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NHS
Hardwick Clinical Commissioning Group

Diabetes UK and Hardwick Clinical Commissioning group

The Future of your Diabetes Care Meeting Evaluation Report

Monday 21 October 2013

THE FUTURE OF YOUR DIABETES CARE

Public engagement event held on 21st October 2013
Proact Stadium Chesterfield

Panel:
Dr Rebecca Davenport, Clinical Lead for Diabetes, Hardwick CCG (RD)
Dr Robert Robinson Hospital Consultant (RR)
Michelle Denyer Primary care Diabetes Specialist Nurse (MD)
Stella Ruston Diabetes Education (SR)
Clive Newman, Head of Strategy & Partnerships, Hardwick CCG (CN)

There was an audience of approx. 40 and the local Voluntary Group had an exhibition stand.

There was a general introduction and welcome by CN who then introduced Dr Rebecca Davenport.

Purpose of the Day:
Diabetes UK and Hardwick CCG are working together to ensure people living with diabetes get a say in the future delivery of services. Hardwick CCG id the new commissioning organisation and are looking to improve diabetes care by redesigning services and the way care is provided, so this is a chance for patients to have their say before changes happen.

Introduction to the work happening in Hardwick CCG
Presentation by Dr Rebecca Davenport

Key points:
Context: – 100,000 patients. 5,000diabetics. 15,000 high risk for diabetes.
Why have a Diabetes Project – Common/Increasing incidence/expensive/high morbidity/preventable/fatal
Where are we now? – Not exactly bad/most indicators at or around national average/high levels obesity and smoking/high levels of amputations
What if we carry on the same? – Incidence is increasing/resources are not/complications are increasing/diabetes Tsunami
Self-Care

- The average type 2 diabetic spends 4 hours a year with a professional
- And the other 8756 self-managing
- Every £1 spent on patient education saves £1.50 in future care costs
- Lifestyle is the only intervention which isn’t harmful
- It can work very effectively with the right motivation and support

Patient Education

- Improve outcomes
- Empowering
- Cost-effective
- Necessary for self-care

Support

- Buddying project
- Walking groups
- Directory of local classes/groups re healthy living and exercise

Professional Education

- Need to ensure we have the skills to empower our patients to self-care
- Also we need to keep our clinical skills honed
- Motivational interviewing
- Foot screening

Feet/Foot Group

- High amputation rates across North Derbyshire and rising. Costs are gigantic
- A review of current foot pathway underway
- A patient held card based on traffic light system to illustrate foot risk to be designed
- The roll out of online learning modules to all foot screeners
- Additional hospital foot clinic

1. Positive things about the care currently received

- Text messages regarding appointments from GP's/ Easy to get appointments
- Regular check-ups
- Eye Screening/Foot Care/Blood tests/BP/Lipids – yearly or ½ yearly pattern
- Apart from eye test all other tests done at the surgery – convenient – very structured
- Hospital Care – consultant and nurse and dieticians
- Excellent Practice Nurse at Avenue House
- Marvellous Surgery (Wingerworth) (Don't know if it's the correct care)
- Good communication at surgery and open surgery in the morning
- Good information on bulletin board, increased information on repeat prescription
- Self-testing equipment provision
- Education – especially ASPIRE
- New diabetic (Diabetes & You)
- Local Diabetes UK Support Group
- Free prescriptions
- Free eye tests
- Up to date
- Opportunity to share things/to talk about how I feel
- Pre diabetes leaflet at surgery
- Podiatry
- Professional knowledge
- PPG – being able to cascade

Negative things about the care currently received

- Have to buy own test strips
- No consistent standard between GP's on knowledge of Diabetes
- Lack of specialist within surgery/ Need a regular review with a dietician
- Training of new nurse specialists within GP practices
- Lack of psychological support/ Asked for counselling not been given/support and rather than antidepressants
- No proper results from Retinopathy screening/ What does letter for retinopathy really mean? No idea if getting worse
- Time in appointments to discuss things with professionals – often just 10 mins
- Lack of detailed results information i.e. "blood pressure ok" not actual reading
- Dumbing down of care – i.e. annual podiatry done by phlebotomist
- Lack of "Type II's on insulin" courses
- Complained for 2 years about symptoms and not checked
- Told welcome to 'club diabetes'
- Difficult to get information about self-help groups and about group education
- Better blood glucose group good - need more
- Foot care needs improving only seen once a year/Not told what risk factor I am with my feet
- Feel like a conveyor belt

