Notice of Meeting

HEALTH & WELLBEING BOARD

The legal status, role and detail about the governance of the Health & Wellbeing Board can be found in Part B, Article 5 of the Council Constitution. Full terms of reference for Board can be found in Part C, Section D. More information about the work of the Board is listed on the Council's website www.lbbd.gov.uk

Tuesday, 4 June 2013 - 6:00 pm

Venue: Conference Room, Barking Learning Centre
2 Town Square, Barking, IG11 7NB

Date of publication: 24 May 2013

Graham Farrant
Chief Executive

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Membership for 2013/14:

Councillor M Worby (Chair)	(LBBD)
Dr W Mohi (Deputy Chair)	(Barking & Dagenham Clinical Commissioning Group)
Councillor J Alexander	(LBBD)
Councillor L Reason	(LBBD)
Councillor J White	(LBBD)
Anne Bristow	(LBBD)
Helen Jenner	(LBBD)
Matthew Cole	(LBBD)
Frances Carroll	(Healthwatch Barking & Dagenham)
Dr J John	(Barking & Dagenham Clinical Commissioning Group)
Conor Burke	(Barking & Dagenham Clinical Commissioning Group)
Martin Munro	(North East London NHS Foundation Trust)
Dr Mike Gill	(Barking Havering & Redbridge University NHS Hospitals Trust)
Chief Supt. Andy Ewing	(Metropolitan Police)
John Atherton (Non-voting member)	(NHS England)

AGENDA

1. **Apologies for Absence**

2. **Declaration of Interests**

   In accordance with the Council's Constitution, Members of the Board are asked to declare any interest they may have in any matter which is to be considered at this meeting.

3. **Minutes - To confirm as correct the minutes of the meeting held on 23 April 2013 (Pages 1 - 6)**

4. **Joint Assessment and Discharge Team (Pages 7 - 11)**

5. **Community Sickle Cell / Thalassaemia Service (Pages 13 - 18)**

6. **Francis Report (Pages 19 - 37)**

7. **CQC Inspection Report on A&E and Emergency Care Plan (Pages 39 - 84)**

8. **Diabetes Scrutiny Review: Planning our Response (Pages 85 - 180)**

9. **Draft Engagement Strategy (Pages 181 - 184)**

10. **Chair's Report (Pages 185 - 192)**

11. **Report of Sub Group(s) (Pages 193 - 196)**

    Feedback on the Learning Disability Partnership Board Away Day

12. **Forward Plan (Pages 197 - 207)**

13. **Any other public items which the Chair decides are urgent**

14. **To consider whether it would be appropriate to pass a resolution to exclude the public and press from the remainder of the meeting due to the nature of the business to be transacted.**

    Private Business

    The public and press have a legal right to attend Council meetings such as the Health and Wellbeing Board, except where business is confidential or certain other sensitive information is to be discussed. ***There are no such items at the time of preparing this agenda.***

15. **Any other confidential or exempt items which the Chair decides are urgent**

HEALTH AND WELLBEING BOARD

Tuesday, 23 April 2013
(6:00 - 7:45 pm)

Present: Councillor M M Worby (Chair), Councillor L A Reason, Councillor J L Alexander, Councillor J R White, Anne Bristow, Helen Jenner, Matthew Cole, Marie Kearns (until Chair of Healthwatch is appointed), Conor Burke, Dr Waseem Mohi (Vice-Chair), Martin Munro, Dr Mike Gill and Chief Superintendant Andy Ewing

Also present: John Atherton (non-voting member, NHS England)

Apologies: None

1. Declaration of Interests

There were no declarations of interest.

2. Appointment of Deputy Chair

Dr Mohi (Chair of Barking and Dagenham Clinical Commissioning Group) was appointed as Deputy Chair of the Board.

3. The Health and Wellbeing Board as a Committee of the Council

The Board noted a presentation from John Dawe (Group Manager, Democratic Services). The presentation outlined:

- The legal status of the Board as a Committee established under the 1972 Act.
- How access to information rules and the Council's statutory Forward Plan apply to the Board
- How Board Members are bound by the Council's Code of Conduct and therefore must complete a Register of Interests
- Definitions of types of personal interest and when Board Members should disclose an interest
- The role of the Council's Monitoring Officer in relation to the Board.

4. Introducing Healthwatch Barking and Dagenham

Marie Kearns presented the report to the Board describing the role of Healthwatch and its relationship with Healthwatch England, the local health scrutiny committee, and the Health & Wellbeing Board. The Board noted the following:

- Staff from the Local Involvement Network have migrated to Healthwatch under TUPE arrangements.
- Healthwatch's Board, including the Chair, has been appointed. The Board comprises of four directors and two associate directors. The structure of the Board ensures good representation and balance as each Director will have

a distinct remit covering all aspects of health and social care.

- Healthwatch has already made links with the Council's Health and Adult Services Select Committee. There has been discussion about avoiding duplication and, where appropriate, working collaboratively for maximum impact.

Cllr Alexander asked how Healthwatch will be able to effectively map the community infrastructure and engage with hard to reach sections of the community. Marie Kearns advised the Board that Healthwatch will be pro-active and go to where service users of all kinds are to collect their views. The hub and spoke model will facilitate this as Healthwatch will be able to draw on existing networks from across the borough.

Cllr White asked how the views of children, particularly those who are in care, will be heard. Marie Keanrs explained that the structure of Healthwatch is designed so that one of the Board Director's remits is exclusively related to Children. Furthermore, through the hub and spoke model, Healthwatch will be able to use its associates to collect and give profile to the views of young people. For example, where appropriate, Healthwatch intends to work with the BAD Youth Forum.

Helen Jenner stated that 31.5% of the borough's population are children and young people. Helen urged Healthwatch to be mindful of this and hoped the work programme of Healthwatch is balanced between children and adult related issues.

Dr Mohi stated that he saw the emergence of Healthwatch as an opportunity for the NHS to engage and communicate with local people. Dr Mohi thought that Healthwatch can play an important role in delivering positive health messages to the community and changing peoples' perceptions of health services. The Board agreed that Healthwatch will be an important channel of communication but felt the potential role Dr Mohi described was outside the remit of Healthwatch.

Helen Jenner advised Marie Kearns to check that all Healthwatch Board Members and staff who will be working with Children have up-to-date Disclosure and Barring Checks (formerly known as CRB checks).

Matthew Cole expressed the need for Healthwatch and Public Health to work together to ensure that the JSNA is reflective of local peoples' needs.

The Chair requested that LBBD's website is used to signpost residents to Healthwatch. The Chair encouraged Healthwatch to closely follow the Board's Forward Plan so that Healthwatch can plan its activities and share views in a timely fashion.

5. Winterbourne View Concordat

Anne Bristow presented the report to the Board. The Board noted there is national funding (roughly £2 million for each of the next two years) which will hopefully flow down to local level. The Board needs to be in a position to bid for funding once more detail is known.

The Learning Disability Partnership Board is in transition so the Board felt it appropriate for Sharon Morrow and Bruce Morris to lead on the initial action with the winterbourne concordat to be taken forward by the Health & Wellbeing Board's Leading Disability sub-group thereafter.

In response to criticism aimed at the Hospital Trust's ability to recognise patients with learning difficulties the Board noted that the CLDT has put in place arrangements whereby each person known to them has a 'health passport' which people with a learning disability carry around information about how they should be treated or cared for. The use of these passports helps identify vulnerable people early and safeguard their wellbeing.

The Board asked how the Police was ensuring safeguarding is high priority. The Board noted that the Borough Commander has re-arranged the roles of his special CID officers so that safeguarding (including compliance and monitoring) is given due attention by a designated officer.

The Board identified communication and awareness between key front line professionals as critical to safeguarding. Where emergency workers such as the Police and nurses are busy and under pressure they might not spot signs of abuse or be alert to the behaviour of colleagues and other professionals.

Cllr Worby asked all agencies to co-operate fully with work relating to Winterbourne View and wanted the Learning Disability sub-group to report back on areas where the concordat is not being delivered.

Anne Bristow suggested that a task for the Learning Disability Sub-Group would be to pull together the various threads from safeguarding initiatives to understand the sum of all parts and address any gaps or weaknesses.

Following discussion of the item, the Health & Wellbeing Board **agreed** to:

- undertake the programme of action identified in response to the Winterbourne View Concordat, requesting that all responsible parties note and commit to their actions within the timescales identified;
- identify any further issues, based on the report and subsequent work, that need to added to the list of commitments;
- delegate the initial action to meet the June 2013 milestone to Sharon Morrow, Chief Operating Officer (CCG) and Bruce Morris, Divisional Director Adult Social Care;
- delegate to the Learning Disability Group to ensure that robust monitoring is in place for the actions identified in the Concordat, and that routine reporting as well as critical exception reporting, is established to ensure that the Health & Wellbeing Board is kept abreast of progress.

6. Social Care NHS Transfer Proposals

The Board was supportive of the package outlined in paragraph 3.1 of the report as presented by Anne Bristow. A bid will now be submitted to NHS England. Board Members agreed to assist in the drafting of the bid submission.

The Board noted that where the funding has been bundled up differently it is likely that the overall pot is smaller where there has been consolidation of several smaller funding streams.

Further detail about the proposals can be sent to Board Members on request.

Conor Burke was keen to see that the impact was clearly measured to show good value for money. The Board will receive an update later in year on the impact the funding has made, this update will link to the Outcomes Framework reporting.

Following discussion of the item, the Health & Wellbeing Board **agreed** that:

- the Corporate Director of Adult & Community Services takes forward the proposals to NHS England to reach an agreement for the spend of the allocation
- there will be a report back to the Board on the final agreement and how funding has benefitted the local health and social care economy.

7. Proposed Review of Domestic Violence Services

Anne Bristow presented the report to the Board. It was noted that it is necessary to review contracts as they expire to ensure that the funding for domestic violence is allocated in a way that achieves maximum impact and results in services that meet the specific needs of residents.

Cllr White requested that the review of domestic violence services is scoped so that it has regard to the impact of domestic violence on children, whose allegations are sometimes not taken seriously.

The Board **agreed** to support the proposal that a review of Domestic Violence services should be undertaken in light of new emerging responsibilities and structures.

The Board **agreed** to commission the Public Health Programme Sub-Group to review the provision of services in the Borough and make recommendations to the Board's July meeting as to which services should be commissioned and how these should be funded.

8. Hate Crime Strategy: Consultation Draft

Cllr Alexander presented the Strategy to the Board and invited comments from Board Members.

The Borough Commander raised concern that homophobic hate crimes are under-reported. He went onto assure the Board that police officers take hate crimes very seriously and that by assigning officers to localities it is hoped the police can build trust among the community to come forward and gather intelligence about hate crimes.

The Borough Commander was supportive of Greater Manchester Police's approach to hate crime which includes cultural differences. Locally the Police have 100 cadets; these young people set a positive example and have a zero tolerance approach to hate crime and bullying.

Cllr White called for age discrimination and victimisation to be included in under the umbrella of hate crimes.

Cllr Worby remarked that hate crime is treated with a degree of reticence and not

considered as criminal by many people. Also witnesses of hate crime rarely challenge or report incidents. Further to this point, Marie Kearns commented that victims of hate crimes are reluctant to go the Police. It was suggested that there is more outreach work to encourage victims to report incidents of hate crime.

The Board questioned whether the term 'hate crime' was powerful or accurate enough to make young people and others come forward and report hate crimes as serious offences. The Board suggested that work is done with the Youth Forum to find a language or terminology that connects with how young people perceive hate crime.

The Board noted the Strategy and the consultation deadline of 16th May 2013 for further comments.

9. Chair's Report

Matthew Cole updated the Board on the measles situation following the outbreak in South Wales. Whilst Barking and Dagenham has had no cases of measles there have been small clusters of cases elsewhere across London. In light of this, a London-wide catch up campaign is being launched to target those who have not been immunised.

Helen Jenner asked Matthew Cole to report back to the London-wide teleconference that attempting to ask schools to be involved in the immunisation of the 10-16 year old cohort during May will be problematic with GCSE and other exams scheduled for that time. Any catch-up campaign will therefore need to be managed carefully as not to disrupt young peoples' education the need to liaise with schools before implementing an immunisation programme is a necessity. Matthew Cole explained that once a plan of action is agreed partner organisations will need to be helpful and co-operative, perhaps at short notice.

The Board noted the Chair's Report.

10. Forward Plan (2013/14)

The Board noted the Forward Plan. Board Members were invited to make suggestions. It was noted that where the Board is new, the Forward Plan is dominated by Council-led business. As the Board develops, and once the Executive Planning Group has met, the Forward Plan will be more inclusive with broader ownership of business and input from Board Members. Connor Burke stressed the importance of assigning reports and items to the appropriate individual/organisation.

The Forward Plan was amended making Matthew Cole the lead report author for the Domestic Violence Review (16 July meeting).

11. Proposed Chairs and Nominations to the Sub-structure

Further to the memberships of sub-groups set out in the report Board Members made additional nominations to fill vacancies within the sub-structure. The following was confirmed:

Executive Planning Group

- Helen Jenner (LBBD) **and**/or Meena Kishinani (LBBD)

Children and Maternity Group

- Jane Hargreaves to be replaced with Jason Hatherill (LBBD)
- Chris Martin to be replaced with Joanne Tarbuck (LBBD)
- Gill Mills (NELFT)

Public Health Programmes Board

- Dr Kalkat (CCG)
- Leilla Horsnell (CCG)

Integrated Care Group

- Dr John (CCG) to co-chair Chair with Jane Gateley (CCG)
- Christine Pryor (LBBD)
- Baljeet Nagra (LBBD)

Mental Health Group

- Chris Martin (LBBD)
- Ken Baker (Met Police)
- Sarah D'Souza or Gemma Hughes (CCG)
- Esther Omigie (LBBD)

Board Members were asked to fill outstanding vacancies as soon as possible so that the sub-groups can begin their work in earnest. Board Members were asked to send nominations to the Chair of the sub-group copying in the Clerk of the Board.

HEALTH AND WELLBEING BOARD

4 June 2013

Title: Joint Assessment and Discharge Service	
Report of the Corporate Director of Adult & Community Services	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision:** Yes
Report Author: Bruce Morris, Divisional Director of Adult Social Care	**Contact Details:** Tel: 020 8227 2749 Email: bruce.morris@lbbd.gov.uk
Sponsor: Anne Bristow, Corporate Director of Adult & Community Services	

Summary:

Opportunities for improved joint working between health and social care have been developed through the Integrated Care Coalition. The shadow Health & Wellbeing Board has previously received presentations and reports on proposals being developed by the Coalition, including a report on the Joint Assessment and Discharge service on 12 March 2013.

This paper provides more detail on the design principles for a joint service that would facilitate the discharge of patients from Queens and King George Hospitals and an implementation plan following a workshop on 29 April 2013 led by LBBD. Key health and social care partners from across Barking and Dagenham, Havering and Redbridge began planning the development of a joint service and it was agreed that LBBD will take the lead on this project on behalf of the coalition.

Recommendation(s)

The Health and Wellbeing Board is asked to note the progress of this project and comment on the design principles and implementation plan. Further updates will be provided to the Board as the project progresses.

Reason(s)

Health and Wellbeing Boards across the three boroughs will have a key role in the governance of the programme. They will need to agree how the new service meets the needs of their local residents and consider implications for other services.

1 Introduction

1.1 Previous reports have described the work of the Integrated Care Coalition and the agreement between the statutory health and social care organisations grouped around the BHR "economy" to explore joint design and planning work on areas where we have a mutual interest.

1.2 Last year Ernst and Young worked with the Integrated Care Coalition on a number of ideas that would potentially make better use of existing resources and improve the experience of local residents. One of the proposals was to consider a joint service that would facilitate the discharge of patients from Queens and King George hospital. On 27 February, the Integrated Care Coalition asked LBBD to undertake further work on designing an integrated team to support people back to home with dignity and respect.

1.3 A workshop was held on 29 April led by Anne Bristow where the key partners of from health and social care in the three boroughs began planning the development of this service. The design principles and key milestones were discussed and partners asked LBBD to lead the work on behalf of the coalition partners.

2 The Design Principles

2.1 The workshop agreed the following six design principles for the Joint Assessment and Discharge (JAD) team:

- The service will be efficient. Both the timeliness and quality of discharge will be improved.
- The service will have authority to make decisions about the need for Continuing Health Care, and these processes will not delay discharge. However, the guiding principle is that patients and their families will not normally be expected to make life changing decisions such as permanently moving to institutional care from an in-patient bed.
- The service will have access to all relevant patient information and this will be shared within the service. The service will work towards a shared information system and provide management reports for Coalition partners to meet the requirements of statutory returns, and provide a better understanding of where further system redesign is required.
- Where patients' hospital admission is a consequence of a breakdown in care and treatment in the community, "long-term conditions"; "primary care" (integrated case management, health and social care clusters etc.) is in the best position to assess risk and review plans for care, support and treatment, and will therefore be responsible.
- However, the primary aim of the service will be to get patients back to their own homes with dignity and compassion managing independently, rather

than directing people to services. This will require knowledge and skills of working with family networks, and utilising community capacity.

- The locus of the service will therefore be in the community, to ensure close working and a seamless patient journey to “primary care”.

3 Project Support

3.1 Partners have agreed to contribute to project support costs:

- LB Barking and Dagenham and LB Havering have each contributed £10,000;
- CCG Barking and Dagenham and CCG Havering have each contributed £10,000;
- LB Redbridge and CCG Redbridge have each contributed £5,000;
- BHRUT and NELFT have each contributed £10,000.

4 Project Group

4.1 The group will include representatives from NELFT, the three boroughs and the Clinical Commissioning Group. Terms of Reference for the project group were agreed at the first meeting on 14 May.

5 Project Milestones

Month	Milestone
May	Project group established
	Terms of Reference of project group agreed
June	Staff engagement
	Implementation Plan designed
July	Management of service agreed
September	Health and Wellbeing Board agreement
October	Integrated Care Coalition agreement
November	Implementation
April	New service begins

6 Mandatory Implications

6.1 Joint Strategic Needs Assessment

Barking and Dagenham's updated JSNA outlines:

- A high level of deprivation which impacts on a gap in life expectancy at birth between males and females
- Mortality rates are higher than the England average
- Significant health inequalities base on ethnicity, with people of black ethnicity more likely to have an emergency hospital admission

Having an integrated and cohesive hospital discharge service that will help support a borough with poor healthy life expectancy is very important. The proposed changes should positively impact on the hospital discharge process with the priority of supporting people in their own home.

The proposed service aligns with a number of themes of the Joint Strategic Needs Assessment, cross-cutting long term conditions, end of life care and emergency re-admissions.

6.2 Health & Wellbeing Strategy

The development of a new Joint Discharge Service will assist with achieving the outcomes of the Health & Wellbeing Strategy. The proposed new service will aim to 'improve health and social care outcomes through integrated services'.

6.3 Integration

The new joint team will be an integrated team merging the functions of several teams across Barking and Dagenham, Havering and Redbridge. The aim is to develop a new seamless service out of hospital.

6.4 Financial Implications

The agreed contributions to project support costs, as detailed in section 3.1, will be met from within current resources of the contributing organisations. At present there are no additional resources to fund the new joint service. As the project group develops the new joint service, the financial implications of the emergent service will be identified and funding aligned within current resources.

Implications completed by: Dawn Calvert, Group Manager Finance, LBBD

6.5 Legal Implications

There are no specific legal implications that arise from this report at this stage.

Implications completed by: Shahnaz Patel, Senior Lawyer, Legal Services, LBBD

7 Non-Mandatory Implications

7.1 Staffing Implications

If the proposals for a joint service are agreed there will potentially be implications for staff who are involved in the hospital discharge process whichever organisation employs them. Formal consultation processes will be used to manage any changes in line with each organisation's agreed procedures.

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HEALTH AND WELLBEING BOARD

4 June 2013

Title: Health & Wellbeing Strategy Priority: Sickle Cell Disease and Thalassaemia	
Report of the Vice-Chair of the Health & Wellbeing Board	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision:** No
Report Author: Sharon Morrow, Chief Operating Officer	**Contact Details:** Sharon.morrow@barkingdagenhamccg.nhs.uk
Sponsor: Dr W Mohi, Chair of Barking and Dagenham Clinical Commissioning Group	

Summary:

The Health and Wellbeing Strategy 2012-15 has prioritised sickle cell services as an area for improvement and integration in 2013. The CCG is leading on the development of a community sickle cell service which will be provided by BHRUT for the Barking and Dagenham, Redbridge and Havering CCGs. The first community site will be based at Barking Community Hospital, with an anticipated start date of June 2013.

The prevalence of sickle cell disease has increased significantly over the last five years and BHRUT manages approximately 5% of the national burden of disease. Approximately half the BHRUT caseload is for Barking and Dagenham patients - Barking and Dagenham has the highest carrier rates of any borough in the country, with the exception of Lewisham which is equivalent.

Joint meetings with BHRUT and CCG commissioners have been established to work through the phased implementation of the service and a community service is expected to operate at Barking Hospital from June 2013.

Recommendation(s)

The Health and Wellbeing Board is asked to note the project and make any comments on this briefing.

Reason(s)

To agree the key design principles and ensure that the project has appropriate planning and support to deliver its key milestones by April 2014.

1. Introduction

1.1. In February 2012, the Health and Adult Services Select Committee (HASSC) considered a report from Dr Ian Grant, Consultant Haematologist BHRUT, on sickle cell disease in Barking and Dagenham. HASSC agreed to ask the Health and Wellbeing Board to consider prioritising sickle cell services, given the rapid growth in demand and the impact of the disease within the next Health and Wellbeing Strategy.

1.2. The Health and Wellbeing Strategy 2012-2015 prioritises sickle cell services as an area for improvement and integration of services in 2013. The key deliverable for this priority is the establishment of a community service for people living with sickle cell disease by May 2013, with the primary outcome being a reduction in A&E attendances for sickle cell disease.

1.3. The CCG is the lead partner for this initiative and in collaboration with Havering and Redbridge CCGs, has commissioned a community sickle cell service from BHRUT as part of the 13/14 contract.

1.4. This paper describes the need and demand for services locally and the progress made in implementing a community service. Partners are invited to comment on the contribution that they could make to improving the health and wellbeing of this population.

2. Background

2.1. Sickle cell is the fastest growing genetically inherited condition in the UK affecting over 1 in 2,000 births and over 10,000 adults living with the condition in the UK. About 0.15% of African Americans are homozygous for sickle cell disease and 8% have the sickle cell trait.

2.2. Sickle cell disease is a life-long disease, with significant morbidity and mortality. The median age of death for people with sickle cell disease is 50 years for men and 55 years for women. Pulmonary complications are the most common cause of death accounting for 28% of all deaths. Complications that result in hospital admission include vaso-occlusive crisis, infection and acute chest syndrome

2.3. Sickle cell disease and trait have been becoming progressively more visible amongst the population of Barking and Dagenham. Given the emergent diversity of the population and increased prevalence of sickle cell disease the capacity of the current services to meet increasing demands has been reviewed.

3. Local need and demand for services

3.1. The changing ethnic demographic of the local population across Barking and Dagenham, Havering and Redbridge has been dramatic; between 2001 and 2012 the estimated proportion of the population identifying as Black African has trebled in Barking and Dagenham and Havering and increased by one and a half times in

Redbridge. It is estimated that just over 6% of the population in 2012 across the three boroughs are identified as Black African.

3.2. The prevalence of sickle cell disease has increased significantly in the last five years. There are around 15,000 people with sickle cell disease in the UK, most of whom are resident in London and the caseload at BHRUT is around 800, which represents approximately 5% of the national burden of disease. In 2012, BHRUT had 156 adults and 170 children registered with Barking and Dagenham GPs on their caseload (50% of total caseload). The number of patients registered with the service at BHRUT has risen by 10% between 2009 and April 2012.

3.3. In Barking and Dagenham, 1 in 297 babies born are affected by significant haemoglobinopathy and Barking and Dagenham has the highest carrier rates of any borough in the country.

3.4. The table below highlights the total number of sickle cell outpatient appointments and A&E attendances for Barking and Dagenham patients in 2011/12.

	Total activity 11/12	**Total cost 11/12**
Outpatient attendances	2,775	£491,991
A&E admissions	244	£354,295

3.5 In addition to health support required for this population, there is also a need for significant psychological, social and welfare support.

4. National Guidelines and Peer Review

4.1. There is a growing body of national guidance and policy relating to sickle cell disease, this includes:

- National guidelines for adults living with sickle cell disease (2008)
- National guidelines for children living with sickle cell disease (2010)
- A sickle crisis (2008)

4.2 Sickle cell disease is explicitly mentioned in the National Service Framework for children and young people and there is also NICE guidance relating to the management of sickle cell crisis.

4.3 There is a national programme of peer service reviews and in February 2013 the national peer review team assessed the service at BHRUT. The review team found a high level of engagement between commissioners, public health and the service and evidence of good practice. It was noted that there was a potential unmet need and that the community aspect of care was inadequate.

4.4 People living with haemoglobinopathy require multi-disciplinary support in acute and maintenance periods. They should have a baseline and annual review and have regular blood tests, medication reviews, immunisation and psychological support

and counselling. At the point of diagnosis, they and their families may need additional support and counselling.

4.5 BHRUT has three haematologists with a special interest in sickle cell disease. Paediatric and adult outpatient and inpatient services are able to deliver all aspects of care and treatment for people affected with sickle cell disease. Universal antenatal screening was introduced in 2003, and couples who could have a child with sickle cell disease are counselled.

4.6 Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHR CCGs) have commissioned BHRUT to establish a community sickle cell service across Barking and Dagenham, Havering and Redbridge. The community service is enhancement of the specialised haemoglobinopathy service currently provided by BHRUT.

5 Management of sickle cell disease

5.1 It will be a nurse led service supported by Consultant Haematologist from BHRUT and this community service will provide direct face to face contact and support through community based drop in and programmed clinics in the three boroughs, in addition to telephone support for professionals and patients.

5.2 It will provide seamless care between community and hospital and help provide social, psychological, counselling and medical care in the community, thus preventing hospital admissions. The local defined outcomes that the BHR CCGs have commissioned from BHRUT for this service are to:

- Reduce A&E repeat attendances
- Reduced Hospital Admissions
- Reduced length of hospital stay
- Improve care and management of patients with long term conditions
- Patient satisfaction and treatment compliance
- Improve care pathways for sickle cell disease in the community
- Reduce acute spend for sickle cell patients

5.3 The first community site will be in Barking and Dagenham, as this borough has a larger proportion of patients with sickle cell disease, with the intention for roll out in Redbridge and Havering. Until the community service is up and running, patients are seen on the Queen's Site.

6 Current Progress and next steps

6.1 Joint meetings with BHRUT and CCG commissioners have been established to work through the phased implementation of the service. To date, the following progress has been made and timelines agreed:

- BHRUT has recruited a lead nurse for the community sickle cell service, with a start date of 10th May 2013.

- Recruitment of the remaining nursing and supportive posts has been completed and the full team will be in post by August 2013.
- Barking Hospital has been identified as the first community site and a site visit with BHRUT and commissioners is planned for Monday 13th May 2013.
- The service will offer initially 1 session per week with the intention to increase to 2 sessions per week at Barking Hospital; iIt is anticipated this service at Barking Hospital will be up and operational by June 2013.
- The other two sites within Redbridge and Havering boroughs, in addition to the frequency of these clinics is yet to be determined and will require input from the commissioners.
- Full implementation of the community nurse-led sickle cell service is planned for September 2013.
- LBBD adult social care will align social work support to the local clinic as it becomes established in Barking & Dagenham ensuring there is good access to information, advice and care and support if required.
- Consideration will be given to how access to housing advice can be improved.

6.2 It is proposed that the monitoring of the delivery plan and outcomes for the sickle cell community service is devolved to the Integrated Care Subgroup of the Health and Wellbeing Board.

7 Mandatory Implications

7.1 JSNA

The Joint Strategic Needs Assessment highlights that 'sickle cell disease and trait have been becoming progressively more visible amongst the populations of outer North East London, most notably in Barking and Dagenham'. Historical activity at BHRUT in 2009 highlighted a case load of 256 in Barking and Dagenham compared to 96 in Havering and 133 in Redbridge. The estimated case load for Barking and Dagenham in 2011 was 366.

7.2 Health & Wellbeing Strategy

Priority 3 under Theme 3 (Improvement) of the Health and Wellbeing Strategy outlines that in 2012/13 work will be undertaken to look into improving the care for those living with sickle cell and thalassaemia.

7.3 Integration

Whilst the commissioning of a community service has been driven by health needs associated with demographic changes, there is the opportunity to consider how

social care, housing services and the local sickle cell thalassaemia support group may support the service once it is established.

7.4 Financial Implications

Funding to commission a community sickle cell service has been approved by the CCG in the commissioning plan for 2013/14.

Implications completed by: Martin Sheldon, Chief Finance Officer, CCG/ONEL

8 Housing Implications

Consultation with the Housing Service has taken place during the development of this report.

Our approach to sickle cell disease is essentially one of prevention and we aim to ensure that any housing advice or solution conforms to three preventative criteria: that the home is dry, warm and accessible. Any individual will be assessed according to their housing need and the impact of sickle cell disease on their day to day life.

We aim to ensure that the home is dry and free from damp and that adequate space is provided. We aim to ensure that the home is warm and energy efficient. We also aim to ensure that the home is accessible, especially that we prioritise homes that are on ground or lower floors. Decent housing is essential to maintain the health and quality of life of those with sickle cell disease. The Housing Strategy Service is keen to further develop a position on sickle cell disease (and thalassaemia) and is happy to engage with the Health and Well Being Board on this issue.

Implications completed by: James Goddard, Group Manager Housing Strategy, LBBD

9 Discussion

9.1 It is suggested that Board discussion focuses on:

- The potential of all partners to contribute to health and wellbeing plans for this population of people with sickle cell disease.
- How the Board will be assured of the impact of the proposals.

HEALTH AND WELLBEING BOARD

4 June 2013

Title: The Francis Report	
Report of the Director of Public Health	
Open Report	**For Decision**
Wards Affected: All	**Key Decision:** Yes
Report Author: Matthew Cole, Director Public Health	**Contact Details:** Tel: 0208 227 3657 Email: matthew.cole@lbbd.gov.uk
Sponsor: Matthew Cole, Director of Public Health	
Summary:	

Robert Francis QC described the extent of older people's care service failures that led to the inquiry, saying: "I heard so many stories of shocking care. These patients were not simply numbers they were husbands, wives, sons, daughters, fathers, mothers, grandparents. They were people who entered Stafford Hospital and rightly expected to be well cared for and treated. Instead, many suffered horrific experiences that will haunt them and their loved ones for the rest of their lives."

