Diabetes in North Somerset (Diagnosis, Treatment and Support)

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Diabetes in North Somerset

(Diagnosis, Treatment and Support)

Introduction

Diabetes is a complex condition. It is a chronic metabolic disorder which increases the risk of damage to the eyes, kidneys, nerves, heart and blood vessels. Since high blood glucose, blood pressure and cholesterol can worsen many of these problems, managing diabetes draws on many areas of healthcare, and care is typically complex and time-consuming (NICE Quality Standard).

> It is estimated that by 2025 more than 4 million people in England will have a diagnosis of diabetes. The current prevalence rate is 6% in England, of which approximately 90% of adults diagnosed with diabetes have the Type 2 variety. *(NICE)*

> People with diabetes in England and Wales are said to be 34% more likely to die earlier than their peers. For Type 1 diabetes, mortality is 131% greater than expected and for Type 2 diabetes it is 32% greater. Life expectancy is reduced, on average, in both types of diabetes. *(HSCIC: National Diabetes Audit)*

In view of the estimated increase in prevalence of diabetes in the next decade and the potential impact of the condition, the diagnosis, treatment and on-going care and support for diabetic patients is important.

This review of the diagnosis, treatment and support of diabetes in North Somerset summarises the feedback we have received from local people about their experiences of diabetes services and based on these, makes recommendations for service improvement.

Diabetes is a key priority for commissioners and providers locally and nationally.

The Care Quality Commission (CQC) has recently undertaken a national review of Diabetes care in community settings and the findings of the Healthwatch North Somerset report will be forwarded to the CQC to feed in to this national overview.

North Somerset Clinical Commissioning Group (CCG) is currently reviewing the diabetes patient pathway and has included the improvement of diabetes services within its operational and strategic plans. Services for people with diabetes require development in terms of ensuring the commissioning of safe

and sustainable services. There is also the potential to realise benefits in the medium to long term through the broader transformation of diabetes pathways. Transformation of services for people with diabetes is a work stream forming part of the CCG's transformation programme for 2016/17. System wide change in diabetes care represent a great number of opportunities for improvement with benefits for people with diabetes, their family and carers, commissioners and providers.

The stated aims of the diabetes transformation project are;

- To reduce the incidence of complications of diabetes
- To reduce the growing numbers of people developing type 2 diabetes due to lifestyle factors, including preparing for the roll out of the National Diabetes Prevention Programme

The key points and themes which were identified as a result of the Diabetes Transformation Project currently being undertaken by the North Somerset CCG have been include in the appendices of this report (see Appendix 5 and Appendix 6).

About Healthwatch North Somerset

Healthwatch North Somerset's statutory duty and remit, which is laid out in The Health and Social Care Act 2012, is to provide a voice for people who use health and adult social care services, by:

Influencing

- Giving people an opportunity to have a say about their local health and social care services, including those whose voice isn't usually heard.
- Taking public views to the people who make decisions – including having a representative on the Health and Wellbeing Board.
- Feeding issues back to government via Healthwatch England and the Care Quality Commission (CQC).

Signposting

- Providing information about health and social care services in the local area. Advising people on where to go for specialist help or information (signposting).
- Helping people make choices and decisions about their care.
- Working closely with other groups and organisations in the local area.

Under the Health and Social Care Act (2012) Healthwatch North Somerset has the following powers and functions.

- A duty on service providers and commissioners to respond to requests of information within 20 working days.
- A duty on service providers and commissioners to respond to recommendations made by Healthwatch North Somerset within 20 working days.
- Make reports and recommendations about services known to commissioners, providers and regulators of health and social care services in North Somerset
- A duty on service providers to allow entry to authorised Healthwatch North Somerset members to conduct announced or unannounced 'enter and view' visits to assess services.
- A seat on North Somerset's Health and Wellbeing Board (People and Communities Board), to promote health improvements and tackle health inequalities.
- A mechanism to make recommendations to Healthwatch England, which may include advising the Care Quality Commission about special reviews or investigations to conduct.

Our Mission:

By offering all people of North Somerset a strong voice we will improve the quality of local health and social care today and for the future.

Background

Healthwatch North Somerset seeks and listens to patient experiences. All feedback is recorded and reviewed quarterly and if a theme is indicated we undertake an evaluation of that specific issue or service. This ensures we respond to the issues that matter to local people.

As a result of feedback received Healthwatch North Somerset has undertaken an independent evaluation of the diagnosis, treatment and support of services for diabetic patients in North Somerset.

This report evaluates the responses received from North Somerset residents with diabetes who were asked about the care they received from the point of diagnosis through to the on-going care and support provided in the management of their condition.

The NICE Diabetes Care Standard describes a high-quality, cost-effective care pathway that, when delivered collectively, should improve the effectiveness, safety and experience of care for adults with diabetes in the following ways:

- Preventing people from dying prematurely.
- Enhancing quality of life for people with long term conditions.
- Helping people to recover from episodes of ill health or following injury.
- Ensuring that people have a positive experience of care.
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

A recommended pathway for treatment of a patient with diabetes from the point of diagnosis has been provided by the Diabetes Network and can be found in Appendix 7 of this report.

Summary

During the period July 2015 – April 2016 Healthwatch North Somerset collected feedback comments from North Somerset residents on the diagnosis, treatment and support available for diabetic patients in the region.

Local people informed us that they considered the diagnosis and treatment of diabetes was, at the least, satisfactory and a significant number considered their diagnosis and treatment was good. Some respondents fed back that although the diagnosis and treatment was good they would have benefited from additional information resources and support.

Aims and Objectives

The aim of this service evaluation is to highlight the issues that the public view as important in supporting their needs from the point of diagnosis of diabetes and throughout their ongoing support of the condition. This evaluation also sought to establish whether the current service provision is appropriate and sufficient to meet the needs of North Somerset residents.

Healthwatch North Somerset has collated the information received from respondents in an accessible and comprehensive way and we have presented affordable, achievable and evidence-based recommendations to stakeholders based on the findings of the report.

Methods

We undertook this review by speaking to local people who have first-hand and recent experience of diagnosis, treatment and support of diabetes. To clarify our understanding of the current situation we also:

- Engaged in discussion with South West Regional Manager of Diabetes UK
- Attended North Somerset Diabetes Transformation Network Meetings (these meetings are attended by key personnel from the local authority, Clinical Commissioning Group and voluntary sector).

The information and feedback obtained from local people was gathered mainly through a questionnaire (see Appendix) which was made widely available via a number of engagement activities which including attendance at and speaking with members of the following groups:

- Weston Diabetes Support Group
- Nailsea and Backwell Diabetes Support Group
- Nailsea Diabetes Support Coffee Morning
- Nailsea Leg Club
- Portishead Diabetes Support Group

We decided to use a questionnaire as this format of feedback often obtains a higher response rate than open questions and it ensures consistency in responses. Using a questionnaire also simplifies the collation and interpretation of responses.

The questionnaire was made available as a hard copy which was handed out to the public during engagement activities. It was also made widely available to complete on-line via a Smart Survey link.

The questionnaire asked respondents to rate various aspects of their diabetic diagnosis, treatment and support as either 'Good', 'OK' or 'Poor' and also offered the opportunity for additional 'free text' comments to be made regarding specific services. The 'Good', 'OK' or 'Poor' scale was adopted as it was clear to interpret and required the minimum of effort on the part of the responder.

The respondents were asked to give the name of the GP practice that they attend and from this information we noted that the respondents represent a relatively wide geographical cross section of the North Somerset community including Weston, Clevedon, Nailsea, Portishead, Yatton and Long Ashton.

In addition to the questionnaire, the results of this review also incorporate the general intelligence received by Healthwatch North Somerset through a variety of means including:

- Letters

- Emails
- Website feedback
- Telephone calls

Within this report, we have captured 57 questionnaire responses from North Somerset users of diabetes services. Some of the questions allowed respondents to provide responses for each service they attended therefore some of the responses will equal more than 57.

During the period that we undertook this evaluation we were approached by Diabetes UK to assist them in gathering separate information from care homes in North Somerset. They provided a questionnaire to form part of a review they were undertaking on how Care Homes manage and support residents with diabetes.

We always seek to work supportively and in co-production with other agencies and distributed the questionnaire on their behalf to every residential care home in the county. In order to incorporate these findings into our own work we utilised the format of the Diabetes UK questionnaire to base our own questionnaire on.

The results of the Diabetes UK questionnaire have been incorporated into this report but have been presented separately towards the end of the main body of the report. The Diabetes UK questionnaire responses have been forward to Diabetes UK and will form part of their national review of Diabetes Care in Care Homes.

Summary of our Findings

The Healthwatch North Somerset Diabetes Questionnaire consisted of six questions covering the issues of diagnosis, treatment and support of diabetes. The questionnaire can be found in the Appendix of this report.

The following pages provide a summary analysis of the responses to each of the questions in the questionnaire.

