Diabetes Public Meeting: Improving Diabetes Care in Hounslow

Report from the Public Meeting held on:
Wednesday 18th March 2015
at Days Inn Hotel, 8 – 10, Lampton Rd, Hounslow
Hounslow CCG Diabetes Public Meeting
Wednesday 18th March 6.30 – 8pm
Days Inn Hotel, 8 – 10, Lampton Road, Hounslow

Hounslow CCG held a Diabetes public meeting on Wednesday 18th March

This was the third meeting held about diabetic care in Hounslow and report on the progress and investment we are making in improving diabetic care locally. The event also provided an opportunity to engage with people who live with Diabetes, to express their views and their experiences of local Diabetes care provision.

The event was attended by approximately 30 people, of whom the majority were type 2 Diabetes patients.

Key People:

Dr Nicola Burbidge (Chair) - Dr Burbidge is the Chair of Hounslow CCG and has been a GP in Chiswick for nearly 30 years. She has taken an active lead in the redesign of local and North West London patient pathways.

Dr Raquel Delgado (GP Lead for Diabetes) - Dr Delgado has been the diabetes lead for Hounslow since October 2012. She is passionately committed to improving diabetic care locally. (Raquel.delgado@nhs.net)

Adeola Adeleke (Diabetes Engagement Officer, Hounslow CCG) – Adeola is working with patients, community groups and the wider Hounslow population to increase awareness of Diabetes, in particular the need to attend for regular checks (Adeola.Adeleke@nhs.net)

Why is diabetes a priority in Hounslow?

- We have approximately 15,000 residents in Hounslow with diabetes.
- We estimate that nearly 5,000 people may have the condition but don’t yet know it.
- Less than half of our patients with diabetes receive all of their annual checks recommended by NICE (National Institute of Clinical Excellence).
- The statistics produced by the National Diabetes Audit on how well we deliver diabetes care show that Hounslow is in the bottom 25% of CCGs in England.
Why has Hounslow historically underperformed?

- We have challenges around the Hounslow population - nearly 50% of population is South Asian, Black African, Black Caribbean background who are at increased risk of developing diabetes
- Language barriers
- There are many people who don’t know they have diabetes and often present with diabetic complications.
- People are not offered annual checks, or do not attend when they are requested to attend.
- We have a transient population - many live 3 or 4 months of the year abroad.
- Variations in diabetic knowledge of GP’s and their practice staff

Where are people receiving their Diabetic Care?

In Hounslow:
- 80% of diabetic patients are being looked after by their GP practices – by GPs or practice nurses.
- 10% of diabetic patients, usually those with more complicated diabetes, are looked after in the hospital or in intermediate care services.
- The majority of Type 1 diabetics and all children are under hospital care.

What checks should you receive annually?

1. HbA1c blood test
2. Lipids (cholesterol fat)
3. Kidney function (blood test)
4. Urine test for protein
5. Feet examined once a year
6. Weight check, given advice if overweight.
7. Smoking status checked
8. Blood pressure
9. Eye Tests (all people with diabetes over the age of 12 should be referred to the retinal screening program, not the opticians)

Why receive 9 care processes?

These annual checks are key in the management of diabetes – raised blood pressure, increased weight, smoking, raised cholesterol, poor glucose level management - all have a direct impact on your eyes, on kidney function, on circulation of the feet, on your heart - putting you at risk of angina, heart attacks and strokes and other diabetes related complications.
What are Care Plans?

Care plans remind your GP what your priorities are. The length of the annual review will vary by practice but it is important that all issues are covered. Your practice may divide up the annual health check into smaller sessions, or offer you a once a year full review and shorter reviews in between. Once the annual health check is completed, your care plan will be updated.

It is recommended that you go to your appointments with questions ready and prepared to get the most out of your appointment. You live with and manage your diabetes and your GP and practice nurse are there to help you do so. Care plans are useful for this. They list what they main areas are for you to discuss and are a means of you recording what the issues are for you.

What is Hounslow CCG doing to improve care?

Over the last 18 months, Hounslow CCG has been working with Diabetes UK to improve care locally.

- We have procured a new Community Diabetes Service which will start on 1st May 2015.
- We are launching an awareness campaign at the end of June, to invite people to visit their GP practices for a diabetes check.
- If people are found to be high risk, they will be signposted to lifestyle programmes and interventions.

The new Community Diabetes Service is provided by Central London Community Healthcare (CLCH) and will offer a Multidisciplinary Team consists of Consultants, Registrars, specialist doctors, specialist diabetes nurses specialist diabetes dieticians, podiatrists, and psychological support and support staff and lay educators who will ensure patients have timely access to care

Our new Community Diabetes service will run meetings with patients with diabetes to get feedback on how their service is working and where improvements can be made.
Opportunities for involvement in Hounslow.

We want to improve healthcare services in Hounslow for diabetes, and we want to involve you, patients and carers, to do this.

- **Diabetes Patient Reference Group**: We want to hear from a wide range of people who have diabetes, who are interested in helping improve local diabetes services in Hounslow.

  The group will advise and support Hounslow CCG on ways we can improve services, encourage ideas on reaching those at risk and sharing information on a variety of topics related to managing all types of diabetes.

- **Diabetes Champions** help us engage with communities at risk, particularly South Asian, Afro Caribbean, Nepalese and Middle Eastern communities. They help us outreach those who have limited English and we welcome people who speak different languages to become Diabetes Champions.