- Nothing going well
- Not told about diet feel like they just want to give information
- Follow up sessions
- Education professional
- Recall at practice – very little “once a year if you are lucky”
- Support and information for carers
- Lack of mentor project

2. What would help to manage diabetes yourself?

- **What services do you want/need access to?**
- Need to be able to get test strips
- Assessed as an individual for need
- Be seen more by Practice Nurse/people well qualified
- Need easier access for appointments
- Conflicting information from professionals – need my nurse/GP to be trained
- Conflicting treatment/feels like no consultation between staff
- Better/easier access for appointment. Whole appointment system at GP surgery needs reviewing
- Access to courses
- Specialist advice in all areas and having confidence in advisor
- Discussion regarding access to test strips and how to interpret results
- Someone to listen to patients, -individual. What I want to do – not what GP’s want me to do
- Shock – sit down for 1hour and discuss lifestyle changes needed – support, progressive support
- Talk to others with diabetes – to help with living – peer support
- Talk to professional that understand condition – lost don’t know what to do.
- Seamless access to a practitioner if an acute problem arises
- Choice of care in hospital, rather than being made to go to GP
- Drop in clinics
- Having a ‘relationship’ with practitioners
- Being able to see the same person about care

- **What information do you need?**
- To have all my results on a print out after I have had my consultation
- Plain English are my eyes worse or better
- Foot care a follow up letter telling me what found
- Variation in information being given to individuals doesn’t feel consistent
- Patient information on courses available
- Knowledge of support groups, when they meet etc and agenda
- Information on risk – to enable informed decisions about treatments i.e. 2 way decision
- Husband with DM – diagnosed 1 year ago, sees GP every 6months – is it enough
- At diagnosis – access to group support/group education
- More equality of knowledge/diabetes provision at practices. At least one nurse with specialist/knowledge/training

- **What would education courses look like?**

- Go to Diabetes UK – can talk to others – only found out about group by accident – took 8years to find out
- What diabetes really is? Should be offered educational for those diagnosed longer and regularly updated
- Possible education that fits in with current lifestyle
- Career as nurse – has an impact on tools and resources used
- A course for patients with Type 2 DM on insulin
- Access to dietician advice
- Lack of knowledge of what is on offer
- Self-help group
- Buddies help
- Diabetes UK care line
- Education Groups

- **How would you like to access the information?**
  - Problem – be able to ring someone who could help
  - Website
  - Information leaflets/posters – Risk for feet
  - E-mail
  - Apps
  - Handouts in addition to information
  - More leaflet packs – Diabetes UK

3. Your experience of diagnosis

- **How long ago were you diagnosed?**
  - Routine health check
  - Following screening as family history of IHD
  - Complained of diabetes symptoms for a number of years before locum GP suggested blood test
  - Blood test in surgery – “welcome to club diabetes”
  - Picked up at gym membership
  - On the spot check – if not done wouldn’t have known for a long time (no symptoms)
  - Feels told “have diabetes” felt like a bereavement = one minute ok and next day life changing
  - Risk factors in family – better screened
  - Accident 9 years ago
  - Lethargic 5 years ago
  - Diagnosed as a child

- **What do you think Hardwick CCG could do to ensure early diagnosis of diabetes?**
  - Need routine screening i.e. every 5years. Particularly if there is a strong family history
  - Included in well man/woman clinic
  - Education of early signs
  - Longer period to discuss it

  - Given either no leaflets or a pile
  - If known by GP able to assess how much to give
  - Risk assessment – Leicester tool
  - Each surgery to have list of peer support
  - Maybe Diabetes UK local group to pair up/contact

- **What support did you receive on diagnosis**
  - Not seen GP for 18/12. Sees practice nurse – one good consultation, one not so good – different nurses
  - No education group offered
  - Took 3 years to get a referral to dietician
  - Given inadequate medication (by mistake)
  - Diabetes specialist nurse came to home
  - Good support at GP surgery seen every week
  - Afternoon about food at surgery
  - Health trainers

- **What other support would you have liked?**
  - More emotional support – not to be just told you have diabetes
  - Clear chart of all results – HbAc1, CHL
  - Nice to know what results actually are – not that they are fine/ok
  - Access to support groups
  - More time with specialist
  - Access to courses - transport
  - Time to talk explain what I can do to help
  - Support for families/carers
  - A cure for diabetes
  - Correct information/be given the right advice – consistency of information

Next Steps

Hardwick CCG Diabetes Leads will consider the comments/suggestions received at the event. Appropriate actions will be taken forward to improve care currently received including access to services, self-management, information available, review of education courses and improved experience of diagnosis.

Regular updates will be provided on the work to be taken forward.