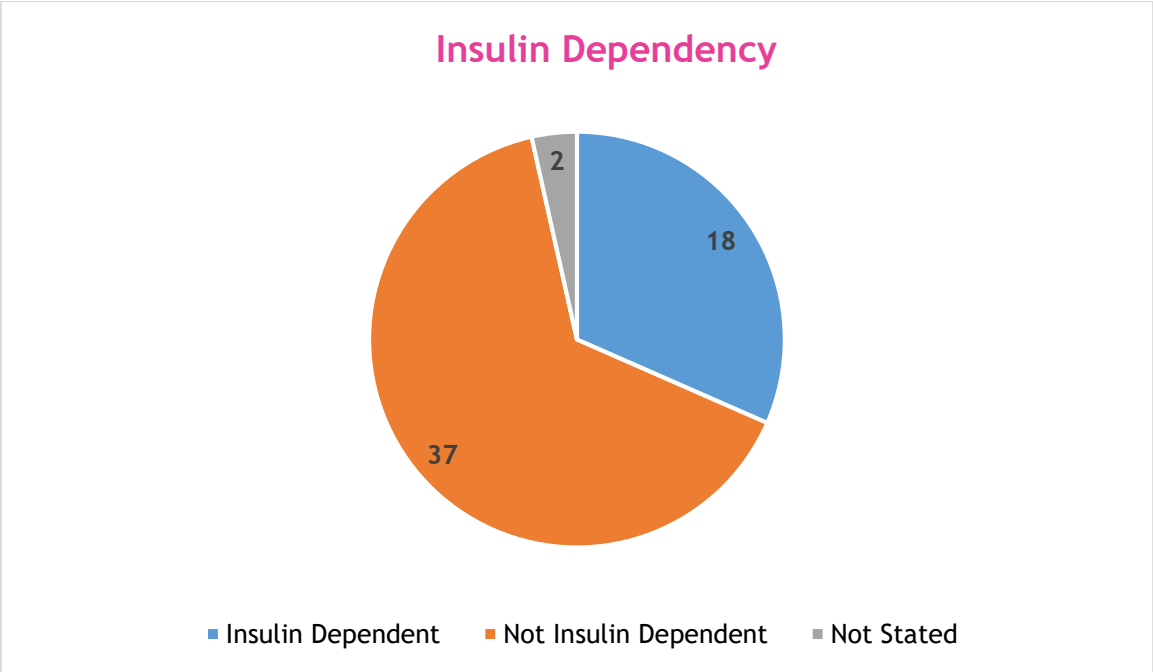
Question 1 - Insulin Dependency

Are you insulin dependent or non-insulin dependent?

Of the 57 respondents surveyed 18, or 32%, stated that they were insulin dependent; a total of 37 (65%), stated that they were not insulin dependent and 2 people (3%), did not answer this question.

The proportion of insulin dependent respondents is quite high, this is explained by the fact that a significant amount of feedback obtained was from attendees of three local diabetes support groups and it can be concluded that invariably the people

who are likely to attend such groups are those with more complex management requirements.



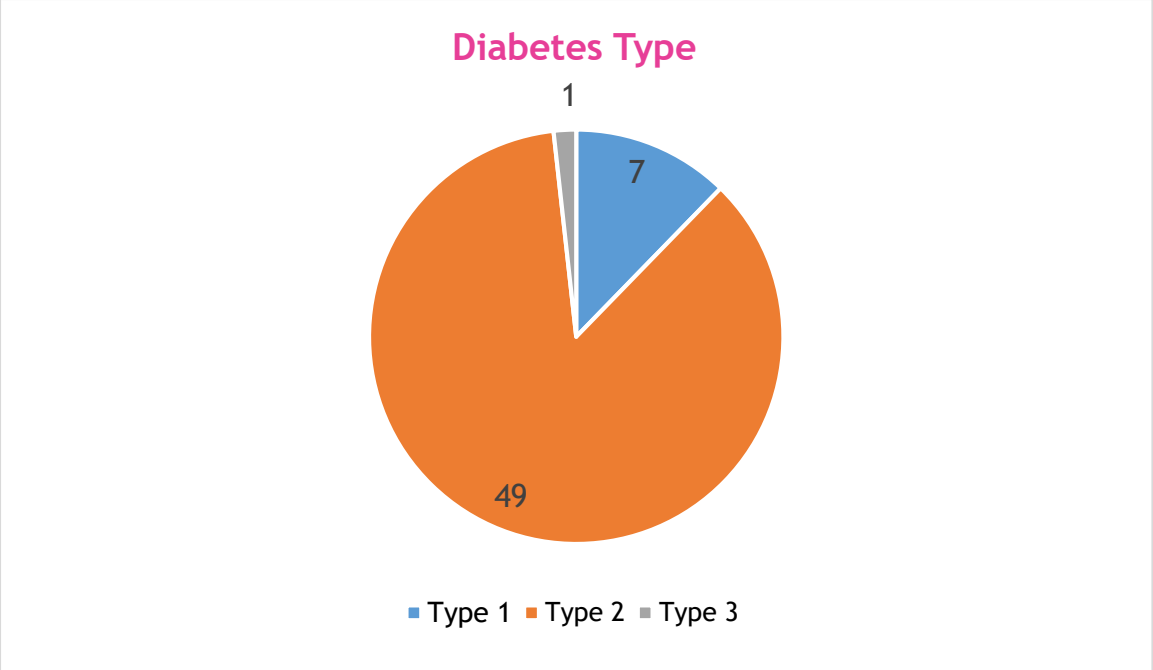
Question 2 - Diabetes Type

Do you have a diagnosis of Type 1 or Type 2 diabetes?

The vast majority of the questionnaire respondents, 49 people, or 88%, stated that their diabetes was of the Type 2 variety and 7 people (12%), stated that they had a diagnosis of the Type 1 variety. This breakdown is shown in the chart below.

The respondent with what has been termed Type 3 diabetes acquired the condition following pancreatic surgery.

According to statistics from Diabetes UK it is estimated that approximately 10% of people with diabetes have the Type 1 variety, whilst 90% have the Type 2 variety. The respondents that took part in the survey therefore appear to be a representative sample in terms of diabetes type.



Question 3 - Diagnosis and Initial Treatment

Was your diabetes picked up at an unrelated GP appointment? If YES what was the quality of your initial treatment and follow up support?

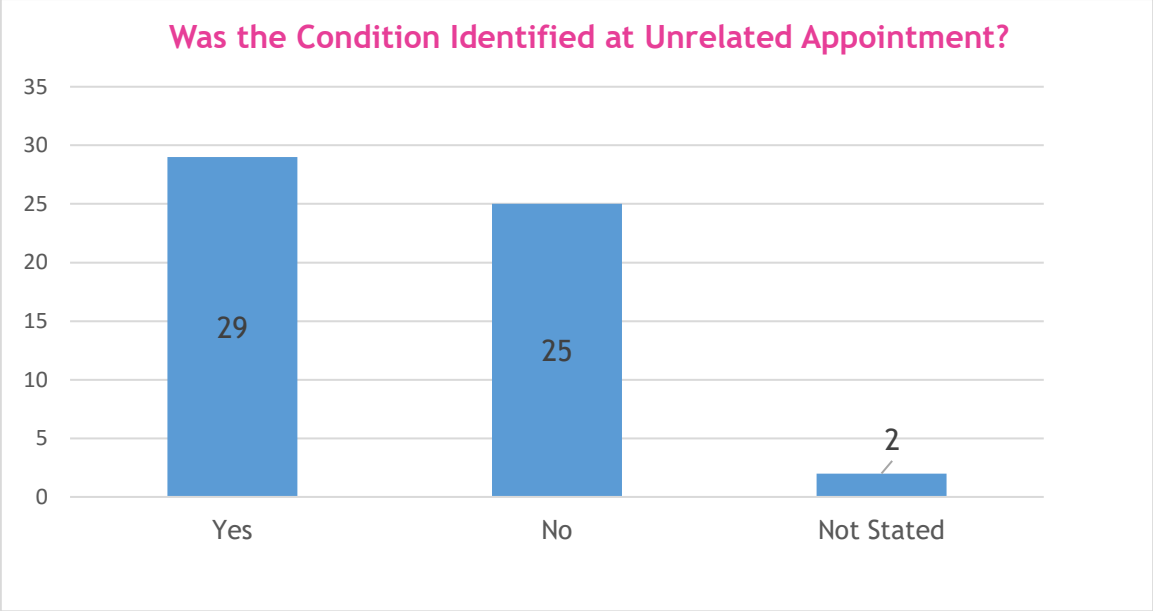
We asked respondents if their diabetes was diagnosed at an unrelated GP appointment. We found that 29 people, or 51%, stated that it was picked up when attending an appointment for an unrelated condition.

Twenty-five people (45%), said that their condition was picked up at a specific diabetes check or as a result of the patient themselves requesting further investigation based on symptoms experienced.

One person was not in the North Somerset area when diagnosed so has not been incorporated into this breakdown and two respondents did not answer this question.