The Public Inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of the Mid Staffordshire NHS Foundation Trust was published on 6 February 2013. It was followed by the Government's response on 26 March 2013, which sets out how the quality of patient care is to be put at the heart of the NHS. Both should have far-reaching implications for the care and support system, not just the NHS. The Public Inquiry's comprehensive Report rightly looks across the whole care system. Robert Francis' emphasis on developing the right culture of care within the NHS, through better leadership, training, information and transparency is the right approach. It is clear that the causes of the Mid Staffordshire Foundation NHS Trust scandal go beyond the NHS and are multi-factorial, requiring solutions that are equally complex and diverse.

Anna Dixon, director of policy at The King's Fund, states "This Report is the latest in a long line of reports on failures of patient care, dating back to the Ely Hospital Inquiry of the late 1960s that have come to similar conclusions. This shows that the real challenge is not the diagnosis and prescription for the problem, it is ensuring that the remedy is administered effectively. Even if all 290 recommendations were implemented now, the fundamental shift in culture can only be achieved if patient care is put top of the agenda for boards and is the first responsibility of professionals working in the NHS. That will take time and commitment over many years."

There were warning signs that spanned patient stories, high hospital death rates

(demonstrated by Hospital Standardised Mortality Ratios), complaints, staff concerns, whistleblowers, governance issues, financial problems and staff reduction. Against this background the challenge remains in every situation to answer the question:

"***What is the 'Index of Suspicion' and at what point do you call time on an NHS or Care Provider?"***

The answer is complex as demonstrated recently when Leeds General Infirmary's children's heart surgery unit was closed for 11 days after NHS England's Medical Director, Sir Bruce Keogh, suspended procedures for what he called a "constellation" of reasons. However, data cannot give the whole picture; it has to be triangulated with other evidence, and there are professional and political judgments to be made. Francis notes this may leave a number of NHS and care providers "on the edge of acceptability".

This Inquiry and earlier well documented systems failings in institutional care settings (such as hospitals or care homes) or community settings (including people's own homes) demonstrate that when individual children or adults are not adequately safeguarded or their quality of care is poor the consequences are both significant and far reaching. It is clear the role of local organisations is very much around ensuring that patients and the public are safeguarded and that poor care is prevented in the first place. This report for the Health and Wellbeing Board, focuses on what needs to be done locally to address the relevant recommendations of the Inquiry.

Recommendation(s)

The Health and Wellbeing Board is asked to:

(1) Consider the report and discuss the implications for Barking and Dagenham.

(2) Agree that the group established by the CCG develops a local response to the Francis Report involving all partners on behalf of the Health & Wellbeing Board.

(3) Refer the following issues to the task and finish group for consideration:-

- the role of GPs in reviewing care standards
- formalised early warning systems and the part they might play
- how patient /user involvement can be strengthened and the mechanisms
- needed for the patient/user voice to be heard by decision makers
- whether the single agency action plans are adequate and what changes are needed to ensure a whole systems approach
- how the Health and Wellbeing Board can gain assurance on behalf of local residents about the quality of our local health and care system
- review progress made by the Clinical Commissioning Group, local NHS Trusts and Foundation Trusts in the implementation of their action plans
- consider the views of the Safeguarding Adults Board and Local Safeguarding

Children Board.

(4) The Health and Wellbeing Board is asked note that a separate report will be presented to the Health and Adult Services Select Committee on the Francis recommendations.

(5) The Director of Public Health meets with his colleagues from neighbouring boroughs to agree an approach to both the identification of problems and solutions required from the analysis of hospital mortality rates.

(6) Receive a progress report to its September meeting.

Reason(s): Under the Health and Social Care Act 2012 the statutory Health and Wellbeing Board has a duty to review and comment on public inquiries into health and social care and make recommendations to improve the quality of care.

1 Introduction

1.1 On 9 June 2010 the then Secretary of State for Health, Andrew Lansley MP, announced a full Public Inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire NHS Foundation Trust ("MSFT"). The Inquiry was established under the Inquiries Act 2005 and chaired by Robert Francis QC, who made recommendations to the Secretary of State based on the lessons learnt from MSFT.

1.2 It is important to note that this Public Inquiry built on the work of the previous Independent Inquiry, also chaired by Robert Francis QC, which looked at the care provided by MSFT between January 2005 and March 2009. This Inquiry considered individual cases of patient care, so that further lessons not already identified by previous investigations could be learned. The Inquiry reported on 24 February 2010.

1.3 The impact of both Inquiries is far reaching across health and social care, and from the highest levels of management to frontline service delivery. A summary of the key findings of both Inquiries is as follows:-

The 2010 Independent Inquiry Report:

- Patients deprived of dignity and respect.
- Most basic standards of care were not observed.
- Staff lacked care, compassion, humanity and leadership.
- Corporate self-interest and cost control were put ahead of patients and safety.
- The patient voice was not heard; nothing effective was done to address patients' complaints.
- Local GPs did not raise concerns until too late.
- PCTs did not effectively ensure the quality of the health services they were buying.

The 2013 Public Inquiry Report:

- Provides detailed and systematic analysis of what contributed to the failings.
- Identifies how the extensive regulatory and oversight infrastructure failed to detect and act effectively to address the MSFT's problems even when the problems were known.

It is important to note that parts of the system the Inquiry was set up to examine have changed significantly in the past two years following the introduction of the Health and Social Care Act 2012. There are no real successor organisations as the responsibilities have been spread across a number of newly created organisations including clinical commissioning groups, NHS England, NHS Trust Development Authority, Public Health England as well as local authorities, Monitor and the Care Quality Commission. In this context the 2013 Public Inquiry Report focuses its recommendations on cultural change rather than structural re-organisation.

2. The Public Inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust – Chaired by Robert Francis QC

> '***The system as a whole failed in its most essential duty – to protect patients from unacceptable risks of harm and from unacceptable, and in some cases inhumane, treatment that should never be tolerated in any hospital***' **Robert Francis QC**

2.1 The Final Report of the Public Inquiry into MSFT provides detailed and systematic analysis of what contributed to the failings in care at the Foundation Trust. It identifies how the extensive regulatory and oversight infrastructure failed to detect and act effectively to address MSFT's problems for so long, even when the extent of the problems were known.

2.2 The Report builds on the first Independent Inquiry, also chaired by Robert Francis QC. Its three volumes and an executive summary run to 1,782 pages, and is structured around:

- Warning signs that existed and could have revealed the issues earlier.
- Governance and culture.
- Roles of different organisations and agencies.
- Present and future.

2.3 It recognises that what happened in MSFT was a system failure, as well as a failure of the organisation itself. Rather than proposing a significant reorganisation of the system, the Report concludes that a fundamental change in culture is required to prevent this system failure from happening again, and that many of the changes can be implemented within the current system. It stresses the importance of avoiding a blame culture, and proposes that the NHS, collectively and individually, adopt a learning culture aligned first and foremost with the needs and care of patients.

2.4 After a million pages of documentary material, 250 witnesses and 139 days of oral hearings the Report made 290 recommendations, which focus primarily on securing greater cohesion and culture across the system. Francis states that 'change will not be brought about by further "top down" pronouncements, but by the engagement of every single person serving patients'. However, he adds no single recommendation should be regarded as the solution to the many concerns identified.

2.5 Key findings:

- The Strategic Health Authority did not prioritise patient safety and defended MSFT rather than holding them to account.
- Monitor focused on corporate governance and financial control without considering patient safety.
- The Department of Health did not give Ministers a full picture when advising that the Trust's application for Foundation Trust status should be supported.
- Healthcare professional regulators, training and professional representative organisations failed to uncover the lack of professionalism and to take action to protect patients.

In summary, the bottom line is, the Inquiry found a fundamental failure of the regulatory and supervisory system which should have secured the quality and

safety of patient care at both a national and local level. Francis states further, that as a result, the public's trust in the NHS was betrayed.

2.6 On the question of "How to re-build that trust?" Robert Francis is clear that a fundamental change in culture is needed which puts patients and their safety first, this involves:

- Every single person and organisation in the NHS needs to reflect on what needs to be done differently in future and how they can contribute to a safer, committed, compassionate and caring service.
- Patients need to be the first and foremost consideration of the system and all those who work in it.

2.7 In response to the evidence Francis fashioned his recommendations around five key themes, which he believes will rebuild public trust in the NHS. The themes are:

- **Standards**: fundamental standards of care 'owned' by staff and patients, policed by Care Quality Commission, non-compliance a criminal offence in some cases;
- **Openness, transparency and candour**: a willingness to receive and act on complaints and feedback; transparency about performance (positive and negative) – an offence to wilfully mislead and honesty with patients (duty of candour with sanctions);
- **Leadership:** strengthened with firmer accountability (fit and proper person test and possible disqualification);
- **Compassion and care**: stronger voice for nursing, values at the heart of recruitment and management, standards, revalidation, regulation of healthcare support workers; and;
- **Information**: all healthcare professionals have a responsibility to help formulate measures of the effectiveness of what they do and to make publicly available.

2.8 At the heart of the Report is a determination that the Inquiry's recommendations and findings be implemented and not suffer the same fate as many previous inquiries. Its first recommendation sets out requirements for oversight and accountability to ensure implementation of its proposals. There are a number of issues falling out of Francis recommendations that the Council, NHS Barking and Dagenham Clinical Commissioning Group and other key players in the local health and social care economy may wish to work through collectively. These include:

- All commissioning, service provision, regulatory and ancillary organisations in healthcare should reflect on the Report and its recommendations and decide how to apply them to their own work.
- The oversight and scrutiny function of the local authorities needs to be strengthened to introduce focused challenge, ensuring patient's views are considered and holding the system to account.
- The newly established health and wellbeing boards need to set down how they will bring that local health and social care system overview and accountability ensuring poor care does not happen in the first place.
- Each organisation should publish, at least annually, a report on its progress in achieving its planned actions.

I hope that the recommendations in this Report can contribute to that end and put patients where they are entitled to be – the first and foremost consideration of the system and everyone who works in it' **Robert Francis QC**

3. Initial Government Response (26 March 2013)

3.1 The Government has issued an initial formal response to the Public Inquiry entitled *"Patients First and Foremost" which was* published at the end of March 2013.

- The response was developed on behalf of the health and social care system and sets out how we are expected to respond to Francis's challenge to make patients 'the first and foremost consideration of the system and everyone who works in it'.
- It includes a statement of common purpose, jointly developed and signed by a wide range of partners who share responsibility for patient care.
- It does not respond to all of the 290 Francis's recommendations but it addresses the key themes of the Francis Report, and sets out the actions to be pursued immediately.
- It focuses on five key areas, with a common thread running throughout of how we can create a culture of compassionate care.

3.2 *Patients First and Foremost* includes a five point plan which is summarised below:

1) Preventing Problems

- **Reducing Regulatory and Information Burdens by One Third**
  Single national portal (Health and Social Care Information Centre) for collecting information and reducing the information burden on the service year on year.
  NHS Confederation has been commissioned to review how the bureaucratic burden on frontline and NHS providers can be reduced.
- **Safety in the DNA of the NHS – The Berwick Review**
  Professor Don Berwick will be working with NHS England to ensure a robust safety culture and a zero tolerance of avoidable harm is embedded in the DNA of the NHS.

2) Taking Action Promptly

Key measures

- **Fundamental Standards -** The Chief Inspector will draw up new simple fundamental standards, which make explicit the basic standards beneath which care should never fall.
- **Time Limited Failure Regime for Quality as Well as Finance -** A new time limited three stage failure regime, encompassing not just finance, but for the first time, quality, will ensure that where fundamental standards of care are being breached, firm action is taken until they are properly and promptly resolved.

3) Detecting Problems Quickly

Key measures

A new regulatory model led by the following:

- **Chief Inspector of Hospitals making assessments based on judgement as well as data.**
- **Chief Inspector of Social Care and possible Chief Inspector of Primary Care**
- **Ratings – A Single Balanced Version of the Truth** - Single assessment biased towards patient experience, comparable to OFSTED reports for schools.
- **Care Quality Commission no longer responsible for putting right any problems identified in hospitals** - Their enforcement powers will be delegated to Monitor and the NHS Trust Development Authority.

Honesty and transparency –

- **Publication of Individual Speciality Outcomes -** This has driven up standards in heart surgery so will be extended to other specialities.
- **Statutory Duty of Candour** - On health and care providers to inform people if they believe treatment or care has caused death or serious injury.
- **Criminal Penalties for Disinformation** - Consider legal sanctions at a corporate level for organisations that alter figures or conceal truth about performance data.
- **A Ban on Gagging Clauses** - NHS staff can speak out and not be vilified.

Engaging and Involving patients –

- **Complaints Review** - Review of best practice being led by Ann Clywd MP and Tricia Hart.
- **All key organisations within the health and care system listening to patients, service users, families, parents and carers.**
- **Patient and Staff Feedback** - Friends and Family Test and NHS Staff Survey.
- **HealthWatch -** Ensuring that the voice of the patient is listened to within the new system.

4) Ensuring Robust Accountability

Key measures

- **Health and Safety Executive (HSE) to use Criminal Sanctions** - Where the Chief Inspector identifies negligent practice in hospitals, he will refer the matter to HSE to consider whether criminal prosecution is necessary.
- **Faster and Proactive Professional Regulation -** Seeking to overhaul 150 years of complex legislation into a single Act that ensures much faster and less reactive actions on individual professional failings.
- **Barring Failed NHS Managers -** Introduction of a national barring list for unfit managers, based on the barring scheme for teachers.
- **Barring System for Health and social care assistants enforced by Chief Inspector** - Ensure that hospitals meet their existing legal obligations to ensure that unsuitable health and social care assistants are barred.
- **Clear Responsibilities for Tackling Failure** - These proposals will resolve the confusion of roles and responsibilities in the system, so it is clear where the buck stops on poor care.

5) Ensuring Staff Are Trained and Motivated

Key measures

- **Health Care Assistant (HCA) Training before Nursing Degrees** - Pilots for students that seek state funding for nursing serve as an HCA for up to a year to ensure frontline caring experience and values, as well as academic strength.
- **Revalidation for Nurses** - Introduce a national scheme for already qualified nurses to ensure that they are up to date.
- **Training, Code of Conduct and Minimum Standards for Healthcare Assistants published** - Additionally, the Camilla Cavendish review will look at how HCAs can provide the safest and most compassionate care.
- **Attracting Professional and External Leaders to Senior Management Roles** - NHS Leadership Academy to build on existing programmes and initiate in programmes for fast-tracking professionals outside the NHS and clinicians from within into leadership roles.
- **Frontline Experience for Department of Health (DH) Staff** - DH will learn from the criticisms of its own role. By 2016, every civil servant in the Department will have real and extensive experience of the frontline.

3.3 Next steps

The Government has committed to the following next steps and will be reporting back in the autumn:

- Considering the 290 recommendations in full.
- Some recommendations will require further development and consultation.
- Further engagement – working across the system and with our stakeholders.

- A further, more detailed response to the 290 in due course, which will include actions resulting from the range of reviews currently underway (complaints, safety, bureaucratic burdens, HCAs).

4. Implications for London Borough of Barking and Dagenham

4.1 Health and Wellbeing Board

The Francis Report touches on a number of the Council's functions: democratic functions including the Health & Wellbeing Board and Health Scrutiny, service delivery and commissioned services. The specific issues are set out below.

4.1.1 The Inquiry did not make reference to health and wellbeing boards as its investigations predate their establishment. The now statutory Health and Wellbeing Board is in a position to take a strategic oversight of how the health and social care system is operating.

4.1.2 It is interesting to note that clinical commissioning groups, NHS Foundation Trusts and NHS Trusts are required by NHS England to review and reflect on the Report at board level. On reading the Governing Body Report of NHS Barking and Dagenham Clinical Commissioning Group and the Board Reports of North East London NHS Foundation Trust and Barking, Havering, Redbridge University Hospitals NHS Trust it is clear that all three are taking the Francis recommendations seriously. However, these initial reports are not surprisingly focussed on the issues for their organisation rather than the wider system. This therefore presents an opportunity to look together through the Health and Wellbeing Board at this system. In addition, the Board should focus on the various reviews that are ongoing following on from Francis such as the review of safety and "zero harm" led by Professor Don Berwick and which are all scheduled to report ahead of the Department of Health's autumn update on the next steps following Francis.

RECOMMENDATION

The Health and Wellbeing Board supports the establishment of a time limited group to develop a local response to the Francis Report involving all partners but led by NHS Barking and Dagenham Clinical Commissioning Group.

4.2 Health and Adult Services Select Committee

The local authority scrutiny committees did not detect or appreciate the significance of any signs suggesting serious deficiencies at the Trust. The evidence before the Inquiry exposed a number of weaknesses in the concept of scrutiny, which may mean that it will be an unreliable detector of concerns, however capable and conscientious committee members may be. Robert Francis QC

4.2.1 A separate report on the implications of the Francis Report will be presented to the Health and Adult Services Select Committee for consideration.

RECOMMENDATION

The Health and Wellbeing Board is asked note that a separate report will be presented to the Health and Adult Services Select Committee on the Francis recommendations.

4.3 **Director of Public Health**

4.3.1 The Francis Report puts specific focus on the Regional Director of Public Health's role in the identification of problems from the analysis of hospital mortality rates. In particular as a public health doctor, Francis noted that even without the benefit of hindsight, the Director did not at the time look more deeply into whether patients' interests were being protected adequately by the steps being taken by the Trust.

4.3.2 Francis makes the following recommendation:

If the local director of public health, becomes concerned that a provider's management of healthcare associated infections is or may be inadequate to provide sufficient protection of patients or public safety, they should immediately inform all responsible commissioners, including the relevant regional office of the NHS England, the Care Quality Commission and, where relevant, Monitor, of those concerns. Sharing of such information should not be regarded as an action of last resort. It should review its procedures to ensure clarity of responsibility for taking this action.

4.3.3 In the new Public Health system, there is not a Regional Director of Public Health. From 1 April 2013, protecting the public's health is part of the statutory responsibilities of the Council's Director of Public Health. The Director of Public Health for Barking and Dagenham working with his colleagues in the London boroughs of Havering and Redbridge and Waltham Forest needs to consider the following four specific messages:

- Patient safety, the effectiveness of treatment and the quality of basic care needs to be prioritised. The Director of Public Health has a statutory responsibility to ensure all three areas are supported, through the provision of information and evidence of what works to colleagues in the acute sector and to NHS Commissioners.
- Targets and outcomes are important, but not at the expense of patient care. They should be meaningful and not a box ticking exercise.
- Francis's fifth recommendation in his Summary is for "*accurate, useful and relevant information"*. The Director of Public Health needs to support a greater understanding and use of measures such as Hospital Standardised Mortality Ratios (HSMRs) as a measure of clinical quality, but also understand the caveats in their use. Data varies in quality and depth, and can be "gamed." The Director of Public Health needs to assure they are accurately interpreted to identify the preventable deaths.
- There were three peer reviews at Mid Staffordshire NHS Foundation Trust between 2004-2007: cancer, critically ill care and care of critically ill children. All raised serious concerns but seen in isolation did not trigger concern. The Director of Public Health has a responsibility to see the wider picture and give advice and should use their Annual Report to highlight areas of concern following analysis of mortality and other indicators. The Health and Social Care

Act 2012 includes a duty on the Director of Public Health to write a report, and a duty on the Council to publish it. The requirement for the report to be annual also allows progress to be recorded and evaluated.

RECOMMENDATION

The Director of Public Health meets with his colleagues in neighbouring boroughs to agree an approach to both the identification of problems and solutions required from the analysis of hospital mortality rates.

4.4 **Social Care**

4.4.1 Whilst there has been an understandable focus on NHS culture and processes, the key findings of the Francis Report also have implications for those working in the social care sector. Like the NHS, social care has a history of serious incidents of care failings, including the death of baby Peter Connelly in Haringey and the independent review into adult care services at Wirral Metropolitan Borough Council. Vulnerable people are at risk of care failings not only in institutions, but also in their own homes and communities.

4.4.2 The reality is that social workers, as well as health professionals**,** worked in MSFT and other hospitals at a time of serious failings, and we should therefore reflect on the role that they might have played to bring to light the unacceptable levels of patient neglect that took place. Francis's 290 recommendations, whilst aimed primarily at NHS care providers, have obvious resonance for the vast army of care workers, care homes and support organisations responsible for the health and wellbeing of the old and vulnerable throughout England. It is acknowledged by the Association for the Directors of Adult Social Services (ADASS) that the Francis Report should not make easy reading for Directors or staff in adult social services departments.

4.4.3 Not only are there similarities in the pressures on social care and the NHS, but the regulator and ministers overlap. The Care Quality Commission remains in place as a cross-service regulator despite its failings and the more stringent inspection and monitoring regime proposed by Francis would certainly impact on social care. Moreover ministers have explicitly made the links, not least as the unsolved issue of integration of health and social care looms large. The analysis and comment outlined in section 6 later on, in this report on the Implications for NHS Commissioners, NHS Barking and Dagenham Clinical Commissioning Group and NHS England is as relevant for Social Care commissioners as it is for NHS.

4.4.4 Commentators are consistent in their view on which of the Report's 290 recommendations have the greatest relevance for social care. They include:

- The proposed duty of candour for the NHS and social care which would require staff to admit mistakes that have caused "death or serious injury" to patients to their employer as soon as possible and calls for prosecution of employers and managers preventing staff exercising their statutory duty (including whistle-blowing over serious concerns).
- A proposed more stringent inspection regime led by the Care Quality Commission including a new power for the Commission to police this duty of candour and prosecute organisations and individuals who break the rule.

- Gagging clauses against whistleblowers that prevent disclosure of care safety concerns would be abolished.
- Healthcare assistants would be regulated. At present, the vet who checks your cat is better regulated than the person who looks after your mum in hospital. What will this mean for social care workforce?
- Senior general managers would have contractually enforceable ethical codes and a "negative register" for the utterly unfit.
- Francis says nothing about the Health and Care Professions Council (HCPC) but warns the Nursing and Midwifery Council that "to act as an effective regulator of nurse managers and leaders, as well as more frontline nurses, [it] needs to be equipped to look at systemic concerns as well as individual ones". This would surely lead to the HCPC having to review its code to provide greater support for whistleblowers and hold managers to account for their conduct.

4.4.5 Social Care is in the spotlight amid almost weekly reports confirming the growing gap between rising need and falling resources in social care. The perfect storm of rising safeguarding referrals, rising numbers receiving care, and rising eligibility thresholds is the most obvious consequence. At the same time there are serious and repeated concerns nationally about conditions in some care homes and support for adults needing support from social workers. The Francis Report was clear that MSFT is not unique, but was the tip of a much wider problem. It is therefore incumbent on the Council to reflect on the implications for its social care services for adults and children, as well as, keeping a tight focus on the safeguarding arrangements.

4.4.6 The Corporate Director for Adult and Community Services and the Corporate Director for Children's Services should delegate the appropriate Council Officers to provide the social care and safeguarding input into the proposed task and finish group to be led by NHS Barking and Dagenham Clinical Commissioning Group.

4.5 **HealthWatch**

"The standard of representation of patient and public concerns has declined since the abolition of Community Health Councils in 2002. It is now quite clear that what replaced them, two attempts at reorganisation in 10 years, failed to produce an improved voice for patients and the public, but achieved the opposite." Robert Francis QC

4.5.1 A key conclusion of Francis is that local patient groups in MSFT were weak, over-reliant on uninformed and untrained volunteers, sometimes in dysfunctional relationships and beset with infighting.

4.5.2 Perhaps the most worrying aspect of the Francis Report is the decline of patient power in the NHS in recent years. Given that government after government has stressed the importance of public and patient involvement and that the coalition has actually made, 'no decision about me without me' its mantra for the NHS, this is the cruellest irony. The Francis Report reminds all of us that whatever pressures we face from commissioners or providers to ignore their needs and their voice is not acceptable.

4.5.3 Francis recommends that patient groups should be properly funded, with training on offer and the ability to carry out inspections something we have known for many

years. Councillors, service users and organisations representing patients and disabled people have shouted it out loud and clear. The simple truth though is that if patients have effective lines of communication and their voices are heard, tragedies such as that at MSFT might never have happened.

4.5.4 At a recent Department of Health Stakeholder's event for patient voice representatives the prevailing view was that the focus should move from so-called paper-based recipes such as patient reported outcome measures, as we have seen both the Winterbourne and Mid Staffordshire NHS Foundation Trust scandals, to making an effective voice real for the individual patient and for their representative groups, organisations and families.

4.5.5 HealthWatch should provide active input in the proposed task and finish group on improving patient involvement and acting on patient's concerns voice.

4.5.6 Alongside the work of HealthWatch, all health and social care organisations will need to respond to concerns from their own patient and service user involvement mechanisms. Separately on this agenda the Board is invited to consider its approach to engagement.

4.6 Local Safeguarding Boards

4.6.1 The report covers a wide range of issues including the need to ensure appropriate safeguarding arrangements for both children and adults at risk. It will be important therefore that the Safeguarding Adults Board and Local Safeguarding Children Board consider the report and that their views form part of the report back to the Health and Wellbeing Board.

5. Implications for North East London NHS Foundation Trust and Barking Havering and Redbridge University Hospitals NHS Trust

It is clear that not just the Trust's Board but the system as a whole failed in its most essential duty – to protect patients from unacceptable risks of harm, and in some cases inhumane treatment that should never be tolerated in any Hospital. Robert Francis QC

5.1. NHS England, acting on Robert Francis's first recommendation, have instructed clinical commissioning groups, NHS Trusts and NHS Foundation Trusts to urgently consider and review what happens in their own organisations in light of the Inquiry's findings, and identify any actions they may need to take to ensure what happened in Mid Staffordshire NHS Foundation Trust does not happen in their organisation.

5.2 This internal review is required to go to the governing body and boards of the various organisations. NHS England and the NHS Trust Development Authority did not mandate an action plan submission, although both North East London NHS Foundation Trust and Barking Havering and Redbridge University Hospitals NHS Trust have developed local action plans for which their boards have taken direct oversight of implementation. It is expected that there could be further central requirements as part of the assurance framework later this year.

5.3 Given that the Clinical Commissioning Group is the main commissioner of both North East London Foundation Trust and Barking Havering and Redbridge

University Hospitals NHS Trust and it is proposed it leads this work, it is also proposed that it provides assurance to the Health and Wellbeing Board on the progress made in the implementation of the Francis Report by both Trusts.

6. Implications for NHS Commissioners, NHS Barking and Dagenham Clinical Commissioning Group and NHS England

6.1 Commissioners are public bodies, visibly acting on behalf of the public and the section of the Inquiry Report about commissioning for standards pulls out the reflections and lessons learned by the Primary Care Trust. The Report suggests commissioning as a practice must be refocused to procure the necessary standards of service as well as what service is provided (outcomes in quality as well as activity). The obvious next steps for Commissioners are to:

- Agree and announce their response to the Francis recommendations.
- Ensure that 2013/14 contracts are 'Francis compliant'.
- Review systems and processes to identify what steps are required to implement relevant recommendations.
- Agree with the North Central and East London Commissioning Support Services areas for joint working to ensure that both the Clinical Commissioning Group and the Support Services are 'Francis compliant'.

6.2 An analysis of where NHS Commissioners should focus and benchmark their approach in moving from the Pre Francis Quality Assurance Culture to the Post Francis Culture one is outlined in the table below:

Pre Francis Culture	Post Francis Culture
Passive	Proactive - looking for signs of concern
Reliant on provider self-declarations	Independent triangulation which tests provider self-declarations
Little patient involvement	Patient experience key to quality assurance
Few effective levers to create change	A range of levers for clinical commissioning groups and NHS England to intervene and ensure improvement

6.3 For the Health and Wellbeing Board the following points could form a useful basis for discussion in working through the scale and impact of Francis's recommendations for NHS and care commissioners:

- the need to improve the understanding of both patients and the public of the role of commissioners;
- the need to demonstrate how nursing practice can be strengthened;
- the need to demonstrate close engagement with patients past, present, and potential to ensure that their expectations and concerns are addressed;
- the need to demonstrate effective complaints handling; and
- the need to demonstrate how we are strengthening information on quality and performance.

7. Implications for General Practitioners (GPs) in Barking and Dagenham

"When analysing the evidence from general practitioners, the inquiry found that local GPs only expressed substantive concern over care at the Trust following the news of the investigation. The inquiry goes on to say that this is not a direct criticism of GPs as they were not explicitly required to act in this way, although it does say that it is unfortunate that "it did not occur to any of them [GPs practicing in the local area] to report" the concerns they had at an earlier stage". Robert Francis QC

7.1 GPs are the most continuous presence in the health system over many years. They are the most important guide and advocate on a patient's journey through the healthcare system.

7.2 The MSFT saga reinforces the patient view that their GP needs to know about the strengths and weaknesses of the local hospitals, and Francis gives GPs "a responsibility to all their patients to keep themselves informed of the standard of service available at various providers in order to make patients' choice a reality". This means every GP having a responsibility to be satisfied that each of their patients received quality care, especially the ones that die or are re-admitted.

7.3 Both Francis Reports were clear that GPs in primary care should undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services, developing an ongoing relationship and recording this through a systematic shared process. The Royal College of General Practitioners Guidance and recommendations to its members following their review of the Francis Report, highlights that:

- GPs should have a role to check on the quality of service, in particular in relation to an assessment of outcomes.
- Internal systems are needed to enable GPs to flag any patterns of concern. In some areas there are alert schemes where feedback goes from GPs to the hospital if they have any concerns.
- GPs have a responsibility to their patients to keep themselves informed of the standards of local services and service providers to inform patient choice.
- GPs have an ongoing responsibility for their patients and that responsibility does not end on referral to hospital.
- GPs should take advantage of their position as commissioners to ensure patients get safe and effective care.

7.4 NHS Barking and Dagenham Clinical Commissioning Group should progress their current work to develop and implement an early warning system that ensures that all member practices' feedback, issues and concerns are formally addressed with providers rather than each GP raising individual issues outside of a formalised early warning system.

8. Implications for Local Members of Parliament

Francis also made reference to the involvement of MPs and their roles. He recommended that MPs be asked to consider adopting a simple system to identify trends in complaints and to consider if individual complaints have wider significance.

9. Mandatory Implications

9.1 Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) has a strong overall mortality analysis as well as a detailed safeguarding element within it. The Director of Public Health will include a dedicated section on hospital mortality rates within the JSNA going forward. This would be supported by greater understanding and use of measures such as Hospital Standardised Mortality Ratios as a measure of clinical quality, but also understand the caveats in their use.

9.2 Health and Wellbeing Strategy

The Health and Wellbeing Board mapped the outcome frameworks for the NHS, Public Health, and Adult Social Care with the Children and Young People's Plan. The strategy is based on four priority themes that cover the breadth of the frameworks and in which a large number of Francis's recommendations can be picked up within. These are: Care and Support, Protection and Safeguarding, Improvement and Integration of Services, and Prevention. Actions, outcomes and outcome measures are mapped across the life course against the four priority themes.

