

25 July 2020: Public and staff Diabetes - Online Engagement session

Facilitator	John Boyman - Head of Public Relations - Strategic Projects	Engagement Team	SE
Speakers	Alex Whitfield – Chief Executive, Hampshire Hospitals NHS Foundation Trust Dr Christian Chilcott - GP and Clinical Lead for Diabetes, North Hampshire Clinical Commissioning Group Sarah Tombling - Diabetes Specialist Nurse, Hampshire Hospitals NHS Foundation Trust Dr Kate Fayers - Consultant Diabetologist, Southern Health NHS Foundation Trust Dr Paul O'Halloran - GP and Diabetes Primary Care Lead, Wessex Strategic Clinical Network Dr Tamara Everington - Chief Clinical Informatics Officer, Hampshire Hospitals NHS Foundation Trust		
Registered participants	28	Participants on Zoom	21
Questions/Comment raised pre-event at registration / website [comments box on Eventbrite registration form]: Ensure total integration - Health, Social, Welfare. Particularly to ensure optimisation of beds and appropriate release of patients to ensure appropriate aftercare.			
Questions/Comments raised during online event: COMMENT: My wife has been a diabetes type 1 patient for 70 years. Through the majority of that period she's been well cared for at Basingstoke. One thing that she'd say is that she lives with diabetes rather than suffers from diabetes. That mental attitude is very positive. She is, in principle, very willing to give support to young mothers with children who are newly diagnosed and answer their concerns of living with diabetes at a young age. So if there's any opportunities in the new structure for patients with that type of diabetes to be part of forums that can assist outside of the clinical teams but from a family or parental point of view, my wife and others in a similar position would be only too keen to join that forum. ANSWER: I think this is important. It's interesting because at a number of these sessions we've run, we've had communities groups say it would be good to have some space and invitations for people who have lived experiences with disease etc to be able to share with people who have just been diagnosed. It's come up through cardiology, respiratory disease etc. We're hearing this message from people who want to help. I would want us, as a system, to be providing these things near to home, not just in a central hospital.			

ANSWER: We could see local support groups having a 'residence' in community diabetes hubs so people have instant access support and advice.

COMMENT: I am chair of the local diabetes group. We are pushing to try and be more involved but it has been somewhat difficult. It took me about 6 months to get agreement that we could at least put up a stand in Basingstoke hospital. It should not have taken me 6 months of continual messaging. Rather unfortunately the first time we would have had a stand was when it was advised that diabetes patients shouldn't go out and about and then a week later there was lockdown. I welcome what people are now saying and that this is important for community hubs. We are here to help and would like to provide the time and effort, and please make use of us as we would be willing to go out into the local communities to give our experience.

ANSWER: I'm really sorry it took that long. Please, anybody on this call, if you're getting blocked and frustrated please drop me an email and that helps. I know it shouldn't, the processes should work, but every now and then I can help unblock. We are trying to work and facilitate ways that community groups can come in because the perspective you bring is different. We think we know what it feels like to be a patient but we don't always, so the patient experiences are important for us to hear.

Thank you for everything you do to support our patients.

COMMENT: As a type 1 and an employee of the Trust, I am looked after very well by West Hampshire Diabetes Service. They have been amazing with me. Previous to that when the service was redesigned I fell through the net so I'd like to be reassured that there will be continuity of care for the patients. It would be nice to think that you could have some patients on your 'senate' to give their input on the way you are going.

ANSWER: We can see in our data that there is something positive in delivering care in that setting. In terms of you being left out of the service, what you're describing is absolutely right and a real thing. It will certainly inform how we change things going forward. I think what will be helpful this time is that we have staff working in the community and the hospital.

ANSWER: To reassure you that with the change in the way we have delivered some of the appointments recently, we are mindful that some of the people might feel like they've slipped through the net, especially over the past year where things have been busy and we haven't had some dietary cover in Basingstoke. We're doing a big piece of work across all services at the moment making sure that we haven't lost anybody to follow-up. But if you feel that you should have been seen or are concerned then please do contact the admin teams at the respective hospitals.

QUESTION FROM CHAT: As a long-time type 2 diabetes patient I think that if you wish to prevent complications that would need more frequent monitoring than the two times a year I currently receive. Annual reviews would be insufficient intervals to provide proper monitoring. I have experienced a clear difference between the quality of diabetes care available at the hospital and that obtained from my local GP surgery. I think the Community hub idea is excellent but the danger is that diluting the range of expertise that Dr Chilcott's slide detailed would undermine the effectivity of the intent

ANSWER: Part of working towards virtualized working is that instead of having a standard six-monthly appointment, you can ask for help when you need it. We also use PIFU - patient initiated follow-up, which is about shifting the mindset. It's less about us dictating, and more of you saying what you need, which may be more or less. It may be every month for a period then less often.