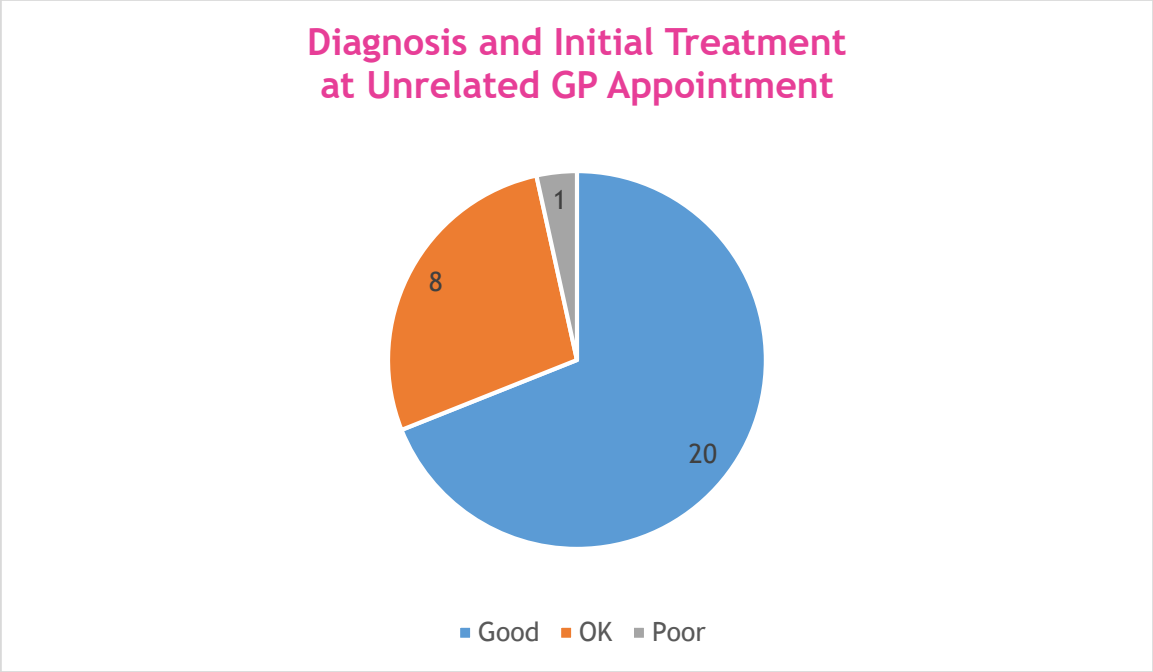
"Very thorough…quick diagnosis."

"Lots of information, a bit of an overload. I felt very down. Not much support around that."



Of the respondents who stated that their diabetes was picked up at an unrelated appointment 20 people, or 63%, rated the diagnosis and initial treatment as 'Good'; 8 people (25%), as 'OK' and 1 person (3%), as 'Poor'.

Two people, or 6%, did not provide any rating for their diagnosis and initial treatment. Again, one person was not in the North Somerset area at the time of their diagnosis which accounts for the remaining 3%.



The one person who provided a rating of 'Poor' commented:

"It was assumed that I was Type 2 because of my age".

Question 4 - Ongoing Care

Which of the following ongoing monitoring do you attend and how do you rate the service?

We asked respondents to rate the ongoing care they received from hospital clinics, GP diabetic clinics and their own GPs.

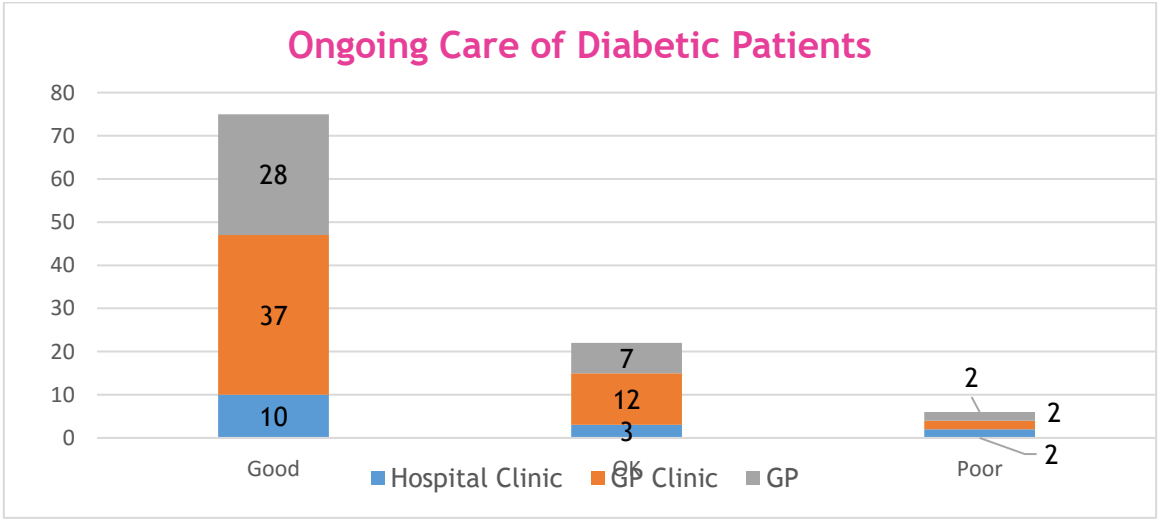
Many of the respondents received ongoing care from more than one service and so rated any or all that applied. Of the responses we received regarding ongoing diabetes care an overwhelming 94% of responses were positive with a rating of 'Good' or 'OK'.

Respondents attending GP diabetic clinics provided 51 responses and accounted for 50% of the total responses received. Of those 37 responses, or 73%, were rated as 'Good'.

GP diabetic clinics received 2 'Poor' ratings amounting to 4% of their total responses; GPs received 2 'Poor' ratings, or 5% of their responses, and hospital clinics also received 2 'Poor' ratings amounting to 13% of their responses. The comments provided with the ratings are below.

"All involved were caring and explained what was going on"

"Rather feel nurse is just going through the motions"



Question 5 - Information and Advice

At diagnosis did you receive information and advice about your condition and how to manage it from your GP, GP Practice Clinic, Hospital Clinic or Community Education Sessions?

We asked respondents to rate the information and advice that they had been provided with since their initial diagnosis and treatment. Many respondents had received information and advice from different sources so rated any or all that applied.

Of these responses almost half, 45%, had received information and advice from their GP diabetic clinic; 15 people, or 23%, from their GP; 15 respondents (18%), from Community Education sessions and 11 respondents (13%), from hospital clinics.

GP diabetic clinics were the most popular service used by our questionnaire respondents to obtain information and advice. Looking at the ratings received for GP diabetic clinics, 27 people, or 73%, were happy with the information and advice provided and offered a rating of 'Good'; 8 respondents (22%), were satisfied and gave a rating of 'OK' and 2 respondents (5%), were dissatisfied and rated the information and advice provided as 'Poor'.

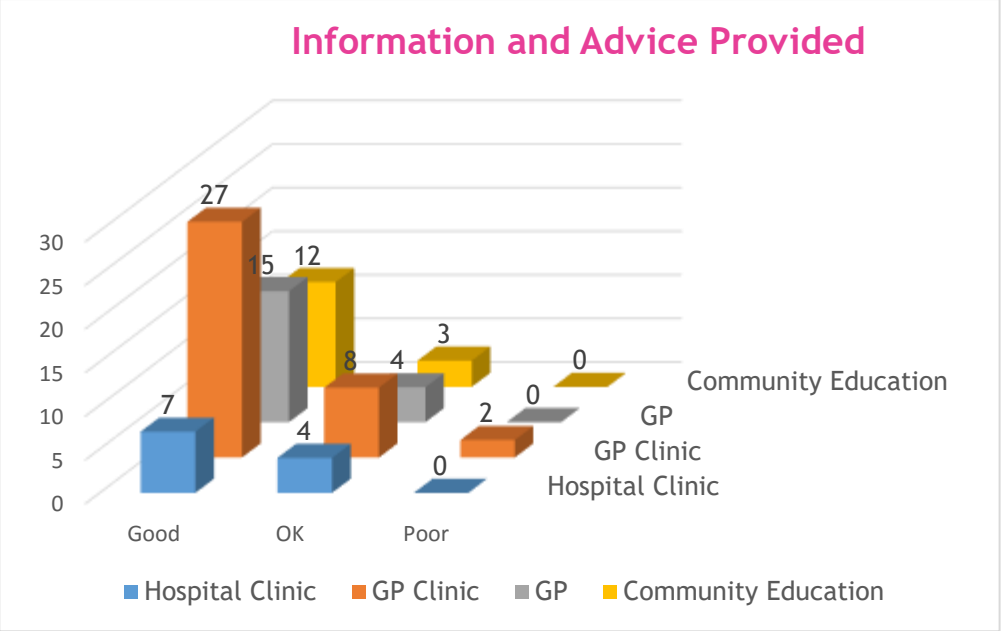
One dissatisfied respondent commented that:

"…been waiting for the DAPHNE and DESMOND course for a long time".

(Details of how to obtain further information about these courses can be found in the Appendix).

Of the remaining information and advice services, GPs, hospital clinics and Community Education sessions, none received a rating of 'Poor', suggesting that respondents were at the satisfied with this aspect of their service.

"More than good – excellent!"



