



## Editorial

Welcome to the Autumn edition.

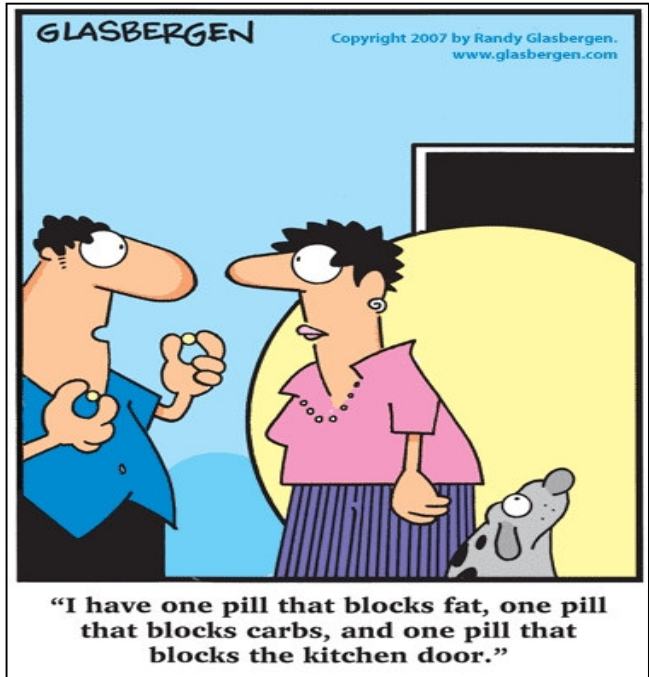
I will be finishing as Editor of Newsweet following the *next* edition. I will have completed two years of service. If anyone is interested in becoming Editor, please contact the NZSSD Executive. There is excellent support and an opportunity to express your views in print.

For now, please enjoy the latest contributions. We again focus on childhood obesity. Northland is one of the few regions in the country to have a dedicated paediatric clinic for overweight children, thanks largely to the energies of Vicki Cunningham. She has summarised her successes for us. Please consider supporting Robert Scragg's petition.

On a different theme, Adrienne Coats of our Northland team reports on a conference on in-patient diabetes management and we have reports from DNSS and NZSSD.

Lastly, don't forget to enrol for the NZSSD meeting in Dunedin (details pg4).

*Nicole McGrath*



## Healthy Lifestyle Programme (HLP)

*Vicki Cunningham, Paediatrician*

Since 2003 Northland District Health Board have been running the HLP for obese children, young people and their families. The HLP is a multidisciplinary programme involving paediatric doctor, nurse, psychologist, dietician, public health nurses, Sport Northland representative and Maori health worker. The philosophy of the programme is to involve the whole family in making "small sustainable steps" towards a healthier lifestyle. We focus on areas of diet, exercise, leisure time activity and stress the importance of family support and involvement. The programme is structured as an 8 week block of 1 ½ hour group education and activity sessions. Regular input and follow up by the HLP team is ongoing for 2 years. The primary outcome measure is body mass index standard deviation score (BMI SDS). Secondary outcome measures are percentage body fat (PBF), waist circumference, metabolic health, fitness and self esteem.

**Results:** Seven groups (57 families) have now completed the 2 year programme and we present their results. There were 29 male and 28 female. Ages ranged from 6.3 – 16.1 years, with a mean of 10.6 years. Self reported ethnicity was Maori in 28 (49%), European in 27 (47%) and other in 2 (4%). Thirty seven (65%) of families enrolled lived in areas with deprivation index 8-10, i.e. most deprived areas, while the remaining 20 (35%) lived in areas with deprivation index 1-7. The study group members were all severely obese (BMI greater than the 99<sup>th</sup> centile). Blood pressure at initial assessment was elevated in 61% of the study group. Half the group had abnormal fasting cholesterol and 22% elevated fasting triglyceride. Ten children had elevated liver enzymes. Thirty three percent had acanthosis nigricans and there was one young person with type II diabetes and one with impaired glucose tolerance. BMI SDS and PBF both showed statistically significant improvement as shown in Graphs 1 and 2 (see over). The reduction in BMI SDS and PBF were modest but sustained over the 2 year period. Improvements in these outcomes were greatest for the youngest age group (<9 years). Outcome on the programme was not affected by gender, ethnicity, deprivation index or baseline BMI SDS group. Waist circumference gain was slowed.

**Conclusions:** We have demonstrated the feasibility of running an interagency multidisciplinary obesity intervention in a provincial centre. The HLP achieved modest but sustained improvements in BMI SDS (reduction of 0.16 standard deviations) and PBF (reduction of 2.3%) however the reduction was sustained for the duration of the 2 year programme. The youngest group (< 9 years) had the greatest success on the programme. Further refinements to the programme are needed to improve outcomes for the older age groups. Future audit of our programme will look at metabolic, fitness and self esteem outcomes. For the severely obese who fail to improve with lifestyle intervention better access to specialist tertiary obesity service, medication and bariatric surgery needs to be developed in New Zealand.

