

Diabetes Care Report

London Borough of Harrow

May 2018



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1. Acknowledgements

On behalf of the Enterprise Wellness Board, the accountable body for Healthwatch Harrow (HWH) we would like to thank all the organisations, volunteers and groups who participated in the diabetes care review; Diabetes UK Harrow, Type 1 Meet Up Group, Harrow CCG, Harrow Diabetes Strategy Implementation Group, Harrow African Caribbean Association, Indian Association of Harrow, Carramea Project and their service users/carers who kindly gave up their time to participate in the focus groups and surveys.

We are also most grateful to the people of Harrow diagnosed with both Diabetes Type 1 (T1) and Type 2 (T2) and their carers who participated in completing our online survey, without whom this report would not have been possible.

2. Executive Summary

In Harrow, diabetes poses a particularly major health problem due to a significantly higher than national average proportion of people with both diagnosed and estimated diabetes. In view of the estimated increase in prevalence of diabetes in the next decade (In Harrow the prevalence of diabetes is estimated to increase by 45% by 2030) the potential impact of the condition, diagnosis, treatment and ongoing care and support for diabetic patients is key.

The rationale for a review of diabetes care in Harrow emanates from the intelligence gathered from our local engagement and concerns raised through our Healthwatch Forums, intelligence gathered from our CRISPI database (Concerns, Request for Information, Signposting and Intelligence), the Harrow CCG Diabetes Strategy for Harrow, and the Harrow CCG Sustainable Transformational Plans (STP). The Health and Wellbeing Board have prioritised diabetes as a major health problem, as the prevalence of both diagnosed and estimated diabetes in Harrow is higher than in neighbouring boroughs and significantly higher than the London and England average.

In this report we will outline the approach taken, share what the people of Harrow who engaged in the survey and focus groups said and look at how this links with the work currently being progressed by the Clinical Commissioning Group/ Strategic Implementation Group in Harrow. The report goes on to highlight gaps and identify improvements required in the provision of Diabetes services in Harrow.

Enterprise Wellness as the corporate entity accountable for the Healthwatch Harrow service, are pleased to present this report which will be shared through our various social media channels and the local media with:

Local Harrow Residents
Harrow CCG Diabetes Strategy Implementation Group
NHS Harrow CCG, Equalities & Engagement Committee
Harrow Council Commissioners
Harrow Health and Wellbeing Board
Health and Social Care Scrutiny Sub-Committee
General Practices
Voluntary and Community Sector
Harrow Clinical Commissioning Group (CCG)
Care Quality Commission (CQC)
Healthwatch England.

The Harrow CCG Diabetes Strategy, highlights Harrow as having amongst one of the highest rates of Type 2 Diabetes in the country. Overweight/obesity, lack of physical activity and the ethnic profile of the borough are particularly important risk factors for Harrow. Harrow's population is non-White (42% Asian, 7% Black). Type 2 diabetes is six times more common in people of South Asian origin and up to three times more common in people of African and African-Caribbean origin. The strategy also estimates that around 14.2% of the new Type 2 diabetes cases in Harrow could be prevented if adults were 100% active, and 5.6% prevented if adults were 50% active.

Harrow residents have the third highest rate of Diabetes in the UK and one of the key aims of the report was to understand if the current diabetes care and services offered is responsive to the needs of the people living with a diabetes condition in Harrow.

The purpose of this report is to provide a summary of the views of Harrow residents on diabetes care in Harrow, those with both Type 1 and Type 2 diabetes and those caring for someone with diabetes. The recommendations from this report will inform and influence the Harrow CCG Commissioners, local Harrow Diabetes Strategy and the delivery of the National Diabetes Prevention Programme (NDPP) through the Harrow Diabetes Strategy Implementation group (HDSIG).

Summary of recommendations

Whilst it is acknowledged that the Harrow CCG Diabetes Strategy has identified some of these areas and work is in progress. The full recommendations are held in

Section 8 of this report, however the key recommendations that need to be addressed are:

1. Every GP Practice to have a Diabetes Specialist Nurse attached to it.
2. Protocol / standards for communication between CCG, LNWHT & CLCH to be implemented ensuring that there is effective feedback and learning between DSNs/Consultants and GP's around the care of diabetes patients and those at risk of diabetes.
3. Development of a more holistic and integrated approach to the provision of services, ensuring sufficient trained resource and expertise and flexibility in provision e.g. evenings and weekends.
4. Raised awareness of and access to structured education programmes, understanding what is available and how to access it.
5. Improved provision of information / guidance in a greater number of languages particularly for the Black and Minority Ethnicity Groups e.g. Asians, Somali, and Middle Eastern Groups.
6. Raised awareness of the local plans of the Diabetes Transformation Programme.

Ash Verma

Chair, Enterprise Wellness

10 May 2018

3. About Healthwatch Harrow

The role of Healthwatch Harrow's service is to ensure the voice, opinions and views of the local community on health and social care matters are listened to and factored in by those responsible for commissioning services, as an integral part of their performance and quality assurance arrangements. Healthwatch Harrow'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.

Monitoring & Scrutiny

Holding health & social care services to account.