9.3 Integration

One of the outcomes we want to achieve for our joint Health and Wellbeing Strategy is to improve health and social care outcomes through integrated services. The Department of Health (DH) have invited health economies to bid to become "pioneers" running large scale experiments in integrated care by September 2013. This will be supported by two further initiatives published in the autumn:

- DH together with the patient group National Voices is developing a set of indicators for integration.
- DH is developing a "plan" for how "how we look after older people most in need of support from the NHS and social care".

9.4 Financial Implications

At the point of writing this report, the financial implications of the recommendations made by this report are not quantified. However any financial implications will have to be contained within council core funding or the ring fenced Public Health grant.

Implications completed by: Dawn Calvert, Group Manager Finance, LBBD

9.5 Legal Implications

This paper sets out the detail and background that led to the Public inquiry of the Mid Staffordshire NHS Foundation Trust chaired by Robert Francis QC. It made findings of serious and systematic failures on the part of the provider Trust Board. The report identified numerous warning signs which should have alerted the Trust to the serious problems that were developing in the Trust.

The report makes very many recommendations which will prevent such failures from ever happening again. In the Governments re- organisation of the NHS it established under the Health and Social Care Act 2102 health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce

health inequalities. They will have strategic influence over commissioning decisions across health, public health and social care. They took their statutory role as of April 2013. This paper makes recommendations to the Health and Wellbeing Board in direct response to the findings of the Francis Report and its implications at a local level.

Implications completed by: Shahnaz Patel, Senior Lawyer, Legal Services, LBBD

9.6 **Risk Management**
The risk is that patient care may be compromised if there is a failure to implement recommendations. The Health and Wellbeing Board needs to take a view on sensible and effective implementation to mitigate and manage risks.

10. Non-mandatory Implications

10.1 **Safeguarding**
Both Inquiries by their very nature had implications for safeguarding for both adults children. The safeguarding arrangements at MSFT failed to prevent, over a number of years, serious incidents of care failings. The Local Safeguarding Childrens Board and the Local Safeguarding Adults Board are considering the Francis recommendations and its implications for local safeguarding arrangements.

11. Background Papers Used in the Preparation of the Report:

The Mid Staffordshire NHS Foundation Trust Inquiry. Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009. February 2010. Chaired by Robert Francis QC
http://www.midstaffsinquiry.com/pressrelease.html

The Mid Staffordshire NHS Foundation Trust Public Inquiry. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Chaired by Robert Francis QC. February 2013. http://www.midstaffspublicinquiry.com/report

Patients First and Foremost. The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry. Department of Health. March 2013
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf

NHS Confederation Member Briefing. Government response to the Francis report.
http://www.nhsconfed.org/Documents/NHS%20CONFED%20BRIEFING%20GOV%20FRANCIS%20RESPONSE.pdf

Association of Directors of Adult Social Services (ADASS) Francis - Government response to be considered in relation to all health and social care services. 25th March 2013.
http://www.adass.org.uk/index.php?option=com_content&view=article&id=913&Itemid=489

Kings Fund. Francis Report Lesson learnt from Stafford.
http://www.kingsfund.org.uk/events/francis-inquiry?gclid=CI3hjdOy97YCFcXKtAod118A0w

Royal College of General Practitioners Position Statement on the Recommendations of the Mid Staffordshire NHS Foundation Trust public inquiry report.

http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z%20policy/RCGP-Response-to-Francis-Recommendations.ashx

Nursing Midwifery Council welcomes the Government's response to Francis.
http://www.nmc-uk.org/media/Latest-news/NMC-welcomes-the-Governments-response-to-Francis/

HealthWatch England. Initial response from HealthWatch England to the Francis recommendations
http://www.healthwatch.co.uk/sites/default/files/francis_position_statement_final.pdf

HealthWatch Essex. The 'Francis Report' – understanding the implications for HealthWatch Essex February 2013.
http://www.healthwatchessex.org.uk/sites/default/files/documents/Agenda%20item%206%20-%20implications%20of%20the%20Francis%20Report.pdf

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HEALTH AND WELLBEING BOARD

4 June 2013

Title:	**BHRUT Progress on Actions Identified by CQC**
Report of the Medical Director, Barking, Havering & Redbridge University Hospitals NHS Trust	
Open	**For Comment**
Wards Affected: None	**Key Decision:** No
Report Authors: Dr Mike Gill, Medical Director Barking, Havering & Redbridge University Hospitals NHS Trust	**Contact Details:** Telephone: 01708 435039 Email: Mike.Gill@bhrhospitals.nhs.uk
Sponsor: Dr Mike Gill, Medical Director, Barking, Havering & Redbridge University Hospitals NHS Trust	

Summary:

This report presents the Emergency Care Improvement Plan for Barking, Havering & Redbridge University Hospitals NHS Trust, which incorporates the actions that the Trust has planned in response to the inspection report undertaken by the Care Quality Commission in late 2012.

The Board is invited to comment and to contribute to the discussion about the wider whole system response, which will be planned through the proposed Urgent Care Board, a workshop for which took place on 24 May 2013.

Recommendation(s)

Board members are recommended to:

- Note the actions being taken by BHRUT to improve emergency care at the Hospital, and provide comment on the plans and progress described;
- Provide comment on the system wide implications of this work, to inform proposals for future co-ordination of urgent care improvement activity.

1 Introduction

1.1 This transformational plan will set out how Barking Havering and Redbridge University Hospitals NHS Trust (BRUHT), will achieve the 95% A&E access target and improve patient experience in line with the agreed trajectory by August 2013, following identification of issues by the Care Quality Commission (CQC). It has been developed in the context of the Health for North East London proposals which received the approval of the Secretary of State, and is focused on a series priority actions across the whole hospital system. The overarching approach is one that seeks to deliver sustainable change: a platform from which more medium and long term goals, designed to deliver the Trust vision, can be successfully realised.

1.2 In terms of monitoring the improvement work, the internal processes for the Trust are described in paragraph 3.3, below. The Trust is also subject to reporting to the NHS Trust Development Authority, as well as periodic further inspection by CQC.

2 Context

2.1 BHRUT has a vision 'to place excellence in patient care at the centre of all we do in healing, caring for and serving our community'. The Trust is on a mission to create a viable and sustainable organisation, working with clinicians, managers, external partners and local people, that meets the needs and expectations of its patients and one which the local community can be proud.

2.2 At the end of 2012 the Care Quality Commission (CQC) made an unannounced visit to the emergency care department at Queen's Hospital and conducted a comprehensive assessment which included observing how the department was being run and talking to staff, patients and their relatives. The CQC concluded that the department was falling short on key national quality standards by highlighting excessive delays for patients receiving treatment and patient dissatisfaction with their experience in the department. Subsequently the Trust has designed a comprehensive plan for addressing the findings of the CQC with particular reference to the whole hospital system and patients flows, rather than a plan based squarely on the Emergency Department only. In parallel the London Quality Programme's Acute Medical and Emergency Surgery Standards have been published and in order to take account of the recommendations, the standards have been embedded into the 'Improving Emergency Care Programme' of workstreams as a 'golden thread'.

2.3 In 2010 the commissioners for North East London consulted with multi-stakeholders and the public on Health for North East London (H4NEL) proposals, aimed at creating a 'hot' site at Queen's Hospital (QH) and a 'cold' site at King George's Hospital (KGH). The proposals outlined in the Decision Making Business Case which was approved by the Secretary of State for Health are now included in the Acute Reconfiguration Programme, and included the following:

- The A&E at King George Hospital (KGH) to close, whilst upgrading the Urgent Care centre (UCC) to operate 24 hours a day.
- The Maternity unit at KGH to close during the 4th Quarter of 2012/13 with births moving to the Queen's site.
- Planned surgery to move from Queen's Hospital to KGH except where there are benefits in co-locating services or on the basis of clinical need.

- Non-elective surgery to be centralised at the Queen's site, with no acute medical or Paediatric beds remaining in the KGH site.

3. The Improving Emergency Care Programme Plan

3.1 This transformational plan has been set out with 10 workstreams scheduled to deliver in August 2013. These will provide the foundation for the transformational capability of a further 3 workstreams which will be executed in the medium to longer term time period, reaching a conclusion in June 2015 when the A&E department at KGH will close in favour of 24 hour Urgent Care Centre with some activity transferring to the Queen's Hospital and Whipps Cross Hospital sites.

3.2 The Gantt chart, figure 1, summarises the scheduled timescales and milestones between now and June 2015.

3.3 The plan is monitored via a series of meetings, as follows:

- **Weekly Emergency Care Project Meetings**
  (12 locked work plans, 12 weekly progress reports)
- **Fortnightly Emergency Care Programme Board**
  chaired by David Gilburt (each executive will briefly present updates on their workstream)
- **Monthly TEC**
  chaired by Chief Executive Averil Dongworth (executive updates will feed into the master plan which will be reviewed by the PMO monthly)
- **Internal Acute Reconfiguration Board**
  chaired by Chief Executive Averil Dongworth
- **Board Meeting**
  decide on resource allocation and hold those overall responsible to account for undelivered action

3.4 The five operational priorities, and their workstreams for 2013-2015, to deliver the Improving Emergency Care Programme are as follows:

1) Accelerate recruitment and retention of medical and nursing staff in ED (Emergency Department)
    a) Consultant recruitment
    b) Improving staff experience
2) Delivering improved pathways to redirect patients from ED and provide improved assessment capacity and capability particularly focusing on older patients
    a) Improving acute medical assessment including GP direct access
    b) Improving assessment for frail elders
    c) Improving the Urgent Care Centre
    d) Improving the ED/UCC estate
3) Improving the experience of patients in the ED
    a) Improving patient safety and experience
    b) Improving the emergency department
    c) Improving paediatric emergency care
4) Implementing 7-day working
    a) 7-day working
5) Improvements focused on the London Quality Programme's Acute Medical and Emergency Surgery Standards and achieving them

a) Surgical assessment unit including direct GP access
b) Improving ambulatory care
c) Care planning and discharge

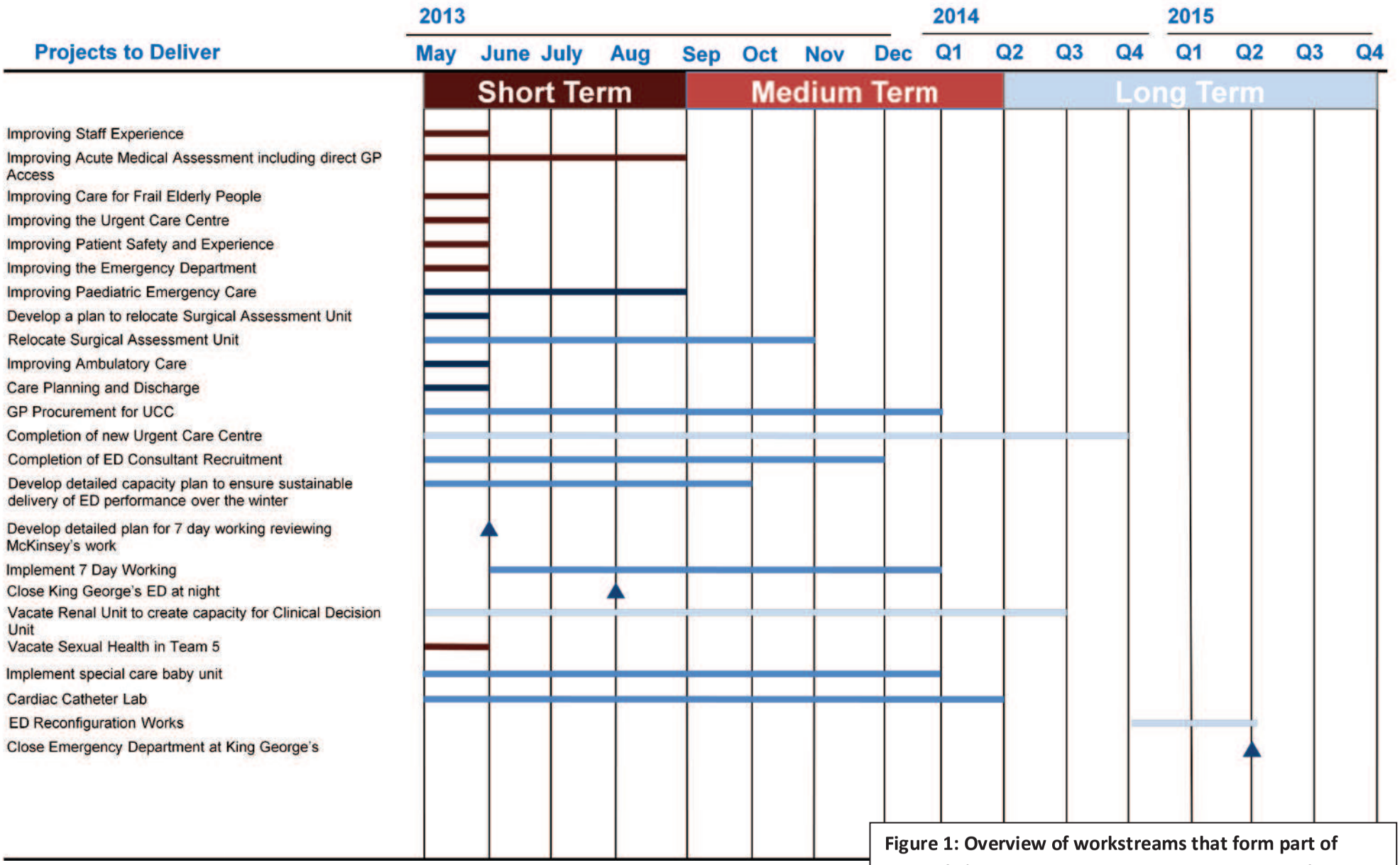


Figure 1: Overview of workstreams that form part of BHRUT's 'Improving Emergency Care Programme'

4 Progress on delivering the immediate priorities of the Emergency Care Improvement Plan

Immediate term priorities

4.1 Appendix 1 contains slides that provide an overview of the progress against the 10 workstreams which have been identified as those critical to the transformation of the whole system and which are scheduled for completion by the end of August 2013. They include priority actions which are already showing signs of improvement and are aligned to the delivery of the London Quality Programme's Acute Medical and Emergency Surgery Standards.

4.2 Those workstreams are:

- Improving patient safety and experience;
- Improving staff experience;
- Improving acute medical assessment, including direct GP access;
- Improving care for frail elderly people;
- Improving the Urgent Care Centre;
- Improving the Emergency Department;
- Improving paediatric emergency care;
- Surgical Assessment Unit including direct GP access;
- Improving ambulatory care;
- Care planning and discharge.

Medium term priorities

4.3 Appendix 2 provides an overview of the current position on the 3 workstreams that have been scheduled for completion by the end of March 2014. The first two are already in train and have detailed plans in place which are included in this document. The plan for 7 Day working is in the process of being developed and it is anticipated that this will be ready for implementation from end of June 2013. These workstreams are:

- Procurement of out-source GP function in the UCC (January 2014);
- Emergency Department consultant recruitment (December 2013);
- 7 Day Working (development phase completion June 2014. Implementation phase completion September 2014).

4.4 In addition the management of capacity/Winter planning will commence earlier than in previous years, with a view to having a fully worked up plan in place by September 2013 with implementation to cover the period October 2013 – March 2014. This is an operational plan which will evaluate the initiatives adopted in the current year to manage surges in demand, and which will align to the 13 workstreams as described in this document.

Longer term priorities

4.5 Finally, longer term goals include the realisation of Health for North East London aims by determining what the precise configuration of services will be across both QH as the 'hot' site and KGH as the 'cold' site. Ahead of this plans to redevelop the

Emergency Department as part of the development of the Urgent Care Centre on the Queen's hospital site is underway and scheduled for completion in December 2014.

4.6 In addition the role of the Clinical Decision Unit alluded to under the Ambulatory Care workstream, is seen as essential to the provision high quality care for appropriate patients in the right setting, thus avoiding unnecessary and inappropriate A&E attendances and admission to acute care. While this is being developed in partnership with NELFT and primary care, the project is dependent on securing suitable accommodation.

4.7 Other critical areas to be monitored closely will be the ongoing recruitment of emergency care consultants, Care of the Elderly consultants and acute physicians.

4.8 Other initiatives are expected to be identified and these will be developed as the Acute Reconfiguration Programme plan evolves.

5 Performance of the Emergency Department to March 2013

5.1 Appendix 3 contains information about the performance of the Emergency Department over the period to March 2013, based on the last reporting period to the public Board meeting.

6 Health & Wellbeing Board discussion

6.1 The information about the Emergency Care Improvement Plan is being presented to the Health & Wellbeing Board in recognition of the crucial part it plays in the overall health economy. Members of the Board are invited to comment on the progress and plans, and to suggest areas where there are greater opportunities for the whole health economy to support the Trust in its work on improving emergency care.

6.2 An Urgent Care Board is in the process of being established across the BHR health economy with the participation of the local authorities, clinical commissioning groups and the health trust. The intention is for this Board to lead the system-wide response and to streamline the multiple reporting processes in place to monitor BHRUT's improvement journey. A workshop was scheduled for Friday 24 May 2013, from which a verbal update will be available at the meeting.

6.3 Officers that are part of the discussions at that Board will note the comments of the Health & Wellbeing Board and reflect them in discussions as the Board and its workplan are shaped. A more formal update will be provided to a future meeting of the Health & Wellbeing Board.

7 Implications

7.1 Joint Strategic Needs Assessment

The 2012 JSNA contained a number of disparate references to urgent and emergency care, spread across a number of areas of analysis. In many respects, it has been superseded in any consideration of the specific issues about emergency care at BHRUT by the more comprehensive work undertaken by CQC. Future iterations of the JSNA would need to refer to this work.

7.2 Health & Wellbeing Strategy

Improvements in local health services, and emergency care in particular, are identified in the Health & Wellbeign Strategy and the considerable work described in these reports are major contributors to those priorities.

7.3 Promoting integration

The Health & Wellbeing Board's duty to promote integration will be discharged through consideration of the BHRUT-specific activities in the context of the wider health system. The establishment of the Urgent Care Board and related processes will be a further opportunity to ensure that integrated programmes of activity are pursued for the improvement of urgent and emergency care across this and neighbouring boroughs.

Appendix 1:
Emergency Care Improvement Plan:
Immediate Term Actions

Improving Patient Safety and Experience

Short Term Goals	Plan	Progress
Leadership	•Set a mission and expected outcome to improve patient experience. •Leadership behaviours/leadership charter. •OIC Nurse quality walk rounds at least 3 x per shift. •Define OIC nurse/co-ordinator roles to ensure flow is maximised. •Performance management of junior staff. •Introduce 'Give a star to a star'. •Clear escalation pathways that allow the department to respond to change. •Improve internal communications via SBAR and leadership charter.	•New lead nurse started 7 May •OIC Quality rounds assurance rounds with lead nurse and matron overseeing •Give a star a star – started •Reviewing compliance against mandatory training and appraisals (which will lead to individual development plans)
Staffing.	•Review staffing establishment to ensure staff on duty match activity. •Strengthen roles and responsibilities. •Improve performance management of bank and agency staff. •Band 7s to lead sickness absence management. •Mentorship/preceptorship for band 5s and support for new starters. •Retention strategy to focus on junior grades of staff.	•New lead nurse started 7 May •Revised staffing for short term •20 wte band 5 nurses recruited •All band 5 nurses accesses the preceptorship programme
Patient safety and experience.	•Increase uptake of patient survey to 15% of attendances. •Display 'friends and family' feedback in public places. •Implement 'the big 3' key areas of focus for the week. •OIC Nurse to include waiting room checks in her daily shift role. •Implement NHS Institute of Innovation 15 steps. •Define a process to identify vulnerable patients and expedite their assessment. •Introduce monthly 'you said we did' posters. •Create a set of '*always*' **events.** **•Reduce medicines incidents via the introduction of a management plan.**	•Increasing survey numbers •Monthly focus on 3 key issues for improvement based on survey started •Focus on medication and medicines for May as one of the top 3 (feeling welcome and discharge) •You said we did posters in place •OIC waiting room regular review

Improving Staff Experience.

Short Term Goals	Plan	Progress
Improve communication to staff.	•Accessible service improvement communication in staff rooms. •Computers in staff rooms. •Purchase emergency care journals. •4 positive messages of the week. •More frequent reception teams meetings.	Service communication is available in staff rooms and reception teams meetings occur monthly. All other actions are on trajectory for completion in May 2013.
Ensure staff engagement in change/service improvement.	•Ask for volunteers on service improvement projects. •Monthly Q&A with senior members of the team. •Staff feedback book. •Align to the Trust Organisational (OD) Development Plan. •Major OD event planned for July 2013.	Staff feedback book in place. All other actions are on trajectory for completion in May 2013.
Ensure consistent staffing levels.	•Overseas recruitment plan for ED Consultants. •Recruitment campaign for nursing.	Overseas recruitment plan is a medium term goal for delivery by December 2013. 20 wte band 5 nurses recruited.
Staff training and development.	•Appraisals and Personal Development Plans. •Ensure training and development takes places and minimise/limit cancellations.	Appraisals require attention to achieve 85% target.
Monitoring improvements.	•Assess baseline from staff survey and reaudit in 3 months. •Retention rate/reduction in turnover. •Sickness absence rates.	Sickness absence rates were well below the Trust target in March 2013 at 2.6%.

Improving Acute Medical Assessment Including Direct GP Access.

Short Term Goals	Plan	Progress
Ensure there is robust and effective medical leadership.	•The Clinical Director for Medicine has overarching responsibility for the MAU. •A consultant has been identified to lead MAU development. •A lead consultant has been identified for ambulatory care.	The following doctors have assumed leadership roles: •Dr Andrew Deaner. •Dr. Aklak Choudhury. •Dr. Gurvinder Rull.
Developing the GP/Ambulatory Unit	•Set up unit on MAU commencing with 6 trolleys increasing to 12. •Implement additional nurse and medical staffing plan. •Communication with GPs.	GP unit with 6 trolleys up and running since February. New staffing establishment for 12 trolleys approved and recruitment in process. Steady increase in GP referrals week on week – from 5 in first week to c. 30 currently.
Improve flow of patients through the medical assessment unit.	•Improve nursing transfer from ED to MAU by ensuring appropriate clinical pathways are followed and documentation is complete. •Improve communication between bed site team, MAU, and ED. •Redesign portering roster. •Relaunch TTAs system to facilitate discharge from MAU.	08.30meeting between bed site team, MAU and ED nurses is resulting increased use of the GP/Ambulatory Unit for appropriate patents direct from ED. Patients remaining in the unit for more than 48 hours the week ending 28tth April 0.0%.
MAU medical assessment JONAH	•Implementation of MAU assessment JONAH, to include MAU and the Short Stay Elderly Unit. •3 month project with external support from QFI.	Project commences 1st June and finishes 31st August 2013.

Improving Acute Medical Assessment including Direct GP Access Continued.

Short Term Goals	Plan	Progress
Admission avoidance.	•Allocation of patients under specialty in MAU to be medically managed by the appropriate specialty. •12 noon medical handover meetings. •Community Treatment Team to operate in MAU. •Post take admission avoidance resource folder available to nursing and medical staff.	•Medical discharges out of hospital direct from MAU are increasing from 69 4 weeks ago to 115 currently.
Staff retention and recruitment.	•Dedicated MAU Manager in place •Recruitment campaign to increase nursing staff. •Recruitment of locum consultants x 3 wte. •Foundation of Nursing Studies working with the MAU nursing team to lift morale.	8 wte band 5 nurses recruited. 8 WTE to be recruited – next recruitment day May 26th 2 x Care of Elderly consultants recruited which will support MAU. Acute physician recruitment underway.
Improving the current environment on MAU to ensure our patients remain in contact with the outside world.	•Installation of patient entertainment systems. •Installation of water fountains and Costa coffee machine. •Large screen TVs in communual areas. •Review of food served in MAU.	On trajectory for delivery Summer 2013.

Improving Assessment for Frail Elders.

Short Term Goals	Plan	Progress
7 day advice and liaison service.	•Assessing medical and nursing staff requirements. •Redeployment of experienced care of elderly consultants. •Agree rota for 7 day working. •Recruitment to Clinical Nurse Specialist posts. •Plan for nursing support at weekends. •Junior doctor support for 7 day working.	On trajectory for delivery Summer 2013.
Establish a short stay elderly care ward. The clinical model to be further refined so that short stay brings an emphasis assessment.	•Completion of Operational Policy. •Manpower requirements in place for nursing and medical staff. •Additional training for ward staff on rapid discharge.	Short Stay Unit opened April 2013. Average length of stay for this patient group has been reduced by 1.5 days. Further development of the assessment model will require 2 further wte Care of the Elderly consultants.

Improving The Urgent Care Centre

Short Term Goals	Plan	Progress
Walk in, Streaming and GP 'see and treat'.	•Develop see and treat model. •Ensure all streamers understand process of redirection to primary and/or community care. •Primary care non- compliance with agreed redirection protocol to be followed up with commissioners. •Liaison with the Hurley Group to ensure GPs have the right skills for streaming and 'see and treat'.	126 patients were streamed back to the community/primary care services week ending 5th May, exceeding the 120 weekly target.
Ambulance flows into the UCC	•Provide LAS with an exclusion criteria. •Provide a self assessment guide for ambulance crews as they arrive at A&E so that they can make appropriate decisions regarding ambulance transfer.	Exclusion criteria in place and agreed, working with LAS to increase daily activity. Direct conveyances to the UCC are increasing gradually: 13.9% currently up from c. 5% since implementation of the exclusion criteria.
Removing unnecessary process and delay within the UCC.	•LEAN methodology exercise to improve internal workings of UCC. •Re-establishment of roles and responsibilities. •Adjustment to infrastructure to aid patient flow.	On trajectory for completion in the summer 2013.
Workforce skills, ROTAs and training.	•Review of staffing levels and development of minimum staffing establishment. •UCC improvement manager	Substantive recruitment in progress Manager in place

Improving The Urgent Care Centre continued.

Short Term Goals	Plan	Progress
Performance data and performance management.	•Measures to improve data capture and reporting. •Pathway improvement: appropriate patient appropriate pathway •Dashboard analysis weekly. Reported at weekly Improving Emergency Care Programme Board, weekly Consultants meeting, and weekly ED Seniors meeting.	Including adult and paediatric attendances, around 31% of patients who present at A&E are seen in the UCC. Less ambulance arrivals this figure is 41%.
Creating a UCC team with high aspirations.	•Establish robust chain of command with well understood thresholds for escalation. •Robust management of the 'shop floor'. •Engender a strong sense of shared purpose.	On trajectory for delivery summer 2013.
Strengthening relationships with partner providers.	•Strengthen operational links with external partners. •Procurement process for out-source GP element to UCC.	An increased number of patients redirected and data shared weekly with CCG's.
Clinical Governance and professional relationships with ED.	•Induction process for locums and contract staff. •Removing obstacles to a smooth referral process to specialties within BHRUT.	The UCC GPs can make direct referrals to specialties. External GPs can also refer direct to specialties.

Improving The Emergency Department.

Short Term Goals	Plan	Progress
Extend and Improve RAT	•Increase RATing to from 17.00 to 22.00. •Review RATing area via LEAN methodology.	•RAT hours extended on a number of days per week but unable to fill further until additional consultants/seniors recruited •RATing improvement to be implemented further by consultant lead in May.
Improve Communication from RAT to Majors	•Improve RAT documentation. •Improve availability of results. •Improve RAT to majors nurse handover.	Completed.
Review role of Majors Co-ordinator/board nurse	•Trial admin role as board post. •Review and implement clear responsibilities of the senior nurse in charge.	•Admin role trial commenced 22nd April. Due for evaluation week commencing 13th May.
Review all equipment in Majors and fixed equipment in Majors cubicles.	•Process for monitoring and checking equipment. •Stock control measures in place.	Completed
Review staffing in Majors	•Recruitment campaign for band 5 nurses. •Review medical staffing and submit rota for EWTD testing.	•20 wte band 5 nurses recruited. •EWTD testing completed.
Improve mental health reviews for patients in ED	•Monthly multi professional meeting to review progress regarding mental health, drugs, alcohol and police. •Review Whipps Cross in reach model. •Review top 20 reattenders for alcohol pathway	•Monthly meetings with key operational partners are in place.

Improving The Emergency Department continued.

Short Term Goals	Plan	Progress
Locums and induction.	•Online induction for medical locums. •Useful contacts list.	Completed.
Specialty input	•Ensure GPs refer directly to specialties. •Feedback to specialties their 'referral to review' performance. •Emergency Access Policy.	•All patients who attend with a 'dear doctor letter' from their GP are referred direct to the relevant specialty.
Monitor improvements through better data and information.	•Recruitment of a dedicated information officer for ED. •Weekly analysis of A&E dashboard and taking forward key points of learning.	•Information Officer commenced in post April 2013. •Weekly analysis reviewed at Programme Board.
Review Management Structure	•New Management team in place: Clinical Director, General Manager, Service Manager and Nursing Lead as of May 4th	•Provide additional support following review at the end of May
Improve data capture	•Review of Symphony data system to ensure live data is captured – internal review completed. ED data steering group established	System review by external consultants week of May 13th

Improving Paediatric Emergency Care.

Short Term Goals	Plan	Progress
Launch NICE guidelines for the management of common conditions.	•Review NICE Guidelines for 'FEVER' and implement •Review NICE Guidelines for 'HEAD INJURY' and implement •Review current guidelines for 'GASTROENTERITIS' , 'BRONCHIOLITIS' and 'ASTHMA' to ensure current and up to date. •Ensure joined up pathways with 'outpatient' based services such as Diabetes Management and Seizure clinics.	•In Progress •Target Completion July/August
Improve the timeliness of responses to the Paediatric ED by Speciality services.	•Establish a case review meeting when breaches of the internal 2 hour target occur •Review the current escalation protocols between clinical and managements teams •Increase Consultant Paediatrician presence within the ED	•In Progress •Target Completion May
Review the Transfer Protocols and policy with CATS.	•Acutely ill children to be managed with a jointly owned and developed policy with CATS, internal teams and receiving hospitals •Development of parent education leaflet	•In Progress •Target Completion May

Improving Paediatric Emergency Care continued.

