was 81.5%. That may

seem poor but the number of attendances (patients turning up) was a record for any month ever and nearly 14% more than in January 2018. National statistics seem to show higher attendances in most hospitals (and Addenbrooke's notes that the increase is greatest in paediatric patients).

What can be done about this? If more people keep coming, performance against target is likely to decline. The hospital's plan emphasises that GP and other services (such as 111) need to be involved in less difficult cases which clog up the A&E system. Discussions appear to be underway on this point involving the CCG, Addenbrooke's and the Cambridge Federation (a group of General Practices of which QEMP is a member).

On the other main targets, Addenbrooke's missed them in January but was doing better than the national average.

- Patients starting cancer treatment within 62 days of urgent GP referral – Addenbrooke's 81.5% versus target of 85% and national score of 76.2%
- Patients having planned operations & care within 18 weeks of referral – Addenbrooke's 89.3% versus target of 92% and national score of 86.7%.

Practice News

The big Practice news of course is the long-planned extension of the surgery with the addition of several additional consulting rooms. But, as many of you will have realised, this is a disruptive procedure and the staff are having to work very hard to keep things running with a clear focus on patient care. In such circumstances, it has not been possible for us to obtain this part of our Newsletter in sufficient detail.

We hope to be able to issue a full update in the next Issue – towards the end of June.

Future Subjects

Sometimes it is not good to be too specific about plans ahead because so many things change. Indeed, I am reminded of something said by Yogi Berra (not the cartoon star, Yogi Bear, but a baseball player and, later, team manager after whom the bear was named). He said "It's very difficult making predictions – (pause) - especially about the future".

Subjects under consideration for this year (we plan four editions in total) could include:

- How does the NHS compare with healthcare in other countries?
- You might have heard about the NHS five year plan and the NHS ten year plan – perhaps we can find out the key points and what that means for us.
- Vaccination! A lot has been said in social media on this subject and some of it is untrue and potentially dangerous

- Health screening – what and why is it done, what can we expect and do we do enough of it?

If you have any ideas or suggestions, let me know and we will see if we can get the relevant information and do something useful (but, of course, the more obscure something is the less appropriate it is for inclusion).

Our Next Talk

Put April 10th in your calendar/diary. This will be about first aid in the home. Parts of it will be very relevant to parents with younger children. Our speaker will be Howard Sherriff, former Director of A&E at Addenbrooke's. Howard is a member of our Committee and also represents our Group on the Cambridge Area Patient Group (which, as an umbrella body, represents the PPGs of most Cambridge practices in meetings with the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG). He will be discussing and demonstrating techniques for common domestic emergency health issues.

St James Church in Wulfstan Way. 6.30-8.00 pm on April 10th

The Poster about this talk is attached for your information. It will be being placed in various sites around the neighbourhood and is being highlighted by the Queen Edith Community Forum in its Weekly Events bulletin (see http://queen-ediths.info/).

Further talks are planned this year in July and September/October
Watch out for the announcements.

A Final Thought

'Practices of all types and sizes need PPGs; insights from patients are essential to ensuring a high quality service, and patients can also bring ideas and actions that directly help other patients. Think about joining your PPG if your practice has one, and about starting one if it does not'

Richard Baker: Professor of Quality in Health Care, Department of Health Sciences, University of Leicester.

If you have any comments on this Newsletter please send them to me at the address shown on the first page

Alan Williams, Chair