Our Mission:

"To champion concerns about health and social care provision based on focused engagement, signposting and monitoring and scrutiny activities gathered from the diverse Harrow resident, working and business community within available resources".

4. Methodology

Survey

Healthwatch Harrow designed a specific diabetes survey in partnership with Harrow CCG and the diabetes patient representatives. This survey was targeted at adults and was completed by people who attended the focus groups and was available online from November 2017 to March 2018.

The survey asked specific questions about people's understanding of their diagnosis, where and how to access support, awareness and type of specific diabetes services they may have received and their general experiences and improvements to the services. The survey questions asked can be found in Appendix 1 and analysis of the responses in Appendix 2.

A total of 125 people completed the survey, of which 70 completed online and 55 people after participation in the focus groups. Whilst the survey asked if the respondent had Type 1 or Type 2 diabetes only 14 of the 125 people completing the survey had Type 1 diabetes. 21 people completing the survey were carers of someone with diabetes

Focus Groups

Five focus groups were carried out with:

- Harrow Diabetes UK
- Diabetes Type1 Meet Up group
- Harrow African Caribbean Association
- Indian Association of Harrow
- Carramea.

Healthwatch Forum

Healthwatch Harrow held 2 forums on 27th September and 29th November 2017 where questions / concerns were raised. Specific questions were asked around diabetes care, what was working and what wasn't working. Comments raised covered how well the Diabetes Specialist Nurses were trained, an improvement in the podiatry services. But lack of accessibility to services, education and waiting times were key themes.

CRISPI

Data was gathered from our CRISPI database (Concerns, Request for Information, Signposting and Intelligence) over the past year and analysed to identify issues and concerns raised about Diabetes care and support services.

National and Local Influences

We carried out desktop research of findings from both National and Local Strategies to identify key trends and influences and how these have influenced the provision of local services and action plans. These included the following documents:

Diabetes GP Survey

Diabetes Strategy for Harrow v 0.4

Harrow Diabetes Strategy Implementation Group Minutes 19/01/18 & 02/03/18

Local Services NW London Diabetes Transformation Programme: 2018 / 2019

North West London Diabetes Transformation Milestone Plan

STP Business Case Executive Summary

HSCIC: National Diabetes Audit

CQC: My diabetes, my care Report 2016

NICE Guidelines [NG28] - Type 2 Diabetes in Adults.

5. About Diabetes

What is diabetes?

Diabetes is a complex lifelong condition that causes a person's blood glucose level to become too high. It is a chronic metabolic disorder which increases the risk of damage to the eyes, kidneys, nerves, heart and blood vessels.

In Type 1 diabetes, the body does not produce insulin and glucose levels increase, which can seriously damage the body's organs. In Type 2 diabetes, the body does not produce enough insulin, or the body's cells do not react to insulin. Type 1 diabetes is often hereditary and diagnosed in childhood and not associated with excess body weight. It cannot be controlled without taking insulin.

Type 2 diabetes is more common in older people and is often associated with obesity. In England around 90% of adults with diabetes have Type 2. When diabetes is not well-managed, it can lead to serious complications such as heart disease, kidney disease, stroke, amputations, and blindness. Usually diagnosed in those over aged 30 and linked with excess body weight and lack of exercise. Usually treated initially without medication.

Patients with diabetes are at higher risk of mental health disorders including depression and psychotic disorders than the general population. People with diabetes are about twice as likely to develop cardiovascular disease, including heart failure, angina, stroke, and peripheral vascular disease. Cardiovascular disease is a major cause of death and disability in people with diabetes and is accountable for 44% of deaths in type 1 diabetics and 52% in type 2 diabetics.

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)

Care Quality Commission (CQC) found that most people experience good community diabetes care overall. However, care was not always found to be flexible and responsive enough to meet people's individual needs. (CQC: My diabetes, my care Report 2016)

At Risk of Type 2 Diabetes

Some people have blood sugar levels above the normal range, but not high enough to be diagnosed as having diabetes. If a person's blood sugar level is above the normal range, the risk of developing full-blown diabetes is increased. It's very important for diabetes to be diagnosed as early as possible because it will get progressively worse if left untreated.

NICE Guidelines [NG28]

The following is a list of the quality standards that should govern commissioning of services for the care and treatment for adults with diabetes provide by NICE. There are separate standards for pregnant women and children and young people.

- Adults at high risk of type 2 diabetes are offered a referral to an intensive lifestyle-change programme
- Adults with type 2 diabetes are offered a structured education programme at diagnosis
- Adults with type 1 diabetes are offered a structured education programme 6-12 months after diagnosis
- Adults with type 2 diabetes whose HbA1c level is 58 mmol/mol (7.5%) or above after 6 months with single-drug treatment are offered dual therapy
- Adults at moderate or high risk of developing a diabetic foot problem are referred to the foot protection service
- Adults with a limb-threatening or life-threatening diabetic foot problem are referred immediately for specialist assessment and treatment
- Adults with type 1 diabetes in hospital receive advice from a multidisciplinary team with expertise in diabetes.

The National Diabetes Audit (NDA) is managed by the Health & Social Care Information Centre in collaboration with Diabetes UK and is supported by Public Health England. NDA measure the effectiveness of diabetes healthcare against NICE Clinical Guidelines & Quality Standards in England and Wales.