Short Term Goals	Plan	Progress
Management of the Critically Ill child	•Review current policies and protocols to ensure 'fit for purpose' •Develop the Resuscitation area in Paeds ED •Create robust escalation protocol for 'backfilling' with routine paediatric staff to avoid consequential delays in the event of a 'crash' event •Review current staffing levels and internal support 'out of hours'	•In Progress •Target Completion May
Patient environment	•To review the provision of play specialists within the ED to improve child experience and reduce anxiety •To develop a multi-functional SSPAU (Short Stay Paeds Assessment Unit) on Tropical Lagoon	•In Progress •Target completion September
Clinical Pathways	•Establish a SSPAU on Tropical Lagoon to appropriate management children attending the ED. •Ensure robust links with Admission Avoidance strategies elsewhere in the organisation •Review CAMHS provision and 'Safeguarding' provision to ensure safe management of vulnerable children.	•In Progress •Target completion September •In Progress •Target completion May

Surgical Assessment Unit including direct GP access.

Short Term Goals	Plan	Progress
Establish a Surgical Assessment Unit (SAU).	•Implementation of a 5 day 'hot clinic' (Monday to Friday). •Implementation a 7 day SAU two trolleys and clinic area on Ocean B.	Clinic commenced on the 4th February 2013.
Communication with GPs and transfer of appropriate patients from the Emergency Department.	•Improve nursing transfer from ED to SAU by ensuring appropriate clinical pathways are followed and documentation is complete. •Improve communication between bed site team, SAU, and ED. •Redesign portering roster. •Communication with GPs •SAU audit completed	Numbers of patients transferred from A&E to SAU on a weekly basis 40 – 60. Numbers of patients referred directly by GPs on a weekly basis 12 – 28. Weekly data shared with CCG's. Audit data shared with CCG quarterly.

Surgical Assessment Unit including direct GP access.

Short Term Goals	Plan	Progress
Establish a Surgical Assessment Unit (SAU).	•Implementation of a 5 day 'hot clinic' (Monday to Friday). •Implementation a 7 day SAU two trolleys and clinic area on Ocean B.	Clinic commenced on the 4th February 2013.
Communication with GPs and transfer of appropriate patients from the Emergency Department.	•Improve nursing transfer from ED to SAU by ensuring appropriate clinical pathways are followed and documentation is complete. •Improve communication between bed site team, SAU, and ED. •Redesign portering roster. •Communication with GPs •SAU audit completed	Numbers of patients transferred from A&E to SAU on a weekly basis 40 – 60. Numbers of patients referred directly by GPs on a weekly basis 12 – 28. Weekly data shared with CCG's. Audit data shared with CCG quarterly.
Plan future of the unit given need for relocation in 6 months.	•Plan in place for relocation by end June 2013. •Implementation phase June – September 2013	On trajectory as per published timescales.

Improving Ambulatory Care

Short Term Goals	Plan	Progress
First fit pathway/acute headache.	•Review pathway with Neurological lead (Dr Wore). •Document and implement.	On trajectory for delivery summer 2013.
Self harm pathway.	•Review pathway with ED lead 9 (Dr Hicks). •Document and implement.	On trajectory for delivery summer 2013.
Rapid access chest pain.	•Review pathway with cardiology leads (Dr Deaner, Dr Salehi and GP). •Document and implement.	On trajectory for delivery summer 2013.
COPD.	•Review pathway with respiratory lead (Dr Fowler). •Document and implement.	On trajectory for delivery summer 2013.
Pulmonary Embolism.	•Audit of current pathway (Dr Rull) •Document and implement changes/lessons learned.	On trajectory for delivery summer 2013.

Improving Ambulatory Care continued.

Short Term Goals	Plan	Progress
Renal Colic	•Review current pathway with Dr Andrew Bolero. •Document and implement changes.	On trajectory for delivery summer 2013.
Cellulitis	•Review current pathway with NELFT. •New pathway commences 1st May.	New pathway for Cellulitis in place and more patients being cared for in the community.
Business case for Clinical Decision Unit. (utilising current area allocated to Renal services)	•Establish operational model. •Draft Business case for discussion. •Sign off at Trust Executive Committee. •Implementation phase	Medium term goal for completion September 2014.
GP Ambulatory Care	•Convert 8 agreed pathways into 'GP appropriate' pathways. •Document and implement. •Communicate to GPs. •Work with GP's on pathways.	On trajectory for delivery summer 2013. Referral details for GPs are posted on the website. Straight forward referral process for GPs in place.
Nursing Home/Care Home outreach.	•Review nursing home data regarding A&E attendances and community input. •Multi agency workshop in summer 2013. •Establish proposal for reducing nursing home patients attendance in A&E.	On trajectory for delivery summer 2013.

Care Planning and Discharge.

Short Term Goals	Plan	Progress
Ward based discharge planning processes are fully effective and when present discharge plans are effectively executed.	•All departments and disciplines are fully engaged with and keeping JONAH up to date. •Investment of 37 wte to strengthen leadership by ward sisters/CN's •Consultants and senior ward nurses lead board and ward rounds, ensuring that TTAs (EDS) are completed during that process. •Increase ward manager capacity to lead JONAH reviews and manage discharges as planned. •A protocol in place to ensure timely access to social workers. •Improve use of the discharge lounge and potering during peak periods. •Address issues of Locum access to key IT systems e.g. PAS. •OT process are refined to reduce likelihood of delays. •Develop policy and process to manage families who apply pressure to keep their relatives in an acute setting.	On trajectory for delivery by 21st July 2013. 37 posts agreed. Recruitment event and open day in June. Event facilitated in April to improve communication between bed/site team, MAU and the wards. Weekly meetings ongoing with key managers
The interfaces with local social care and community bed provision are clearly understood and operating effectively.	•Daily communication with senior managers at NELFT and escalation of rehab patients delayed in the system. •Development of a policy and process that manages the discharge of patients to care/nursing homes as well as the restarting care packages. •Develop a clear, effective process for rehab referrals through collaboration between BHRUT therapies and NELFT community rehab services. •Address issues for healthy non weight bearing patients.	On trajectory for delivery by 21st July 3013. Additional community bed capacity provided until end of April. Community provision needs to be assured as capacity is not aligned to patient choice.
An effective performance framework linking overall performance with local (ward and department) level is in place.	•Agreed set of ward metrics in place: •Performance manage with ward teams led by matrons. •Communicate the approach with the wider organisation (ADOs and GMs)	On trajectory for delivery by 21st July 3013.

Appendix 2:
Emergency Care Improvement Plan:
Medium-Term Actions

Procurement of out-source GP function in the UCC.

Short/Medium Term Goals	Plan	Progress
•Service Specification	•Develop service specification.	On trajectory for delivery Summer 2013.
•Service Level Agreement.	•Development of contractual arrangements with performance metrics and penalties for non-achievement of KPIs.	On trajectory for delivery Summer 2013.
•Procurement process.	•Invite expressions of interest on OJEU website. •Provide pre-qualifying questionnaire and Service Specification to prospective bidders. •Shortlist those to provide Intention to tender document.. •Selection process August/Sept. •Award contract October. •New provider commences operations January 2014.	On trajectory for new provider to commence January 2014.

Emergency Department Consultant Recruitment

Medium Term Goals	Plan	Progress
Recruitment options	•Engage with an external agency to undertake executive search and international recruitment. •Advertise vacancies on NHS Jobs.	Recruitment strategy in place and commenced.
Confirm established posts to be recruited to and displace agency	•7 ED consultants •15 middle grades •17 basic grades •1consultant with special interest •2 clinical fellows	Trajectory agreed to meet target
Implementation of revised, attractive, consultant roles.	•Develop creative 'joint' roles across ED and specialties e.g Critical Care.	Job description for joint role for ED and critical care out to advert.
Selection process.	•Interview panel and selection process to be determined. •Anticipated to commence Summer 2013.	Late Summer 2013 selection with start in post anticipated by December 2013.
Recruitment of Clinical Fellows	•Advertise posts	Interviews May 23rd 2013
Retention.	•Changes to clinical and managerial leadership. •New clinical and managerial team in place	New Clinical Director commenced in 2nd May 2013. New management and nurse lead in place May 2nd

Appendix 3:
Performance information on Emergency Department

To March 2013

Emergency Care Pathway Dashboard

Barking, Havering and Redbridge University Hospitals NHS Trust

Hospital	King George's Hospital
Reporting D…	27 Mar 2013

Within threshold | Within 10% of threshold | Outside threshold | No threshold

		Metric	Threshold	Yesterday 26/3/2013	Snapshot last week 19/3/2013	Average 7-days wk ending 26/3/2013	Average 7-days 2012 wk ending 26/3/2012
System overall	4 Hour Performance	% of patients treated & discharged in 4 hours	Above 95.0%	95.4%	72.9%	91.9%	92.3%
		Resus Breaches	Below 1.0	2.0	2.0	1.6	1.7
		Majors Breaches	Below 10.0	4.0	36.0	10.0	13.7
		UCC Breaches	Below 1.0	0.0	5.0	0.3	0.9
		Paeds Breaches	Below 1.0	2.0	5.0	1.9	0.7
		Other Breaches	Below 1.0	0.0	1.0	0.3	0.0
		Total Breaches	Below 14.0	8.0	49.0	14.0	17.0
Emergency Department	Arrival flow	Total attendances	Below 200.0	173.0	181.0	173.4	219.7
		Ambulance to ED as % of overall attendances	Below 25.0%	28.3%	32.6%	27.3%	23.8%
		Ambulances to ED	Below 60.0	49.0	59.0	47.4	52.3
		Ambulance to UCC as % of ambulances	Above 20.0%	6.1%	6.8%	3.9%	11.2%
	Flows within ED/UCC	Numbers into majors (inc Triage; excl Resus)	Below 107.0	88.0	84.0	88.7	92.7
		Numbers direct into minors	Above 66.0	42.0	45.0	38.0	53.9
	Speed of care in ED	% of 1st clinical assess in ED <30mins	Above 80.0%	91.3%	85.6%	93.7%	83.2%
		% refer to specialities < 120mins	Above 80.0%	89.7%	51.9%	77.9%	67.3%
		% of specialist response < 60mins	Above 80.0%	51.7%	50.0%	55.7%	50.7%
		Average time spent in ED (admitted patients)	Below 180 Mins	222.0	413.7	250.3	284.8
		Average time spent in ED (not admitted patients)	Below 120 Mins	148.9	203.8	169.5	177.7
	Admissions	Total admissions from ED	Below 68.0	50.0	50.0	45.7	56.7
		Admissions from ED as % of total attendances	Below 25.0%	28.9%	27.6%	26.4%	25.8%
		Total admissions that were Ambulance arrival	Below 30.0	27.0	25.0	22.4	25.6
Assesment & Wards	MAU	Direct MAU admits from GPs	Above 4.0	0.0	0.0	0.0	0.0
		Average length of stay on transfer in MAU (days)	Below 1.0 Days	0.0	1.0	0.9	1.1
		Average length of stay on discharge in MAU (days)	Below 2.0 Days	0.0	1.2	1.1	1.3
		MAU transfers	Above 17.0	30.0	15.0	20.6	20.6
		MAU discharges home	Above 17.0	0.0	0.0	0.0	0.0
	Medical ward discharges	Total number of medical discharges (Med & CoE only)	Above 17.0	17.0	21.0	18.4	17.9
		% of pre 11am discharges (Med & CoE only)	Above 25.0%	5.9%	4.8%	7.0%	8.0%
		Average active spell LOS (days; Med & CoE only)	N/A(Days)	-	-	-	-
		# of active patients >14days (Med & CoE only)	N/A(Number)	0.0	0.0	0.0	0.0

Emergency Care Pathway Dashboard

Barking, Havering and Redbridge University Hospitals NHS Trust

Hospital	King George's Hospital
Reporting Date	27 Mar 2013

Legend: Trend from the previous week (PW)

XX Last 7 days average
Wed 20 Mar 2013 - Tue 26 Mar 2013

PW: Previous week average
Wed 13 Mar 2013 - Tue 19 Mar 2013
SW: Six week average
Wed 06 Feb 2013 - Tue 26 Mar 2013

Ward	Daily medical discharges		Pre 11a.m. discharges (% of total)		Weekend discharges (% of total)		Average LOS active (days)		Average LOS on discharge (days)		Patients >14 days active (% of active patients)	
Ash	↓ 3.3	PW:3.7 SW:3.2	↓ 0.0%	PW:7.7% SW:7.1%	↓ 8.7%	PW:15.4% SW:12.2%	- -	PW:8.1 SW:8.1	↑ 16.3	PW:8.3 SW:11.5	- -	-
Elm	↑ 1.7	PW:1.6 SW:1.5	↓ 8.3%	PW:18.2% SW:8.2%	↓ 16.7%	PW:18.2% SW:12.3%	- -	PW:11.0 SW:11.0	↓ 17.9	PW:18.5 SW:21.2	- -	-
Erica	↓ 0.9	PW:1.6 SW:1.0	↓ 0.0%	PW:45.5% SW:18.8%	↓ 0.0%	PW:9.1% SW:4.2%	- -	PW:16.8 SW:16.8	↓ 4.0	PW:21.5 SW:17.6	- -	-
Fern	↑ 2.1	PW:1.6 SW:2.2	↓ 6.7%	PW:9.1% SW:6.5%	↑ 20.0%	PW:18.2% SW:9.3%	- -	PW:11.0 SW:11.0	↓ 13.6	PW:27.1 SW:15.9	- -	-
Gardenia	↑ 3.3	PW:3.0 SW:3.6	↓ 4.3%	PW:4.8% SW:5.1%	↑ 30.4%	PW:14.3% SW:14.3%	- -	PW:5.2 SW:5.2	↑ 8.7	PW:6.4 SW:6.2	- -	-
Gentian	↓ 3.6	PW:5.3 SW:5.2	↑ 12.0%	PW:10.8% SW:11.5%	↑ 16.0%	PW:2.7% SW:7.9%	- -	PW:3.1 SW:3.1	↑ 7.6	PW:5.5 SW:7.0	- -	-
Holly	↑ 3.6	PW:2.9 SW:3.3	↑ 12.0%	PW:5.0% SW:10.6%	↓ 8.0%	PW:10.0% SW:8.8%	- -	PW:7.5 SW:7.5	↓ 9.2	PW:9.6 SW:10.7	- -	-
Overall	↓ 18.4	PW:19.6 SW:19.9	↓ 7.0%	PW:11.7% SW:9.0%	↑ 15.5%	PW:10.9% SW:10.2%	- -	PW:8.5 SW:8.5	↑ 11.2	PW:10.8 SW:10.8	- -	-

Emergency Care Pathway Dashboard

Barking, Havering and Redbridge University Hospitals NHS Trust

Hospital	King George's Hospital
Reporting Date	27 Mar 2013

Legend

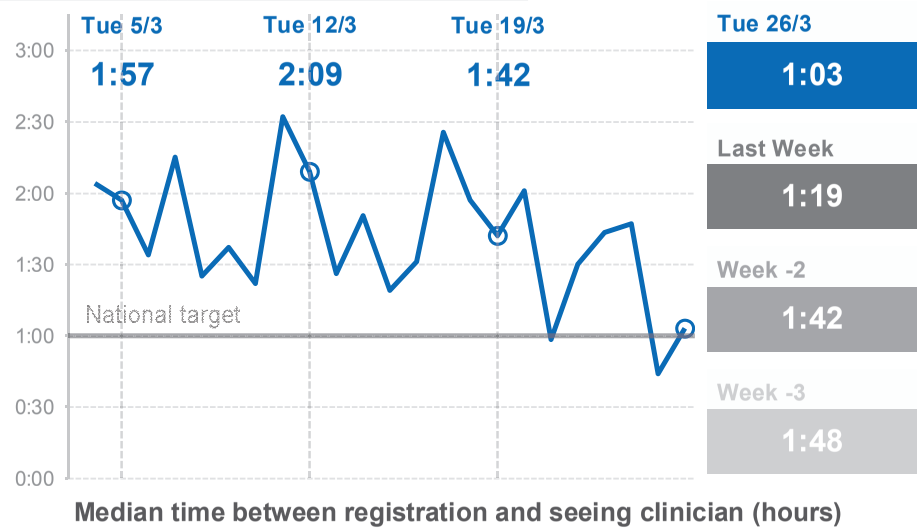
Trend from the previous week (PW)

XX Last 7 days average
Wed 20 Mar 2013 - Tue 26 Mar 2013

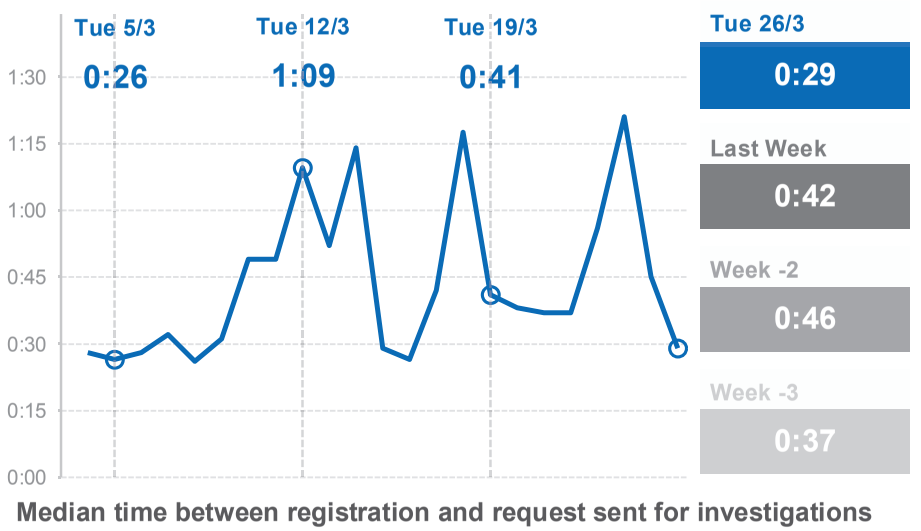
PW: Previous week average
Wed 13 Mar 2013 - Tue 19 Mar 2013
SW: Six week average
Wed 06 Feb 2013 - Tue 26 Mar 2013

Ward	Daily medical discharges	Pre 11a.m. discharges (% of total)	Weekend discharges (% of total)	Average LOS active (days)	Average LOS on discharge (days)	Patients >14 days active (% of active patients)
Ash	PW:16.7% SW:16.7%					
Elm	PW:26.1% SW:26.1%					
Erica	PW:41.2% SW:41.2%					
Fern	PW:23.3% SW:23.3%					
Gardenia	PW:7.7% SW:7.7%					
Gentian	PW:0.0% SW:0.0%					
Holly	PW:11.5% SW:11.5%					
Overall	PW:16.8% SW:16.8%					

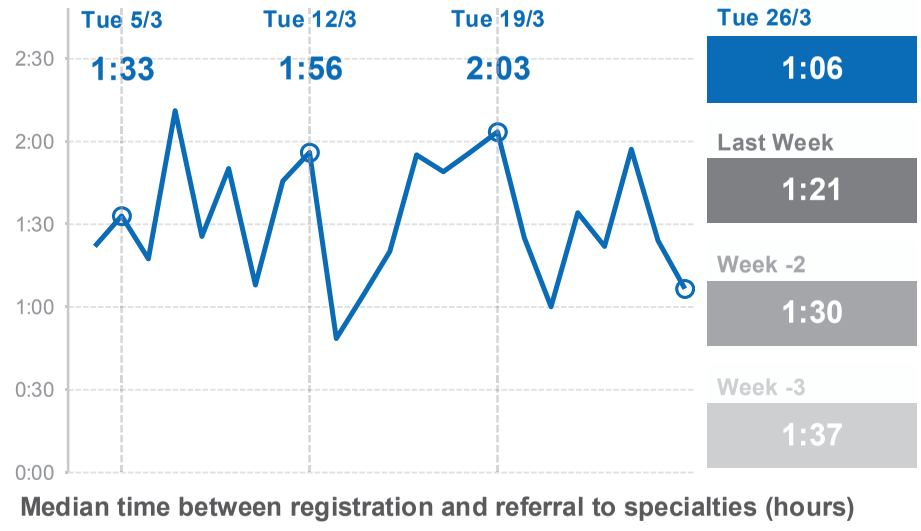
Hospital	King George's Hospital
Reporting D…	27 Mar 2013



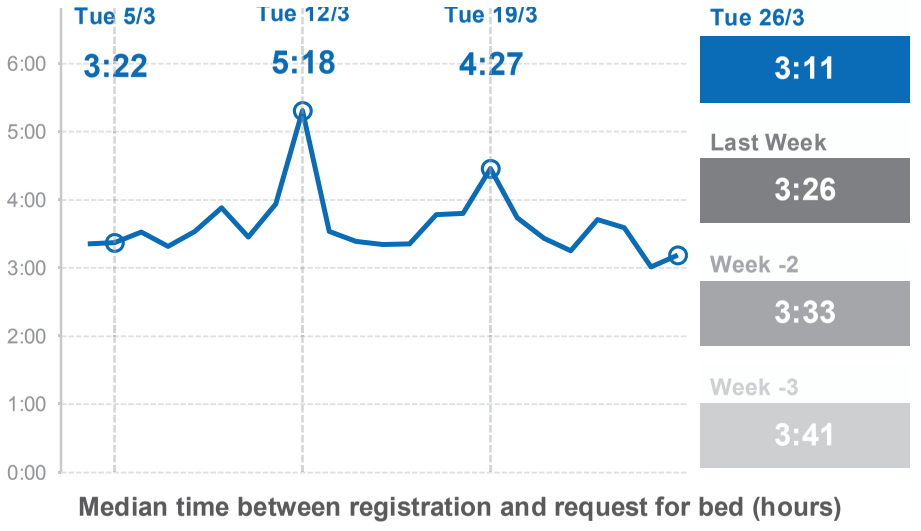
Median time between registration and seeing clinician (hours)



Median time between registration and request sent for investigations (hours)

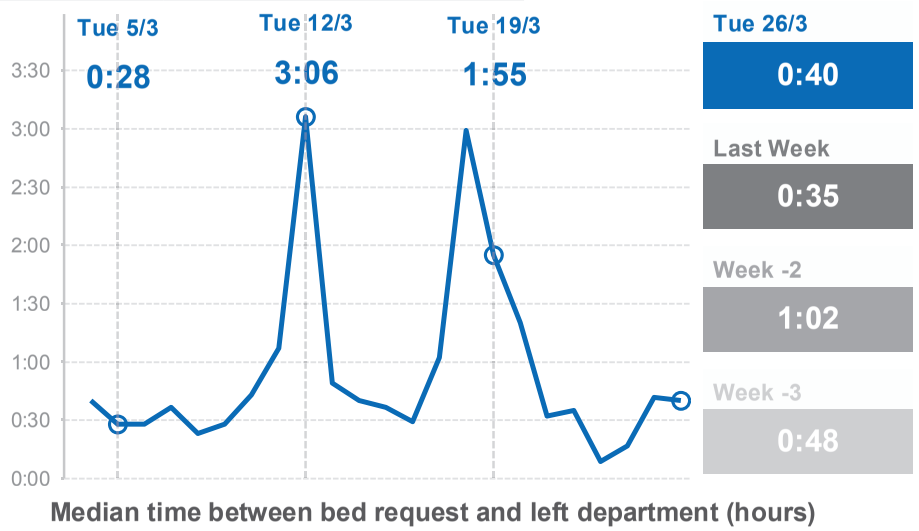


Median time between registration and referral to specialties (hours)



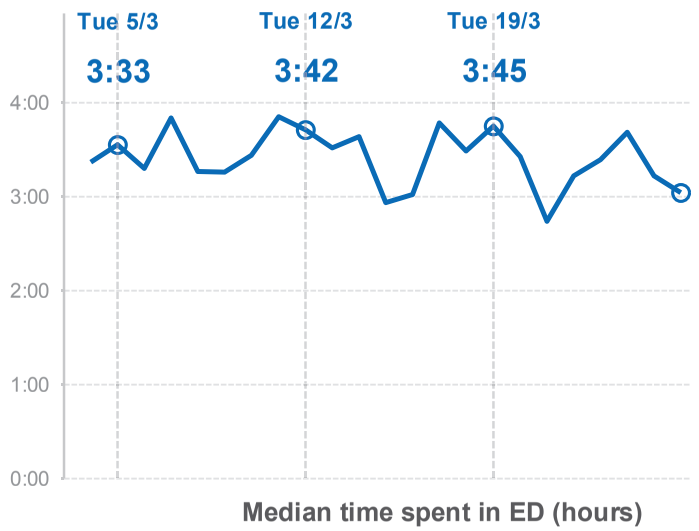
Median time between registration and request for bed (hours)

Hospital	King George's Hospital
Reporting D…	27 Mar 2013



Tue 26/3	Last Week	Week -2	Week -3
0:40	0:35	1:02	0:48

Median time between bed request and left department (hours)



Tue 26/3	Last Week	Week -2	Week -3
3:02	3:19	3:28	3:33

Median time spent in ED (hours)

Reattendance rate

Last Month	Previous Month
11.7%	11.3%

Emergency Care Pathway Dashboard

Barking, Havering and Redbridge University Hospitals NHS Trust

Hospital	Queen's Hospital
Reporting D…	27 Mar 2013

Within threshold | Within 10% of threshold | Outside threshold | No threshold

		Metric	Threshold	Yesterday 26/3/2013	Snapshot last week 19/3/2013	Average 7-days wk ending 26/3/2013	Average 7-days 2012 wk ending 26/3/2012
System overall	4 Hour Performance	% of patients treated & discharged in 4 hours	Above 95.0%	80.9%	72.7%	81.8%	86.4%
		Resus Breaches	Below 2.0	5.0	12.0	5.9	3.6
		Majors Breaches	Below 36.0	51.0	83.0	47.1	40.9
		UCC Breaches	Below 2.0	2.0	2.0	5.0	4.1
		Paeds Breaches	Below 1.0	14.0	15.0	11.7	9.1
		Other Breaches	Below 1.0	5.0	9.0	5.3	1.3
		Total Breaches	Below 42.0	77.0	121.0	75.0	59.0
Emergency Department	Arrival flow	Total attendances	Below 412.0	404.0	443.0	412.9	435.1
		Ambulance to ED as % of overall attendances	Below 25.0%	31.7%	28.9%	28.5%	27.8%
		Ambulances to ED	Below 120.0	128.0	128.0	117.9	120.9
		Ambulance to UCC as % of ambulances	Above 20.0%	16.4%	14.8%	14.2%	7.1%
	Flows within ED/UCC	Numbers into majors (inc Triage; excl Resus)	Below 160.0	123.0	116.0	127.4	144.6
		Numbers direct into UCC	Above 100.0	85.0	114.0	101.1	97.9
		Numbers treated in UCC(Adults & Paeds)	Above 160.0	87.0	128.0	116.6	122.3
		% of attending adults into UCC	Above 40.0%	30.1%	35.7%	34.5%	31.5%
		Redirects to GP/Community (% of Walk-ins)	Above 10.0%	3.3%	0.3%	3.1%	3.3%
	Speed of care in ED	% of 1st clinical assess in ED <30mins	Above 80.0%	72.8%	69.3%	77.6%	79.8%
		% refer to specialities < 120mins	Above 80.0%	64.4%	59.3%	69.0%	70.5%
		% of specialist response < 60mins	Above 80.0%	50.0%	36.3%	51.5%	55.2%
		Average time spent in ED (admitted patients)	Below 180 Mins	344.0	426.7	342.1	290.9
		Average time spent in ED (not admitted patients)	Below 120 Mins	148.6	181.3	158.5	167.9
	Admissions	Total admissions from ED	Below 102.0	78.0	99.0	83.6	100.7
		Admissions from ED as % of total attendances	Below 25.0%	19.3%	22.3%	20.2%	23.1%
		Total admissions that were Ambulance arrival	Below 60.0	47.0	67.0	48.0	59.0
Assesment & Wards	MAU	Direct MAU admits from GPs	Above 8.0	3.0	2.0	1.9	0.4
		Average length of stay on transfer in MAU (days)	Below 1.0 Days	0.0	0.7	0.9	0.8
		Average length of stay on discharge in MAU (days)	Below 2.0 Days	0.0	1.2	0.9	0.8
		MAU transfers	Above 38.0	33.0	30.0	28.7	28.9
		MAU discharges home	Above 32.0	15.0	16.0	17.6	15.7
	Medical ward discharges	Total number of medical discharges (Med & CoE only)	Above 45.0	45.0	36.0	32.3	25.9
		% of pre 11am discharges (Med & CoE only)	Above 25.0%	6.7%	8.3%	10.6%	8.8%
		Average active spell LOS (days; Med & CoE only)	N/A(Days)	-	-	-	-
		# of active patients >14days (Med & CoE only)	N/A(Number)	0.0	0.0	0.0	0.0

Emergency Care Pathway Dashboard

Barking, Havering and Redbridge University Hospitals NHS Trust

Hospital	Queen's Hospital
Reporting Date	27 Mar 2013

Legend: ↑ ↓ Trend from the previous week (PW)

XX Last 7 days average
Wed 20 Mar 2013 - Tue 26 Mar 2013

PW: Previous week average
Wed 13 Mar 2013 - Tue 19 Mar 2013
SW: Six week average
Wed 06 Feb 2013 - Tue 26 Mar 2013

Ward	Daily medical discharges		Pre 11a.m. discharges (% of total)		Weekend discharges (% of total)		Average LOS active (days)		Average LOS on discharge (days)		Patients >14 days active (% of active patients)	
Bluebell A	↓ 2.9	PW:3.7 SW:3.5	↑ 25.0%	PW:3.8% SW:11.2%	↑ 30.0%	PW:7.7% SW:12.4%	- -	PW:7.2 SW:7.2	↑ 11.4	PW:7.4 SW:10.0	- -	-
Bluebell B	↑ 3.9	PW:3.1 SW:3.4	↓ 7.4%	PW:13.6% SW:7.1%	↑ 11.1%	PW:9.1% SW:13.1%	- -	PW:11.0 SW:11.0	↓ 10.0	PW:12.7 SW:9.7	- -	-
CCU	- 3.0	PW:3.0 SW:2.9	↑ 4.8%	PW:0.0% SW:9.0%	↑ 19.0%	PW:14.3% SW:18.1%	- -	PW:4.7 SW:4.7	↓ 4.7	PW:7.1 SW:5.5	- -	-
Clementine A	↑ 3.6	PW:3.4 SW:3.3	↓ 4.0%	PW:4.2% SW:9.1%	↓ 12.0%	PW:16.7% SW:12.8%	- -	PW:14.5 SW:14.5	↓ 8.4	PW:16.1 SW:9.8	- -	-
Clementine B	↑ 3.4	PW:3.1 SW:3.6	↓ 0.0%	PW:4.5% SW:6.9%	↑ 8.3%	PW:4.5% SW:8.6%	- -	PW:8.3 SW:8.3	↑ 10.6	PW:10.4 SW:9.5	- -	-
Harvest A	↓ 2.3	PW:3.7 SW:2.7	↓ 18.8%	PW:34.6% SW:20.3%	↓ 0.0%	PW:23.1% SW:17.3%	- -	PW:12.8 SW:12.8	↑ 18.0	PW:10.9 SW:12.3	- -	-
Mandarin A	↓ 3.0	PW:3.9 SW:3.5	↓ 0.0%	PW:11.1% SW:12.2%	↑ 14.3%	PW:7.4% SW:14.5%	- -	PW:8.5 SW:8.5	↓ 9.7	PW:9.9 SW:10.3	- -	-
Sky A	↑ 5.7	PW:5.1 SW:3.6	↑ 22.5%	PW:16.7% SW:19.7%	↓ 7.5%	PW:19.4% SW:15.2%	- -	PW:8.8 SW:8.8	↓ 6.8	PW:6.9 SW:8.9	- -	-
Sunrise A	↓ 2.1	PW:3.7 SW:2.7	↓ 6.7%	PW:7.7% SW:12.0%	↓ 6.7%	PW:23.1% SW:14.3%	- -	PW:11.2 SW:11.2	↑ 13.8	PW:9.2 SW:11.7	- -	-
Sunrise B	- 2.4	PW:2.4 SW:2.6	↑ 11.8%	PW:0.0% SW:7.2%	↓ 11.8%	PW:17.6% SW:8.8%	- -	PW:8.0 SW:8.0	↑ 15.8	PW:11.4 SW:14.0	- -	-
Overall	↓ 32.3	PW:35.3 SW:31.9	↑ 10.6%	PW:10.5% SW:11.5%	↓ 11.9%	PW:14.6% SW:13.4%	- -	PW:9.7 SW:9.7	↑ 10.2	PW:10.0 SW:10.0	- -	-