It is recommended that everyone with Type 1 or Type 2 diabetes and/or their carer is offered a structured education programme at (or around) the time of diagnosis, with annual review of their self-care needs. *(National Institute for Care Excellence).*

The percentage of newly diagnosed people who attended an education course in North Somerset in 2012-2013 was 0.2% compared to the England average of 3.6%. The participation rate of GP practices for North Somerset in the National Diabetes Audit 2012-13 was 57.7% which should be taken into account when interpreting results. *(HSCIC: National Diabetes Audit 2012-2013)*

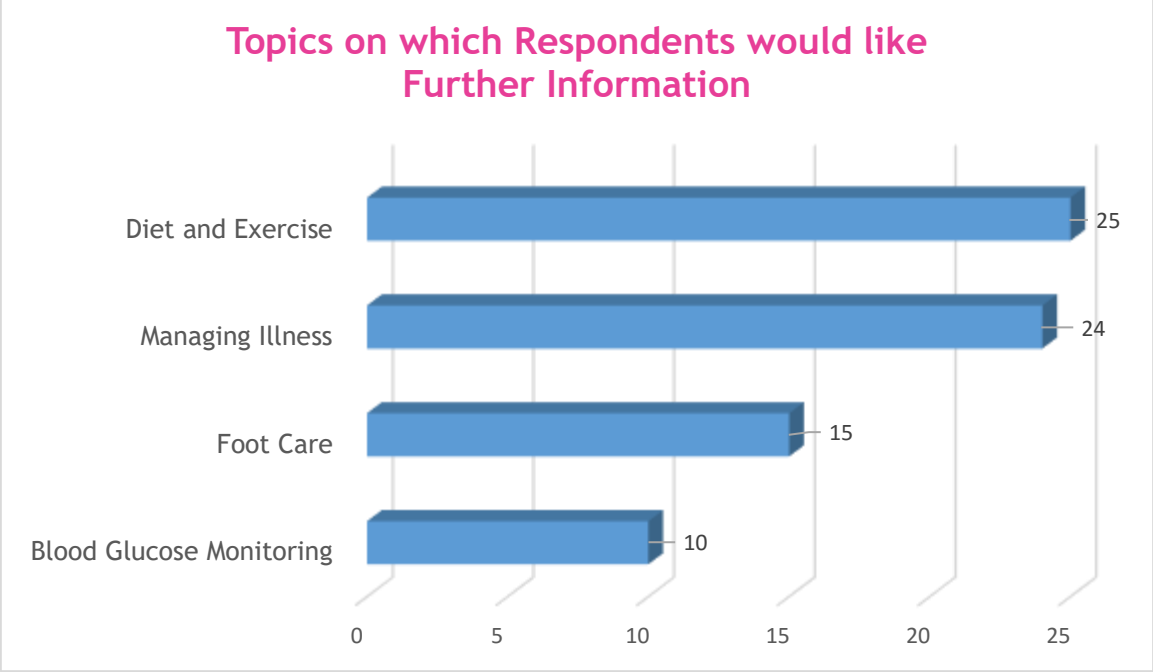
We asked if respondents felt it would be helpful to have further information on certain topics. Once again the respondents were not limited to just one option and as a result many people suggested they would benefit from receiving further information on several different topics.

It appears that two topics, 'Diet and Exercise' and 'Managing Illness', were very popular choices, with respectively 25 respondents, or 34% and 24 people (42%) requesting this further information, indicating that additional information on these topics would be helpful for them.

A total of 15 people, or 20% of those that gave a response to this question, indicated that additional information on foot care would be helpful and 10 respondents (14%), stated that they would benefit from further guidance on blood glucose monitoring.

A total of 12 people, or 21% of the total respondents, indicated that they did not require any further information on any topic. Given this, it appears that a significant number of the respondents who indicated they would like more information required information on a variety of topics rather than details relating to one specific area.

> *The importance of a healthy lifestyle avoiding the problems caused by diabetes and, for some, monitoring blood glucose and altering doses of insulin, makes education for people with diabetes a central part of management.* (NICE).



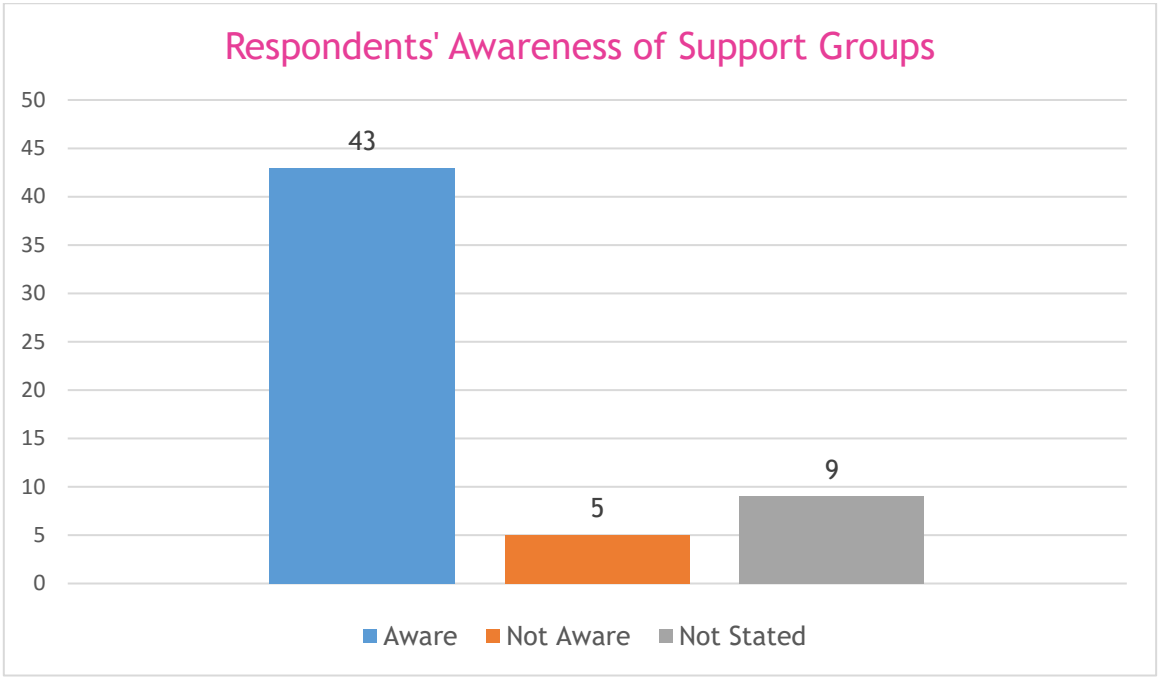
Question 6 - Support Groups

Have you been informed about local and/or national support groups? Do you attend or would you attend if you know about them?

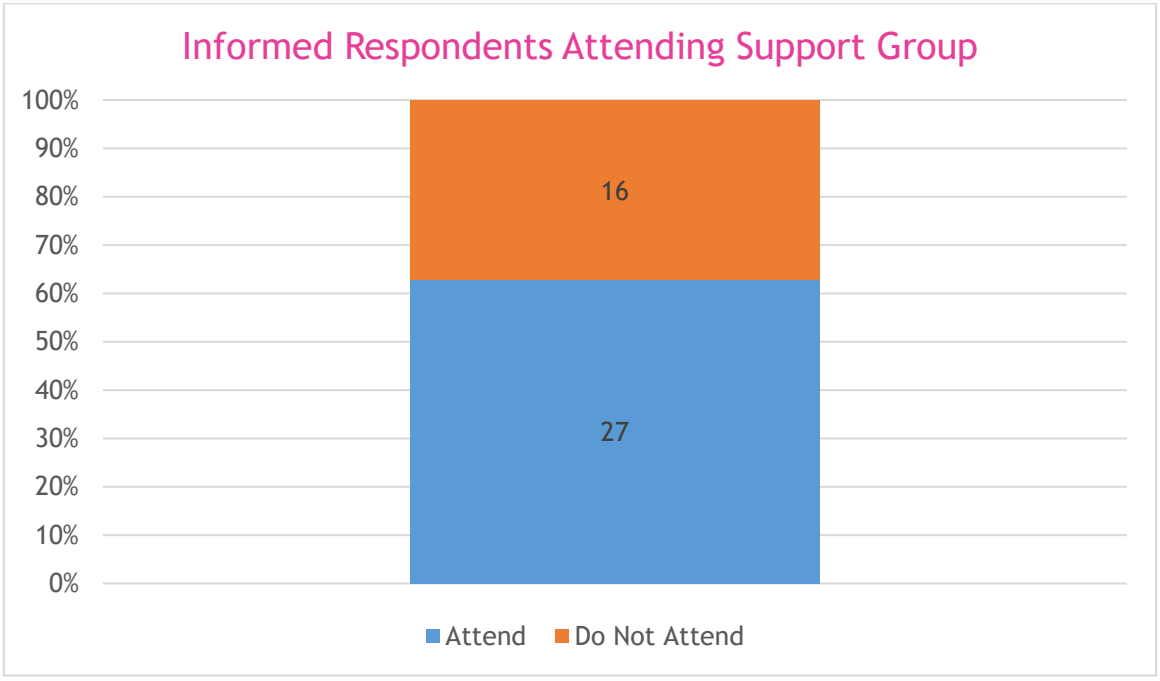
When asked if they had been informed of support groups for people with diabetes 43 people, or 75%, responded that they had been informed; 5 people (9%), stated that they had not been informed and 9 people(16%), did not respond to this question.

Of the respondents that had been made aware of support groups, 27 people, or 64%, did currently attend a support group. One respondent commented that they were considering joining a local support group.

"Very helpful, and it is interesting to speak to others with diabetes and find out how they cope".