6. Key findings - Survey & What you said

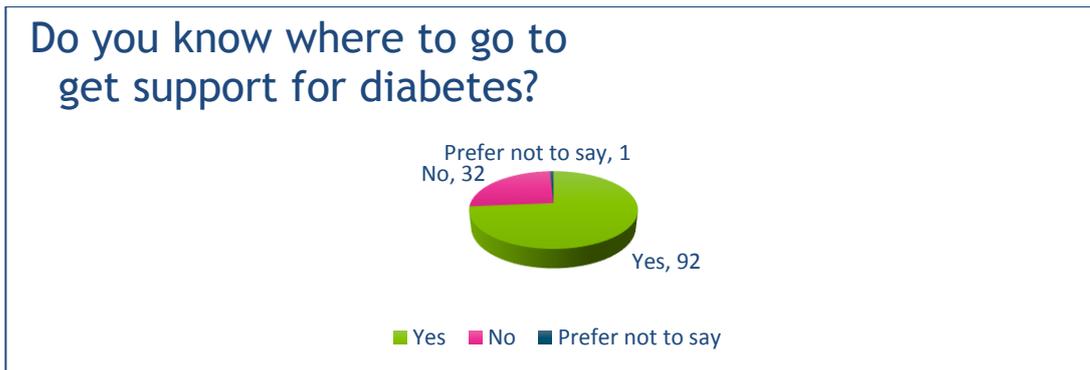
Survey

Full details of the survey are shown in Appendix 2. Key points were:

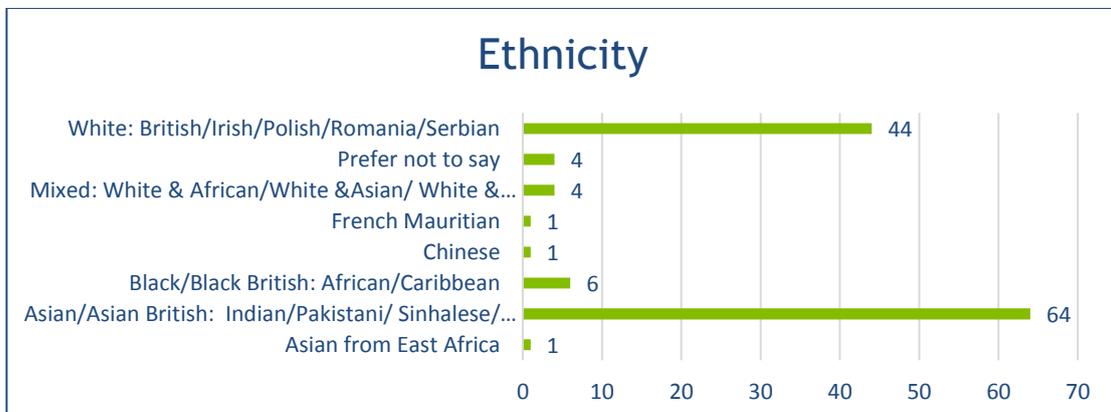
78% of those surveyed were aware of the signs and symptoms of diabetes



73% of those surveyed know where to go to get support



51% of the respondents were of Asian/ Indian, Sinhalese /Sri Lankan / Tamil/ Afghan/ Bangladeshi communities



Comments from survey and focus groups

Diabetes Nurse comes once a month, struggling to contact the nurse and have follow up appointment.



“We have to chase up the DNS all the time to make an appointment”. Average waiting time to see a DSN is 3 months.”

“I am quite happy with the service provided.”

“I believe prevention is the best cure.”

“The annual podiatry checks are superficial and don’t cover all of the recommended checks. For those with Type 1 diabetes it would be far more appropriate to have an annual check with a Diabetes specialist, not a GP We already have to attend SO MANY appointments.”

“Went to Podiatry once - was told not bad enough - won't see me again.”

“The need for more joint up and coordinated appointments for podiatry, eye screening and annual checks, one stop shop approach where the appointments are all coordinated and offered in one place. Services are currently fragmented and need for more holistic service provision with evening and weekend appointment availability for working age group”

“More education and signposting; awareness around medication, food, exercises and mental health.”

“Diabetes Education awareness raising for children to enable them to educate parents where English is not their first language around diet and healthy eating choices.”



“Annual Check-ups- GPs continue to carry out blood tests to monitor Kidney function but are no longer are testing diabetic patient’s urine for protein.”



“There is a lack of information on how to access a diabetes management course. Most at the Harrow group have never been offered education. GPs need to attend courses, so they can ‘sell’ benefits convincingly. Can course graduates help sell to those who are reluctant to attend - or can taster evenings be organised before enrolling (for T1 courses, as these ARE available for XPERT)?”