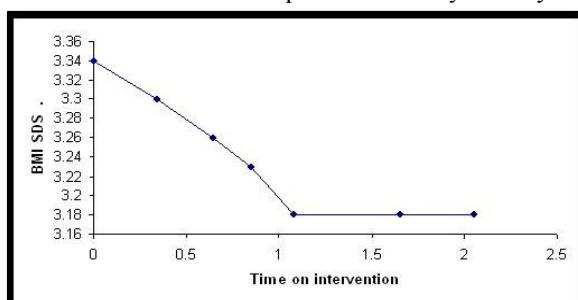


FIG1. BMI SDS change over time on HLP (years)

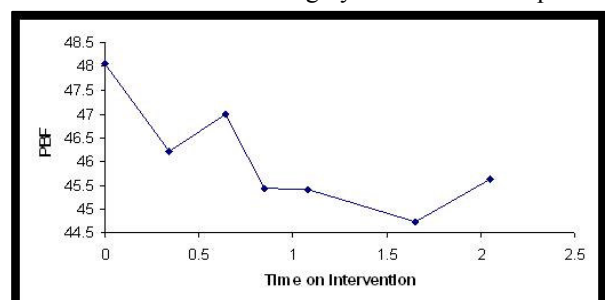


FIG 2. % Body Fat change over time on the HLP

## Admission to hospital: making it better for people with diabetes

*Adrienne Coats*

People with diabetes are high users of the healthcare system. They are admitted to hospital more frequently than people without diabetes and on average experience longer hospital stays. Admission is often as a result of complications of diabetes – cardiovascular disease for instance. Whilst the primary diagnosis must remain the central focus of care, it is essential that diabetes is well managed during this time. Research demonstrates that good glycaemic control during hospitalisation leads to decreased morbidity and mortality.

However, the reality is that for many people with diabetes, an admission to hospital can be a challenging and anxious time. This may occur for a number of reasons. Some of the concerns that have been identified by patients include:

- Loss of autonomy and empowerment with diabetes cares such as self monitoring of blood glucose, and self administration of diabetes medications and or insulin
- The failure to achieve good glucose control during the hospital stay
- The timing of meals in relation to medications/insulin and the composition of meals
- The treatment of hypos

In New Zealand there is no standard code of practice to promote consistency of in-patient diabetes care across the country. There is no nationally accepted document for patients about care in hospital. In response to these concerns, a small working party convened in Palmerston North in March. The brief was to develop a “Patient Charter for In-Patients with Diabetes”.

The team lead by Dr Paul Drury and Pauline Giles (Clinical Nurse Specialist) and supported by Novonordisk included Diabetes specialist staff from 7 DHBs, representatives from Diabetes New Zealand and the Ministry of Health.

A first draft of a charter was developed with reference to the 2008 Diabetes UK Position Statement - improving inpatient diabetes care – what care adults with diabetes should expect when in hospital. The draft has now been circulated for discussion to interested parties and remains a work in progress.

## Chairperson’s Report DNSS

The Diabetes Nurse Specialist Section is an association of nurses who provide diabetes education, clinical management and support for people and their families affected by diabetes. This encompasses people with diabetes, their families/whanau and the communities in which they live. The Diabetes Nurse Specialist Section believes in working collaboratively with other health professionals to provide quality education for all. Within the Treaty of Waitangi we work alongside people with diabetes to provide clinical expertise and to empower people to manage their condition. The DNSS committee meets quarterly and 5<sup>th</sup> meeting prior to the AGM, which occurs in conjunction with NZSSD annual conference. Work is progressing for the DNS Study Day on the 30<sup>th</sup> June 09 following the AGM, the focus of the study day this year is pregnancy and diabetes. Membership of the section continues to grow with the membership currently at 330. With a wealth of experience in the speciality area of diabetes and actively contributes nationally and internationally through various forums. The DNSS has established an honorary lifetime award for outstanding contributions to the section and diabetes, we have received two nominations so far and these will be acknowledged at the AGM. The honorary board will be posted on the website. The quarterly newsletter ‘On Target’ is posted on NZNO website and is circulated via a communication email tree. Any members that do not have an email tree receive a posted copy via NZNO administration staff. The DNSS executive committee is investigating the feasibility of offering a one off grant (in the first instance) for educational/conference assistance (within New Zealand) in 2010. Watch this space.

