

Diabetes UK and Diabetes Service Meeting with Clitheroe stakeholders 12/3/2013

Diabetes UK Leading Session

Positives

Positive Diabetes Services currently being offered

Paediatrics

- Very good service
- Seen every 3/12
- 24 hour access to expert advice
- At diagnosis seen by MDT and psychology services all prior to discharge
- Home visits and school visits which included teacher training and trip advice for the children.

Longridge

- Retinal and foot screening good, results prompt all other care poor no one could interpret blood glucose testing eventually referred to Preston for structured education (DESMOND) and consultant team support.

Clitheroe Pendle Side

- Diabetes service at above good. Provide adequate information seen on a regular basis and had good contact with the nurses.
- Good access to meters and monitors

Local Chemist

- Offer annual medication reviews
- Good information and support service
- Delivery of medication

Things to be Improved

- Paediatrics no parent support group and no child groups.
- Lack of parent education support ie CHO counting.

Blackburn Hospital

- Appointments being cancelled repeatedly
- Feel isolated
- Unable to get contact with the staff
- Never see the same person twice
- No continuity of care
- 2 parents concerned re transitional clinic
- Cancellation of hospital eye appointments

GP's

- A GP in Oswaldtwistle allegedly knew very little about Diabetes and requested that the person brought leaflets back from Diabetes UK meeting for him.
- Another issue was delay in diagnosis of a child despite the parent pointing it out repeatedly.
- One lady described how for 18/12 she had woken up with blood glucose levels of 3mmol/l and disturbed sleep for approx.. 18/12. Was also found to be hypertensive when seen by the team at Preston.
- A diagnosis was delayed by 5 years
- A patient attending a Sabden GP was allegedly told to go away and live a healthy life style
- Unable to get GP appointments
- Unable to obtain test strips and monitors had no idea why they would be refused
- One patient describe how she had been a Type 2 Diabetic for 25 years and never seen a registered dietician
- Patients and GP's unaware of local patient education
- Community medical and nursing staff not adequately trained

Accrington PALS model

- Thought the service model was good
- More personal
- Access to MDT available
- Liked the idea of back to basics approach
- Telephone support
- Would like GP training to be formalised or pass on to another service ie PALS to deliver Diabetes care
- Diabetes records held in 1 place
- Appointments not repeatedly cancelled
- Consultant access with no red tape
- Covers the closer to home imitative (transforming community services)

- Would be ideal if delivered in Clitheroe Hospital if this happens a member of Diabetes UK support group would attend to chat and support patients

Diabetes Patient Event – Haslingden Link Community Centre Rossendale 5/6/2013

Discussion 1 – Opinions of Current Care

Positives:

- Regular Medication review
- Informative discussions in Bacup delivered by Practice Nurses
- Structured Education Programs – X-PERT, DAFNE
- Blood test availability at practice
- GP referral to access gym
- DSN education re diet – physically shown around supermarket (?)
- Voluntary support group availability
- Pregnancy care
- DUK education 6 week course re food/food labelling (Now Stopped?)
- Retinal Screening – 12 months
- Podiatry service delivered from Haslingden & Rawtenstall. Regular foot checks
- Community care for house-bound patients
- Ability to speak to Diabetic Team at RBH during times of concern

Improvements:

- GP visit 'Felt like a box ticking exercise'
- Conflicting advice from GP/PN
- Variation in care practice to practice
- A lack of information sharing between health services
- Medication follow-ups?
- Access to insulin education programs
- Referrals to Podiatry – Some accessing private services for checks
- Patient/GP/PN knowledge of support groups e.g. Diabetes UK
- Some still travelling for blood to be taken & provided with little if any information regarding meaning of blood results.
- Lack of diabetes clinics at Rawtenstall HC
- BSL interpreter – don't have option of using own preferred interpreter
- No known method for those hard of hearing/deaf to make appointments at Bacup HC
- No appointment reminders
- Diabetes education refresher training?
- Sub-speciality knowledge of diabetes e.g. following routine surgery for unrelated matter
- Long education waiting list for X-PERT/DAFNE

- Care co-ordination post-discharge/primary secondary care gap
- Inconsistency in delivering care e.g. role of HCA?

Discussion 2 - The proposed model for Rossendale/further ideas/Concerns?

- Rossendale Hub & Bacup to be focal points due to access/transport
- Drop-in sessions?
- Access within 24 hours for emergencies?
- Greater access to education courses?
- Refresher courses?
- Website links
- Interpreters
- Access to psychologist?
- Reminder Service e.g. appointments
- Out of hours – Saturday clinic once a month?
- Out of hours contact for Diabetes enquiries?
- Establish links with GP Practices – Would they be willing to refer? Clear pathway development.
- Shared HCP/Patient care plans
- Blood test available before appointment?

Service Promotion Ideas

- Local and regional press
 - Radio Lancashire
 - Supermarkets
 - Leisure Centres/Sports Clubs
 - Post Office
 - Libraries
 - GP Surgery/Additional health care service awareness
 - Pharmacy
 - Internet/Social Networks
 - Support Groups
- } Public Areas

Diabetes Patient Event – Christ Church, Nelson Pendle 14/08/2013

Discussion 1 – Opinions of Current Care

Positives:

- Regular Medication review
- Podiatry Care
- Emergency Care
- Structured Education Programs
- Blood test availability at practice
- DSN support
- Practice Nurse – screening/testing
- Retinal Screening – 12 months
- Access to Consultant/Diabetes Specialist Team at BGH
- Annual GP Reviews
- GP access via telephone
- Pendle hospital care
- Access to blood glucose meters at BGH
- Supply of test strips
- Communication re Appointments

Improvements:

- Service accessibility – not all in one place
- Charge for services e.g eye care
- Knowledge of sub-speciality staff at RBH e.g appropriate use of insulin
- Education courses – not widely available
- Inconsistency in quality/accessibility (Standardised protocol)
- Support for those starting insulin
- Explanation on diagnosis
- Access to testing strips
- Exercise options
- Emergency access to Podiatrist?
- Additional point of access – referral to specialist Diabetes service
- No recall system for Podiatry
- Only see first 12 patients at drop-in centre
- Not aware of “hot foot” line at ELHT
- Inconsistency in Podiatry referral – some to GP practice?
- Appointments – Access (RBH)/Local support group/shared records
- Cancellations & delays
- Care plan (shared?)

Discussion 2 - The proposed model for Rossendale/further ideas/Concerns?

- Local clinics – Community hospital/Yarnspinners
- Drop-in sessions?
- Interpreters
- Self-referral?
- Greater access to education courses?
- Incorporate exercise provision
- Establish links with GP Practices – Would they be willing to refer? Clear pathway development.
- Shared HCP/Patient care plans
- Need to raise a
- Awareness of specialist service

Service Promotion Ideas

- Pendle Radio/2BR
- Local press – Citizen/Burnley Express/Nelson Leader
- CVS
- Health Watch Lancashire
- Church & Mosques
- Local Shops
- Library
- Pharmacies
- Opticians
- Supermarkets
- GP Practices