COMMENT: I am a support volunteer for Diabetes UK. The problem with PIFU is that quite a lot of people you speak to, although they want to contact you, they won't phone up. I know someone who hasn't had a blood test for 4 months who won't phone up the surgery. So that is a problem. Once some of the type 2s come out of the system, they just get on with their lives.

ANSWER: The other things we've done is design a whole electronic outcome which means we shouldn't lose sight of any patients. We know we have lost sight of patients in the past and that's not good at all. The new system will make us aware of when people are not engaging and we will take steps to address that. You're right that sometimes those who need care the most are least able to ask for it.

ANSWER: I agree that we need to be more nuanced in how often we see people and it may not be seen physically. In north and west Hampshire we have treatment to target which is about agreeing a target with the patient and making sure you see them as frequently as you need to until you hit that target. Then when you're at the target, it may be you agree that you'll see each other on an annual basis but we're here if you need us. It's about changing it to what that individual patient needs. Variability is key.

ANSWER: We now have a better sight of the data than ever before. We can use the data to spot the people who have missed a blood test.

COMMENT: More general point that I have observed in outpatients. A lot of patients are chair-bound. There are complications with using hoists used in hospitals and those provided in the community. If carers put the patient in the chair at home, there's no opportunity for putting that patient on a trolley or a bed because the sling is different from the sling used with the hoist used in hospitals. There is an incompatibility with the equipment used within the hospitals and similar equipment used in the community and it has led to missed opportunities, cancelled appointments and I think there's scope here for improvement for patients having this difficulty.

ANSWER: I get this and have been looking at this for a long time. To reassure you that when patients are in hospitals there is a concerted effort to get the equipment used in hospital the same as that that goes out to the community. Previously when wards needed a certain piece of equipment, there wasn't a universal package. We're starting to work very closely to make sure the equipment is the same. It's a slow, gradual process of moving the equipment over so it is the same. Hopefully by the time we move over to the new hospital, and a lot before then, it should be the same.

QUESTION FROM CHAT: Have moved to low carb diet which has had real benefits in terms of blood results and weight. Is encouragement and support for these types of

initiatives and voluntary groups being given consideration. Can roll out of CGM and artificial pancreas technology be speeded up to improve control and quality of life for type 1 diabetic individuals? Cost effectiveness may be longer term but quality of life pretty immediate

ANSWER: One of the things that is so brilliant about working in a diabetes service is the ability to develop a bespoke fit, identifying the individual needs of what each patient needs. They are all subtly different. It's a brilliant topic to work in and identify what they require. There are some people with some super-specialist requirements which might mean us having to refer those patients out of the area. They are a small group of patients. For the bulk it's about connecting with them to help them make changes and lifestyle changes. It might be around dietary changes. Everybody is different and that's the lovely thing with working in this specialty.

CGM - Continuous glucose monitoring. Some patients don't monitor at all, some finger prick with a monitor, and some type 1 might use a new patch, and some have a more advanced monitor that can alarm you if you go low.

QUESTION: I always get a bit worried about centralisation because I've seen a lot of it and not always the best solutions. I know they've built new hospitals but they've closed cottage hospitals and they were the buffer between GPs and the big hospitals. From an IT point of view, it's great to get the data in a central place and then distribute the processes.

ANSWER: The whole debate about centralising and close to home is really interesting. We already run all our acute stroke care from Winchester and all our acute cardiac from Basingstoke. We've seen real improvements in outcomes. Acute means, if you're going to have a stent fitted within an hour or two of a cardiac event, you go to Basingstoke where there is a team 24/7. If you need follow up care you have it more locally, as well as outpatients. It's the balance where you need a whole team available in an instant with expensive kit and balancing that with all the diagnostics tests closer to where people live. It's not a binary conversation - centralise v put everything out. There are some things that work well centrally and others that work better locally.

ANSWER: We've managed this well in hemophilia care. People have their plan and it's visible to the whole system. On a day-to-day basis care is delivered to people in their homes or local surgery. It's about making sure we've got the benefits of centralisation against what works well in local care.

ANSWER: Thank you for hearing patients' opinions. I work with the community and acute, so I am in a good position to access patients notes but IT has always been our weakest point. Different services don't know what the other has done which sometimes leads to duplication which isn't good for the patients and conflicting opinions. I am in a good position that I can access it all. IT is going to be essential that we can access different things. One-stop shops are the way forward where instead of coming to 5 different venues for 5 different appointments, they come to one venue for everything.

I wanted to note that diabetes is increasing and years ago when it moved out of the hospital into GP surgeries it added extra burden to the GPs. They are doing an excellent job but they will need to have some extra support especially as we know

about the legacy effects. The hub idea is one of the good ideas that can bring everything together - GP, community and secondary care.