Of the 5 people who said they had not been advised of a support group, 4 people, or 80%, said that they would have attended had they been made aware of one.



Additional Intelligence

In addition to the questionnaire responses Healthwatch North Somerset received a small amount of additional non questionnaire feedback regarding diabetes treatment and support which can be found below.

Positive Feedback Received

Patient with diabetes and emphysema said "looked after well" by GP and very "happy with service".
Patient changed surgery and diagnosed with diabetes on first visit.
Patient said staff at GP Practice provide really good care that helped manage insulin enormously.
GP Practice was very quick to diagnose and respond to diabetes.
Patient with diabetes said GP Practice is "great and couldn't fault it".
Patient said GP Practice is great for sorting out vascular stockings. Also when has an appointment due gets a reminder letter.
Patient said podiatrist at GP Practice is great and "can't speak highly enough of her".
Patient said "care from Weston General Hospital for diabetes has always been great".
A member of the Weston Diabetic Support Group said "had learned more from the group than from the GP or nurse".
Diabetic professional said that believes people learn more about managing their condition from a support group than from doctors or nurses.

Negative Feedback Received

GP failed to diagnose diabetes after patient had consulted about symptoms over a long period of time.
GP seemed reluctant to diagnose diabetes and kept telling the patient he was "good for his age".
Patient said difficult to manage medication as brands keep changing.
Patient said diabetic needles changed without notice and didn't like the new type. Patient was allowed to go back to previous brand but worried that funding cuts will mean has to use whichever brand is the cheapest.

Patient said diabetic medication changes in appearance quite often so difficult to keep track if you're on lots of different tablets.
Diabetic service at Weston General Hospital. They don't know what they're doing.
Diabetes service at Weston General Hospital is not good.

Residential Care Home Questionnaire

Coinciding with the data collection period for this report, Healthwatch North Somerset was approached to undertake a piece of work in conjunction with Diabetes UK.

A questionnaire (see Appendix), designed specifically for care homes by Diabetes UK, was posted by Healthwatch North Somerset to the Managers of 110 residential care homes in North Somerset and achieved a 37% response rate. Of the 41 surveys that were returned to us, the following information has been extracted.

Summary of our Findings

Question 1 - Diabetes Prevalence in Residential Care Homes

Do you have any residents with diabetes? If so how many?

In 41 North Somerset residential care homes, a reported 42 residents have insulin dependent diabetes and 75 have non-insulin dependent diabetes. This suggests that on average each care home that responded has 3 residents with diabetes.

Only 3, or 7%, of the 41 homes stated that they did not at the time of responding have any residents with diabetes, suggesting that diabetes is a fairly common condition in the residential care home environment.

Question 2 - Staff Training on Diabetes

Have any of your staff undertaken any diabetes training in the last 2 years? If yes what?

A total of 36, or 88%, of the 41 care homes that responded stated that staff had undergone some form of diabetes training in the last two years.

The staff at five care homes in North Somerset have not undertaken diabetes training in the last two years.

The training that respondents stated had been undertaken was a mixture of face-to-face training sessions with a Trust or training provider, and /or on-line or distance learning. Training undertaken by care home staff within the last two years included the following.

- Diabetes Awareness
- How to Assist Insulin Administration
- Managing Diabetes
- Supporting Patients on Insulin
- Diabetes Signs and Symptoms
- Taking Blood Glucose Measurement

The questionnaire did not ask how many staff had undertaken training. An analysis of the appropriateness and sufficiency of the training undertaken is beyond the scope of this report.

Diabetes UK guidelines have indicated that "*a lack of structured diabetes-related experience and knowledge exists among various categories of care home staff, and that well-designed training and educational programmes are essential*".

And that "*Each care home should expect to have one or more members of care staff who have received training and education in the basic management of residents with diabetes within care home settings. Areas of diabetes knowledge and training deemed important include avoidance and management of hypoglycaemia, importance of good glycaemic control, foot and eye care, ensuring that nutritional assessment, guidance and dietary reviews are in place, and 'sick day' rules*".

(Diabetes UK Good clinical practice guidelines for care home residents with diabetes 2010).

Question 3 - Monitoring the Condition of Diabetic Residents

Do you screen for / assess blood glucose / eye problems / blood pressure / foot problems / dietary needs?

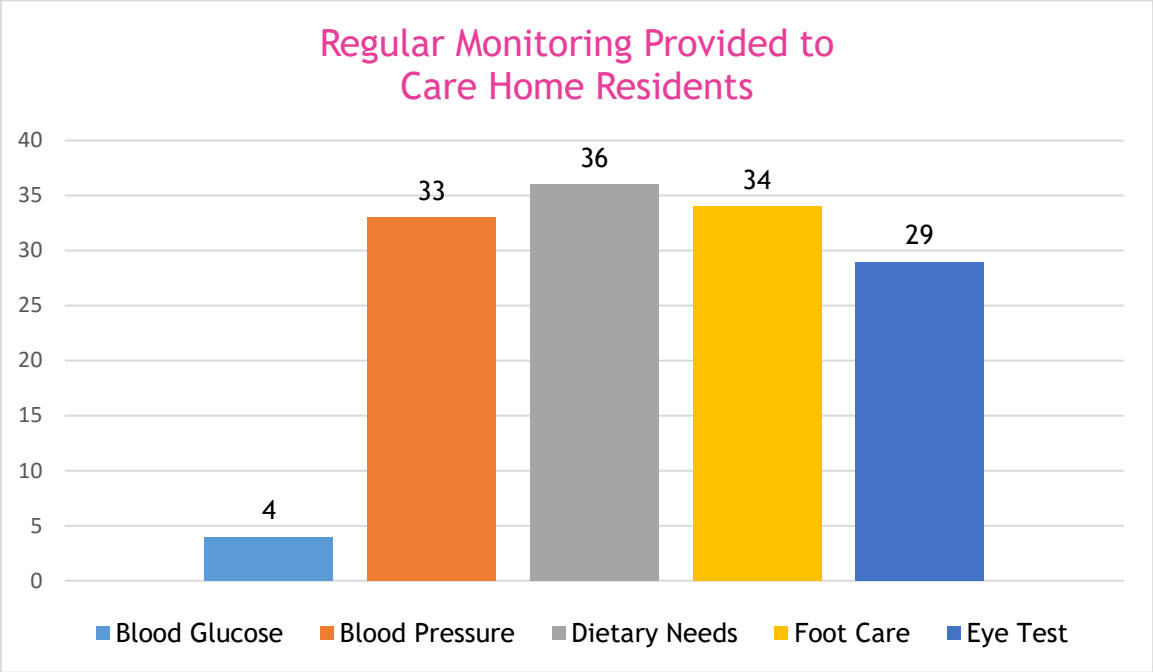
The chart below gives a breakdown of responses received about the routine monitoring carried out for all residents in the responding care homes.

Blood Glucose: A total of 4 care homes, or 10% of those that responded, indicated that they monitor blood glucose routinely for all residents.

Annual Eye Test: A total of 29 (70%), offer an annual eye test to both diabetic and non-diabetic residents.

Blood Pressure: Of the 41 responses, 33 (80%), indicated that they monitor blood pressure for all residents in their care.

Foot Care: A total of 36 (88%), stated that they provide foot care.



These figures indicate that a total of 35 of the care homes that responded to the questionnaire, or 85%, do not routinely check blood glucose levels for all residents, but have indicated that this is a routine check carried out for residents diagnosed with diabetes.

Of those 35 care homes, 8 do not provide an annual eye check and 5 do not provide routine foot care for all residents.

Only 3, or 7%, of the responding care homes advised that they routinely carry out all of the checks indicated for all residents.

Two care homes did not answer this question.

Question 4 - Reviewing the Condition of Diabetic Residents

Do your residents with diabetes attend hospital diabetic clinics, GP diabetic clinics or neither?

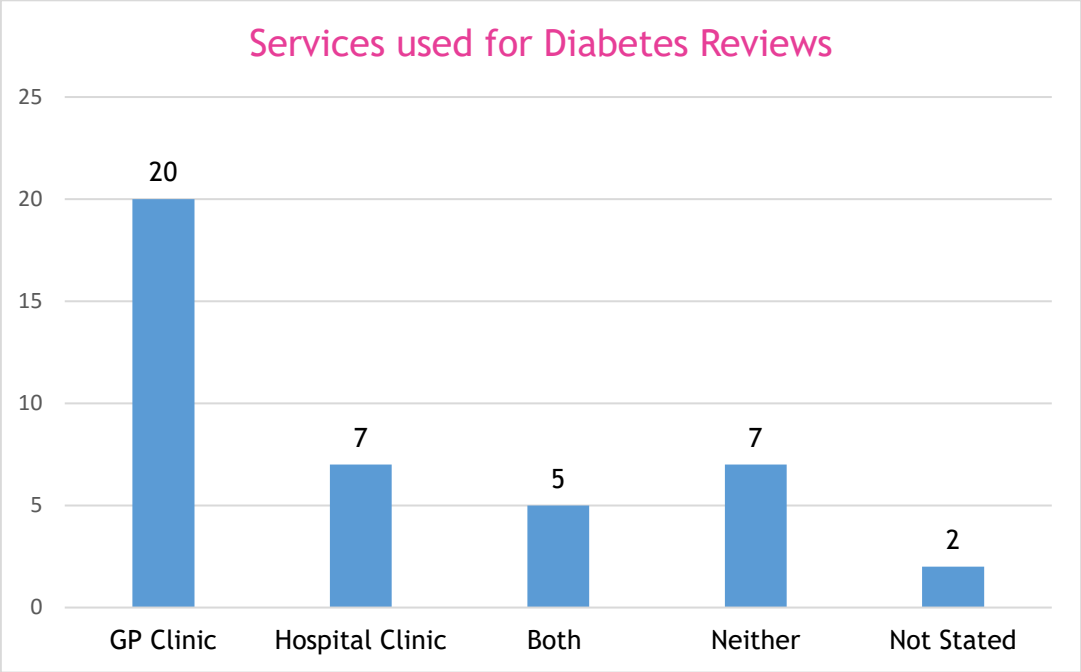
The responses from residential care homes are indicated in the chart below of the services used by residents to have their diabetic condition reviewed.