“GPs do not follow the Diabetes UK 15 checks which should be done for the people with Diabetes”

“More BSL Interrupters to facilitate access to information for the deaf community, workshops created for the deaf patients to learn more about diabetes”

“Harrow Council is restricting the use of test strips to non-type 1 diabetics; whilst this saves money it is possibly counter-productive”



e *A directory of diabetes- related services would be useful, especially in poster or leaflet format.* **g**

Key themes from what you said:

- A shortage of Diabetic Specialist Nurses (DSN), currently there are 4 DSN in Harrow to support 32 GP surgeries and another 2 DSN to be recruited. The majority experienced great difficulty to see their DSN with wait times up to a month to see a DSN.

“It is impossible to get an appointment to see the DSN - they only visit surgery once a month. The old one left and the new one is very inexperienced.”

- Lack of access to Structured Education Programmes, many respondents requested better access and ongoing education, information, knowledge and advice around their diabetes condition for themselves and their carer’s and around prevention, diet and exercise, awareness of service provision and self-management. Particularly relevant to those from the BAME community, where English is not their first language.

“Our community Indian, Tamil needs to be educated”

“The value of peer support in being able to share and offer guidance and support to others around different treatment and managing the condition”

- Lack of coordinated appointments across podiatry, eye screening and annual health checks. Services are currently fragmented and there is a need for more holistic approach including providing evening and weekend appointments.

“We need shorter waiting times for Podiatry. More talks, groups, discussions to learn more about diabetes and how to help myself.”

- Insufficient diabetes awareness for:
 - Parents where English is not their first language around symptoms, prevention, diet and healthy eating choices
 - Teachers around identifying the signs and symptoms and understanding how to support children with Diabetes
 - GP’s lack of expertise or time to understand the complexity of the condition or the time to offer a comprehensive clinical assessment or consistent and accurate advice to patients.

“Diabetes Education awareness raising for children to enable them to educate parents where English is not their first language around diet and healthy eating choices”

“People need more information about signs and conditions and to educate the local community in different languages”

- Lack of awareness around prevention - People at risk of developing diabetes, wasn’t part of the survey but was a general observation picked up through the comments raised in the focus groups.

“Need to educate the younger generations about awareness of diabetes.”

“Development of diabetes community health champions.”

7. National & Local Picture

The findings of this report have identified some positive areas such as awareness around knowledge of diagnosis and where to get support but some key areas for improvement have also been identified. It is encouraging to see that these have been recognised at a national and local level. The following is a high-level summary of the National Picture and the work that is already in progress in Harrow, which once implemented should address a great number of the concerns identified in this report.

National

National estimates suggest 15% of the population with diabetes remain undiagnosed.

The NHS Five Year Forward View focus on improving diabetes prevention and the introduction of the NHS Diabetes Prevention Programme aims to support people who have been identified as at high risk of developing Type 2 diabetes to become healthier.

Diabetes UK held a nationwide conversation with over 9,000 people affected by diabetes. What they said was 'living with diabetes is hard'. 'There's never a day off.' Key themes were the need for:

- More support for emotional and psychological health.
- Better access to healthcare professionals who understand diabetes.
- Better access to technology and treatments.
- Widely available information and education.
- More support and understanding at work and school.

Local

At a local level, diabetes poses a particularly major health problem in Harrow, due to a significantly higher than national average proportion of people with diagnosed diabetes, and low physical activity rates. There are currently 16,927 patients (17+ year olds) in Harrow with diagnosed diabetes [QOF, 2014/15] (8.8% of the population - higher than the national average of 6.4%). In Harrow the prevalence of diabetes is expected to increase by 45% by 2030.

There are a number of reasons that could account for the higher-than-national average proportion of our population with diabetes. Some of the key reasons outlined in the Harrow CCG Diabetes Strategy for Harrow are:

- Harrow has a high proportion of BME (Black and Minority Ethnic) patients: 54% of Harrow's population is non-White (42% Asian, 7% Black). Type 2 diabetes is six times more common in people of South Asian origin and up to three times more common in people of African and African-Caribbean origin. There is limited awareness and poor uptake of relevant behaviour change or preventative services such as psychological support, healthy eating, and physical activity
- Physical inactivity: Only 76.9% of people in Harrow do any walking at least once a week which is below the England average of 80.6%. Harrow is 2nd lowest in London. Deaths can be significantly reduced through physical activity. It is estimated that around 14.2% of the new Type 2 diabetes cases in Harrow could be prevented if adults were 100% active, and 5.6% prevented if adults were 50% active
- Poor diet, which can increase the risk of Type 2 diabetes
- Deprivation: People living in the most deprived parts of the borough are 2.5 times more likely to have Type 2 diabetes than those living in the least deprived areas
- Childhood obesity is an increasing problem, representing the future patients with Type 2 diabetes. For year 6 children, Harrow ranks statistically above the England average (20.8% Harrow prevalence against the England average of 19.1%). For children in Reception year, Harrow's 9.3% prevalence is similar to the England average of 9.5%
- There is limited focus on identifying 'at-risk' populations.

The local Public Health estimates suggest that there could be over 4,000 people with undiagnosed diabetes in Harrow. The prevalence of both diagnosed and estimated diabetes in Harrow is higher than in neighbouring boroughs and significantly higher than the London and England average.

North West London

Harrow CCG are working in close partnership with the other 7 CCGs in North West London, to share best practice and pool and share resources. The North West London Diabetes Transformation Programme was formed to identify the strategic objectives and drivers for change across NW London as agreed by the 8 CCG's and NHS London.

