

The Somerset Diabetes Service Newsletter

Somerset Diabetes Service Newsletter for Patients and Carers

Issue No 2 Summer 2011

Welcome to the second issue of the Somerset Diabetes Service Newsletter for Patients and Carers

This newsletter contains information for patients and carers on a range of service developments that have been introduced for adult patients with diabetes in Somerset over the past 12 months and outlines plans for the future.

In the summer of 2008, the Somerset Primary Care Trust (NHS Somerset), in partnership with Diabetes UK, consulted with patients and carers and with service providers on how future services should be developed to meet the needs of growing numbers of patients being diagnosed with diabetes.

The service developments currently being introduced in Somerset are a response to the feedback from the consultation.

Somerset Diabetes Service redesigned to meet needs of growing number of people with diabetes

The number of people with diagnosed diabetes in Somerset reached a record high of 24,400 last year, an increase of over 5000 (27%) compared with 5 years ago. A further 6,000 people with diabetes are estimated to be undiagnosed.

The increase in the number of people with diabetes was anticipated in Somerset and the Service Specification for the Somerset Model of Care for Adult Patients with Diabetes, which was approved by the NHS Somerset Professional Executive Committee in February 2009, was specifically designed to meet the needs of growing numbers of people with diabetes.

A key aim of the new Model of Care was to ensure that all people with diabetes in Somerset have access to high quality, accessible services, with care provided in the right place at the right time by the right people.

After an initial preparation period, the new care Pathway was introduced in April 2010. The focus for the first 12 months has been on **enhancing and expanding community diabetes services** and providing **education and training for both professionals and newly diagnosed patients**.

The focus for the coming year will be on embedding the new pathway in GP practices, reducing the gap between diagnosed and undiagnosed, tackling the education needs of patients who did not have structured education at the time of diagnosis, and providing diabetes awareness training for care home staff.

Progress so far

Key themes from the 2008 consultation

Whilst patients were generally happy with their care, they wanted **more information** about their condition, **more choice and control** over how their care was managed and **more control over their care in hospital**.

Variation in services and health outcomes

The review in 2008 found that health outcomes in Somerset were better overall than the national average. However, services were provided in different ways across the county and there was also variation in health outcomes at local level.

The full report on the 2008 consultation on diabetes services is available on the NHS Somerset website at <http://www.somerset.nhs.uk/welcome/world-class-commissioning-partnerships/ltc-networks/diabetes> or you can telephone 01935 384082 for a hard copy.

Enhancing and expanding community services..

- The new Specialist Diabetes Nursing and Dietetics Course got off to an excellent start in 2010, with over 2700 clinic attendances in its first year as a county-wide service.
- This service was introduced primarily to help patients having difficulty keeping their blood sugar levels under control.
- The staffing establishments of the community podiatry and dietetic services have also been increased.

Education and training..

- Diabetes Information Packs are now being issued routinely by GP practices to people with newly diagnosed diabetes.
 - Nearly twice as many people with diabetes accessed a structured education course in the past 12 months compared with two years ago (over 800 in total)
 - A training and support programme has been introduced for GP practice staff, with on-line diabetes care guidance about to be launched.
 - Diabetes care training has been introduced for non-specialist ward staff in hospitals.
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Working together

with your healthcare team

The Somerset Diabetes Service is the umbrella term for all the services contributing to the care of adult patients with diabetes.

Doctors and nurses from across Somerset have worked together with managers to combine, enhance and add to existing services to meet the varying needs of growing numbers of patients across the county with diabetes.

The Somerset Diabetes Service aims to provide care that is personalised, responsive and holistic in the context of how people want to lead their lives.



To achieve the best possible diabetes care, it is essential for you to work in partnership with your diabetes healthcare team and use your combined experience and expertise to agree what care and support you need. Your diabetes care may be provided in different settings by different professionals, depending on your needs, which may vary over time. We have identified below some of the different people who may be part of your diabetes healthcare team and may contribute to your care plan.

- ❑ **Consultant Physician/Diabetologist:** a doctor who specialises in diabetes, often (but not always) seen at a hospital, clinic or diabetes centre
- ❑ **Diabetes Specialist Nurse:** a nurse with specialist expertise in diabetes who works solely with people with diabetes
- ❑ **District Nurse:** (now called **Community Nurse**) – a generalist community nurse involved in a wide range of care provided in people's homes and residential homes
- ❑ **GP (General Practitioner)** – medically trained family doctor, with wide range of medical expertise. May play key role in monitoring your diabetes and prescribing treatment.
- ❑ **Ophthalmologist:** a doctor with specialist training in the diagnosis and treatment of conditions that affect the eyes
- ❑ **Pharmacist:** a person with expertise in the use of medicines, many also provide lifestyle advice and carry out medicines use reviews
- ❑ **Podiatrist:** a person with expert knowledge and a recognised qualification in conditions of the foot and lower limbs, may be based in the community or in acute hospital
- ❑ **Practice Nurse:** a nurse based at your surgery who may provide your diabetes care. Some may have specialist knowledge of diabetes.
- ❑ **Psychologist:** an expert in psychology who may help you with some of the psychological difficulties of living with diabetes, anxiety or depression
- ❑ **Registered dietitian:** a person who can work with you to assess your eating habits and help you make lifestyle and food choices to manage your diabetes.

How are we doing?

One year on, we are now at the stage of evaluating the initial impact of the Diabetes Model of Care and we would appreciate your input.

There are some early signs that the increasing focus on diabetes care is beginning to lead to improved clinical outcomes (specifically around glucose control).

But what we really need to know at this stage is **what the care experience has been like for you over the past 12 months.**

To this end, we have enclosed a questionnaire with this newsletter which we would be grateful if you would complete and return in the pre-paid envelope provided **by Wednesday 22 June.**

The aim of the questionnaire is to find out the extent to which which you feel you have had the support and information you needed over the past 12 months to be in the control of your own care.

The intention is to repeat this questionnaire on an annual basis, with this year serving as a baseline for future benchmarking.

We recognise that there is still much to do to continue to improve diabetes services in Somerset. We feel that working together with patients and carers, we can make this happen.

Thank you for your ongoing support for the improvement of diabetes care in Somerset.

Contact:

For copies of this newsletter or details of events please contact: Hayley Wright, Secretary, Strategic Development Directorate, NHS Somerset

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Information can be posted if necessary, and can be made available in other languages and formats.

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