*Mary Meendering, Chairperson DNSS,  
7<sup>th</sup> April 2009*

## **NZSSD Membership Subscriptions are due!!!!**

If you have not paid your annual membership subscription fee (\$50), could you please contact the Membership Secretary (Victoria Farmer) by email: [nzssdmembership@gmail.com](mailto:nzssdmembership@gmail.com) or by phone (03) 470 3805. The new membership year began on 1 April 2009 at which time ALL members received an invoice requesting they pay their subscription fees. Those who have not paid for the year 1 April '08—31 March 2009 will therefore owe 2 year’s worth of subscription fees—a total of \$100.

Section 3) f) ii) of the NZSSD Constitution states: “Any member who is in default of any payment of subscription for a period of six months from its due date shall be liable for termination of their membership by resolution of the Executive Committee. Upon such termination they shall cease to be a member of the society, but shall be liable for all payments accrued up to that time.”

## Is this what we want in schools for our children? 2002 NZ Children's Nutrition Survey

Associate Professor Robert Scragg

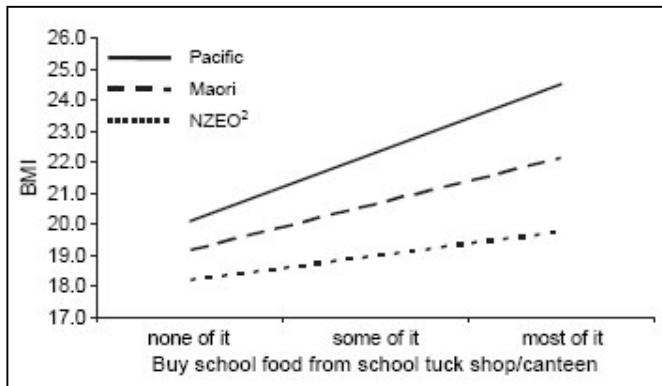


Figure taken from Utter et al. Correlates of body mass index among a nationally representative sample of New Zealand children. *International Journal of Pediatric Obesity* 2007; 2: 104-113.

Dear colleagues,

You may have seen recent news reports that the Education Minister, Anne Tolley, has removed the requirement for schools to only sell healthy foods on school premises. This requirement was implemented by the previous Government, to take effect from June 2008. While working with schools on an obesity prevention project in Auckland, my research colleagues and I noticed that this Ministerial requirement had a significant effect on the attitudes and actions about the healthiness of foods sold in school canteens - because schools knew they would be evaluated by the Education Review Office (ERO). Now that the requirement for healthy foods has been removed, it is likely that schools will revert to selling junk foods.

The Green Party is circulating a petition to re-instate the requirement for schools to sell healthy foods on their premises. I am not a member of the Green Party, but I believe this issue is wider than party politics as it reverses a key strategy aimed at changing the school environment so that it is less obesogenic.

Results from the NZ national children's nutrition survey show that children buying food from school canteens have higher obesity levels than children who don't (please see above graph).

Selling junk food in schools sends our children and youth the message that junk food is OK to eat. We don't sell tobacco in schools because it is unhealthy. So, why are we selling junk food in schools, when we have evidence it is unhealthy?

If you are concerned about this change by the new Education Minister, please sign this petition (along with your colleagues and friends) and post it to Parliament House (freepost). Only your signature and name (make sure it is legible) are required on the petition (address is no longer needed).

Further information on the petition is available from the following website: <http://www.greens.org.nz/healthyfoodinschools>

## RECOMMENDED READING and a DIFFERENT PERSPECTIVE:

Montori VM, Fernández-Balsells M. Glycemic Control in Type 2 Diabetes: Time for an Evidence-Based About Face? *Ann of Int Med* [Epub ahead of print] 2 June 09

For those of us at the coal face, where the ever decreasing HbA1c targets remain elusive for many patients, this paper, provided by Tim Cundy, suggests that tight glycaemic control burdens patients with difficult to achieve goals and offers uncertain benefits in return.

**Abstract:** "Some diabetes guidelines set low glycaemic control goals for patients with type 2 diabetes mellitus (such as a hemoglobin A(1c) level as low as 6.5% to 7.0%) to avoid or delay complications. Our review and critique of recent large randomized trials in patients with type 2 diabetes suggest that tight glycaemic control burdens patients with complex treatment programs, hypoglycemia, weight gain, and costs and offers uncertain benefits in return. We believe clinicians should prioritize supporting well-being and healthy lifestyles, preventive care, and cardiovascular risk reduction in these patients. Glycaemic control efforts should individualize hemoglobin A(1c) targets so that those targets and the actions necessary to achieve them reflect patients' personal and clinical context and their informed values and preferences."



### NEWS FLASH

Has the Government employed someone who worked for British Tobacco to interrogate the Ministry of Health (MOH) with respect to funding of NGOs for obesity prevention?

Carrick Graham of CGL Group Public Relations, was previously Director of British American Tobacco New Zealand and up until 2006 Mr Graham was an ardent defender of British Tobacco here in New Zealand. He is a fellow of the NZ Public Relations Institute and now has his own PR consultancy business. He has requested, via the MOH, a list of all obesity related service providers.