Emergency Care Pathway Dashboard

Barking, Havering and Redbridge University Hospitals NHS Trust

Hospital	Queen's Hospital
Reporting Date	27 Mar 2013

Legend

Trend from the previous week (PW)

XX Last 7 days average
Wed 20 Mar 2013 - Tue 26 Mar 2013

PW: Previous week average
Wed 13 Mar 2013 - Tue 19 Mar 2013
SW: Six week average
Wed 06 Feb 2013 - Tue 26 Mar 2013

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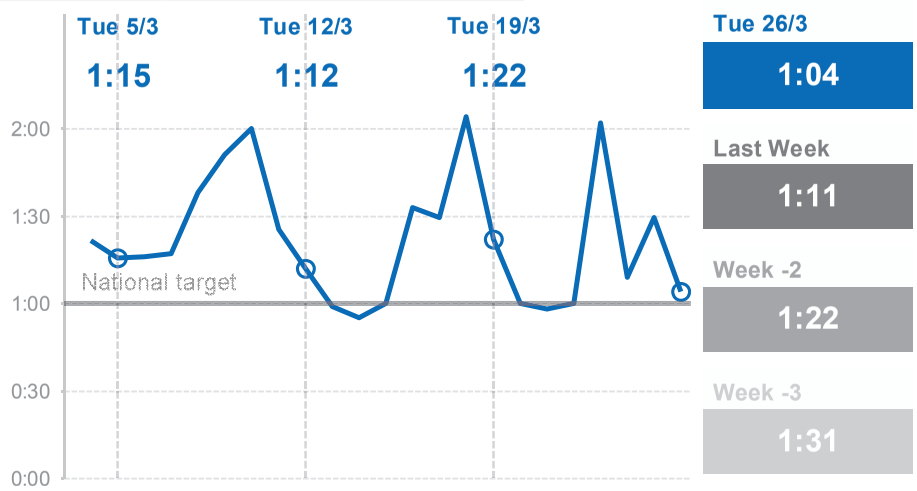
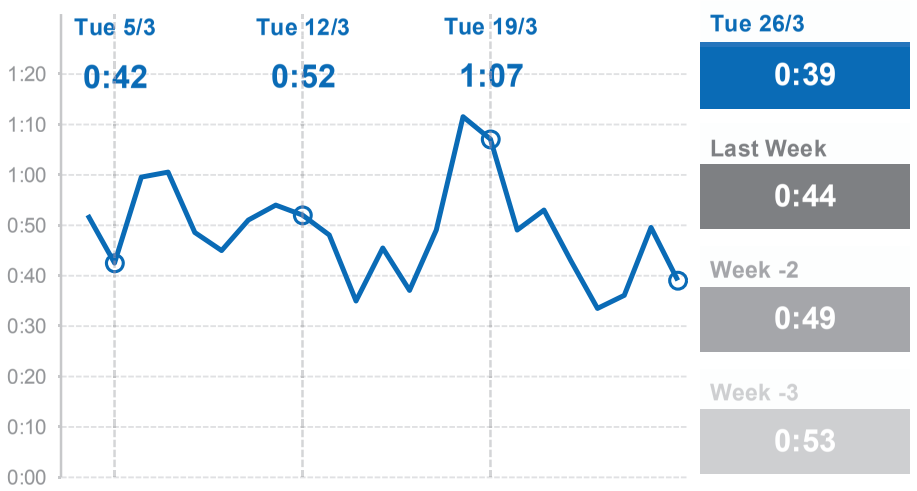
Bluebell B	PW:25.0% SW:25.0%					
CCU	PW:12.5% SW:12.5%					
Clementine A	PW:34.5% SW:34.5%					
Clementine B	PW:16.7% SW:16.7%					
Harvest A	PW:27.6% SW:27.6%					
Mandarin A	PW:17.2% SW:17.2%					
Sky A	PW:23.1% SW:23.1%					
Sunrise A	PW:34.5% SW:34.5%					
Sunrise B	PW:23.3% SW:23.3%					
Overall	PW:22.5% SW:22.5%					

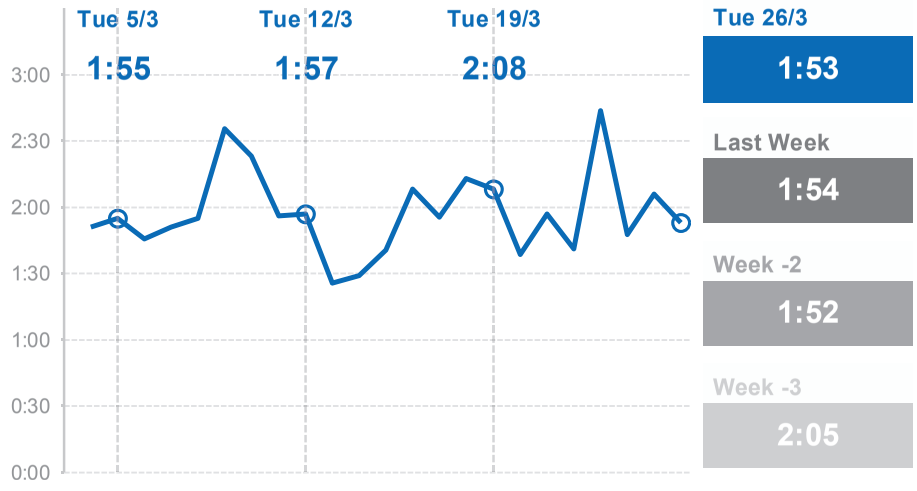
Hospital	Queen's Hospital
Reporting D…	27 Mar 2013



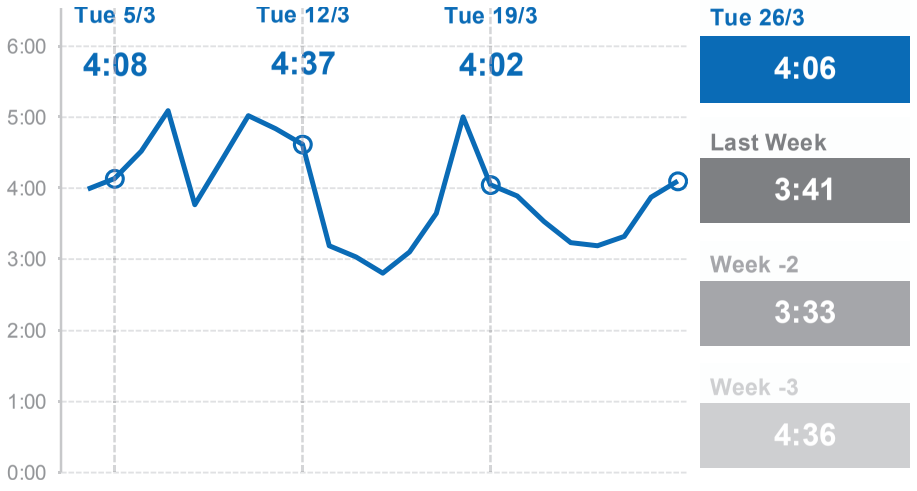
Median time between registration and seeing clinician (hours)



Median time between registration and request sent for investigations (hours)

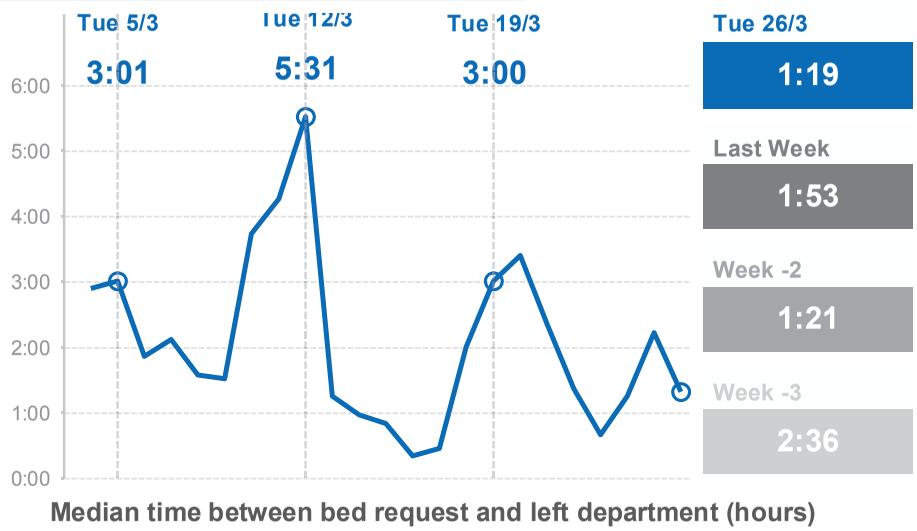


Median time between registration and referral to specialties (hours)



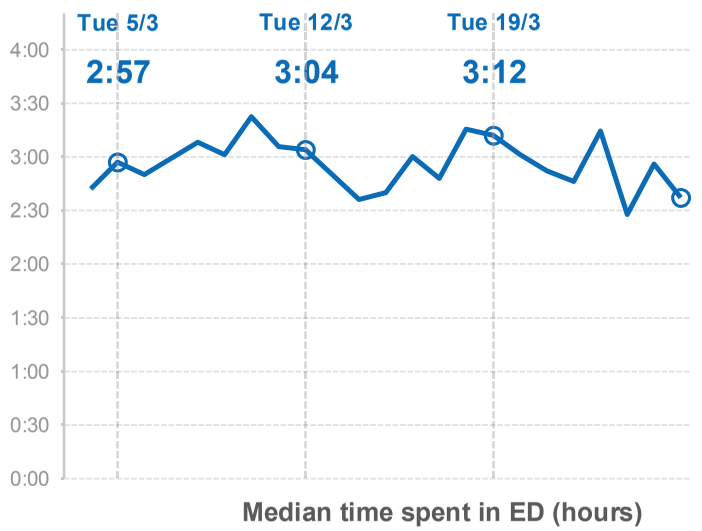
Median time between registration and request for bed (hours)

Hospital	Queen's Hospital
Reporting D…	27 Mar 2013



Tue 26/3	Last Week	Week -2	Week -3
1:19	1:53	1:21	2:36

Median time between bed request and left department (hours)



Tue 26/3	Last Week	Week -2	Week -3
2:37	2:51	2:59	3:05

Median time spent in ED (hours)

Reattendance rate

Last Month	Previous Month
14.4%	13.6%

Emergency Care Pathway Dashboard

Barking, Havering and Redbridge University Hospitals NHS Trust

Hospital	Trust (QH+KGH)
Reporting D…	27 Mar 2013

Within threshold | Within 10% of threshold | Outside threshold | No threshold

		Metric	Threshold	Yesterday 26/3/2013	Snapshot last week 19/3/2013	Average 7-days wk ending 26/3/2013	Average 7-days 2012 wk ending 26/3/2012
System overall	4 Hour Performance	% of patients treated & discharged in 4 hours	Above 95.0%	85.3%	72.8%	84.8%	88.4%
		Resus Breaches	Below 3.0	7.0	14.0	7.4	5.3
		Majors Breaches	Below 46.0	55.0	119.0	57.1	54.6
		UCC Breaches	Below 3.0	2.0	7.0	5.3	5.0
		Paeds Breaches	Below 2.0	16.0	20.0	13.6	9.9
		Other Breaches	Below 2.0	5.0	10.0	5.6	1.3
		Total Breaches	Below 56.0	85.0	170.0	89.0	76.0
Emergency Department	Arrival flow	Total attendances	Below 612.0	577.0	624.0	586.3	654.9
		Ambulance to ED as % of overall attendances	Below 25.0%	30.7%	30.0%	28.2%	26.4%
		Ambulances to ED	Below 180.0	177.0	187.0	165.3	173.1
		Ambulance to UCC as % of ambulances	Above 20.0%	13.6%	12.3%	11.2%	8.3%
	Flows within ED/UCC	Numbers into majors (inc Triage; excl Resus)	Below 267.0	211.0	200.0	216.1	237.3
		Numbers direct into UCC/Minors (excl. KGH UCC)	Above 166.0	127.0	159.0	139.1	151.7
		Numbers treated in UCC(Adults & Paeds)	Above 160.0	87.0	128.0	116.6	122.3
		% of attending adults into UCC	Above 40.0%	30.1%	35.7%	34.5%	31.5%
		Redirects to GP/Community (% of Walk-ins)	Above 10.0%	3.3%	0.3%	3.1%	3.3%
	Speed of care in ED	% of 1st clinical assess in ED <30mins	Above 80.0%	78.3%	74.0%	82.4%	80.9%
		% refer to specialities < 120mins	Above 80.0%	69.9%	56.9%	71.5%	69.3%
		% of specialist response < 60mins	Above 80.0%	50.4%	40.7%	52.7%	53.5%
		Average time spent in ED (admitted patients)	Below 180 Mins	296.3	422.4	309.6	288.7
		Average time spent in ED (not admitted patients)	Below 120 Mins	148.7	187.5	161.6	171.1
	Admissions	Total admissions from ED	Below 170.0	128.0	149.0	129.3	157.4
		Admissions from ED as % of total attendances	Below 25.0%	22.2%	23.9%	22.1%	24.0%
		Total admissions that were Ambulance arrival	Below 90.0	74.0	92.0	70.4	84.6
Assesment & Wards	MAU	Direct MAU admits from GPs	Above 12.0	3.0	2.0	1.9	0.4
		Average length of stay on transfer in MAU (days)	Below 1.0 Days	0.0	0.8	0.9	0.9
		Average length of stay on discharge in MAU (days)	Below 2.0 Days	0.0	1.2	0.9	1.0
		MAU transfers	Above 55.0	63.0	45.0	49.3	49.4
		MAU discharges home	Above 49.0	15.0	16.0	17.6	15.7
	Medical ward discharges	Total number of medical discharges (Med & CoE only)	Above 62.0	62.0	57.0	50.7	43.7
		% of pre 11am discharges (Med & CoE only)	Above 25.0%	6.5%	7.0%	9.3%	8.5%
		Average active spell LOS (days; Med & CoE only)	N/A(Days)	-	-	-	-
		# of active patients >14days (Med & CoE only)	N/A(Number)	0.0	0.0	0.0	0.0

Emergency Care Pathway Dashboard

Barking, Havering and Redbridge University Hospitals NHS Trust

Hospital	Trust (QH+KGH)
Reporting Date	27 Mar 2013

Legend: Trend from the previous week (PW)

XX Last 7 days average
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Ward	Daily medical discharges		Pre 11a.m. discharges (% of total)		Weekend discharges (% of total)		Average LOS active (days)		Average LOS on discharge (days)		Patients >14 days active (% of active patients)	
Ash	3.3	PW:3.7 SW:3.2	0.0%	PW:7.7% SW:7.1%	8.7%	PW:15.4% SW:12.2%	-	-	16.3	PW:8.1 SW:8.1	PW:8.3 SW:11.5	-
Bluebell A	2.9	PW:3.7 SW:3.5	25.0%	PW:3.8% SW:11.2%	30.0%	PW:7.7% SW:12.4%	-	-	11.4	PW:7.2 SW:7.2	PW:7.4 SW:10.0	-
Bluebell B	3.9	PW:3.1 SW:3.4	7.4%	PW:13.6% SW:7.1%	11.1%	PW:9.1% SW:13.1%	-	-	10.0	PW:11.0 SW:11.0	PW:12.7 SW:9.7	-
CCU	3.0	PW:3.0 SW:2.9	4.8%	PW:0.0% SW:9.0%	19.0%	PW:14.3% SW:18.1%	-	-	4.7	PW:4.7 SW:4.7	PW:7.1 SW:5.5	-
Clementine A	3.6	PW:3.4 SW:3.3	4.0%	PW:4.2% SW:9.1%	12.0%	PW:16.7% SW:12.8%	-	-	8.4	PW:14.5 SW:14.5	PW:16.1 SW:9.8	-
Clementine B	3.4	PW:3.1 SW:3.6	0.0%	PW:4.5% SW:6.9%	8.3%	PW:4.5% SW:8.6%	-	-	10.6	PW:8.3 SW:8.3	PW:10.4 SW:9.5	-
Elm	1.7	PW:1.6 SW:1.5	8.3%	PW:18.2% SW:8.2%	16.7%	PW:18.2% SW:12.3%	-	-	17.9	PW:11.0 SW:11.0	PW:18.5 SW:21.2	-
Erica	0.9	PW:1.6 SW:1.0	0.0%	PW:45.5% SW:18.8%	0.0%	PW:9.1% SW:4.2%	-	-	4.0	PW:16.8 SW:16.8	PW:21.5 SW:17.6	-
Fern	2.1	PW:1.6 SW:2.2	6.7%	PW:9.1% SW:6.5%	20.0%	PW:18.2% SW:9.3%	-	-	13.6	PW:11.0 SW:11.0	PW:27.1 SW:15.9	-
Gardenia	3.3	PW:3.0 SW:3.6	4.3%	PW:4.8% SW:5.1%	30.4%	PW:14.3% SW:14.3%	-	-	8.7	PW:5.2 SW:5.2	PW:6.4 SW:6.2	-
Gentian	3.6	PW:5.3 SW:5.2	12.0%	PW:10.8% SW:11.5%	16.0%	PW:2.7% SW:7.9%	-	-	7.6	PW:3.1 SW:3.1	PW:5.5 SW:7.0	-
Harvest A	2.3	PW:3.7 SW:2.7	18.8%	PW:34.6% SW:20.3%	0.0%	PW:23.1% SW:17.3%	-	-	18.0	PW:12.8 SW:12.8	PW:10.9 SW:12.3	-
Holly	3.6	PW:2.9 SW:3.3	12.0%	PW:5.0% SW:10.6%	8.0%	PW:10.0% SW:8.8%	-	-	9.2	PW:7.5 SW:7.5	PW:9.6 SW:10.7	-
Overall	50.7	PW:54.9 SW:51.7	9.3%	PW:10.9% SW:10.5%	13.2%	PW:13.3% SW:12.2%	-	-	10.5	PW:9.2 SW:9.2	PW:10.3 SW:10.3	-

Emergency Care Pathway Dashboard

Barking, Havering and Redbridge University Hospitals NHS Trust

Hospital	Trust (QH+KGH)
Reporting Date	27 Mar 2013

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Clementine B	PW:16.7% SW:16.7%					
Elm	PW:26.1% SW:26.1%					
Erica	PW:41.2% SW:41.2%					
Fern	PW:23.3% SW:23.3%					
Gardenia	PW:7.7% SW:7.7%					
Gentian	PW:0.0% SW:0.0%					
Harvest A	PW:27.6% SW:27.6%					
Holly	PW:11.5% SW:11.5%					
Overall	PW:20.3% SW:20.3%					

Emergency Care Pathway Dashboard

Barking, Havering and Redbridge University Hospitals NHS Trust

Hospital	Trust (QH+KGH)
Reporting Date	27 Mar 2013

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Ward	Daily medical discharges		Pre 11a.m. discharges (% of total)		Weekend discharges (% of total)		Average LOS active (days)		Average LOS on discharge (days)		Patients >14 days active (% of active patients)	
Mandarin A	↓ 3.0	PW:3.9 SW:3.5	↓ 0.0%	PW:11.1% SW:12.2%	↑ 14.3%	PW:7.4% SW:14.5%	- -	PW:8.5 SW:8.5	↓ 9.7	PW:9.9 SW:10.3	- -	-
Sky A	↑ 5.7	PW:5.1 SW:3.6	↑ 22.5%	PW:16.7% SW:19.7%	↓ 7.5%	PW:19.4% SW:15.2%	- -	PW:8.8 SW:8.8	↓ 6.8	PW:6.9 SW:8.9	- -	-
Sunrise A	↓ 2.1	PW:3.7 SW:2.7	↓ 6.7%	PW:7.7% SW:12.0%	↓ 6.7%	PW:23.1% SW:14.3%	- -	PW:11.2 SW:11.2	↑ 13.8	PW:9.2 SW:11.7	- -	-
Sunrise B	- 2.4	PW:2.4 SW:2.6	↑ 11.8%	PW:0.0% SW:7.2%	↓ 11.8%	PW:17.6% SW:8.8%	- -	PW:8.0 SW:8.0	↑ 15.8	PW:11.4 SW:14.0	- -	-
Overall	↓ 50.7	PW:54.9 SW:51.7	↓ 9.3%	PW:10.9% SW:10.5%	↓ 13.2%	PW:13.3% SW:12.2%	- -	PW:9.2 SW:9.2	↑ 10.5	PW:10.3 SW:10.3	- -	-

Emergency Care Pathway Dashboard

Barking, Havering and Redbridge University Hospitals NHS Trust

Hospital	**Trust (QH+KGH)**
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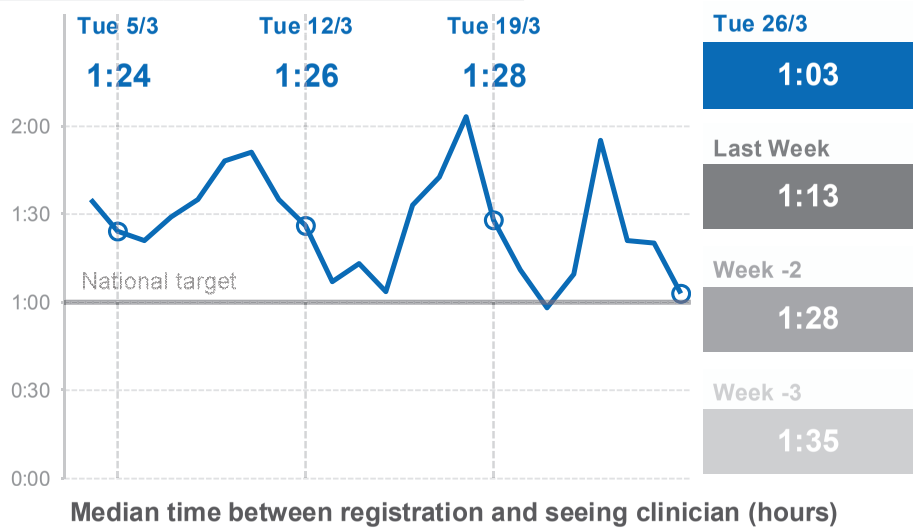
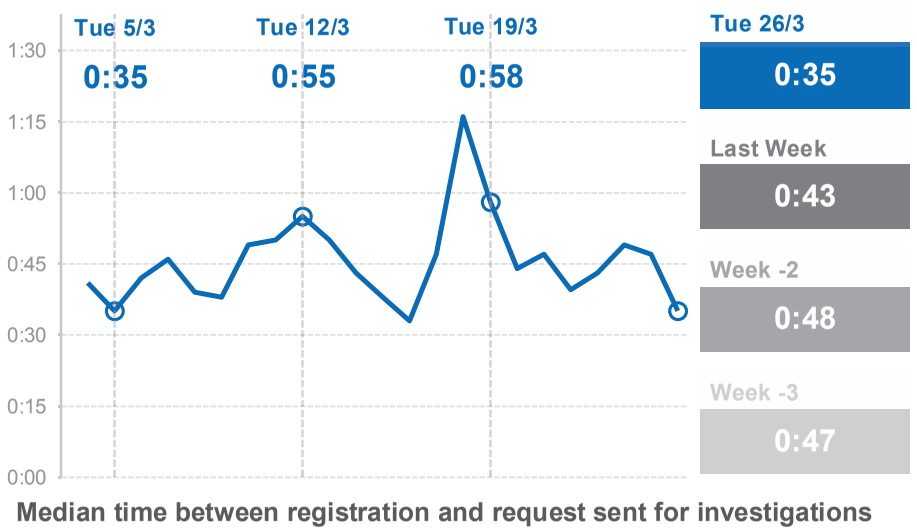
Sunrise A	PW:34.5% SW:34.5%					
Sunrise B	PW:23.3% SW:23.3%					
Overall	PW:20.3% SW:20.3%					

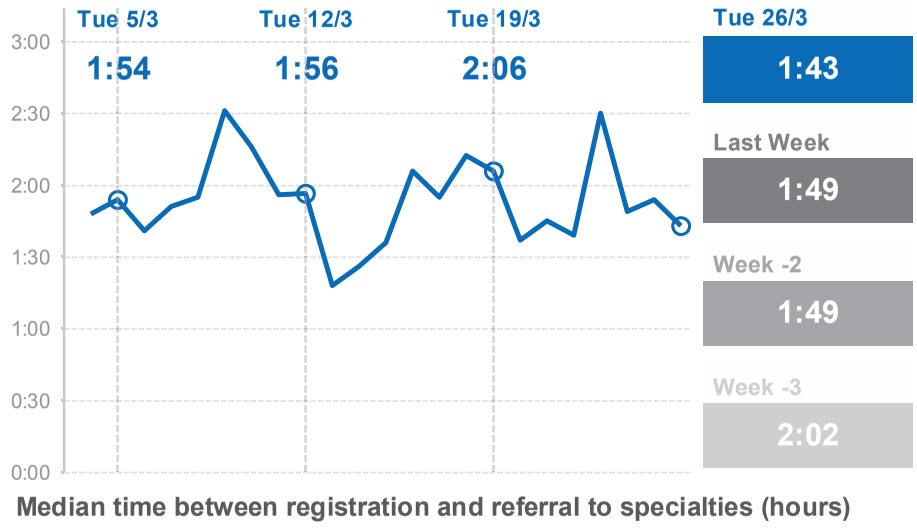
Hospital	Trust (QH+KGH)
Reporting D…	27 Mar 2013



Median time between registration and seeing clinician (hours)



Median time between registration and request sent for investigations (hours)



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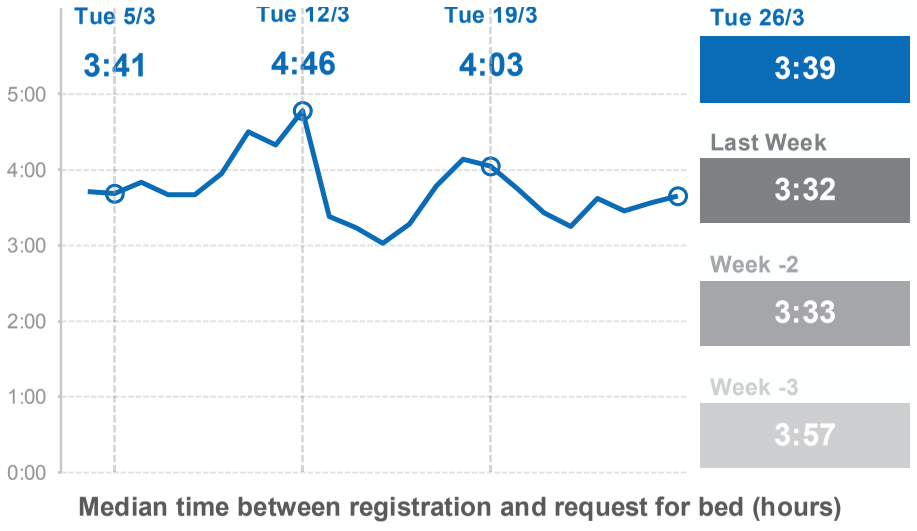
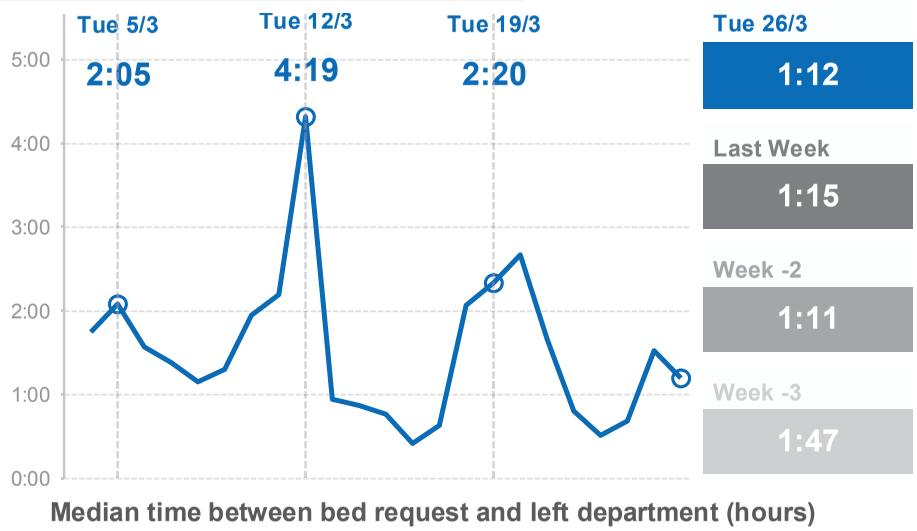
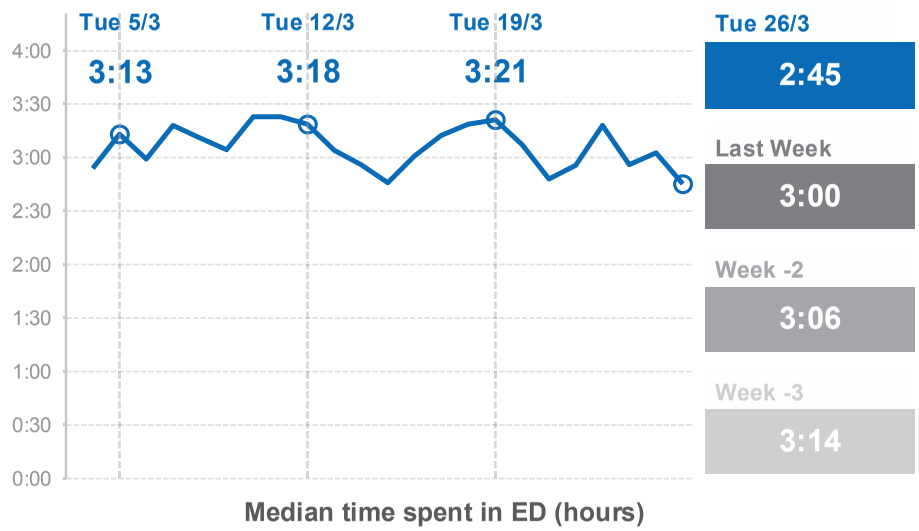


Median time between registration and request for bed (hours)

Hospital	Trust (QH+KGH)
Reporting D…	27 Mar 2013



Median time between bed request and left department (hours)



Median time spent in ED (hours)

Reattendance rate

Last Month	Previous Month
13.5%	12.9%

HEALTH AND WELLBEING BOARD

4 June 2013

Title: Diabetes Scrutiny Review: Planning Our Response	
Report of the Corporate Director of Adult & Community Services	
Open Report	**For Decision**
Wards Affected: All	**Key Decision:** No
Report Author: Matthew Cole, Director of Public Health	**Contact Details:** Tel: 0208 227 3657 Email: Matthew.Cole@lbbd.gov.uk
Sponsor: Anne Bristow, Corporate Director of Adult & Community Services	

Summary:

Between July 2012 and March 2013 the Health and Adult Services Select Committee (HASSC) carried out themed investigations into the management of diabetes locally in response to user dissatisfaction with aspects of the service and a perception of high levels of complications and ill health associated with the disease.