COMMENT: The diabetes specialist nurses at Basingstoke hospital have always been very responsive to queries and requests for help - if the Community hubs had that level of responsiveness it would be excellent.

ANSWER: The national programme is about money for a new acute hospital but that feels so unambitious for our population. What we want to do is understand what is the right model of care. If that then requires more investment for other facilities then let's work together to get it. If we all work together and have a coherent vision which is centred around what our patients and our population needs, I am convinced we will find the money to do that because it will be the right thing to do. If we can keep people fitter and healthier, and treat them closer to where they live, then the hospital won't need to be as big.

ANSWER: If we invest now in really good community diabetes you'll prevent the need to go into hospital.

ANSWER: I have the benefit of seeing lots of different diabetes services all around Wessex, and I think there is no doubt at all that community diabetes services are key. People with diabetes have a huge journey. The services that work well, work well as teams. The big message is that the bulk of the work is done in the community, we all want an acute hospital that deals with acute problems but then works together with the community to continue ongoing maintenance. What Covid has exemplified is some of the problems with acute care - we can't know when we'll need it and we want good care, but hopefully we won't need to go anywhere near a hospital at all. That's where the teams need to work together. This includes GPs and their extended team.

COMMENT: I would love to know how the new hospital will facilitate teams working together in the community and during the acute phase. Facilitate the communication. Well done everyone getting on the call - it's evidence of how much is changed. It can be done.

ANSWER: It's all to know people as people when face-to-face. When you see people rather than electronically they are people not just on a screen. I think the process of deciding what we're going to put in a building will pull us together. How do we get patients with living experience of this in the conversation right from the beginning, so by the time it's being built we are one team?

COMMENT: The surgery has served me very well for the last 14 years since I was diagnosed with Type 2. Their system works very well. I get plenty of feedback, I do wonder about these hubs and if it becomes somewhere less local, I might not be so happy about the situation. My personal situation I have a lot to be thankful for the care and attention given to me by Overton.

One of the possible sites which has been highlighted for the new hospital is by J7 of the M3. That whole area is subject to quite a lot of development proposals but it is currently totally without public transport. I'm not sure what noises the trust is making to Hampshire County Council and the borough on insisting on a western bypass for Basingstoke. From Overton I can get to Frimely in 35 minutes if there are no problems on the motorway. If you consider that and think of some of the outlying areas which might be served by the

new hospital, without a bypass for Basingstoke then you've got serious access problems for people in the north of the county getting to the hospital.

The ring-road is notorious for being congested. You have to bear in mind the total time it takes to get somewhere.

ANSWER: We haven't made any decisions on sites but we have 9 possible sites that we're looking into. I was in a meeting yesterday with Hampshire County Council and Basingstoke and Deane Borough Council looking at all the transport issues around the sites on our list making sure the motorway routes and the public transport routes are taken into account. Part of the funding we have already received is to do transport surveys - working out distances etc.

ANSWER: The community hubs will be in addition to what you receive from primary care, not instead of. You'll get what you're getting now, if not more from your primary care team, and the community diabetes hubs will be in addition to that if you need their expertise. It may be somewhere for retinal screening, for a talk or social engagement event.

COMMENT: One of the issues about diabetes is that it is one of those life-long things and type 1 and type 2 are so different. If you're 8 years old and diagnosed with type 1, the issues are very different from when you are 70 and diagnosed with type 2. I know you are engaging with primary care but the systems need to involve primary care, as the bulk is done by primary care so the IT systems in primary care need to link in. Blood tests are really good now because the systems link in. Buildings can create an us-and-them package, so a shiny new building will be brilliant for acute care but we need to look at integration and working together.

Chat download anonymised

Dr Christian Chilcott: NHCCG Clinical Lead for Diabetes: Such an important point to share XX. Thank you

Dr Christian Chilcott: NHCCG Clinical Lead for Diabetes : Good to see you XX!

As part of the Winchester and Eastleigh Diabetes Uk group we welcome any opportunity to talk to and meet to support newly diagnosed

Dr Tamara Everington - HHFT: There was a great piece of research showing that putting young and old together to share experience led to better health for all - completely fits with XX's points.

As a long-time type 2 diabetes patient I think that if you wish to prevent complications that would need more frequent monitoring than the two times a year I currently receive. Annual reviews would be insufficient intervals to provide proper monitoring. I have experienced a clear difference between the quality of diabetes care available at the hospital and that obtained from my local GP surgery. I think the Community hub idea is excellent but the danger is that diluting the range of expertise that Dr Chilcott's slide detailed would undermine the effectivity of the intent

sharing experiences with new patients could even be done via zoom or other virtual forums

Have moved to low carb diet which has had real benefits in terms of blood results and weight. Is encouragement and support for these types of initiatives and voluntary groups being given consideration. Can roll out of CGM and artificial pancreas technology be speeded up to improve control and quality of life for type 1 diabetic individuals? Cost effectiveness may be longer term but quality of life pretty immediate.