- **Public Awareness** - Hounslow CCG, Public Health and Diabetes UK are working on a campaign to increase diabetes awareness. This will include a roadshow, billboard and street level campaign in June 2015.

- Across North West London we are also looking at developing **new technology solutions** such as phone applications to help people manage their long term condition, such as Diabetes.

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**Roz Rosenblatt**

London Regional Manager for Diabetes UK

“When we had the first public meeting last year, we asked what was going well and what needed to change. You’ve taken on board what needed to change and I’m pleased to hear about the new service. There is a real opportunity to change and improve care. It won’t happen overnight, but the new service is a good start. We will keep watching you and continue to be a critical friend”.

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**Celia Golden**

Trustee, Healthwatch Hounslow

“Healthwatch Hounslow have been concerned about the prevalence of Diabetes in Hounslow and the service offer to support patients. We have been part of discussions with Diabetes UK and Hounslow CCG to raise awareness of diabetes amongst hard to reach and seldom heard communities including Somali, Asian and Disabled communities.

Healthwatch Hounslow therefore welcomes the proposed new commissioning investment to respond to the incidence of diabetes and is reassured by the Hounslow CCG’s plans to provide a consistent service across the Borough which marks a positive new service direction for patients.

This is a key priority for Healthwatch Hounslow and we will continue to monitor and support Hounslow CCG’s efforts to reduce health inequalities by evidence based commissioning and consultation with residents and third sector organisations.”
### Questions asked by members of the public at the meeting

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<td>What is the population of Hounslow?</td>
<td>Our population registered with a Hounslow GP is 290,000 – which is more than the borough resident population of about 250,000</td>
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<td>Does ageing put you at risk of diabetes?</td>
<td>Yes; we have a service called NHS health checks. They target people over the age of 40. One of the checks they do is a diabetes test. We diagnose a lot of people with diabetes through NHS health checks.</td>
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<td>What is a care plan? (see above for more information)</td>
<td>It contains all your blood results and any treatment plan, it outlines any areas for improvement,</td>
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<td>Can you stop becoming diabetic?</td>
<td>You can reduce your risk but some patients, such as South Asians, are at greater risk, particularly if they are overweight, smoke and have a family history of diabetes. You can change your lifestyle - stop smoking, lose weight, become more active and this can reduce the risk – or delay the onset of diabetes. It is estimated that 20-30% of people at ‘high risk’ will go on to develop diabetes.</td>
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<td>Are you still supporting the expert diabetes course as part of the new service?</td>
<td>Yes, people can be referred by their GP or refer themselves to the expert programme. We offer a range of diabetes education programmes, included programmes for people with Type 1 diabetes.</td>
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<td>You recommend having 9 health checks but the person carrying these out needs to be knowledgeable about them</td>
<td>From May 2015, our new community diabetes service will to work alongside GPs and nurses to improve their skill levels and education in diabetes care. Clinicians are assigned to each practice across Hounslow and we will also have a dedicated diabetes podiatrist. The consultants will deliver education to (and at) GP practices and discuss complex patients, rather than the GP sending the patient to a hospital-based clinic</td>
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<td>What about access to podiatry services?</td>
<td>We will have a diabetes specialist podiatrist as part of the new service. We are also working with West Middlesex University Hospital to develop a 5-day access to a podiatry clinic, providing a walk-in service for patients known to the podiatrist. If people are at high risk of developing an ulcer and they see an ulcer in the foot, they can go straight to the hospital clinic. The clinic will only see patients known to the service. There is also a nail cutting service available for those with diabetes unable to do it themselves. Non-diabetic patients with long term conditions that require assistance with nail cutting will still go to the Community Podiatry service as the previous arrangement. The CCG has not decommissioned any aspect of the community Podiatry service for long term conditions patients. Diabetic Patients (including those with co-morbidities) will go to the new Diabetes foot protection service for nail cutting.</td>
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<td>Paediatric diabetes</td>
<td>We have 123 children with diabetes in Hounslow. Another nurse and consultant have been appointed to the team and will start in June 2015. The service wants to increase psychological support, particularly important for the children and parents – and more dietician support. We are working to the best (cont./)</td>
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paediatric tariff – encouraging best practice. This means more appointments and 24 hour access. If a child has just been diagnosed, they can see a paediatric nurse within 24 hours. If a child is known to have diabetes and is admitted, they will have access to a nurse or consultant. Education and support to families and to primary, secondary schools and nurseries to provide staff to support.

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<td>Do you have a smart card, or do you not?</td>
<td>People on insulin treatment, will have an insulin passport to carry with them. We are working on a patient ‘app’ where you can store information on a smartphone application. Your care plan will have your medical history and is your clinical document</td>
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<td>How will you measure the new contracts?</td>
<td>We want to make sure practices give each diabetic patient the 9 checks a year, we can track this through the ‘dashboard’ on SystemOne – it is generated from data on the GP system. We will be able to see how many patients receive the 9 care processes and how well they are managed. System One is where your computerised medical history is stored by GPs. All your results, medication, records from hospital consultations are stored there. The new service will be able to see that information as well. It is one of the elements, shared records will increase better diabetes care.</td>
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<td>What do you envisage the spread of diabetic nurses to be? How many practices? Occasional visits?</td>
<td>The diabetic nurses will work in all localities to support diabetic patients, working predominantly where the need is greatest. The model is flexible. GPs are the key people. They care for you every day. The new service will enable them to deliver that care better.</td>
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