A total of 5 of the homes, or 12%, utilise both hospital and GP diabetic clinics for patient reviews; 20 (49%) currently use only GP diabetic clinics and 7 (17%), use only hospital diabetic clinics.

7, or 17%, of the responding care homes stated that their diabetic residents attend neither a GP nor hospital diabetic clinic.

Of the 41 respondents, 2, or 5%, did not answer this question.

A total of 23 of the respondents, or 56%, claimed to know who the Diabetic Specialist Nurse in their area was.



Diabetes UK state that high quality diabetes care and management of diabetic residents in care homes requires the input of a wide range of primary care professionals including GPs, Diabetes Nurses and Community Nurses.

(Diabetes UK: Good clinical practice guidelines for care home residents with diabetes 2010).

CQC Guidance states 'Most diabetes-related problems in care homes are linked to failure to follow a structured approach to recognising and managing the condition; • screening on admission • good day to day diabetes care practice • access to specialist medical advice • comprehensive annual diabetes reviews • regular diabetes assessments and care by GPs' (Guidance for CQC staff: Inspecting the quality of care for residents with diabetes mellitus living in care homes 2015).

Additional Note: One care home Manager felt that it would be useful if care home staff could be trained to administer insulin.

Recommendations

Healthwatch regulations stipulate that service providers and commissioners have a duty to respond to local Healthwatch reports and recommendations within 20 working days, in writing, to acknowledge receipt and to explain what action they intend to take or if they do not intend to take action they must explain why. (Health and Social Care Act 2012: Addendum to summary report: issues relating to local Healthwatch regulations).

Healthwatch North Somerset recommends the following based on the feedback received by the public in North Somerset.

We believe the following three recommendations to be achievable, affordable and evidence based.

1. To ensure that all Residential Care Home Managers in North Somerset are aware of the principles of diabetes best practice in Residential Care Homes as outlined by the Diabetes UK National Guidelines and Guidance for CQC Staff.

This report found that of those who responded, 12% had not undertaken diabetes training for staff in the last two years and 85% do not routinely check blood glucose levels for all residents. Of those that responded 44% did not know who their local diabetes nurse was and 17% of diabetic residents do not receive or attend external professional diabetic support for their condition.

2. To increase the provision of local diabetes support group information at an appropriate stage in the treatment of each diabetic patient in an accessible format.

Although 75% of respondents had been made aware of support groups available, this figure could be improved upon by ensuring up to date information is held by GPs, GP Practice diabetic clinics and Hospital clinics, and that staff in primary care settings provide this information at an appropriate stage in the treatment of each diabetic patient in an accessible format.
This ties in with the North Somerset CCG aim to develop and improve diabetes pathways in the community and with the BNSSG Sustainability and Transformation Prevention and Self Care agenda.

3. To increase awareness of and ensure the availability of accessible additional diabetes information resources, particularly on 'Diet and Exercise' and 'Managing Illness' at an appropriate stage in the treatment of each diabetic patient.

Respondents fed back that they would benefit from further information and diabetes resources and support including on the issues of 'Diet and Exercise' and 'Managing Illness'. As above, this ties in with the North Somerset CCG aim to develop and improve diabetes pathways in the community and with the BNSSG Sustainability and Transformation Prevention and Self Care agenda.

Distribution of the Report

This report will be forwarded to the following parties for a response prior to becoming available to the wider public.

1. North Somerset Council
2. North Somerset Clinical Commissioning Group
3. North Somerset Community Partnership (NSCP)

It will also be forwarded to:

4. Healthwatch England
5. NHS England
6. Care Quality Commission

Appendix 1: Reponses from Commissioners and Providers

Response from North Somerset Clinical Commissioning Group, North Somerset Council and North Somerset Community Partnership

04/08/2016

North Somerset Clinical Commissioning Group (CCG), North Somerset Council (NSC) and North Somerset Community Partnership (NSCP) welcome this valuable report and insight into diagnosis, treatment and support for people with diabetes in the local area.

It is encouraging that 94% of responses to the Healthwatch questionnaire were positive with a rating of 'good' or 'OK' and that 75% of respondents had been informed of the local support groups for people with diabetes. However there is opportunity for improvement as represented by the recommendations made by Healthwatch and this is further re-enforced by the survey representing the views of 57 people out of a total of over 10,000 people living with diabetes in North Somerset. In addition a significant amount of the feedback obtained was from attendees of the 3 local diabetes support groups who are likely to be well informed about diabetes and local service provision.

The response from the CCG, NSC and NSCP falls into 2 categories;

1. Response to the recommendations
2. Points of accuracy

Response to recommendations

North Somerset CCG, NSC and NSCP embrace the recommendations made by Healthwatch and commit to taking the following actions in response;

Recommendation 1;
To ensure that all Residential Care Home Managers in North Somerset are aware of the principles of diabetes best practice in Residential Care Homes as outlined by the Diabetes UK National Guidelines and Guidance for CQC Staff.

Response;
NSC holds standard contracts with care homes which focus upon the meeting of resident's needs. The contract process provides the mechanism to address any concerns regarding standards of care.
As part of the community diabetes service commissioned by North Somerset CCG and provided by NSCP a number of training packages are provided for care staff, including staff working in care homes. In addition the NSCP diabetes team provide bespoke training and support for care home staff in the management of specific diabetes residents and treatment regimens.
In order to raise awareness of the principles of diabetes best practice in care homes NSC will;

- Include the best practice standards in a communication to all the local care homes
- Include the best practice standards on the agenda for the providers forum, which all care home managers are invited to attend

Recommendation 2;
To increase the provision of local diabetes support group information at an appropriate stage in the treatment of each diabetic patient in an accessible format.

Response;
In North Somerset all those newly diagnosed with diabetes are provided with a purple folder of information. This includes information about the local provision of peer support.
North Somerset CCG and NSCP have recently undertaken a piece of work in order to remodel the offer of education for adults with type 2 diabetes in the local area with the aim of making it more accessible to a greater number of people. This work also involved a change in provider. The new NSCP service launched on 1st October 2015 and an early success has been that a greater number of people are now referred to the service. Quality Outcomes Framework data shows that 94.33% of those newly diagnosed with diabetes during 2014/15 were referred for structured education. All those referred to the service are provided with information about the local peer support available alongside the information about the choices of education on offer. Also representatives of the local support groups attend the education sessions; this has been the practice for some time and will continue. In addition to this North Somerset CCG will undertake the following actions in order to further raise awareness of the local provision of peer support for people with diabetes;

- Review the information provided on the diabetes pathways about the local peer support provision, which is available in all local GP practices via the electronic system the Map of Medicine
- Include information about the peer support provision in a communication to the GP practices

Recommendation 3;
To increase awareness of and ensure the availability of accessible additional diabetes information resources, particularly on 'Diet and Exercise' and 'Managing Illness' at an appropriate stage in the treatment of each diabetic patient.

Response;
North Somerset CCG and NSCP have recently undertaken a piece of work in order to remodel the offer of education for adults with type 2 diabetes in the local area with the aim of making it more accessible to a greater number of people. This work also involved a change in provider. The new NSCP service launched on 1st October 2015. Part of this work has included the introduction of short form education sessions for people who have been living with diabetes for any length of time. This is a significant enhancement to the previous offer which was only for those newly diagnosed or new to using insulin. The new short form sessions are covering a range of topics. In order to increase awareness of and ensure the availability of accessible additional diabetes information resources, particularly on 'Diet and Exercise' and 'Managing Illness' NSCP will;

- Ensure that these topics are covered in the short form educational sessions being offered
- Work with the North Somerset Diabetes Network to review the written information provided locally about these aspects of diabetes management and identify and implement any opportunities for improvement

North Somerset CCG and NSCP would welcome support and collaborative working with Healthwatch in order to reach those people who do not currently access the education offered in order to understand their needs and wishes.

Points of accuracy

1. Percentage of newly diagnosed who attend an education course in North Somerset in 2012/13 was 0.2% compared to the England average of 3.6%

The above data is dated and was prior to GP practices monitoring the numbers of those newly diagnosed with diabetes being referred to structured education in house. Quality Outcomes Framework data recorded directly by GP practices shows that 94.33% of those newly diagnosed with diabetes during 2014/15 were referred for structured education.

