

67 ± 19, $p < 0.05$) and traditional starts (77 ± 17 to 61 ± 13, $p < 0.05$). Weight (kg ± SD) also improved (112 ± 24 to 108 ± 24, $p < 0.05$; and 118 ± 28 to 114 ± 27, $p < 0.05$). There were no significant inter-group differences. Groups required less staff time per patient: 65 vs 90min.

Conclusion: Group starts have improved follow-up rates and led to reductions in weight and HbA1c which are at least as good as traditional 1:1 starts. Patient feedback has also been very positive and the improved experience used fewer staff resources.

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'Doctor, I forgot my glucose diary!'

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Aims: Capillary blood glucose (CBG) testing is useful in clinician-directed and self-management of diabetes. The National Institute of Clinical Excellence (NICE) recommends CBG monitoring. People with diabetes often forget to bring their CBG meters and diaries to clinic. The aim of this study was to assess the trends surrounding this.

Methods: A 27-point anonymous questionnaire was distributed amongst 117 people attending diabetes clinics in a large teaching hospital. Information regarding trends surrounding CBG meters and diaries were obtained.

Results: In this study, 59% people did not bring their CBG diaries, with the majority (29%) reporting having forgotten; 73.5% did not bring their CBG meters, with over half (58.6%) reporting having not been asked to do so. There was no difference between genders or type of diabetes noted in these parameters. Sixty-one per cent of the two largest ethnic cohorts – White and Asian – did not bring their diaries. In those with English as a second language, 66% lapsed. Responders were mainly (75.3%) between the ages of 41 and 80 years. A majority (57.4%) of retired individuals did not bring their diaries. Sulphonylurea and insulin therapy is associated with hypoglycaemia: 90.9% on sulphonylureas and 52.9% on insulin did not bring their diaries. Remarkably, those individuals without their diaries had a lower median HbA1c (68.5mmol/mol vs 72mmol/mol).

Conclusions: In our study, CBG diaries and meters were not available in a majority of cases to discuss patient care. We propose that diabetes charity organisations and healthcare professionals impart more knowledge to people living with diabetes surrounding the importance of this.

Acknowledgement: MS Mastand and GS Rai contributed equally to the writing of this abstract.

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Dietary self-care and negative emotions in Type 2 diabetes: 'I break it and then I feel guilty and then I don't go back'

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Aims: To understand the experiences of maintaining good dietary self-care required of people with Type 2 diabetes and the meaning of negative emotions in the context of dietary self-care. This is

explored by examining situations resulting in negative emotions, types of negative emotions experienced and coping with negative emotions and poor dietary self-care.

Methods: The interpretative phenomenological analysis (IPA) approach was used to explore in-depth dietary self-care and negative emotions. Thirteen people with Type 2 diabetes from the Endocrinology and Diabetes Centre of the Birmingham Heartlands Hospital, Birmingham, UK, were interviewed to gain in-depth insight into their experiences. Transcripts of interviews were analysed using IPA to generate meaningful themes.

Results: Three super-ordinate themes were identified: dietary self-care – a constant challenge; negative emotions – a cause or a consequence; and coping with negative emotions and learning to live with 'the diet'. Situations involving poor diet were identified to understand the context of negative emotions. While perceived dietary restrictions resulted in frustration, anger and depression, maintaining dietary self-care resulted in irritation, annoyance, regret, guilt, anger and depression, and the consequence of poor dietary self-care was frustration, depression and anger. Patients rationalised to coping with these negative emotions and poor dietary self-care, acknowledging the importance of good dietary self-care.

Conclusions: This study fills a gap in literature, contributing largely to the understanding of negative emotions and dietary self-care. It proposes a possible cycle of poor dietary self-care and negative emotions and suggests the need to break this cycle (where one exists) to maintain good dietary self-care.

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Impact of the RAPSID education programme on diabetes knowledge among people with Type 2 diabetes

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Aims: To assess the impact of a workshop for patients with known Type 2 diabetes on diabetes knowledge.

Methods: Participants in RAPSID (Randomised Controlled Trial of Peer Support in Type 2 Diabetes) (n = 1,362) were invited to attend a 3.5h workshop to increase basic diabetes knowledge on entry into the trial. Attendance was not required for trial entry. The format was based upon the 'empowerment approach' of Funnell/Anderson and included four topics addressing key aspects of care and common myths, followed by a question and answer workshop. Participants had already completed a baseline questionnaire and completed knowledge questionnaires based upon the Revised Diabetes Knowledge Scale (RDKS) before and after the workshop.

Results: Overall, 912 participants attended the workshop, of whom 565 completed both the pre- and post-questionnaire. Those completing the pre-/post-questionnaires had similar demographic/clinic characteristics to others, besides a higher baseline knowledge (15: 11 ± 3 vs 10 ± 3; $p = 0.002$) and higher quality of life (EQ5D scale: 73 ± 18 vs 70 ± 21; $p = 0.007$). The 10-item RDKS increased from 69% ± 19% to 78% ± 18%; $p < 0.001$. Those treated with insulin (15.2% of participants) increased their knowledge least (5% ± 12% vs 10% ± 17%; $p = 0.009$). Expectations were met in 93.5% of participants in an anonymous post-workshop survey. Aspects thought to be particularly useful related to diet/carbohydrates and medications. Sessions frequently turned into group consultations.