Appendix A is a copy of the Health and Adult Services Select Committee Scrutiny Review into Type 2 Diabetes Services across the London Borough of Barking & Dagenham.

Appendix B is the Diabetes Action Plan. This Action Plan translates the aspirations of the Select Committee's Scrutiny Review into potentially deliverable actions.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

1) Discuss and agree the Action Plan
2) Review the Action Plan quarterly
3) Provide a summary of progress to HASSC in six months at their meeting in November 2013
4) Refer to a sub-group of the Health & Wellbeing Board for the ongoing monitoring of the Diabetes Action Plan. It is recommended that this is either through the Integrated Care sub-group or the Public Health Programmes sub-group.

Reason(s):

- To consider and formally respond back to HASSC on their scrutiny review
- To take forward the findings and recommendations of the HASSC review into diabetes services.

1 Introduction

1.1 Between July 2012 and March 2013 the Health and Adult Services Select Committee carried out themed investigations into the management of diabetes locally in response to user dissatisfaction with aspects of the service and a perception of high levels of complications and ill health associated with the disease.

1.2 The Health and Adult Services Select Committee produced ten recommendations for actions. Appendix B represents the conversion of the recommendations into a draft action plan for discussion and agreement. A number of recommendations are subdivided into a number of actions.

1.3 The key recommendations are around:

- Examining the needs of people living with diabetes
- Improving the early diagnosis of diabetes
- Improving patient understanding, knowledge and compliance
- Improving the frequency and quality of annual (diabetic) health checks
- Diabetes pathway analysis, redesign and improvement.

2 Mandatory Implications

2.1 Joint Strategic Needs Assessment

This report suggests minor changes to the diabetes section of the JSNA which have been incorporated into the JSNA planning process. Otherwise, this report is consistent with the JSNA themes of improving early diagnosis and robust, evidence based early management of clinical cases.

2.2 Health and Wellbeing Strategy

The scrutiny review supports key actions and deliverables outlined in the Health and Wellbeing strategy and its delivery plan. In particular, this document compliments the Health and Wellbeing Strategy themes around integration of care and disease prevention.

2.3 Integration

One of the outcomes we want to achieve for our joint Health and Wellbeing Strategy is to improve health and social care outcomes through integrated services. Type 2 diabetes affects both children and adults. Although, disproportionately more adults are affected by Type 2 diabetes.

To deliver the Diabetes Scrutiny Review Action Plan – a high level of collaboration will be required that span the life course as outlined in the Health and Wellbeing Strategy. Effective delivery of this Action Plan should promote integration within and across services.

2.4 Financial Implications

At the point of writing this report, the financial implications of the Diabetes Action Plan are not quantified. However any financial implications will have to be contained within council core funding or the ring fenced Public Health Grant.

Implications completed by: Dawn Calvert, Group Manager Finance, LBBD

2.5 Legal Implications

There are no specific legal implications that arise from this report.

Implications completed by: Shahnaz Patel, Senior Lawyer, Legal Services, LBBD

3 Appendices

3.1 Appendix A: Health & Adult Services Select Committee Scrutiny Review into Type 2 Diabetes Services across the London Borough of Barking & Dagenham.

3.2 Appendix B: Diabetes Action Plan – from Health and Adult Services Select Committee May 2013.

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Scrutiny Review

Health & Adult Services Select Committee

September 2012 – March 2013

Review on Type 2 Diabetes Services across the London Borough of Barking and Dagenham

Contents

Foreword

The number of people in the borough living with Type 2 diabetes continues to rise. However, we have learned that it is one of those conditions where with the right help and advice, individuals can live healthy lives for longer.

For those living with diabetes, the right care and lifestyle changes can help them avoid complications such as blindness and amputation. For everyone else, making good choices now can reduce the risk of diabetes developing or can help limit the severity of the condition.

It has been a real eye opener to speak to people who live with Type 2 diabetes in the borough. We have heard about the impact that the condition has on people's lives day-to-day and the very real issues that people who live with Type 2 diabetes experience in terms of information, support and care.

We are pleased that diabetes is showing as a priority in the Health & Wellbeing Strategy and would urge the Health & Wellbeing Board to fully consider this report and take forward our recommendations.

The Select Committee would like to express their thanks to those who attended Committee meetings and supported our investigation. The effort and contribution of everyone we met indicated a clear commitment and energy amongst all of those working to improve diabetes care in Barking and Dagenham.

Cllr. Sanchia Alasia
Chair, Health & Adult Services Select Committee

Executive Summary and Recommendations

Type 2 diabetes is a serious health concern for Barking and Dagenham with more than 9,000 people already diagnosed. With the changes to the ethnic makeup of the population and the challenges associated with increases in adult obesity, experts believe that the numbers of people likely to develop diabetes in the next twenty years are set to rise by 50%.

In addition to primary care and community services required to support and maintain the health of people living with Type 2 diabetes, the development of complications as a result of poor management of the condition will continue to put pressure on existing services.

Members of the Health & Adult Services Select Committee (HASSC) were concerned by the expected increase in prevalence and the release of a National Audit Office report in 2012 which highlighted the need to improve the national delivery of high standards and value for money in diabetes care. As a consequence, the Committee decided to carry out an in-depth scrutiny which reviewed the current provision of services and information available to people living with Type 2 diabetes in the Borough. The scrutiny review was carried out between September 2012 and February 2013.

The Select Committee's investigations looked closely at the services and support available in the Borough for people who had just been diagnosed and were living with Type 2 diabetes and how they could be helped to manage their condition more effectively.

A number of issues were identified including the expected prevalence and diagnosis rates for Type 2 diabetes in Barking and Dagenham and the lack of up-to-date baseline data. The review also highlighted a lack of consistency in the execution of diabetes health checks across GP surgeries as well as the up-take of annual appointments by patients, especially in light of the number of emergency admission rates for diabetes-related illness. Additionally, HASSC questioned the availability of information for people who were already diagnosed and newly diagnosed with Type 2 diabetes which might help them better understand their condition, particularly in regard to self management and long-term complications.

HASSC were pleased to see that, broadly speaking, all of the right services were in place and working to a good standard. However, with a renewed emphasis on integrated working and sustained activity to improve the take-up of health checks both for diabetics and those at risk, the borough could do more to prevent the awful complications of this condition. Given the high costs of diabetes-related medication in the borough, this could also release valuable resources for this and other priorities.

The detailed recommendations made by HASSC are presented on the following two pages.

Recommendations

A number of proposals were suggested throughout the scrutiny process, and these have been collated to form the following recommendations.

Recommendation: Prevalence data

It is recommended that a future iteration of the Joint Strategic Needs Assessment provides a clearer account of the source of competing data and the 'best estimate' that the borough is using to monitor its progress and identify the challenge it faces in addressing undiagnosed diabetes.

Recommendation: Improving screening and diagnosis

It is recommended that a programme of proactive screening opportunities is established, linked to improved entry routes to an integrated diabetes care pathway, with more medical professionals seeking opportunities for the proactive identification of diabetes in their patients and service users, and for GP's to take a more pro-active role in diagnosis.

Recommendation: Patient understanding of health checks

Specifically, it is recommended that action is taken to improve patients' understanding of the annual diabetes health checks, what they should expect to receive, and their importance in preventing complications.

Recommendation: Clinicians' adherence to health check process

It is further recommended that the CCG takes steps to ensure that all clinicians are familiar with the NICE recommendations for the Annual Health Check and have arranged the provision of high-quality interventions, with associated processes for prompt arrangement of patient appointments and their reminders.

Recommendation: Performance monitoring of the health check process

For the longer term, it is recommended that the data is improved and the baseline for understanding uptake of the nine health checks is brought up to date, with on-going robust monitoring thereafter.

Recommendation: Information and advice

The Committee recommends that the whole range of information provided to people already diagnosed and people newly diagnosed with Type 2 diabetes is reviewed, ensuring that it gives them what they need to know to improve self-management of their diabetes and their understanding of long-term complications.

Recommendation: Young people's support (Type 1 and Type 2)

That the Health & Wellbeing Board facilitates consideration of how young people with diabetes (either Type 1 or Type 2) could be supported in the Borough, inviting the participation of the health group of the Barking & Dagenham Youth Forum.

Recommendation: Younger adults developing Type 2 diabetes

That the Diabetes Support Group participates in a short review of the support needs of younger adults developing Type 2 diabetes, and how they may be met from a service user led group, led by an agency to be identified by the Health & Wellbeing Board.

Recommendation: Learning from South West Essex

That the Health & Wellbeing Board ask Public Health professionals to work with commissioners and North East London NHS Foundation Trust to understand the reasons why services which are on the face of it similar appear to be linked to different outcomes for patients, and to capture the lessons for future local commissioning.

Recommendation: Reviewing the integrated care pathway

That the Health & Wellbeing Board oversees a review of the care pathway to ensure that all opportunities for joint working are being harnessed and that the flow of patients between services is effective.

About this Scrutiny Review

The Health and Adult Services Select Committee agreed to carry out an in-depth scrutiny review of diabetes services and support for diabetics in Barking and Dagenham. The review focuses on Type 2 diabetes and how Type 2 diabetics could be helped to manage their condition more effectively.

Following initial scoping discussions, the Select Committee agreed a project plan for the scrutiny review at their meeting on Wednesday 4 July 2012. The scrutiny review has been primarily conducted through a number of themed investigative sessions over the period from July 2012 to March 2013.

Over the course of the review, the Select Committee conducted their investigations through a number of different channels, and received information from a wide range of sources, including:

- Clinicians at Barking, Havering & Redbridge University Hospitals Trust (BHRUT)
- Porters Avenue Integrated Diabetes Service
- North East London Foundation Trust (NELFT)
- NHS North East London and the City (NELC)
- Barking & Dagenham Clinical Commissioning Group (CCG)
- Barking and Dagenham Council
- South West Essex Community Services – Diabetes (SWECS)
- Diabetes UK
- Patients and carers from Barking & Dagenham Diabetes Support Group and other patient engagement forums
- Clinical and GP specialists
- Pharmacists
- Retinopathy services
- Barking and Dagenham Local Involvement Network (BDLINk)

Members also invited people living with Type 2 diabetes to participate in a survey to give the Committee more insight into how patients manage their diabetes, what services patients use and their thoughts and experiences of service provision in Barking and Dagenham. The results of this, along with the information gathered in sessions and site visits have also informed the findings and analysis of this final report.

About the Health & Adult Services Select Committee (HASSC)

HASSC consisted of the following nine Councillors in the 2012-13 municipal year:

- Councillor S Alasia (Chair)
- Councillor E Keller (Deputy Chair)
- Councillor L Butt
- Councillor J Davis
- Councillor A Gafoor Aziz
- Councillor M McKenzie MBE
- Councillor C Rice
- Councillor A Salam
- Councillor J Wade

Elaine Clark, Secretary of the Barking & Dagenham Diabetes Support Group was appointed as a Co-opted Member of the Select Committee to give advice and lend expertise to the evidence gathering. In her role as Co-optee Elaine was the voice for local diabetics (and their carers) ensuring that the opinions of the support group and their experiences of local services were raised during the Committee's discussions.

Matthew Cole, Joint Director of Public Health provided professional advice and support to the Committee.

Anne Bristow, the Corporate Director of Adult and Community Services, nominated as the HASSC Scrutiny Champion, supported the Select Committee throughout the review and provided expertise and guidance.

Scope of the review

HASSC particularly wished to explore how diabetics could be helped to manage their condition effectively. Members noted the timely release of a National Audit Office report on the need to improve the national delivery of high standards and value for money in diabetes care.

In establishing the review, HASSC identified five areas which it would explore as part of the review and these form the basis of this report:

THEME 1: Prevalence
What is the expected prevalence of Type 2 diabetes against the number of known diagnosed diabetics?

THEME 2: Provision of health checks
How does Barking and Dagenham compare with the targets - are people with Type 2 diabetes having the nine annual health checks recommended by the National Diabetes Framework?

THEME 3: Provision of information
How sufficient is the readily available information for people living with Type 2 diabetes?

THEME 4: Hospital admissions
Is the current provision of services reducing high hospital admission rates?

THEME 5: Costs of diabetes
What is the annual spend on diabetes-related treatments for Barking and Dagenham

Conduct of the review

The scrutiny review took place around five themed sessions.

A **Patient Perspective Session** was held in September 2012 to explore the experiences of patients and carers with Type 2 diabetes and services in the Borough. The session allowed patients and carers to talk to Members about their experience of living with Type 2 diabetes, the problems they have faced since diagnosis and how they access services. Representatives attended from patient engagement groups such as the Barking and Dagenham Diabetes Support Group, Patient Advice and Liaison Service (PALS) at Barking,

Havering & Redbridge University Hospitals NHS Trust (Queen's Hospital) and Barking and Dagenham Local Involvement Network (BDLINk).

The session was very useful and Members were able to ask how diabetics manage Type 2 diabetes on a day-to-day basis and their experiences of diabetes care provision and availability of information in the borough.

In December 2012, representatives from Diabetes UK and South West Essex Community Diabetes Service (SWECS) attended to talk to Members about examples of **Good Practice**. Members were able to look at service provision and performance at SWECS to understand how it compares to Porters Avenue Services. Members were also able to consider some of the issues raised by Diabetes UK about quality of foot checks.

Two sessions were held in January and February 2013 which focused on **Service Provision** across the Borough. Representatives were invited from a number of care services including Clinical services (GP's and GP's with Special Interest [GPwSI]), Low Vision/Retinopathy services, Community Nursing, Mental health Services, Pharmacists and staff from the Integrated Diabetes Service at Porters Avenue. Members had an opportunity to discuss some of the key issues of service provision including service integration, quality of service and how to improve the patient experience.

A copy of the notes from each of the session is included in Appendix 1.

Site Visits

In addition to information gathering sessions, Members also carried out two site visits.

Members attended a Barking & Dagenham Diabetes Support Group meeting. This really helped Members experience first-hand the work that the support group do in terms of keeping its members informed about diabetic health issues and services available. On the evening of the site visit, a nurse from Porters Avenue attended to talk about the importance of foot health and long term complications of ignoring foot care.

Members also visited Porters Avenue Integrated Diabetes Services where they were able to meet with staff and discuss in more detail problems around educating young people about diabetes and the importance of a healthy lifestyle and what we can do as a Borough to raise awareness about diabetes among the general population.

Survey

In order to better understand the patient perspective, the Committee proposed a survey of people who are currently living with Type 2 diabetes and people who care for someone with Type 2 diabetes. The survey was distributed between 28 November 2012 and 31 January 2013 and aimed to find out more about diagnosis, provision of information, support for both patients and carers and accessing services and education programmes. A copy of the survey can be found at Appendix 2.

In order to ensure the highest return rate possible, the survey was distributed through a number of routes, including on-line via the Council, Barking & Dagenham LINk and Clinical Commissioning Group websites, with additional hardcopies of the survey were provided to the B&D Diabetes Support Group and GP surgeries with diabetic clinics. Council officers and volunteers also undertook sessions at the Barking Learning Centre and Dagenham Library during January 2013.

The survey closed on 31 January 2013 with a total of 62 responses received. The findings from the survey are included throughout this report and a full analysis of the results may be found in Appendix 3.

It is important to note that since Type 2 diabetes affects only approximately 7.3% of the Borough population, the number of respondents was expected to be relatively low.

A note of caution should be given about the survey results. The number of respondents cannot be considered representative of all patients living with Type 2 diabetes in the Borough since the demographics of the survey respondents are not reflective of the demographics of the general population of the Borough:

- 81% of the respondents were between 40-74 (40-59 year olds 44%, 60-74 year olds 38%)
- 67.3% were from a 'White British' background
- 86% stated 'English' as their first language

What is Diabetes?

Diabetes is the name used to describe a metabolic condition of having higher than normal blood sugar levels. There are different reasons why people get high blood glucose levels and so a number of different types of diabetes exist.

Most of the food we eat is turned into sugars for our bodies to use for energy. The main sugar is called glucose, which passes through the gut wall into the bloodstream. However, in order to remain healthy, blood glucose levels should not go too high or too low.

Therefore, when blood glucose levels begin to rise after eating, the level of a hormone called insulin should also begin to rise. Insulin works on the cells of the body to make them extract glucose from the bloodstream. Some of the glucose is then used by the cells for energy and some is converted into glycogen or fat (both of which are stores of energy). When blood glucose levels begin to fall (between meals), the level of insulin falls. Some glycogen or fat is then converted back into glucose which is released from the cells into the bloodstream.

The pancreas, an organ that lies near the stomach, makes insulin to stimulate the cells of our bodies to extract glucose from the bloodstream. Insulin is produced in the beta cells of the pancreas. When you have diabetes, your body either doesn't make enough insulin or can't use its own insulin as well as it should. This causes sugars to build up in the blood.

Type 1 Diabetes

- Type 1 develops if the body cannot produce any insulin. It usually appears before the age of 40 and especially in childhood. It is the less common of the two types and accounts for around 10% of all people with diabetes.
- Type 1 cannot be prevented and is treated by daily insulin doses – taken either by injection or via an insulin pump – as well as a healthy diet and regular physical activity. In Type 1, the insulin-producing cells in the pancreas have been destroyed. It is not known exactly why these cells have been damaged.

Type 2 Diabetes

- Type 2 accounts for around 90% of people with diabetes. It is treated with a healthy diet and increased physical activity. In addition, tablets and/or insulin may be required.
- Type 2 develops when the body can still make some insulin, but not enough, or when the insulin produced does not work properly (insulin resistance). Risk factors for developing Type 2 include family history, ethnicity, being overweight or having a large waist, high blood pressure, heart disease or having had a heart attack.

Diabetes is becoming increasingly common throughout the world, including the UK, due to increased obesity.

If left untreated, diabetes can lead to complications such as loss of feeling in fingers and toes (a condition called diabetic neuropathy), kidney problems, heart problems, loss of vision (through a condition called retinopathy) and other disorders. At advanced stages, diabetes can cause kidney failure, lower-extremity amputation, blindness and stroke.

However, complications can be prevented or significantly delayed by keeping good control of the diabetes, blood pressure and cholesterol levels.

The symptoms of diabetes

Diabetes is predicted by a clear set of symptoms, but it still often goes undiagnosed. The main initial signs of diabetes are:

- Increased thirst;
- Increased need to urinate;
- Increased hunger.

Type 1 diabetes symptoms often appear suddenly and can additionally include:

- High levels of sugar in the blood and urine;
- Weight loss;
- Weakness;
- Tiredness;
- Mood swings;
- Nausea;
- Vomiting.

Type 2 diabetes symptoms tend to come on very gradually, and include most in the list above. Additionally, skin infections, blurry vision, tingling or dry skin are also relatively common symptoms. The gradual onset of symptoms means that it is important that people are not tempted to dismiss the symptoms as simply getting old.

Possible complications of diabetes

Short-term complications include a very high blood glucose level, which is not common with Type 2 diabetes, but is more common in untreated Type 1 diabetes when a very high level of glucose can develop quickly. However, a very high glucose level develops in some people with untreated Type 2 diabetes.

Long-term complications, where blood glucose levels are higher than normal over a long period of time, can gradually damage blood vessels. This can occur even if the glucose level is not very high above the normal level. This may lead to some of the following complications (often years after the disease first develops):

- Atheroma (furring or hardening of the arteries). This can cause problems such as angina, heart attacks, stroke and poor circulation.
- Kidney damage which sometimes develops into kidney failure.
- Eye problems which can affect vision (due to damage to the small arteries of the retina at the back of the eye).
- Nerve damage.
- Foot problems (due to poor circulation and nerve damage).
- Impotence (again due to poor circulation and nerve damage).

The type and severity of long-term complications vary from case to case. Some people do not develop any at all. In general, the nearer the blood glucose level is to normal, the lower the risk of developing complications. Risk of developing complications is also reduced if you deal with any other risk factors that may be present, such as high blood pressure.

Who is at risk of developing Type 2 diabetes?

Type 2 diabetes often develops in people who are over the age of 40 years old and who may also have one or more of the following risk factors:

- A close family history of the condition, in parents, or siblings;
- Being overweight or obese;
- Having a waist measurement of more than 80cms (31.5in) if you are a woman, or 94cms (37in) if you are a man.

In addition, there are increased risks for certain groups within the community, including particular ethnic groups or those who have experienced other serious health conditions. Some examples include:

- People of South Asian origin (Indian, Bangladeshi and Pakistani) are six times more likely to develop Type 2 diabetes than any other ethnic group;
- There are links to other common conditions such as Poly Cystic Ovarian Syndrome, although the links are not fully understood;
- Those with heart disease or who have had a heart attack.

A condition called ‘impaired glucose intolerance’ may also precede a diagnosis of diabetes, often by many years, and will be evidenced by moderately raised levels of blood glucose. Both conditions (impaired glucose intolerance and diabetes) can be brought on during pregnancy.

Theme 1: Prevalence

What we currently know about prevalence

The Association of Public Health Observatories (APHO) data shows that average registered adult prevalence of diabetes in England is about 5.5%, and that 90% of adults with diabetes have Type 2 diabetes. Whilst this sort of diabetes usually appears in adults who are middle aged or older, there are an increasing number of children and younger people being diagnosed and this is linked to rising obesity prevalence in young people.

The Joint Strategic Needs Assessment 2012 found that in Barking and Dagenham, at the end of March 2012, 9,523 people had been diagnosed with diabetes, a rise of 14% since 2009/10, although it is estimated that at least 1,642 people remain undetected as at November 2012.

Figure 1 - Prevalence of diabetes in Barking & Dagenham

Year	Actual number of people with diabetes	Predicted number	Estimated undetected	Diagnosed prevalence	Predicted prevalence
2009/10	8,349	9,426	1,100	4.5	5.1
2011/12	9,523	11,049	1,642	4.9	5.7

Source: Public Health Observatory Diabetes Prediction Modelling and Quality Management and Analysis System QMAS

However, a Diabetes Audit undertaken by the NHS Information Centre in 2010/11 reported 9,125 diabetes registrations, which is consistent with the increase from 4.5% diagnosed prevalence to 4.9% shown above.

Availability of Baseline Data for Barking & Dagenham

As part of the scrutiny process, Members raised some concern that there was a disparity of information relating to prevalence data for diabetes in Barking and Dagenham. The data presented to Members throughout the scrutiny process all agree that the prevalence of diabetes is increasing although there is a lack of consistency around the figures themselves.

Figure 2 - Variations in prevalence of diabetes data

Organisation	Porters Avenue	JSNA 2013 / Public Health Observatory
Data	9305 (6.12%)	9,523 (4.9%)

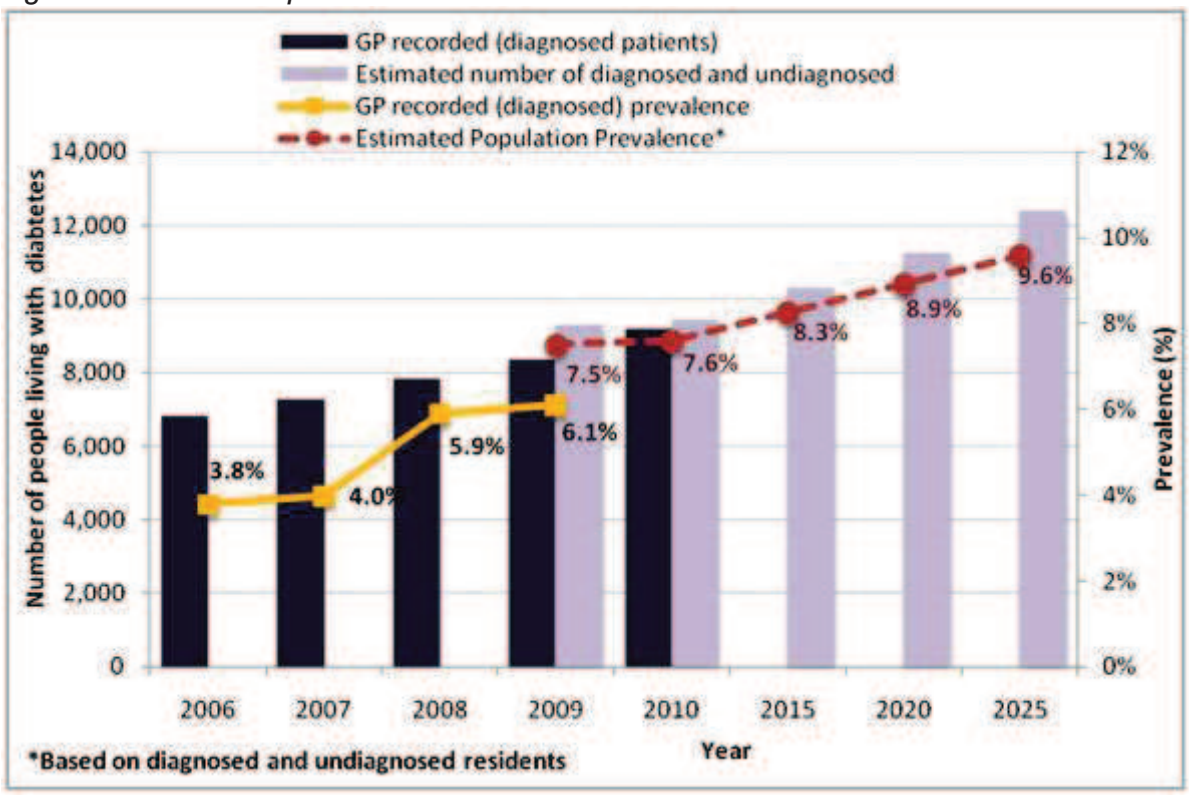
However, what service providers at all of the sessions agreed is that the figure is set to increase due to the changing socio-ethnic make-up of the borough.

Predicted prevalence of diabetes

With increases in adult obesity and the challenges associated with poor diet and lack of exercise, the incidence of diabetes is predicted to increase over the coming years. Estimates indicate that diabetes is expected to increase by about 50% over the next twenty years as related conditions such as obesity continue to rise, so that by 2030, 14,000 people are expected to be living with diabetes in Barking and Dagenham.

The data also indicates that the gap between the actual number of people diagnosed and the expected diabetes prevalence is narrowing across the borough. While this could reflect an increase in levels of diagnosis, the changes in ethnic make-up of the Borough means that the model could actually be an underestimate.

Figure 3 - Predicted prevalence of diabetes in B&D



Association Public Health Observatories (APHO), Disease prevalence Models (2010) and Quality Outcomes Framework 2009-2011 data (from QMAS)

Variances in prevalence data across the borough

The prevalence of diagnosed diabetes in Barking and Dagenham varies from 2.4% to 7.9% between GP practices in the borough as of November 2012.

The JSNA 2010/11 argues that difference in prevalence across GP practices is directly related to the variation in demography such as the number of elderly patients, those from a

minority ethnic group, and those who are obese: all factors which increase the likelihood of a person developing Type 2 diabetes. The JSNA also suggests that:

> ***"further analysis is needed to determine whether there is any correlation between poor diabetes control and the population demography of the practice population, or whether the variation in control is more likely to be due to the effectiveness of the support patients receive, and the systems and processes within the practices which help support good management."***

The three demographic factors most closely associated with the likelihood of developing Type 2 diabetes, obesity, ethnicity and age (particularly where two or more of these factors are combined) are prominent in the demographic make-up of the population and must be taken into account when predicting future prevalence models.

Obesity

Obesity is a firmly established risk factor for developing Type 2 diabetes and as increased levels of obesity in the population rise, so too will the likelihood of Type 2 diabetes.

The 'Annual Report of the Director of Public Health for Barking & Dagenham 2013' found that Barking and Dagenham is estimated to have the highest percentage of obese adults in London, with more than one in four adults obese, the third highest rate of child obesity in England at Year 6 [10-11 years] (26.9%) and the second highest at Reception age [4-5 years] (13.7%).