Also North Somerset CCG and NSCP have recently undertaken a piece of work in order to remodel the offer of education for adults with type 2 diabetes in the local area with the aim of making it more accessible to a greater number of people. This work also involved a change in provider. The new NSCP service launched on 1st October 2015 and an early success has been that a greater number of people are now referred to the service. Those referred are then offered a choice of educational options, including taught courses.

2. Page 13 - DAPHNE and DESMOND

DAPHNE and DESMOND are examples of diabetes education packages which can be purchased. These programmes are not used in North Somerset where a local approach to education for people with diabetes has been developed over the last 10 years in order to meet the needs of local people.

3. Page 4 – should read;

'The key points and themes identified as a result of the diabetes transformation project data and evidence review undertaken by North Somerset CCG have been included in appendix 5 of this report. The areas which North Somerset CCG have identified as representing an opportunity for improved care and management have been included in appendix 6 of this report.'

4. Page 34 appendix 6 should read;

'North Somerset Clinical Commissioning Group has identified opportunities for improved care and management which are;

- Reduction in the number of diabetic foot problems and amputations
- Reduction in the incidence of complications of diabetes requiring admission to hospital
- Improve the quality and equality of prescribing of diabetes medication
- Reduction in spend on anti-diabetic medication (e.g. metformin and insulin) per person with diabetes
- Ensuring that care provided for people with diabetes across North Somerset is of equality quality across the patch
- Increase in quality of care
- Development and improvement of diabetes pathways in primary care, secondary care and the community'

5. Page 32 appendix 5 should read;

'The following information represents a summary the key points and themes which have been identified as a result of the data and evidence review completed as part of the Diabetes Transformation Project being undertaken by North Somerset Clinical Commissioning Group.
The information provides an evidence based summary of the current picture of care for people with diabetes in North Somerset.'

6. Page 7 & 27

References should be to the North Somerset Diabetes Network rather than the North Somerset Diabetes Transformation Network.

Response from NHS England-South (South West)

Thank you for the opportunity to comment on the report. We are always keen to understand the provision from the service user perspective and the findings in the report will inform our discussions about diabetes in our Assurance meetings with North Somerset CCG. North Somerset CCG is actively engaged with the SW Clinical Network (SWCN) and the cardiovascular work programme for diabetes which is based on the national priorities.

Response to recommendations

Recommendation 1

To ensure that all Residential Care Home Managers in North Somerset are aware of the principles of diabetes best practice in Residential Care Homes as outlined by the Diabetes UK National Guidelines and Guidance for CQC Staff. "Each care home should expect to have one or more members of care staff who have received training and education in the basic management of residents with diabetes within care home settings. Areas of diabetes knowledge and training deemed important include avoidance and management of hypoglycaemia, importance of good glycaemic control, foot and eye care, ensuring that nutritional assessment, guidance and dietary reviews are in place, and 'sick day' rules".

Response;

This should be a shared action with the commissioners of care home services. However the community Diabetes Specialist Nursing service in North Somerset also offers various training opportunities for care homes and we understand provides individual and group sessions for care homes that request more support. North Somerset CCG is also working with the SWCN to improve the pathway of care for patients with hypoglycaemia. A number of the patients are from care homes and it is anticipated that some education for care home providers will be delivered as part of this work.

Recommendation 2

To increase the provision of local diabetes support group information at an appropriate stage in the treatment of each diabetic patient in an accessible format. Although 75% of respondents had been made aware of support groups available, this figure could be improved upon by ensuring up to date information is held by GPs, GP Practice diabetic clinics and Hospital clinics, and that staff in primary care settings provide this information at an

appropriate stage in the treatment of each diabetic patient in an accessible format. This ties in with the North Somerset CCG aim to develop and improve diabetes pathways in the community and with the BNSSG Sustainability and Transformation Prevention and Self Care agenda.

Response;

As suggested peer support and appropriate advice is so important in supporting self-care in diabetes. It is impressive that 75% of respondents have knowledge of their local support group in North Somerset but this may have been influenced by the target group who completed the questionnaires. We are aware that North Somerset CCG has worked hard to remodel the Structured Education offer for patients with Type 2 diabetes and that all patients at diagnosis receive a booklet with advice and information. In addition an information sheet which includes information of the support groups is sent to all those referred to the education programme for adults with type 2 diabetes. The leaflet is currently being updated to make the information look more professional than the current sheet.

Recommendation 3

To increase awareness of and ensure the availability of accessible additional diabetes information resources, particularly on 'Diet and Exercise' and Respondents fed back that they would benefit from further information and diabetes resources and support including on the issues of 'Diet and Exercise' and 'Managing Illness'. As above, this ties in with the North Somerset CCG aim to develop and improve diabetes pathways in the community and with the BNSSG Sustainability and Transformation Prevention and Self Care agenda.

Access to diabetes structured education is a national priority; the aim is to support more people to manage their own care effectively. The SWCN is working with CCGs in developing a toolkit to help support optimal delivery of structured education. We know the uptake for structured education is low and the toolkit will provide guidance on how to ensure high quality structured education is easily accessible, including various options for patients with diabetes to support their knowledge and understanding. A request would be, if this survey is repeated in the future it would be helpful to investigate a wider population of patients with diabetes who currently choose not to access structured education or peer support, to understand how commissioners could best meet their needs.

Appendix 2: Acknowledgements

Healthwatch North Somerset would like to thank the public of North Somerset for providing feedback on their experiences of diagnosis, treatment and support of diabetes. In particular, we would like to thank the following:

- Weston Diabetes Support Group
- Nailsea and Backwell Diabetes Support Group
- Nailsea Diabetes Support Coffee Morning
- Nailsea Leg Club
- Portishead Diabetes Support Group
- South West Regional Manager of Diabetes UK
- North Somerset Diabetes Transformation Network
- North Somerset Residential Care Homes

Appendix 3: HWNS Diabetes Questionnaire

Healthwatch North Somerset Diabetes Questionnaire

Healthwatch North Somerset are currently looking at the level and quality of diabetes care in the region. This is an anonymous survey, the results of which will be collated into a comprehensive report and given to providers, commissioners and regulators both locally and nationally to inform and influence future service provision. If you prefer to fill this questionnaire in on-line, please follow the following link http://www.smartsurvey.co.uk/s/RLNHX/

1. **ARE YOU:**

   INSULIN DEPENDENT ☐ **NON INSULIN DEPENDENT** ☐

2. **DO YOU HAVE A DIAGNOSIS OF:**

   TYPE I ☐ **TYPE 2** ☐

3. **DIAGNOSIS**

   Was your diabetes picked up at an unrelated GP appointment?

   YES ☐ **NO** ☐

   If **YES** what was the quality of your initial treatment and follow up support?

   GOOD / OK / POOR (please circle your answer)

Please add any further comments.

   If **NO** and you attended your GP with diabetes symptoms, what was the quality of you're:

   i) Diagnosis? *GOOD / OK / POOR (please circle)*

   ii) Initial treatment and follow-up? *GOOD / OK / POOR (please circle)*

Please add any further comments.

4. ABOUT YOUR CARE:

Which of the following ongoing monitoring do you attend and how do you rate your care?

Hospital Diabetic Clinic ☐ *GOOD / OK / POOR (please circle)*

Practice Diabetic Clinic ☐ *GOOD / OK / POOR (please circle)*

GP ☐ *GOOD / OK / POOR (please circle)*

Name of GP/Clinic/Hospital attended……...

How often is your condition reviewed?

3 mths ☐ 6 mths ☐ 12mths ☐ 18mths ☐

Please add any further comments.

5. EDUCATION AND INFORMATION:

At diagnosis did you receive information and advice about your condition and how to manage it from any of the below?

GP ☐

GP Practice Clinic ☐

Hospital Clinic ☐

Community Education Sessions ☐

How useful did you find the information / advice you were given?
GOOD / OK / POOR (circle your answer)

Would you be interested in follow up education sessions **YES** ☐ **NO** ☐

Would you like further information on any of the following?

Foot care in a home environment ☐

Diet & exercise for patients with Diabetes ☐

Blood glucose monitoring ☐

Dealing with illness & Diabetes ☐

Please add any further comments

6. SUPPORT:

Have you been advised of local/National diabetes support/info groups?

YES ☐ **NO** ☐

Do you attend/use or would you attend/use if you knew about them?

YES ☐ **NO** ☐

Please add any further comments including the name of the group or other resources you have used

Appendix 4: Diabetes UK Care Homes Questionnaire

QUESTIONNAIRE

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1. Do you have any residents with diabetes? If so, how many?

INSULIN DEPENDENT ☐ NON INSULIN DEPENDENT ☐

2. Do you screen for or assess any of the following?

	Only people with diabetes	All Residents
BLOOD GLUCOSE	☐	☐
ANNUAL EYE TEST	☐	☐
BLOOD PRESSURE	☐	☐
FOOT CARE	☐	☐
DIETARY NEEDS	☐	☐

3. Do your residents with diabetes attend

a) HOSPITAL DIABETIC ☐ CLINICS

b) GP DIABETIC ☐ CLINICS

c) NEITHER ☐

If neither, how often is medication reviewed by the patient's GP?