[NZSSD Conference](#)[30 June - 3 July, Dunedin.](#)

**Registration is now open** and can be done online at:

<http://www.akblimited.co.nz/nzssd.htm>

**Earlybird registrations** close 29 May.

[Applications are now invited for...](#)

⇒ **The Eli Lilly Diabetes Nursing Research Award - \$10,000.**

Applications close 31 May 2009.

Full details can be found on the NZSSD website.

For other details please contact Barbara Critchlow (Eli Lilly and Company Ltd.):

Phone: (09) 523 9308 or (021) 226 2886.

To receive the application form as a Word document, please email:

[bcritchlow@lilly.com](mailto:bcritchlow@lilly.com)

⇒ **NZSSD Conference grants**

Applications close 29 May

\$10,000 has been put aside to assist non-physician members of NZSSD with the conference's registration costs. The amount awarded to individual members will be decided by the NZSSD Executive after the closing date.

The application form and details of the grant can be found on the NZSSD

[Upcoming meetings....](#)

- **American Diabetes Association Scientific Meeting.** New Orleans, 5-9 June.
- **Australian Diabetes Society meeting.** Adelaide, 26-28 August.
- **European Association for the Study of Diabetes (EASD) meeting.** Vienna, 30 September to 2 October.
- **International Diabetes Federation (IDF) meeting.** Montreal, 18-22 October.

**NEWSWEET** is the newsletter of the New Zealand Society for the Study of Diabetes (NZSSD).

Contributions are welcome and should be sent to the Editor: Nicole McGrath

[Nicole.McGrath@northlanddhb.org.nz](mailto:Nicole.McGrath@northlanddhb.org.nz)

**Website:** [www.nzssd.org.nz](http://www.nzssd.org.nz)

[NZSSD President's Report:](#)[A Final Word....](#)

This is my last President's Report since the Executive will move from Dunedin in a few months. I would like to take this opportunity to review some of the accomplishments that have been achieved over the last 3 years.

**Strategic Plan:** the first NZSSD Strategic plan was an early initiative of this Executive. It has given us direction and purpose and has made this term much more satisfying in terms of reaching targets and accomplishing goals. We will have an updated strategic plan ready to hand on to the next executive!

**Website:** the NZSSD website has gone from strength to strength under the able stewardship of Chris Booker. We feel that this is the best way to keep the membership up-to-date with what the organisation is up to and with latest news.

**Newsweet:** we changed this to an electronic newsletter and under the editorship of Nicole McGrath the publication is in great shape. Thank you Nicole for all your hard work.

**Secretariat:** the development of a secretariat that could provide professional services to NZSSD has been a major advance. The secretariat is based in the Edgar National Centre for Diabetes Research here in Dunedin and is currently managed by Victoria Farmer and Chris Booker. This should provide NZSSD with a stable and viable platform for the future.

**Medical Director:** a 1 year position has been established for a Medical Director and an announcement is expected imminently as to who will be appointed to this inaugural position. We hope additional funding will be found to create a permanent position for this exciting and vital role in the Society.

**Workforce:** The recently published workforce survey has thrown up some interesting findings. Notably there is dramatic inconsistency in provision of services on a nationwide basis that needs attention at government level. It also highlights that there is nowhere in New Zealand that currently has acceptable diabetes service provision. Details on the Diabetes Nurse Educator workforce should be made available soon.

**Membership:** a strategic initiative was to increase the number of primary care workers in the membership. We have offered 1 year free membership to general practitioners and practice nurses working with a PHO and have had a very good response. We hope that this initiative will continue as we try to grow the organisation.

**DNZ:** we have enjoyed very good relations with DNZ over the past few years and hope that this will be maintained. The Medical Director will provide an excellent means to ensure this occurs.

**Meetings:** we have been fortunate enough to have 2 fantastic annual meetings during our time as the Executive, the combined NZSSD/ADS meeting in Christchurch in 2007 and the 7<sup>th</sup> International Diabetes Federation Western Pacific Region Congress held in Wellington in 2008. I would like to thank all those involved with both of these meetings. We hope that the Dunedin meeting (30 June – 3 July) this year will be just as successful.

Finally I would like to express my sincere thanks to every member of the current Executive. It has been a pleasure working with such a dedicated and good natured group of people. You have given up your free time and worked extremely hard to assist the organisation. Because of this you have made a real difference. I hope that other members of NZSSD will now take up the challenge and continue this important work.

I have enjoyed my time as President of NZSSD. Being President is a bit like managing a patient with Type 1 diabetes – currently we have reasonable glycaemic control and complications are all stable but a severe hypo or DKA could be just around the corner. Hopefully we will have transferred the patient by then!

Best wishes,



Patrick Manning, NZSSD President