Adult obesity is a serious problem in Barking and Dagenham with one in four adults with a BMI (Body Mass Index) of more than 30. The Annual Report also found that obesity rates vary according to socio-economic status, with ***"low income and deprivation having a greater impact on female obesity levels than male. In addition, there is a higher prevalence of obesity among some ethnic groups, in particular among Black Caribbean and Pakistani women....The high costs of obesity result from the increased risk of many chronic conditions, including diabetes…."***

Ethnicity

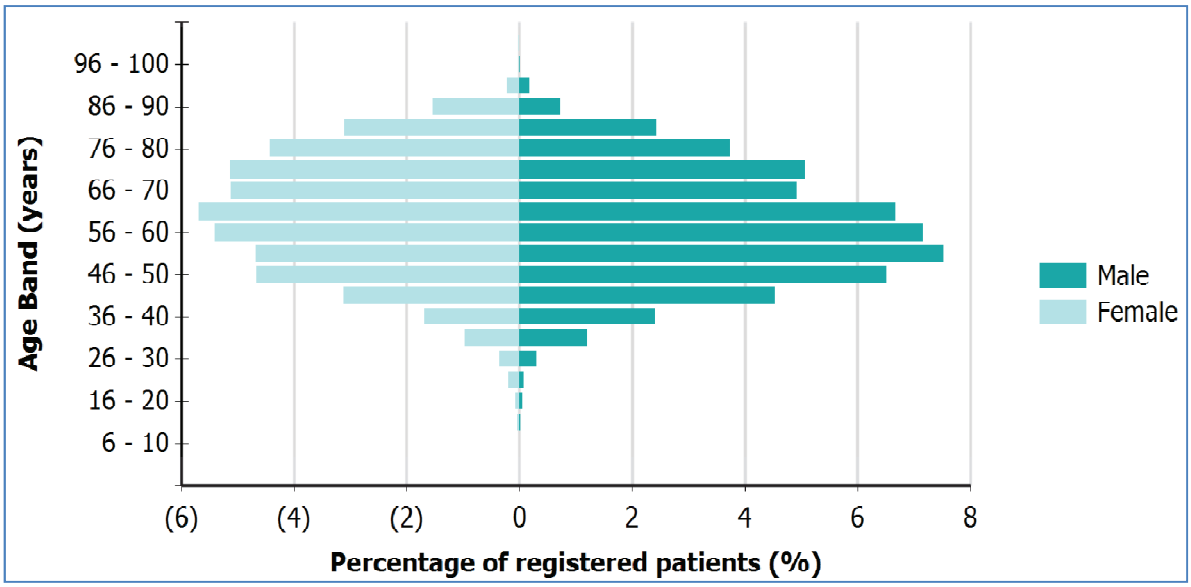
The 2011 census shows that an estimated 16.4% and 18.14% of the borough's population is South Asian and African/African-Caribbean respectively, some of the ethnic groups that are more significantly affected than others by Type 2 diabetes. Type 2 diabetes is up to 6 times more likely in people of South Asian descent and up to three times more likely in African and African-Caribbean people.

This means that an expected continued increase in the prevalence of Type 2 diabetes is also likely. At present there is no diagnosis data available which shows the breakdown of Type 2 diabetes against ethnicity.

Age

The 2011 census data shows that a majority of residents in the Borough are in the age range most likely to develop Type 2 diabetes (40+ years) and this should be taken into account when combined with other factors such as ethnicity and obesity when predicting future prevalence models.

Figure 4 - Age and gender of people with Type 2 diabetes in Barking & Dagenham



Source: National Diabetes Audit (2010/11)

The National Diabetes Audit found that in Barking and Dagenham, the highest numbers of Type 2 diabetics were in the 51 to 65 age group.

Gap between diagnosis and predicted prevalence

With an estimated 1,642 people living with undetected diabetes, the Committee was interested to hear from witnesses about the potential improvement that could be made in diagnosis rates. Representatives attending the sessions confirmed that there is little funding for local screening events although Pharmacists and staff at Porters Avenue do run ad hoc events and that commissioners may wish to explore the option of Pharmacists providing screening tests to help make screening for Type 2 diabetes more easily accessible.

In addition, there was a consensus that all medical practitioners, GPs amongst them, require ongoing training about Type 2 diabetes to ensure that all opportunities are being taken to identify those at risk and living with the disease, as well as to keep up to date with current medication and research.

Given the changing demographics of the borough, it was also suggested to Members that work is required which looks at actively screening people who have a high risk of developing diabetes such as people from African/Afro-Caribbean and Asian backgrounds.

Funding for screening programmes should also be considered to help make screening more accessible as well as thinking more proactively about other ways of screening people for diabetes for example, holding sessions at pharmacies, supermarkets, holy places and car parks in order to reach people who do not routinely go to GP surgeries.

Members also felt that commissioners need to ensure that guidelines are being followed to check other disease registers for people who may potentially have diabetes e.g. asthma register.

Recommendations

The Committee felt that a lack of accurate baseline data, for both diagnosis and expected prevalence data, will make it more difficult to accurately predict future trends and commissioning requirements especially in light of the fact that current prediction models are based on historical data (2010/11).

Members suggest that baseline data should include the actual number of people already diagnosed with Type 2 diabetes together with a demographic breakdown.

Recommendation: Prevalence data

It is recommended that a future iteration of the Joint Strategic Needs Assessment provides a clearer account of the source of competing data and the 'best estimate' that the borough is using to monitor its progress and identify the challenge it faces in addressing undiagnosed diabetes.

Recommendation: Improving screening and diagnosis

It is recommended that a programme of proactive screening opportunities is established, linked to improved entry routes to an integrated diabetes care pathway, with more medical professionals seeking opportunities for the proactive identification of diabetes in their patients and service users, and for GP's to take a more pro-active role in diagnosis.

Theme 2: Provision of health checks

Establishing national standards for diabetes care

There are a number of national guidelines which set out the standards for diabetes services which commissioners must incorporate when commissioning local diabetes services. The two main guidelines are the National Service Framework for Diabetes and the National Institute of Health and Clinical Excellence (NICE) Quality Standards for Diabetes.

The National Service Framework for Diabetes

The National Service Framework (NSF) was established to improve diabetes services through setting national standards to ***"drive up service quality and tackle variations in care."*** The Framework aims to enable more people to live free of diabetes and free from the complications of diabetes and their consequences.

Under the NSF, diabetes services should be:

- **Person-centred:** empowering the individual to adopt a healthy lifestyle and to manage their own diabetes, through education and support which recognises the importance of lifestyle, culture and religion, and which, where necessary, tackles the adverse impact of material disadvantage and social exclusion.
- **Developed in partnership:** ensuring goals and the respective responsibilities of the individual and the diabetes team are agreed and clearly set out in a regularly reviewed care plan.
- **Equitable:** ensuring that services are planned to meet the needs of the population, including specific groups within the population, and are appropriate to individuals' needs.
- **Integrated:** drawing on the knowledge and skills of health and social care professionals across a multidisciplinary diabetes health care team, including primary care and social care as well as specialist services.
- **Outcomes oriented:** narrowing the inequalities gap between those groups whose outcomes are poorest and the rest; minimising the risk of developing diabetes and its complications and maximising the quality of life for individuals by empowering staff to deliver, evaluate and measure care.
- **Delivering this vision** and embedding these principles in practice requires staff throughout the NHS to understand the experience of diabetes and diabetes care, and to recognise the expertise of people who live with diabetes. The aims will be to empower people with diabetes through skills, knowledge and access to services to manage their own diabetes and fulfil their potential to live long lives free of the complications that can accompany diabetes.

In particular, the NSF sets out the expected health checks and treatment options that should be available to all type 2 diabetics. In particular, Standards 10 and 12 seek to ensure that all young people and adults with diabetes will receive regular surveillance for the long-term complications of diabetes, and that all people with diabetes requiring multi-agency support will receive integrated health and social care.

The National Institute of Health and Clinical Excellence (NICE), Quality Standards for Diabetes.

The National Institute of Health and Clinical Excellence (NICE) published a Quality Standard for diabetes in 2011 which supports the existing NSF and provides a definition of ***'good quality'*** care. The NICE quality standards enable:

- health and social care professionals to make decisions about care based on the latest evidence and best practice.
- patients understand what service they can expect from their health and social care providers.
- NHS trusts to quickly and easily examine the clinical performance of their organisation and assess the standards of care they provide.
- commissioners to be confident that the services they are providing are high quality and cost-effective.

The standards include giving people knowledge to understand their condition to help with self-management through structured education programmes, access to specialist diabetes advice, care planning discussions and annual checks. A summary of the standards is included in Appendix 4. Full details of the standard are available on-line: http://guidance.nice.org.uk/QS6

The Nine Health checks

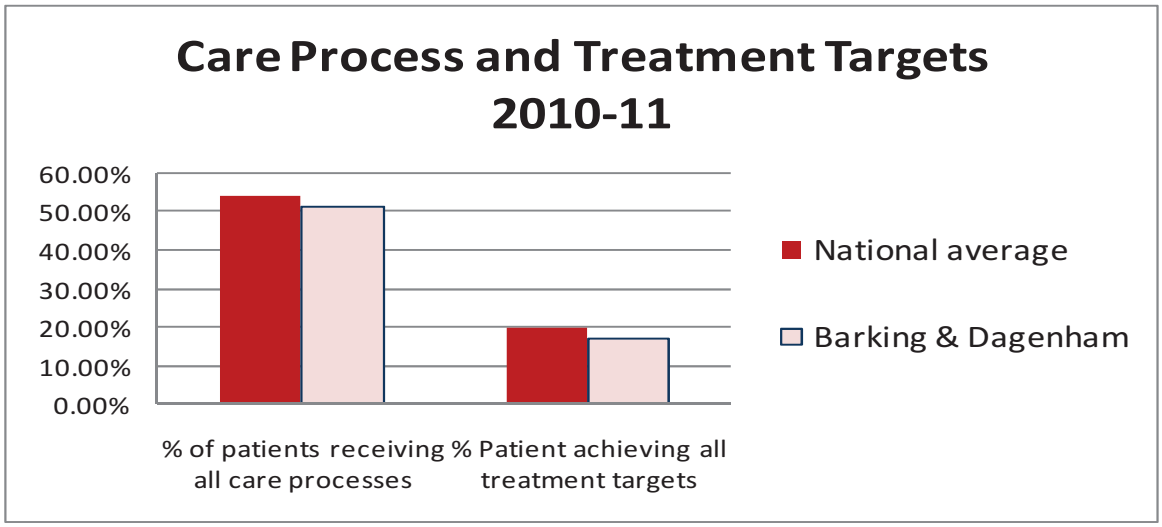
To help achieve these standards, NICE recommend nine key health tests which people living with Type 2 diabetes should have annually to help monitor and manage their diabetes and to reduce the risk of complications such as amputations. The nine annual health checks for people with diabetes are:

1. Weight and BMI Measurement
2. Blood pressure
3. Smoking status
4. Blood test (HbA1c – blood glucose levels)
5. Urinary albumin test (or protein test to measure the kidney function)
6. Serum creatinine test (creatinine is an indicator for renal function)
7. Cholesterol level check
8. Eye check (retinopathy screening)
9. Foot check

Uptake of Recommended Nine Health Checks in Barking and Dagenham

The National Diabetes audit 2010/11 found that only 51.2% of people living with diabetes in Barking & Dagenham are receiving all 9 of the annual essential healthcare checks.

Figure 5 - Care Process and Treatment Targets for Barking & Dagenham



Health and Social Care Information Centre (HSCIC)

The National Diabetes Audit (2010/11) reviewed the performance of the annual health checks in Barking and Dagenham and found that just over half (51%) of people with diabetes get all of them annually; the corresponding national figure is 54%. The audit was undertaken over a three year period (1 April 2008 to 31 March 2011) and Barking and Dagenham were identified as performing in the bottom 25% of PCTs.

The audit also found that people with Type 1 diabetes are less likely than those with Type 2 to receive all the tests annually – 38% against 53% – and that in both categories, people under 55 are less likely to receive all the tests than people over 55 years.

The table below gives an overview of performance against each test, as identified by the National Diabetes Audit 2010/11.

Figure 6 - Percentage of all patients in B&D receiving NICE recommended care processes

Care Process recorded	Percentage of registered patients in PCT	Percentage point change since 2009-2010	Median score across all PCTs	National quartile ranking
All Care Processes*	51.2%	+16.69%	55.5%	3
Blood Creatinine	91.0%	-0.25%	93.1%	4
Blood Pressure	94.6%	-0.62%	95.2%	3
BMI	87.7%	-3.74%	90.0%	4
Cholesterol	90.1%	-0.49%	91.7%	4
Eye Screening	82.3%	+25.23%	82.4%	3
Foot Exam	84.9%	-0.05%	84.5%	2
HbA1c**	89.6%	+0.37%	92.9%	4
Smoking Review	84.1%	-3.68%	85.7%	3
Urinary Albumin	71.2%	+10.87%	76.3%	4

**People registered with diabetes receiving all nine key processes of care processes*
*** For patients under 12 years of ages, 'all are processes' is defined as HbA1c only as other care process are not recommended in the NICE guidelines for this age group*

Source: National Diabetes Audit (2010/11)

The latest Joint Strategic Needs Assessment still bases its judgment of performance against these essential annual health checks on the basis of the 2010/11 data. Whilst the sample size was small, a more recent indicator is provided by the Patient & Carer Survey commissioned by the Select Committee. It suggests that there has been relatively little consistent improvement in the take-up, although the consistency of eye checks appears to be positive. However, this cannot compare to the standard of data in the original 2010/11 audit. The clinicians who addressed the Committee during the review confirmed that they see Barking and Dagenham as having a low percentage of people having annual health reviews, with significant variation in take-up numbers across different practices.

This continued questionable performance suggests that more robust and consistent data needs to be employed to drive improved delivery.

Figure 7 - Prevalence of annual health checks in Barking & Dagenham

Health Check	Annually	Sometimes	Never	Didn't Know they should
Kidney check (creatinine and albumin)	59.2%	4.1%	8.2%	4.1%
Blood pressure	77.6%	16.3%	0.0%	0.0%
Weight check	73.5%	14.3%	2.0%	0.0%
Cholesterol level	77.6%	10.2%	2.0%	2.0%
Eye check	98.0%	0.0%	0.0%	0.0%
Leg and feet check	71.4%	10.2%	2.0%	2.0%
Blood glucose levels (HbA1c)	42.9%	6.1%	0.0%	0.0%
Support for smoker	8.2%	6.1%	10.2%	4.1%
Personal health and care plan*	26.5%	10.2%	16.3%	8.2%

**This information was requested in the survey to ascertain how many people reviewed their care plan annually.*

Diabetes Patient and Carer Survey 2012-13 LBBD

Patients' perception of health checks

The JSNA 2013 suggests that the diabetes focus group (consulted as part of the JSNA review) felt low levels of annual checks may be due to the following factors:

- Not being invited annually – patients were often reminding their practice that they were due testing not vice versa;

- Lack of automated invitations;
- Inability to get appointments at convenient times especially for people of working age (hence the lower completion rate in under 55 year olds).

Members felt that additional work is need to better understand why this may be the case and to work towards not only encouraging patients to have their annual check but to ensure that GPs maximise the number of annual reviews that they do.

Only a small percentage of people indicated that they didn't know they should be having annual checks, which therefore suggests that, by and large, patients are aware that annual check-ups should take place. In terms of the low take-up, therefore, there are three possible conclusions which may be drawn from this:

- The patient does not understand the importance of having annual checks or does not understand what the Annual Health Check involves;
- GPs may not be reinforcing the importance of the tests and actively encouraging patients to have an annual check up;
- In some cases, there may be other reasons, unique to individuals, as to why regular health checks are not being followed up.

Clinicians who participated in the scrutiny process said that GPs and nurses should ensure that they explain to the patients the purpose of the annual review and what to expect. They felt that booklets explaining what happens in the annual reviews are essential as significant number of people do not seem to understand what to expect.

The Committee were concerned that if the annual checks are not regularly taking place, patients are more likely to develop future complications which may have been avoided. Members recommend that information about the importance of annual health checks, and what patients should expect from them, is provided to people with diabetes.

Foot Health

People with diabetes are more likely to be admitted to hospital with a foot ulcer than with any other complication of diabetes. This is due to the fact that diabetes can cause poor circulation and reduced feeling in the feet, as well as inhibiting healing. The Annual Foot check should include:

- Testing sensation and pulse
- Examination for signs of deformity, infection or ulceration
- Checking footwear is suitable
- Discussing any pain or previous ulceration

The ***'Healthy Feet'*** campaign promoted by Diabetes UK focuses on providing advice about maintaining healthy feet and the importance of annual feet checks.

The National Diabetes Audit found that 84.9% of people with diabetes in Barking and Dagenham received a foot check in 2010/11. The audit also showed that of those who did receive the annual foot check, patients reported that the level of the foot check is poor. It should be noted that this information is based on patient satisfaction and what is not clear is whether the patient understood what they should expect from their annual foot check. Given that this is the most common complication, it is concerning that it ranked in the bottom five of the regular health checks amongst respondents to the Patient & Carer

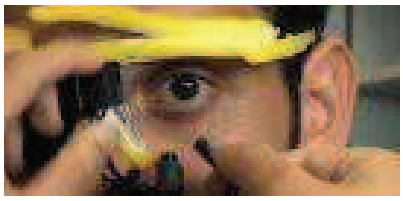
Survey. However, it appears to correlate with the feedback from clinicians who attended the Committee, who reported that the quality of foot checks among local practitioners varied and that not all of the elements of the foot checks were being completed. For example, feedback received by clinicians from patients indicates that some GPs do not check footwear or routinely carry out a pulse test. They also reported that some patients said that their GPs did not even inspect their feet. Representatives of the CCG attending the sessions advised Committee Members that it needed to increase awareness of the importance of foot checks and health checks in general to ensure that they are being carried out properly.

Care plan review

It has already been discussed that one of the factors for reducing the risk of complications is to adopt a healthy lifestyle which includes good diet and exercise and yet the figures from the Patient & Carer survey show that of those who responded, only 26.5% regularly review their care plan. What is not clear is of the 73.5% not reviewing their care plan, how many are no longer following it; and whether there had been any significant health changes as a result.

Pharmacists attending the Service Provision session expressed concern that care plans often didn't take into account all of the different services available, because the care plan always end at surgery level. The representatives suggested that GP's should work to develop partnerships between pharmacists, other professionals and the public to enhance shared care, especially in changing patterns of behaviour among patients to move towards ***'self-care'***.

Eye health: diabetic retinopathy screening



As is shown in the data on health checks, the proportion of people offered a retinopathy screen is high. This also leads to the number of people with diabetes in Barking and Dagenham who have retinopathy diagnosed by screening being above the national average. However, at present only around 80% of people accept the offer of retinopathy screening. Encouraging more people to take up the offer of screening and reduce their risk of eye disease progressing is another important opportunity to improve their health.

The borough's Vision Strategy 2010-2015 identified that of those people with diabetes who were screened, over 1,750 had some degree of retinopathy. It further identified that over 2,100 people with diabetes had failed to attend their retinopathy screening appointments, which roughly correlates to the 20% identified in the JSNA as not taking up the offer. This has led to additional appointments being offered to encourage everyone to have at least 3 fixed appointments for screening, plus an open offer of being able to phone up and choose a screening date at any time.

Retinopathy services provided evidence to the Committee during the review. At the session on 31 January 2013, representatives from the Retinopathy Service at Porters Avenue reported concern that, while there is good uptake for the retinopathy screening, patients do not always understand that they also need to have the annual NHS eye test. This potentially leaves other health issues, such as glaucoma, undetected. The results from the Patient & Carer survey showed that 98% of respondents had an annual eye check but it doesn't indicate whether that included the NHS standard eye test, and there is no

method for tracking whether patients are having both retinopathy screening and an NHS eye test at present.

Overview of the issues presented around health checks

What has become apparent through the scrutiny is that the current screening process for complications associated with diabetes is not performing as well as it should be, in certain areas. This view is supported by pharmacists, GPs and healthcare workers who attended the information gathering sessions.

Members heard that training for GPs is provided across the borough, but that clinicians suggested that the training focuses primarily on medication and could be enhanced to provide wider professional development around encouraging patients to more effectively self-manage their diabetes.

When the issues above were presented to representatives from the CCG in March 2013, the CCG agreed that the standards of care across the borough, particularly in regard to the standard and adherence to the 9 NICE health checks was not consistent from all GP surgeries. HASSC welcomed the assurance that the CCG would address these findings through a programme of peer review and would also review GP training on diabetes.

Recommendations

Based on the information received by the Committee, Members concluded that there was a need to raise awareness amongst both diabetic patients and their community health professionals (GP's and practice nurses in particular) about the importance of the annual health checks.

Recommendation: Patient understanding of health checks

Specifically, it is recommended that action is taken to improve patients' understanding of the annual diabetes health checks, what they should expect to receive, and their importance in preventing complications.

Recommendation: Clinicians' adherence to health check process

It is further recommended that the CCG takes steps to ensure that all clinicians are familiar with the NICE recommendations for the Annual Health Check and have arranged the provision of high-quality interventions, with associated processes for prompt arrangement of patient appointments and their reminders.

Recommendation: Performance monitoring of the health check process

For the longer term, it is recommended that the data is improved and the baseline for understanding uptake of the nine health checks is brought up to date, with on-going robust monitoring thereafter.

Theme 3: Provision of information

From the outset of the diabetes scrutiny review, Members were particularly interested in looking at the information and advice which was available to people with Type 2 diabetes. At the Patient Perspective session issues were raised that the availability of information was poor, specifically the guidance and help provided by GPs to those who are newly diagnosed, and about the complications which may be associated with poor management of diabetes.

Those whom the Committee interviewed displayed some measure of consensus on the point that information is poor, especially around managing the condition and the long term impact if diabetes is not managed well. One representative said that:

> ***"Information and communications are very poor in the borough [about long term complications]. I was not told about what to do after I lost my leg for 6 years. I started losing my sight 4 years ago and had to pack up work. I drove an automatic car before that but losing my sight has meant life has changed."***

It was also felt that the lack of information about the seriousness of the condition can cause people to think that it ***"…it won't happen to them…."*** And that having the right information early enough might make people take diabetes more seriously.

Patient representatives and GP's generally agree that complications related to Type 2 diabetes may be preventable with education about self-management.

Service providers felt that while there is information available, as a Borough we should be taking a more targeted approach to produce better outcomes, for example, targeting the general population with information about the signs and symptoms of diabetes.

Why is the provision of information important?

Both patients and health care professionals who participated in the scrutiny process agreed that good quality information about Type 2 diabetes is essential to help:

- Reduce the risks of developing Type 2 diabetes;
- Recognise the signs and symptoms of Type 2 diabetes and get early diagnosis;
- Inform people how to manage their condition effectively post-diagnosis;
- Reduce the likelihood of developing long-term complications.

The Joint Strategic Needs Assessment cites research that found that many patients locally had not been informed about what their target levels of blood sugar were, and so could not actively participate in their own care. Others saw their results – for example, glucose control or cholesterol – and thought them high but their medications weren't changed and they were not given any instructions. Service providers generally agreed that providing patients with better information about their condition and the service expectations would improve self-management and help to change patterns of behaviour to develop a healthier life-style.

Standard 3 of the National Framework supports this view and identifies the importance of empowering people with diabetes in order to help them gain more control over the day-to-

day management of their condition to ***"enable them to experience the best possible quality of life."*** This includes areas such as:

- Knowing how to recognise and act upon symptoms
- Dealing with acute attacks or exacerbations of the disease
- Making the most effective use of medicines and treatment
- Understanding the implications of professional advice
- Establishing a stable pattern of sleep and rest and dealing with fatigue
- Accessing social and other services
- Managing work and the resources of employment services
- accessing chosen leisure activities
- Developing strategies to deal with the psychological consequences of illness
- Learning to cope with other people's response to their chronic illness.

One of the key learning points from the scrutiny process is that people living with Type 2 diabetes are required to make lifestyle changes which they may find difficult to adapt to at the beginning.

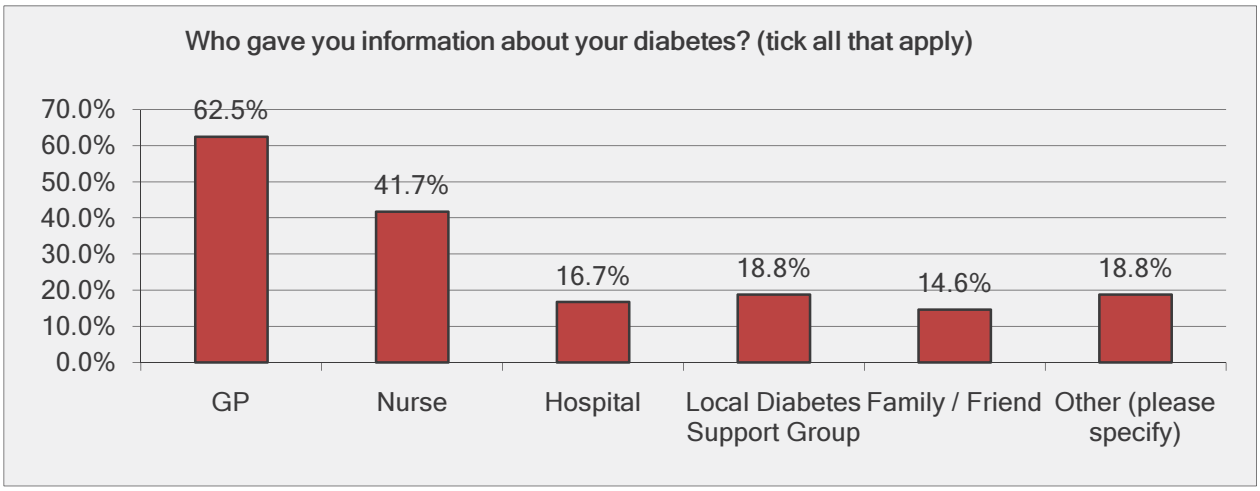
How can patients in Barking and Dagenham currently access information?

As part of the scrutiny process Members requested a review to see what information was already available. The review has identified a number of different ways in which a person living with Type 2 diabetes could access information.

General Practice

In contrast to the feedback from the patient perspective session, the data from the Patient & Carer survey suggests that GPs are the primary source of information at point of diagnosis, with 62.5% receiving information from this source. A large proportion of those attending the patient perspective session had lived with diabetes for a number of years, and it is reasonable to interpret this difference as indicating that, since their experience of being diagnosed, the process has improved for patients.

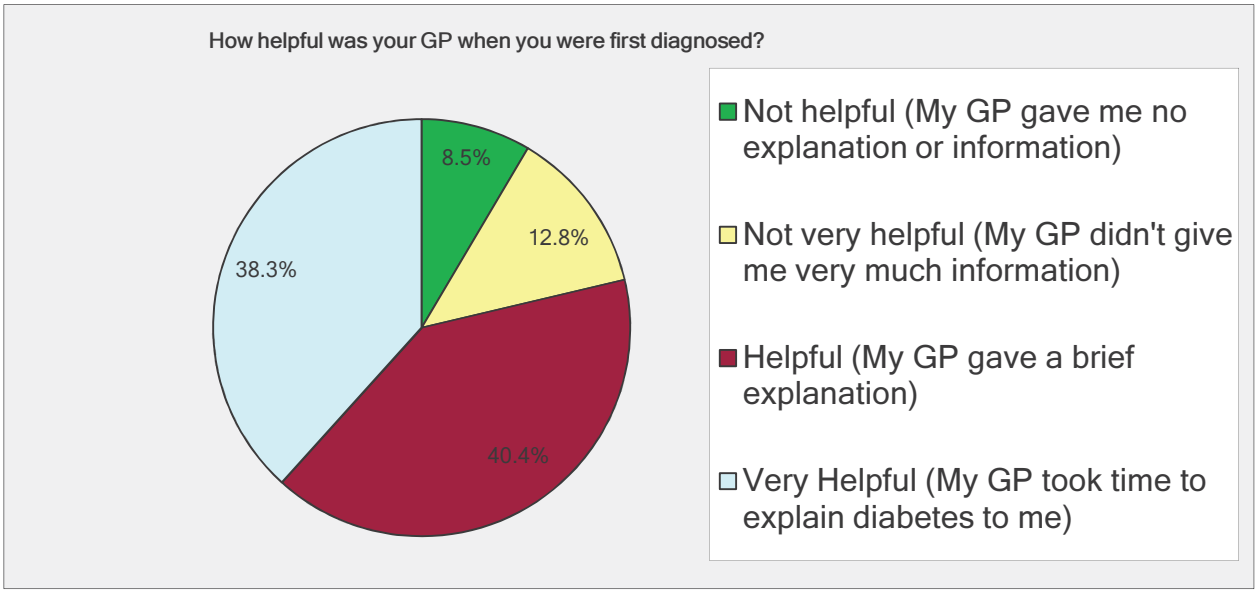
Figure 8 - 'Who gave you information?'



Taken from the HASSC Diabetes Patient and Carer Survey 2012-2013

78.7% of respondents also thought that the knowledge and support from their GP was helpful or very helpful with only 8.5% saying that their GP gave them no explanation or information upon diagnosis.

Figure 9 - 'How helpful was your GP?'



Taken from the HASSC Diabetes Patient and Carer Survey 2012-2013

Members also noted that GPs were providing information across a broad range of subjects including managing diabetes and the long-term health impacts of diabetes.

Figure 10 - 'What sort of information did they give you?'

Information	Response (%)
Information about diabetes	72.3%
How to manage my diabetes	78.7%
Information about diabetes medication	46.8%
Dietary information	66.0%
How to live with diabetes	40.4%
Long term health impacts of diabetes	53.2%
Other (please specify)	8.5%

Taken from the HASSC Diabetes Patient and Carer Survey 2012-2013

Of those that responded, 89.6% said that this information was ***'fairly helpful'*** or ***'very helpful'*** which suggests that GPs are a good source of information once a patient has been diagnosed. It is also a very different position reflected during the patient perspective session and reflects the GP education and training around Type 2 diabetes.

On-line Resources

There are a number of resources available to people with Type 2 diabetes on-line. Information on the websites is comprehensive and covers a broad range of areas including:

- Identifying the symptoms of diabetes;
- Information about Type 2 diabetes;
- Diabetes at different life-stages: children, young people, older adults;
- Living with Type 2 diabetes;
- Food and recipes and tips on healthy life-style;
- Treatments;
- Self-management including information about annual health checks;
- Complications;
- Support and user forums.

Some of the best websites include Diabetes UK and NHS Choices.

Information about national frameworks and what patients should expect from their annual health checks are also available via the Diabetes UK and the Department of Health websites.

Education Programmes

Porters Avenue offer an education programme called DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) for anyone who has been diagnosed with Type 2 diabetes. It is a one-day programme which helps develop knowledge and understanding about Type 2 diabetes, how to control it, and the long-term impacts of the condition. The target audience are people with poorly controlled diabetes, hypoglycaemia and new and existing Type 2 diabetics.

Voluntary Support Groups

In Barking and Dagenham there is only one voluntary support group available to people living with Type 2 diabetes, the Barking & Dagenham Diabetes Support Group. The group provides advice and support to patients as well as carers of people living with diabetes. The group meets regularly and is attended by healthcare professionals.

While the Support Group is open to anyone with Diabetes or affected by Diabetes (such as a carer) the majority of people who attend the Support Group are 50+. The Support Group found that when younger people did attend they tended not to become regulars. Parents of young children with diabetes have attended, and they are often referred to the Havering Family Diabetes Group in Harold Hill. This group has other parents and a crèche facility as well as offering different programmes for people living with diabetes. It is not known how many people have been referred to this group.

Members were appreciative of the energetic work that the Diabetes Support Group put into improving services for their members. However, with an increasingly younger cohort of

people living with diabetes, the Committee would like to see if there was an opportunity for the Support Group to look at ways to attract younger members.

Members also felt that there is a lack of co-ordinated support for children and young people within the Borough and recommended that this should be explored in more detail.