3mths ☐ 6mths ☐ 12mths ☐ 18mths ☐

4. Have any of your staff undertaken any diabetes training in the last 2 years?

YES ☐ NO ☐

If yes, what?

5. Who is the Diabetic Specialist Nurse in your area?

Name: Don't Know

Appendix 5: Diabetes Transformation in North Somerset

The following information represents a summary of the key points and themes which have been identified as a result of the Diabetes Transformation Project undertaken by the North Somerset Clinical Commissioning Group.

This information provides an evidence based summary of the current picture of care for people with diabetes in North Somerset.

Data Summary

- Diabetes prevalence is growing by more than 3% each year in North Somerset.
- Diabetes prevalence is slightly lower than the England average; 5.7% vs 6.2%.
- North Somerset CCG has a high admission rate to hospital due to diabetes in comparison to its peers.
- North Somerset CCG has a high spend on anti-diabetic medication per person compared to its peers.
- Spend on diabetic drugs is rising steadily each year; in April 2012 spend was approximately £200k per month, rising to around £270k per month by June 2015.
- Levels of deprivation are higher in the Weston and Worle areas of North Somerset.
- GP practices with high deprivation appear to have the highest rates of admission to hospital for diabetes complications.
- Outpatient rates are much higher in the Weston and Worle part of the CCG patch.
- GP Practices in Portishead, Clevedon and the rural areas of North Somerset provide a higher number of the nationally set diabetes checks and more patients meet national targets for HbA1c (blood sugar), blood pressure and cholesterol.
- Hospital admissions due to diabetic foot conditions are increasing; from 147 in the financial year 2011/12 to 326 in 2014/15.
- In particular there have been large increases in cellulitis and lower limb ulcer admissions due to diabetes in the last few years. In 2011/12 there were 55 admissions due to cellulitis in people with diabetes, in 2014/15 there were 102. Lower limb ulcers in people with diabetes increased from 13 to 85 in the same period.
- Minor amputation rates are increasing, but major amputations have reduced since 2008.

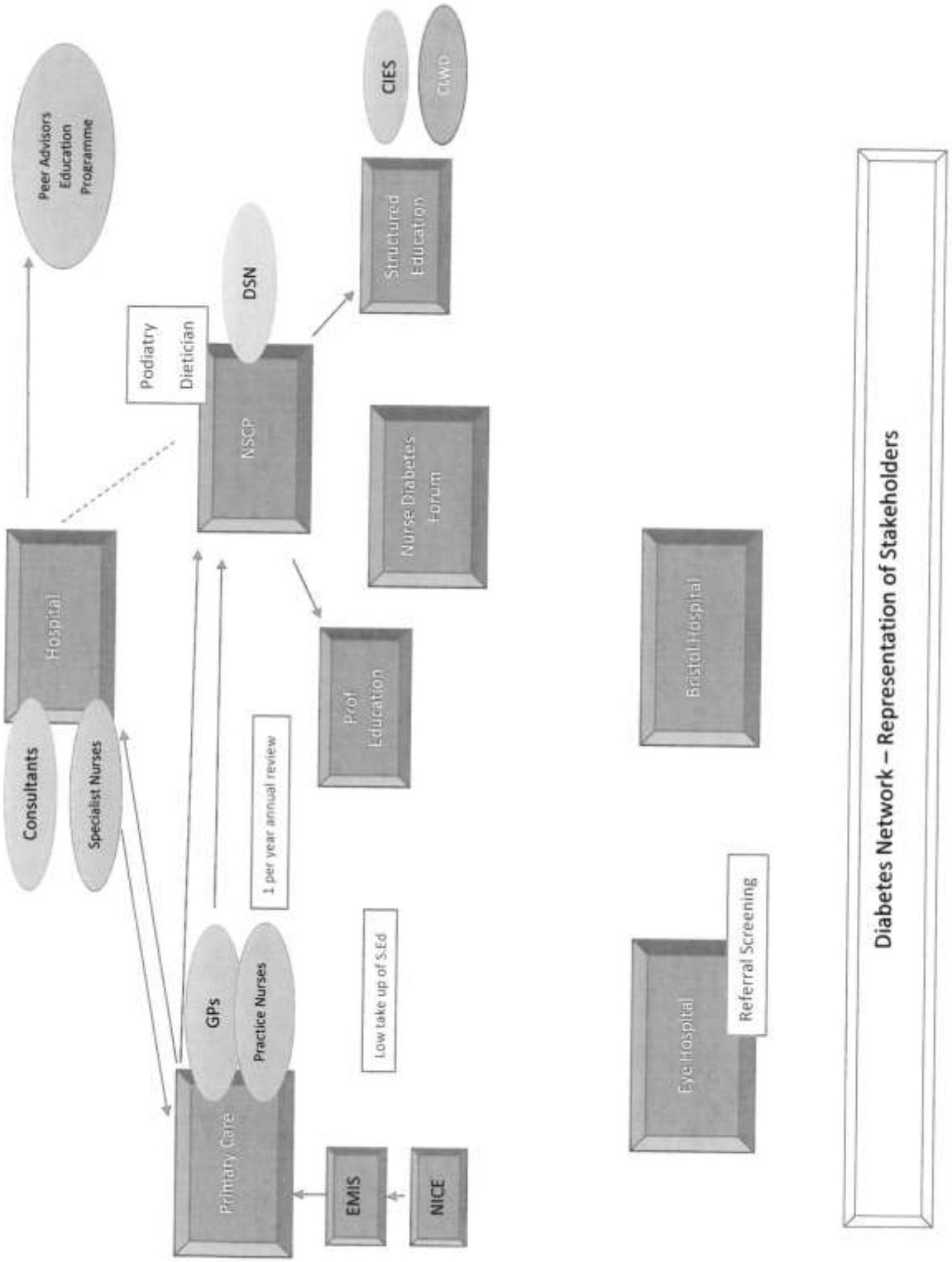
- There are significant numbers of people with diabetes with moderate and high risk feet who are not known to the community podiatry service. These people should be receiving care in the community for their feet according to national guidance.
- Portishead and Clevedon locality has the highest percentage of people with diabetes with moderate and high risk feet receiving care from the community podiatry service.
- Portishead, Clevedon, and Worle localities have seen the biggest percentage increase in admission rates due to diabetic hypoglycaemia in the last 2 years.
- A total of 12% of the North Somerset population is estimated to have non-diabetic hyperglycaemic putting them at high risk of developing type 2 diabetes.

Appendix 6 – Opportunities for Improved Care and Management

The North Somerset Clinical Commissioning Group have identified opportunities for improvement in current diabetes care and management. Specifically they are looking to:-

- Reduce diabetic foot problems and amputations;
- Reduce incidence of complications requiring hospital admission;
- Improve quality and equality of prescribing diabetes medication;
- Ensure care provided across North Somerset is of equal quality;
- Develop and improve diabetes pathways in primary care, secondary care and the community.

Appendix 7 – Care Pathway for Diabetic Patients in North Somerset



Appendix 8 – Useful Information and Support

- Association of British Clinical Diabetologists
  www.diabetologists-abcd.org.uk/home.htm
- Bristol Community Health
  http://briscomhealth.org.uk/diabetes-education-courses/
- British Dietetic Association
  www.bda.uk.org
- DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) Course
  www.diabetes.co.uk/education/desmond.html
- DAFNE (Dose Adjustment for Normal Eating) Course
  www.diabetes.co.uk/education/dafne.html
- Diabetes UK
  https://www.diabetes.org.uk
- Institute for Innovation and Improvement: Think Glucose Campaign
  www.institute.nhs.uk/quality_and_value/think_glucose/welcome_to_the_website_for_thinkglucose.html
- Nailsea, Backwell and District Diabetes Support Group
  www.nailsea-diabetes.org.uk/
- Nailsea District Leg Club
  www.legclub.org/leg-club-directory/view/66
- National Support for People Living with Diabetes
  www.diabetes.org.uk/Documents/About%20Us/Our%20views/Care%20recs/Care-homes-0110.pdf
- NHS Diabetes
  www.nhsiq.nhs.uk/legacy-websites/nhs-diabetes-and-kidney-care.aspx
  NHS Choices
  www.nhs.uk/

- NICE guidance on service pathways and care homes
  www.nice.org.uk
- North Somerset Council On-Line Directory
  http://nsod.n-somerset.gov.uk
- Portishead Diabetes Support Group
  Call 01275 841630
- Weston Diabetes Support Group
  Call 01934 628985

Appendix 10: References

- North Somerset Community Partnership

  www.nscphealth.co.uk/services
- North Somerset Clinical Commissioning Group

  www.northsomersetccg.nhs.uk/
- NHS Outcomes Framework 2012

  www.gov.uk/government/uploads/system/uploads/attachment_data/file/213789/dh_123138.pdf
- National Diabetes Audit

  www.hscic.gov.uk/catalogue/PUB12259/nda-audi-ccg-eng-nsmr-11-12-rep1.pdf
- Public Health England

  http://healthierlives.phe.org.uk/
- NICE (National Institute for Care Excellence)
  www.nice.org.uk
- NICE Diabetes Quality Standard
  www.nice.org.uk/guidance/qs6/chapter/introduction-and-overview
- HSCIC (Health and Social Care Information Centre): National Diabetes Audit
  www.hscic.gov.uk/nda

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