The STP Business Case Executive Summary outlines that NW London have agreed the improvement of diabetes management aligned to the priority

areas outlined in the 2016/17 CCG Improvement and Assessment Framework, which are:

- Improve structured education uptake in order to improve self-care
- Tackle unwarranted variation in achievement of the NICE recommended treatment targets for blood pressure
- Reduce amputation rates through improvements in foot care pathways
- Improve in-patient care and reduce length of stay in acute hospitals through increased provision of diabetes specialist nurses
- Maximise National Diabetes Audit (NDA) participation
- Maximise diabetes prevention through the National Diabetes Prevention Programme (NDPP).

Key outcomes indicators are:

- Reduced prevalence gap of selected long-term conditions
- Improved secondary prevention outcomes for patients with diabetes
- Improved self-care
- Reduction in unscheduled admissions
- Reduced complications rates (includes primary and secondary diagnosis in hospital data).

Harrow

The Harrow Diabetes Strategy Implementation Group has been established to implement the Diabetes Transformation Programme at a local level and to working in collaboration with all key stakeholders across North West London.

The Harrow programme has established 4 projects to improve the service for patients with diabetes or those at risk of developing diabetes.

These projects are:

1. Diabetes Self Care (Structured Education)

By increasing the uptake of self-care programmes; digital, face to face and peer to peer programmes. This will improve people's quality of life, reduce complications of diabetes, increase Type 2 diabetes remission rates and reduce medicine dependency and dependency on clinical interventions.

2. Integrated Diabetes Care

By control of the 3 treatment targets (HbA1c \leq target (variable), blood pressure \leq 140/80, cholesterol \leq 4mmpl/L), which will make a significant difference to reduction in clinical complications, non-elective admissions, morbidity and mortality. Reduce variation by implementing digital dashboards to support clinical management and patient self-management, improve consultant led specialist diabetes services in primary and community services. Redesign of inpatient and outpatient diabetes care and integrating diabetes services in an ICO format with a single service specification.

3. Diabetes Foot Care

Aims to bring amputation rates down by the provision of a 7 day a week multi-disciplinary foot service, optimising patient flow by recruiting co-ordinators who will facilitate pathway navigation and patient flow. Standardise foot pathways and establish renal and vascular foot pathways.

4. Type 2 Diabetes Prevention

Aims to prevent Type 2 diabetes by maximising uptake of Type 2 National Diabetes Prevention Programme and piloting the NDPP digital offer. It will also focus on children and young adults and work with teams to impact food poverty and obesity.

8. Recommendations

The information presented highlights the variations in accessibility and quality of diabetes services across the primary, hospitals and community base and the need to improve awareness and education around diabetes for diabetes patients, their carer's, families and the wider diverse community groups and residents of Harrow.

It is recognised that Harrow Clinical Commissioning Group are already developing programmes and initiatives such as the Food Smart Campaign, Know Diabetes Website and promotion of the National Diabetes Prevention Programme to meet these challenges.

Specific recommendations based on the workshops and survey undertaken:

- 1. Every GP Practice to have a Diabetes Specialist Nurse attached to it.** At the time of producing this report there are 4 in place with 2 more being recruited covering 32 GP Practices. Feedback from our survey and the GP survey highlights the need to reduce waiting times for appointments and to have DSN more accessible and connected to the GP practice and community.
- 2. Effective shared learning and feedback on Protocol/ standards and good practice across key stakeholders, CCG, LNWHT & CLCH, GP's DSNs and, Consultants to be implemented** ensuring that there is effective feedback and learning between and GP's around the care of diabetes patients and those at risk of diabetes. The GP survey statistics show that 73% of GP surgeries do not think that the feedback and learning is effective.
- 3. Development of a more holistic and integrated approach to the provision of diabetes services,** ensuring sufficient trained resource and expertise and flexibility in provision e.g. evenings and weekends. The GP Survey asked about 9 areas of training and 4 of these showed a lack of confidence in providing the service and being in need of training. Our survey showed services are currently fragmented with the need for a more joined up approach and access for evening and weekend appointments. A number of surgeries were prepared to deliver more support / services provided resources and funding were required.
- 4. Raised awareness of and access to structured education programmes,** understanding what is available and how to access it. Non-attendance at booked training also needs to be monitored and followed up, to understand why people are not attending. Covering the following areas:
 - At risk of diabetes
 - Prevention
 - Recognition of symptoms

- Diagnosis
 - Self-Management
 - Services available.
5. **Improved provision of information / guidance in a greater number of languages particularly for the Black and Minority Ethnicity Groups e.g. Asians, Somali, and Middle Eastern Groups.** This will lead to a greater awareness of the symptoms and what you can do to help prevent getting diabetes and knowing where and how you can get support if you are diagnosed.
 6. **Raised awareness of the local plans of the Diabetes Transformation Programme.**

9. Conclusion

The analysis, findings and recommendations in the report will provide and inform the wider Harrow Diabetes Strategy Implementation Group to bringing greater coherence, consistency and performance in Diabetes care in the Borough in the future.