With the government's proposed push to help with obesity control will this give you an opportunity to do more in prevention as Covid has highlighted the impact of obesity and diabetes on Covid?

PPG involvement in all of this is important I think

I am also a member of Basingstoke Diabetes UK. I am served by Watership Down Practice and we had started Group Diabetes sessions before Covid. We have since tried Zoom meeting. I believe that these sessions need to be increased not only in numbers but also in frequency. They can be a great boost for people especially those that live alone.

comment above [*regarding more frequent monitoring*]- I think it's up to us a patients to highlight any complications - e.g. if our own daily blood readings start to rise, etc. I have always found my doctors surgery there for advice in such circumstances. I don't think a standard of more than one or two appointments/reviews is necessary or the best use of resources

Dr Christian Chilcott: NHCCG Clinical Lead for Diabetes : XX, prevention and helping with tackling obesity is such a key area for all of us to focus on - health, education, Local councils, sports bodies etc. Effort put into this now will reap benefits for years to come. And not just with Diabetes!

Thanks Christian - I totally agree¹

The diabetes specialist nurses at Basingstoke hospital have always been very responsive to queries and requests for help - if the Community hubs had that level of responsiveness it would be excellent.

I agree, Basingstoke Nurses are brilliant always in my experience.

I have had type 1 for two years and the diabetes team of in the Lasham unit have always been incredibly helpful and supportive- thank you to them

Hi, I am XX, Group Secretary of the Aylesbury Vale Group of Diabetes UK, based in Aylesbury, Buckinghamshire. We are also keen to be linked in with our local Hospital (Stoke Mandeville Hospital), If I can ask colleagues in the Hampshire local Diabetes UK Groups to contact me on XX, this would be appreciated, as we would benefit from advice and knowledge in engaging with Hospitals and NHS in general.

My wife has Type 1 for last two and a half years and Lasham Unit nurses have always been very helpful and reachable. The Lasham Unit and staff is vital for the community.

Dr Christian Chilcott: NHCCG Clinical Lead for Diabetes : XX: Good to see you! Group Diabetes sessions have been really popular at Watership Down Health. They are such a good way to help support those with diabetes. Both face to face and now virtually. Thank you for your feedback I will pass it on to Faye and the team!

Dr Tamara Everington - HHFT: Important messages - in building new solutions we must remember to maintain and build in all the great things that happen now (as well as getting rid of unnecessary steps)

Hello Dr Fayers, what is CGM?

Thanks Dr. Fayers

The establishment of Community hubs will be defined by available budget. Is it too early to understand the number of Community hubs across north Hampshire ??

Dr Christian Chilcott: NHCCG Clinical Lead for Diabetes : XX: Simple answer is yes it is too early. But Community Diabetes hubs do not need the high tech/ standards of hospital buildings so will be relatively value for money. The main cost with hubs will be ensuring there is a high quality team to be part of the Diabetes team.

Dr Christian Chilcott: NHCCG Clinical Lead for Diabetes : Joined up IT! The Holy Grail of super effective health care.

I certainly think that Eye screening would benefit from a central hub the current new system where you may have to go somewhere to have your eye screened that is not on a bus route so have to drive or be driven, and if you have no choice to drive yourself you have to wait a couple of hours to go home. This is a problem we hear about a lot, the old vans that were accessed by supermarkets made life easier. Small point but important.

At present Eye screening done at different location from Lasham unit and not at a central location. A central unit/place for anything related to Diabetes might be a decent idea.

I am part of the ZOE Covid study, are others also part of this?

Very Good Point XX

Oxlade I have to leave but a big thank you for the care I get for my TDI from Kates team

Dr Paul O'Halloran: Good to see you XX! Many thanks, Paul

I have one question. Is existing hospital likely to be completely moved from Aldermaston Road (existing site) in Basingstoke?

Alex Whitfield - CEO HHFT: Hi, XX - all options still on the table - no decisions at this stage!

thanks everyone

Dr Tamara Everington - HHFT: Thank you all

Dr Christian Chilcott: NHCCG Clinical Lead for Diabetes : Thank you all. Good to hear your ideas and views.

Thanks Alex and everyone. Existing site is best suited for all of our town in my personal view.

I mean the present hospital location on Aldermaston Road.

Thank you to everyone who organised this event.

Thank You All.

Bye

Report written by: SE