This report will be presented at the Healthwatch Harrow Forum on 16th May 2018 and to the Harrow Diabetes Strategy Implementation group, Harrow CCG and to the Harrow CCG Commissioners and Harrow Health & Wellbeing Board.

Next Steps

Healthwatch Harrow will monitor how the key actions and recommendations from the report will be implemented by the Harrow Diabetes Strategy Implementation Group.

Appendix 1: Online questionnaire

Diabetes Health Questionnaire

This questionnaire is about helping to improve the Diabetes health service in Harrow. Please answer honestly. There are no right or wrong answers. Please be assured we will keep your answers completely confidential. **Please note Questionnaire completion date is Friday 19th January 2018**

Male Female Prefer not say (please tick)

Age group: 18-24 25-35 36-45 46 -55 56-64 65 & Above

Which area of Harrow do you live in?

.....

Ethnicity

White: British/Irish/Polish/Romania/Serbian **Black/Black British:** African/Caribbean

Asian/Asian British: Indian/Pakistani/ Sinhalese/ Sri Lankan Tamil/Afghan/Bangladeshi

Mixed: White & African/White &Asian/ White & Caribbean Chinese

Other, please state.....

1. Do you have diabetes?

Yes No

If yes please tick

Type 1 Type 2

2. Do you care for someone living with diabetes?

Yes No

3. Are you aware of the signs and symptoms of diabetes?

Yes No



If yes please state
.....
.....
.....
.....

4. Do you know where to go to get support for diabetes?

- Yes No

If yes please state
.....
.....
.....

5. How would you best describe your experience of using diabetes services in Harrow and please state which services you have used?

- Podiatry Retinal Screening GP Annual checks Diabetes Education Programmes
- Harrow Health walks Active 10 None

Additional comments on your experiences of using diabetes services in Harrow.

.....
.....
.....
.....

6. What improvements or changes would you like to see in diabetes services In Harrow?

.....
.....
.....
.....

Your Contact Details for feedback (optional)

Name:

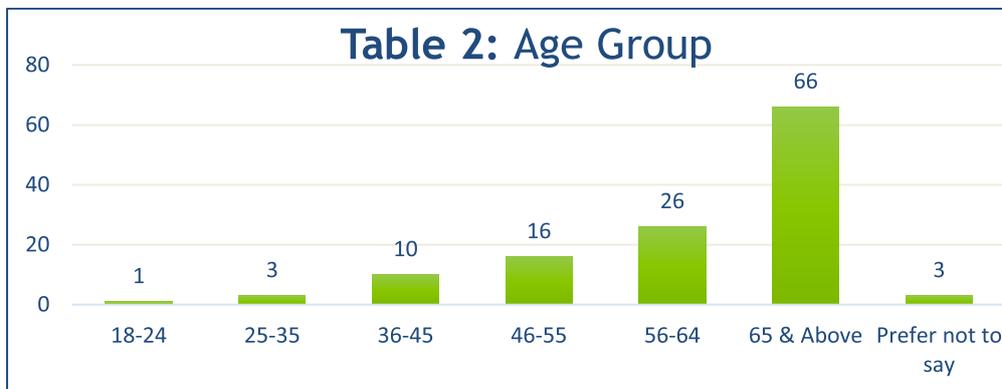
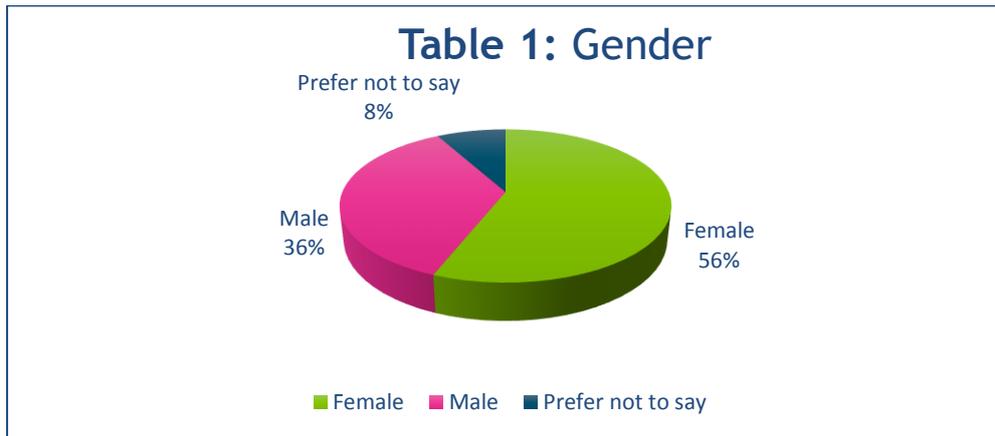
Email:

Contact number:

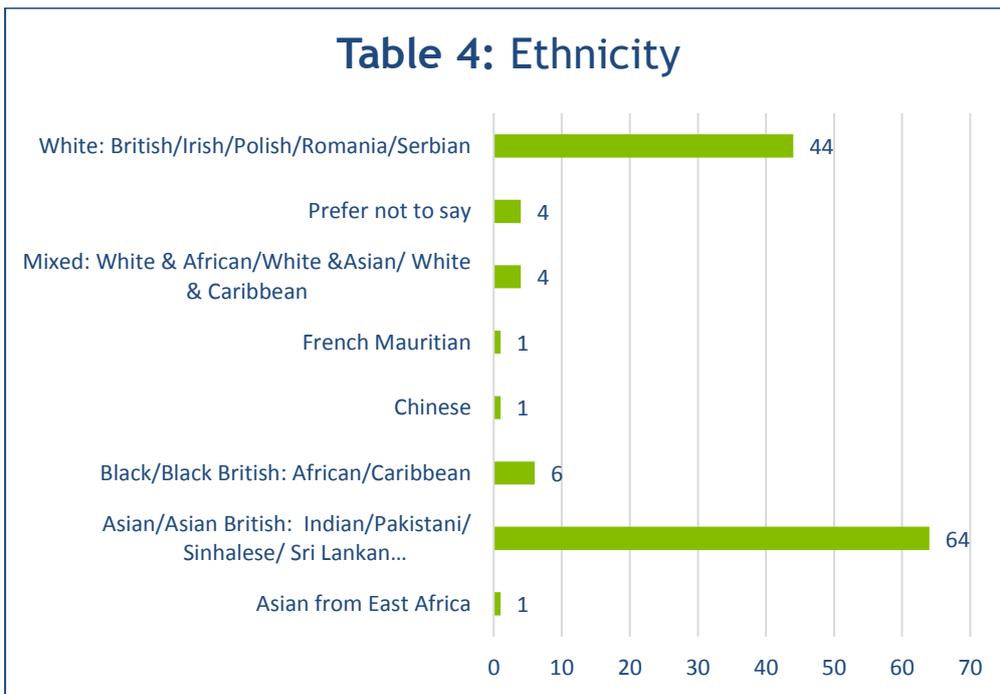
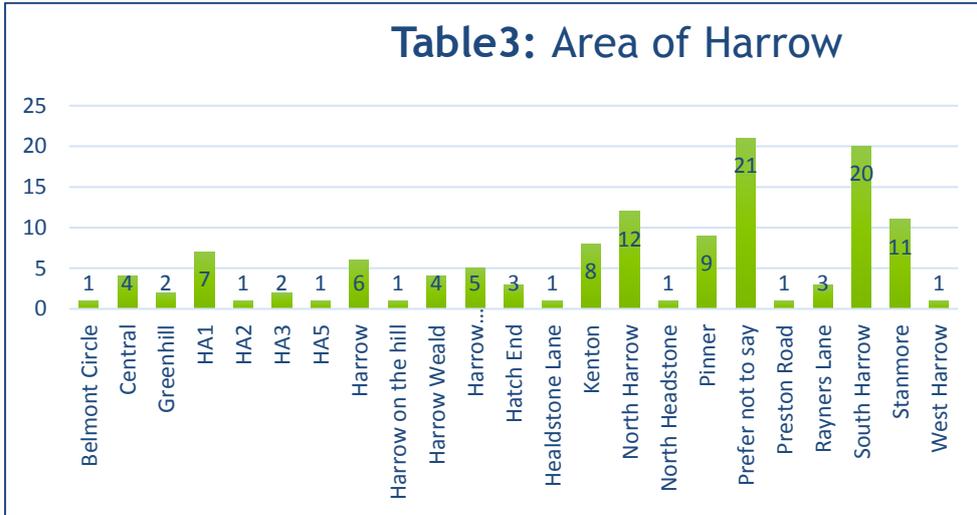
Appendix 2 Survey Analysis Tables

a) Questionnaire & Surveys

Survey Demographics



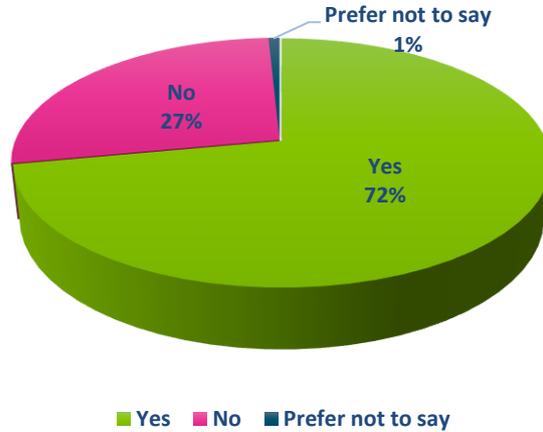
74% of the respondents were over the age 56 and above



51% of the respondents were of Asian/ Indian, Sinhalese /Sri Lankan / Tamil/ Afghan/ Bangladeshi communities

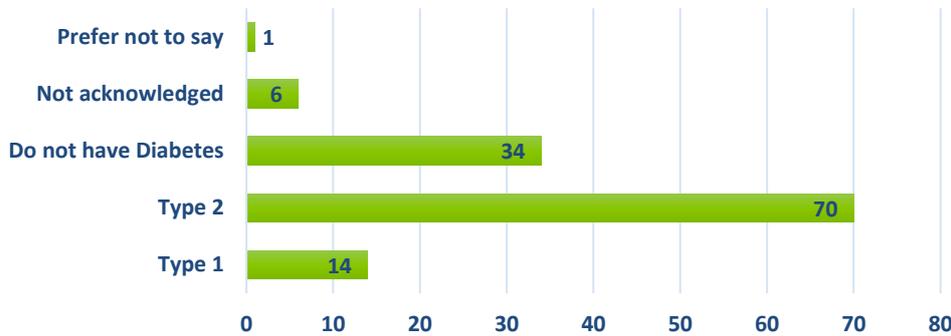


Table 5: Do you have Diabetes?



27% of the respondents who responded to not having diabetes were a carer for someone living with Diabetes

Table 6: Type 1 or Type 2?



56% of the respondents had Type 2 diabetes, 11% Type 1 and 27% were carers who did not have diabetes



Table 7: Do you care for someone living with Diabetes?

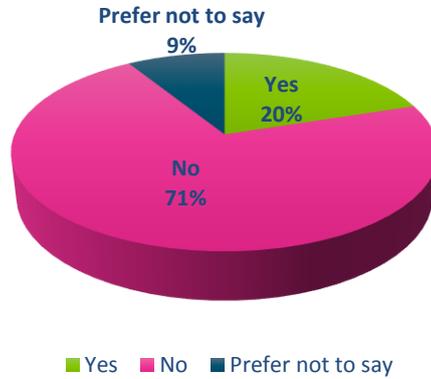
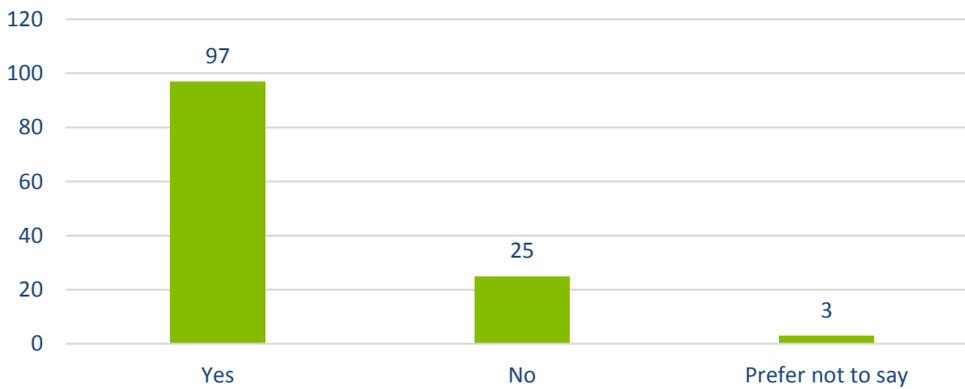
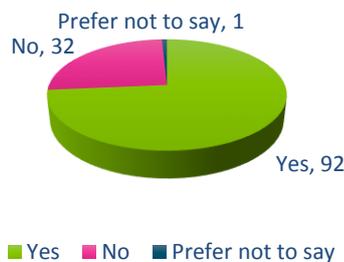


Table 8: Are you aware of the signs and symptoms of diabetes?



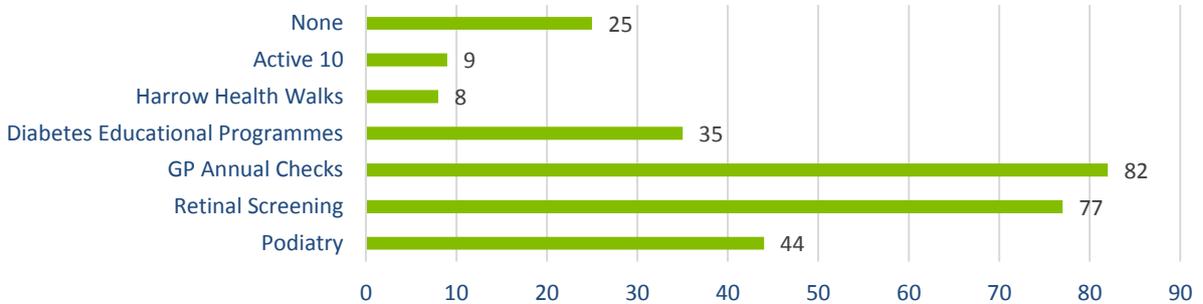
78% of those surveyed were aware of the signs and symptoms of diabetes

Table 9: Do you know where to go to get support for diabetes?



73% of those surveyed knew where to go to get support for diabetes

Table 10: How aware are you of these services?



Awareness of services: retinal services 62%, GP annual checks 66%, podiatry 35%, Diabetes education programmes 28%, Active 10 and Harrow Healthy Walks 14%, not aware of any diabetes services 20%

References:

<https://preventing-diabetes.co.uk/north-west-london/>

<http://www.knowdiabetes.org.uk/CommunityServices.aspx>

<https://harrow.diabetesukgroup.org/>

<http://www.londonscn.nhs.uk/publication/understanding-diabetes-in-london/>

<http://www.harrow.gov.uk/localoffer/services/health/health-services-for-adults/diabetes-specialist-nursing-service>

<https://www.lnwh.nhs.uk/services/a-z-services/d/diabetes-and-endocrinology/>

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