Information provided to professionals to support their work

It was also clear during the patient perspective session that patients were not aware of the services available to them, for example financial advice. This point was also raised by a GP with a special interest (GPwSI) who attended the session on 13 February. He noted that GPs do not always have enough information about what services are available in the Borough. For example, in 2010 a booklet was issued to GPs advertising the different exercise schemes available which proved useful when GP's were developing a care plans with patients. This booklet has not been re-issued. The feedback from GPs suggests that they would be happy to sign-post services if they knew what was available.

As an example, DABD UK provides a range of services to support independent living and to promote independence. This service is available to patients living with Type 2 diabetes, and their welfare benefits service provides a free and confidential advice on matters such as help completing benefit forms, benefit entitlement checks and income maximisation. DABD representatives attended the B&D Diabetes Support Group on 11 February 2013 to advertise their services, but it is clear that more could be done to put this information into the hands of professionals working with those with diabetes.

It was clear from both the information gathering sessions and site visits that better sign-posting of services is required. This is not limited to patients and carers but also to GPs and other service providers.

When CCG representatives were presented with these findings in March 2013, HASSC were pleased to be assured that the CCG are currently reviewing diabetes literature and will particularly review information packs that are given to patients in light of the concerns raised by HASSC.

Culturally relevant information

In Section 1, it was advised that the survey respondents were not reflective of the Borough demographics as a whole. What the scrutiny could not identify is how difficult it is for people from different ethnic backgrounds to access information particularly where there are language barriers.

Porters Avenue offers a variation on the DESMOND programme which is specifically aimed at people from different ethnic backgrounds and includes an interpreter.

Members felt that any work around information and sign-posting services should take into account the diverse demographics of the population of Barking and Dagenham.

Recommendations

Members recommend that further work is required to ensure that there is adequate information and support for people living with Type 2 diabetes in the Borough.

Recommendation: Information and advice

The Committee recommends that the whole range of information provided to people already diagnosed and people newly diagnosed with Type 2 diabetes is reviewed, ensuring that it gives them what they need to know to improve self-management of their diabetes and their understanding of long-term complications.

This could include, but not limited to:

- Affordable healthier food options (at home and in the workplace)
- Active involvement in negotiating, agreeing and owning goals
- Understanding the consequences of different choices

The Committee also recommends that this review takes account of the need to ensure that the information and advice reflects the changing diversity of the population, and is easily accessible by the target audiences.

Support for younger people

Although it is outside the scope of the scrutiny, Members were concerned that there is not enough targeted support for younger people in the Borough, for both Type 1 and Type 2 diabetes. There are likely to be two age groups affected: firstly, younger people, including children, who may be more likely to have Type 1 diabetes; secondly, and more within the scope of this report, those between the ages of approximately 30-50 who may be developing Type 2 diabetes as a result of lifestyle factors.

The Committee felt that work needed to be carried out to explore what both of these groups would like, noting that their needs are likely to be different, and to foster a service user-led response to the need for more support services in each case. For the younger age range, it may be that the health group of the Barking & Dagenham Youth Forum would like to undertake some work on this issue.

Recommendation: Young people's support (Type 1 and Type 2)

That the Health & Wellbeing Board facilitates consideration of how young people with diabetes (either Type 1 or Type 2) could be supported in the Borough, inviting the participation of the health group of the Barking & Dagenham Youth Forum.

Recommendation: Younger adults developing Type 2 diabetes

That the Diabetes Support Group participates in a short review of the support needs of younger adults developing Type 2 diabetes, and how they may be met from a service user led group, led by an agency to be identified by the Health & Wellbeing Board.

Theme 4: Hospital admissions

Barking and Dagenham has the highest emergency admission rate to hospital in London. Around 40% of hospital admissions are unplanned and a ***"significant proportion of these are related to conditions such as congestive heart failure, diabetes, asthma, angina, epilepsy and high blood pressure, which generally should be managed without emergency admission."*** (Annual Report of the Director of Public Health, 2013)

In 2011-12 there were 100 admissions per 1,000 population in Barking & Dagenham, which was an increase of 11.4% from the level in 2010-11. More significantly, for those conditions (called 'ambulatory care sensitive conditions') that give rise to a higher risk of admission, the rate was 16.5 per 1000 population at a total cost of £5.5m per year. Diabetes is one of these conditions. The pressure on accident and emergency services and the use of hospital beds is substantial, adding to the challenges that Barking, Havering and Redbridge University Hospitals NHS Trust face in meeting the demands of the local population.

It is therefore the complications arising from poor management of diabetes that place a pressure on local hospital services. Both the Director for Public Health Annual Report and the JSNA 2013 found that in Barking and Dagenham the rate of emergency admissions for diabetes is above the national average (in the top 10% in London) and is also high for planned admissions.

The JSNA suggests that this indicates a lack of sufficient support and care in the community, with care being hospital-focused. This view was supported by the B&D Diabetes Support Group who suggested that when someone has a problem but can't get hold of a GP, they ring the emergency doctor who advises them to go to A&E. This may be an issue regularly raised with the general population, but it is an added concern given the risks facing those managing their diabetes.

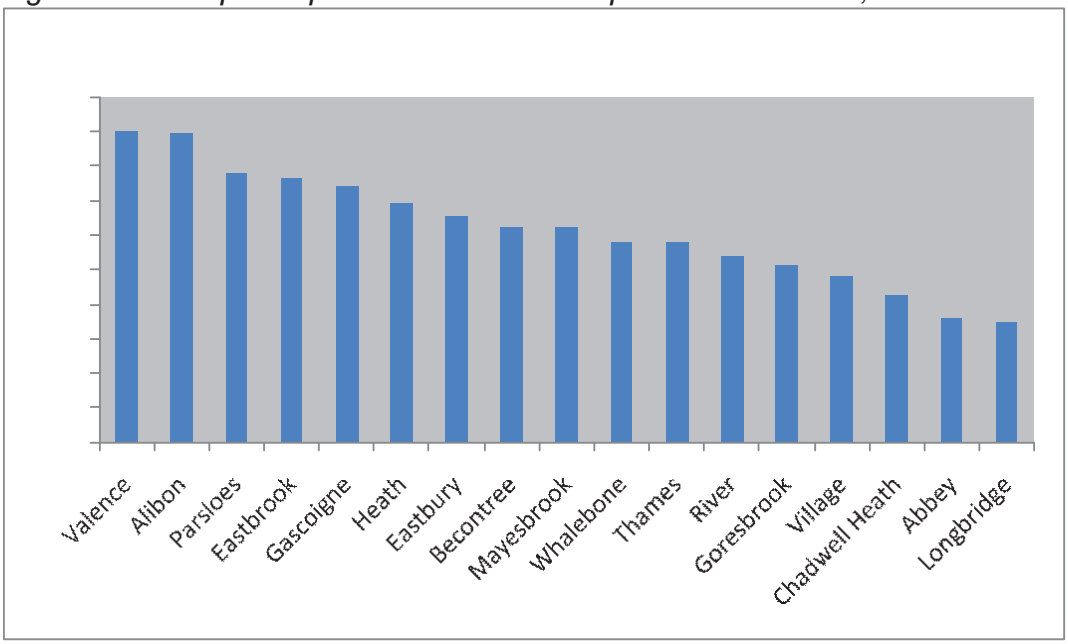
Figure 11 - Rate of Emergency Diabetic Admissions per 100 on the diabetes register (2010/11)

	Rate of Admission (%)
England	1.6
London	1.6
Barking & Dagenham	**2.1**
Havering	1.6
Redbridge	1.1
Waltham Forest	1.2

Source: NHS comparators (2010/11 data)

Admission rates also vary between wards with Valence and Alibon wards having the highest annual hospital admission episodes.

Figure 12 - Hospital Episodes for Diabetes per 1000 Patients, B&D wards



Source: NHS Secondary Uses Service (data warehouse), analysis by Peter Condon

Members were concerned that the data surrounding hospital admission rates is based on 2010/11 data and felt that baseline data for 2011/12 should be made available.

Integrated services for better diabetes management

South West Essex Community Services (SWECS) Diabetes Service

Representatives from South West Essex Community Diabetes Service (referred to here as SWECS) were invited to attend a HASSC session on 12 December 2012 to discuss the community diabetes services.

South West Essex has a prevalence of 5.4% of adults with diabetes. The service was commissioned in April 2011 to provide a diabetes hub within the community, and has since been cited for its excellent outcomes, particularly in reducing diabetes-related hospital admissions. The team includes 1 assistant practitioner, 7 diabetes nurses and 1 nurse consultant, 1 specialist dietician and Clinical consultants from Basildon Hospital.

Representatives from SWECS advised members that since the start of the integrated service, staff have found that patients are showing better care and management of diabetes, improved glycaemic control and improved quality of life. In particular, there are no longer any outpatients at Basildon Hospital with patients being seen at one of 13 outreach clinics across the Borough. The service includes diabetes education (similar to Porters Avenue) and has around 4,000 patients and includes home and care home visits.

Members were interested to note the reasons that SWECS gave for the reduction in hospital admissions, which included:

- **Good relationship with acute colleagues**
  Staff work closely with ambulance staff who report that repeat admissions often don't want to say anything in case they get ***"into trouble"*** with their GP for not looking after themselves. Ambulance staff refer repeat admissions to the 'Hub'

so that nurses can make a home or care home visit. Nurses also work closely with GPs to help review their diabetic patients.

- **Urgent referrals**
  SWECS nurses have adopted a ***'no barriers'*** attitude which means they will see patients without a referral if they receive urgent calls from GPs or Basildon Hospital to avoid a person going to A&E.

- **Work in partnership with GP practices**
  SWECS nurses work in GP practices not only to help with the shortfall in expertise and resources in GP practices but also to up-skill staff. They also run an annual conference for all staff in their area and a forum every 3 months to promote diabetes education. They also noted that a large group of nurses means that there is a lot of expertise and support amongst each other.

- Patients are being **moved through the pathway quickly**.

When the Committee compared the information presented about SWECS to that provided by Porters Avenue Integrated Diabetes Service, they were interested to note the similarities, and the opinion of many of the professional witnesses that there is little practical difference in the operation of the two services. However, it is clear that the outcomes being achieved are markedly different. The Committee were surprised to hear that there had been relatively little exchange of knowledge and best practice between the two services. The Committee suggested that an exchange of information would be of particular benefit to integrated community services locally as they look for ways to improve the outcomes from the local diabetic care pathway.

Integration of Services in Barking & Dagenham

The Committee heard from some clinicians that there was scope to review the care pathway to improve its integration across different services, to ensure that all the relevant players are included, and to understand how each service can offer support. Taken together with a review of best practice, Members felt that commissioners in Barking and Dagenham need to review the way in which individual services work together to form a more holistic approach to patient management. As an example, care plans should take into consideration how pharmacists access support and advice.

Members of the Committee also reflected that, with the changes in responsibility across the health system, any review of integrated service delivery may need to confirm that the correct information sharing protocols are in place to ensure that patient information is passed between services safely and efficiently.

At a meeting in March 2013 in which CCG representatives were presented with the findings of this report, HASSC were pleased to be assured that the CCG have established a diabetes forum to address areas for improvement. The diabetes forum will particularly look at developing services at Porters Avenue and learning from national and local best practice examples, such as South West Essex.

Recommendations

Recommendation: Learning from South West Essex

That the Health & Wellbeing Board ask Public Health professionals to work with commissioners and North East London NHS Foundation Trust to understand the reasons why services which are on the face of it similar appear to be linked to different outcomes for patients, and to capture the lessons for future local commissioning.

Recommendation: Reviewing the integrated care pathway

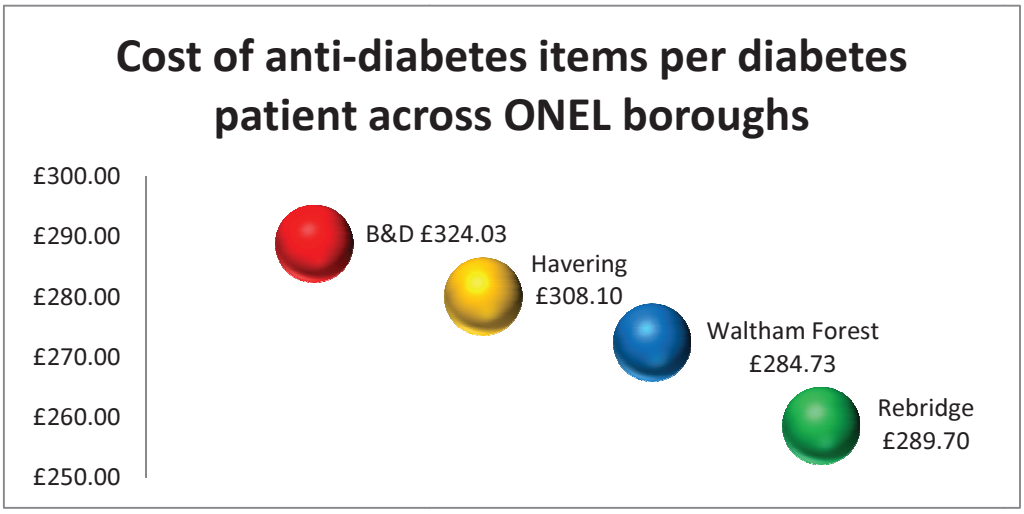
That the Health & Wellbeing Board oversees a review of the care pathway to ensure that all opportunities for joint working are being harnessed and that the flow of patients between services is effective.

Theme 5: Annual cost of diabetes

At a national level, spending on diabetes is amongst the highest. In Barking and Dagenham some elements of the cost are notably high.

In particular, Barking & Dagenham have the fifth highest number of prescription items and spending costs in London. In 2009/10, NHS Barking & Dagenham spent £2.4m on anti-diabetic prescription items, which equates to £287 per known diabetic at the time. In 2010/11 the overall cost for anti-diabetes items (measured per diabetic patient) was found to be higher than any other Outer North East London (ONEL) borough. This suggests that people may not be managing their condition as effectively as they could be.

Figure 13 - Cost of Anti-diabetic items per patient



Source: Yorkshire and Humber Public Health Observatory (YHPHO), Diabetes health intelligence

Testing equipment

The 2013 review of the Joint Strategic Needs Assessment has pointed out that certain aspects of expenditure are high, such as blood glucose testing strips. It cites evidence that home blood sugar testing in Type 2 Diabetes does not influence long term control but yet the spending is high in the borough, and this may be one area in which expenditure could be reduced. In particular, it recommends that these ***costs "be reviewed by the Clinical Commissioning Group, as there are obvious costs savings with no detriment at all to patient care."***

However, anecdotally, home testing is popular with patients who feel it offers an element of control, despite the evidence that, in the main, this doesn't always translate into better management of blood sugar levels, so any removal of this option would need to be managed carefully to maintain the commitment of diabetics to their treatment and food regimes.

Adherence to medicines programmes

Expenditure may also be affected by patients not taking medication correctly. Pharmacy representatives who addressed the Committee advised that, while medicines are still the most 'common therapeutic intervention', patients are not taking them correctly:

- 30-50% prescriptions are estimated not to be taken as intended;
- 5% of hospital admissions are due to the preventable adverse effects of medicines (*all medicines, not just diabetes medicines*);
- For 41% patients, there had been little or no explanation of the side effects of their medication, which can affect adherence to the prescribed regime.

Recommendations

In terms of the recommendations arising from this section, Members are minded to support the Joint Strategic Needs Assessment's own recommendation to review cost of testing equipment. Additionally, the Committee considers it sensible to factor into the review of the care pathway the opportunities to improve cost-effectiveness of community services and to improve adherence to medicine programmes by individuals.

Therefore there are no specific recommendations relating to cost above and beyond those already identified by Public Health and clinicians.

Conclusion

Diabetes is a big problem and is set to grow in the future especially in light of its association with related conditions such as obesity. There is currently little funding for targeted screening events to identify people with a higher risk of developing diabetes which could have a real impact on improving the current levels of diagnosis. The review has highlighted the need to find better ways to engage with the people most likely to develop Type 2 diabetes to raise awareness about the condition and help people recognise the early symptoms.

For those people who have already been diagnosed, early detection aligned with good quality information and advice could help patients to better understand and manage their condition. Providing patients with knowledge about life-style choices can help to reduce the likelihood of developing avoidable long-term complications such as blindness and lower limb amputation – which places additional pressures on social care resources and the acute sector, but most importantly stops people living fulfilling and healthy lives.

The cost of diabetes medication is higher in Barking and Dagenham than elsewhere and there are real gains to be made both in terms of improving people's health and lowering costs. Furthermore, General Practice needs to be consistent with the standard of diabetic care provided across the borough. Increased performance monitoring against NICE's nine annual health checks could help to drive up the quality of diabetic patient care, as well as helping patients to manage their condition more effectively and prevent long-term complications from developing.

The presentation by South West Essex Community Diabetes Services has demonstrated the benefit of integration and communication between professionals and it is hoped that professionals within Barking and Dagenham can meet with North East London Foundation Trust to understand the reasons why similar services appear to be linked to different outcomes for patients, and to capture these lessons for future local commissioning to improve the way in which patients move between services and prevent the need for secondary care.

We welcome the move of Public Health to the local authority and the opportunity that this brings for more joined-up thinking about the way in which work on other health conditions may impact Type 2 diabetes, for example, tackling issues around obesity and smoking cessation will help to reduce the levels of people likely to develop the condition.

This report identifies ways in which the Health & Wellbeing Board may wish to address some of the issues when developing future delivery plans and we are pleased that the Chair of the Health and Wellbeing Board has assured the Select Committee that the findings of this review will inform the next iteration of the Health and Wellbeing Strategy. All of the main building blocks for effective diabetes service provision appeared to us to be in place, but greater emphasis needs to be placed on ensuring full take-up and improved promotion if every opportunity is to be harnessed to minimise the serious impacts of this condition. It is hoped that the recommendations identified by HASSC are taken forward.

Appendices

1. Session notes from the Committee's investigations
2. Copy of the Patient and Carer Diabetes Survey
3. Findings from the Patient & Carer Survey results
4. Overview of the National Standards Framework for diabetes
5. Site visit 'Menu of Involvement'

Appendix 1 Information Gathering Session Notes

Patient Perspective Session

Date of Session: 12 September 2012

Organisations: Barking and Dagenham Diabetes Support Group
Barking and Dagenham Local Involvement Network (BDLINk)

How long have you suffered from diabetes?
I've been a type 2 diabetic for 21 years. In this time I have had a leg amputated and suffered from kidney problems.
I was diagnosed 20 years ago. As a result of my diabetes I have lost ½ an eye, had a toe amputated, suffered from osteoporosis, and lost some of the sensation in my legs.
Type 2 for 10 years.
I have been a diabetic for 37 years, the only problem I have is mild neuropathy.
What were the first symptoms of diabetes that you noticed? What made you go to your GP?
I had an extremely stressful job and high blood pressure so I went regularly to my GP. Eventually the GP said I was diabetic but I'd had no symptoms to indicate it, it was "out of the blue".
I had a chest infection and went into hospital and was diagnosed there with asthma and diabetes.
I was passing a lot of water and started to get infections so I went to my GP.
It's in everyone but something sets it off. Insulin is created naturally in the pancreas, but with Type 1, the body stops making insulin which makes it work properly. Mostly affects younger people under the age of 40. With Type 2, the body makes insulin but either doesn't make enough or the quality isn't as good as it should be. You might need to change your diet e.g. not as much carbohydrates and sugar. If that doesn't work you go on tablets and if that still doesn't work you go on insulin. Taking insulin in this case doesn't make you a Type 1.

They are two separate illnesses but as serious as each other if undiagnosed.

How supportive was your GP when they told you that you had diabetes? (E.g. did they give you the right advice and information?)

When I took my mother to the GP he admitted that he knew very little and if she wanted to know she had to go to the hospital. She was referred immediately to hospital for tests.

Oldchurch Hospital gave mum and appointment for a month's time. When she went to her appointment the doctor said she should have been dead by then and wondered why hadn't come earlier.

On one occasion the GP was visiting mother and noticed her blood monitor and asked her to do a blood test on him as he thought he had it.

Mother was Type 1 so I knew what to stop eating. I lost 1 ½ stone in weight.

The first time I'd been to the doctor in 17 years as I was generally in good health. The GP was not very supportive.

My GP has changed but the GP I've got now doesn't know much either.

Can you tell us about how you felt when you found out you had diabetes

I never believed I would get it even though mother had it because read somewhere that it wasn't hereditary. I was devastated.

Mother said start off on tablets but I went straight onto injections as a Type 1.

My mother was the only one who provided any support as she knew a little as she was a diabetic but she didn't know very much because she didn't really want to know more.

People generally didn't know much about it so I read books, went to the library to research myself (we didn't have the internet then) to read what to do. I did this until about 5 years ago. At that time I saw a nurse at the surgery for asthma and I came across information about the DAFNE programme. The nurse said someone in borough was doing that and that she would put her in touch with me. I met Elaine Whitlock who runs the service team at Porters Avenue who said they had a course which teaches people about diabetes. I would have to attend daily for week but the course was excellent.

I found out about the pen which meant that I could play around with mealtimes and as a schoolteacher that was brilliant. I had written to ask about it earlier but was advised that had to apply to the hospital and be referred to see if I was suitable to handle a pen.

DAFNE revolutionised my life for handling and managing my diabetes.

Can you tell us about your day-to-day routine

I check my blood sugar level as soon as I get up. I check 3-4 times per day. Most evenings I don't take insulin as in morning my level is very very low. I don't find it difficult to wake up and get up out of bed.

I check my blood sugar levels and a car worker visits me to help with showering, dressing and breakfast. I take 32 tablets and 4 injections a day to keep my insulin levels steady plus other medication for the pain in my legs and aspirin to thin the blood. I'm pretty much housebound unless there is a care worker to visit and take me out. I only get out once a week due to budgets for having carers. I have injections 4 times a day and 32 tablets.

Not everyone who gets diabetes is overweight, I was 13 stone but due to insulin, I put on weight. It's not always true and GPs say that being overweight is why people get diabetes.

I take tablets to absorb my help absorb diabetes medication which is normally around 120 units and 100 units. I also take medication for my heart and neuropathy (my nerves are dying off below knees).

Is there a stigma around diabetes? (e.g. weight)

Yes. I was only 12 stone before I was diagnosed but since having my leg amputated I have put on 15 stone. My family know I'm not a big eater. It was also uncomfortable using a prosthetic limb.

Is it difficult to take the stigma?

The point is that *[name withheld]* is not overweight.

Type 2's tend not to be overweight.

There was a recent report in a paper where a doctor in Canada said that if you're diabetic it's your own fault.

That's insulting.

Some doctors say you are a 'bit diabetic'. You can't be a bit you either are or you aren't.

How did you feel when you found out your family member had diabetes?

My mother was diagnosed with diabetes very late in life. Mum had been to her GP with weight loss and had blood tests. At the hospital she was checked for infection and was asked if she'd lost weight and I said another GP investigating that so nurse left it. Mums health stabilized. She also suffered depression. Her weight remained fairly stable.

When we were in the GPs surgery I saw a poster giving the 6 symptoms of diabetes including excessive tiredness, genital itching and weight loss so I asked for an appointment to see the nurse. Mother did urine sample and blood sugar test which was 3 times higher than it should be.

Mother had an elder sister at the same GP surgery but around the time that mum was diagnosed (aged 76 at diagnosis) the surgery did away with over 75 health checks. One of the first things my aunt was asked for during a health check (when they still did them) was urine sample. If mother had been for a health check she might have been diagnosed sooner.

Once she was diagnosed she was quite good and was monitored regularly for the nine points test. The diabetes was caught and controlled but few years later she started getting back trouble and dementia. I took her to doctors for something else and mentioned the memory issues to the GP who thought it could be a complication of the diabetes. He sent her for an MRI which showed that the blood was not circulating around the brain as a direct result of complications due to diabetes. I think that if she had been diagnosed properly it might have been avoided.

I feel that the late diagnosis made things more difficult than needed to be for me and my mother which frustrates me.

It didn't really affect my daily life too much although I had to go to the hospital with my mother for regular blood tests. The bigger impact was her dementia managing her diabetes was easy in comparison. We had 2 care workers visiting a day to help and give me respite. Financing her care was a concern.

If the doctor is interested in patients, and if their knowledge was as such, I'm sure that they should be able to do what's necessary. But many have an ignorance of diabetes and don't know what it is so they can't follow up.

It is similar to many years ago with knowledge of sickle cell. As a country, diabetes has come a long way but it's not as it should be and we still a lot to learn. There is a stigma being placed on weight. We need to look at Type 1 and where that crossover is, to be alert to yourself, about what is happening.

How has caring changed your life?

Mum did blood tests until the diabetes stable. The doctor did do annual checks but in the end the

diabetes became secondary to the dementia.

In due course mum needed two carers a day and I needed a respite.

Over the years there are complications developing which had a massive impact. Mum was very good with her diet and the nurse did advise her that she could have an occasional treat.

My husband had diabetes for 11 years before he lost his sight. We had three teenage children and I had to become a full time carer.

I couldn't change my mortgage and had to go into shared ownership housing association.

He never came to terms with the blindness and our youngest daughter remained his little girl in his mind. There were lots of other complications such as kidney damage, several small strokes and heart attacks.

[Name withheld] was not a good diabetic, he smoke and drank.

Some days I would spend 8 hours a day at the hospital for 33 weeks while he was there as couldn't be left alone. He was 51 and had dementia in end.

As for the impact, I was a widow at 50. He was not there to give his daughter away or for his grandchildren. Our youngest left school four years after he died and is now 18. I'm a single parent and as the family situation changes the emotions come back again.

It affects the whole family. You need the support in beginning. No one tells you what to do for example, if lose a leg and no one checks you are doing things correctly (e.g. medication). No one's there, it's not fair and it's hard work. There was no information from GPs.

Information and communications are very poor in borough. I was not told about what to do after lost my leg for 6 years. I started losing my sight 4 years ago and had to pack up work. I drove an automatic car before that but losing my sight has meant life has changed. I had my own house and there's no help for you if you own your own home.

2 years ago, ATOS told me I could go back to work but I need to be wheeled about it.

I had to stop work and because of my assets I was not eligible for benefits and had to sell my house. I have received help from the Independent Living Association but because of a cut to their funding they cannot support me as much; this is a shame because you get used to dealing with people and then it changes. DABD are hard to contact and I have no one to help me with form filling to get financial support.

My father was a stroke patient and my cousin had a stroke. People with disabilities don't get the funding they used to and it's very difficult. My cousin was told to sell his house to cover his costs, but he has six children, and where do you live once you've sold your house?

As an authority, we would like to move into a direction of taking this into schools to catch it early. Educating children about health issues should be on curriculum so that they learn how to take care of own health.

We still have best system in country.

Where should support come from?

The tragedy is that complications are preventable with education.

Hospital budgets take up 20% of in-patients for diabetes related–issues worldwide.

We eat too much of wrong stuff, you only have to look at the ingredients on the side of packets; it's like a listing in a chemical factory.

Type 2 is preventable, Type1 isn't. People think it's not serious or it won't happen to them. Getting children involved is a brilliant idea. People do not understand the complications that come with diabetes and better public awareness would help.

Type 2's use services through the hospital.

I was diagnosed at Queen's and one of things that was really apparent at the time was the inconsistency between what the hospital and GP said. The communications element and opinions of individual consultants, doctors and nurses about the right thing to do varies.

Diabetes is an individual thing as well as growing problem in the community. Individuals can help themselves by getting the right advice which is most important.

There are no hard and fast rules for dealing with it but we need experts to actually deal with individuals that are diagnosed in a way the patients can understand.

Individuals need to take responsibility too; it wasn't until I had my leg amputated that I woke up to the challenge of living with diabetes.

People rely on hospitals instead of managing their condition properly, this is wrong and people need to use programmes like DAFNE and get better educated.

What do you think is good about the services locally?

Porters Avenue is excellent when you've been diagnosed. You are not given a 10 minute slot like at a GP surgery. The clinic gives you the time you need as diabetics have a lot of questions. The

leaders there insist the patient has time to talk.

I have to keep a daily diary for blood sugar levels, food, amount of carbohydrates, insulin, ratios, and driving. They go through it with you.

The GP hasn't a clue. You need expertise in running these services.

The nurses at Porter's Avenue inspire confidence; they have the doctor's ear, are knowledgeable, and can spot the signs quickly. Non-specialist centres do not understand diabetics; the staff in those places do not have the right training. For example, I had a foot problem and was on crutches for a year and 2 weeks (and within 6 days of foot amputation). The Podiatrist sent me to a different doctor for different treatment and the foot healed. The GP wouldn't have known about this treatment.

The same applies to Type 1 and 2. If the GP doesn't know there is nowhere else to go.

Type 1's go to hospital annually and this is no good as once per year although they are good when you are there.

We need a community service to help which not only deals with helping a diabetic but also prevention of complications. They try to get into communications and advise people about diabetes.

All of the facilities are in same building and should be expanded not reduced. Diabetes is on increase in B&D so the service needs expanding.

We no longer have to go 'pillar to post' because we have all of the specialists under one roof. Funding for this service needs to be protected.

The service isn't there to go out to everyone.

There are also psychologists available at Porters Avenue. They have a complex care clinic weekly which sees 10 patients a day including a podiatrist and dietician.

You need to be referred but the service is brilliant.

Mum was referred to a dietician but they didn't want to know due to funding issues.

Porters Avenue is an integrated service which works together. How did you get on before?

When I was first diagnosed services were brought in from Havering as there was nothing in B&D.

I came to the launch night of Porters Avenue. We would like a drop-in service especially at night when there is nowhere to go or anyone to call – even just for advice. B&D Diabetes Support Group people often call me or the Chair. We often need reassurance, especially as a carer, so it

would be good to have someone to talk to as carers get no information or training.

Porters Avenue has been there four years and is continuing to develop and we should be proud of it and promote it. You need it in beginning though not when it's too late.

I was in a car crash four years ago. The paramedic at the scene took my blood and asked where my insulin was as my blood sugar level was 23. I didn't know I was even diabetic so I went to the doctor who didn't even give me a diet sheet or any information. Mum had it and also had no information.

We have to be more forceful and demanding when going to see doctors. This is what actually happens. When we go to the doctor, challenge them to find out what is happening. We owe it to ourselves to get a second opinion. We depend on the NHS for care.

Thanks for saying something good about one of our services. When go to the doctor demand and ask questions, it doesn't matter if they think you are a trouble maker, it's for your own benefit. Make sure they are uncomfortable and know you want a second opinion. If you are not comfortable demand the service from them if they are not giving you the service you want, talk to someone.

Question to Committee: What will happen now?

We are trying to hear from a patient perspective from both carers and sufferers.

As a health committee we will come up with recommendations, continue to support what's working well and look at changes that are required.

The meetings are in the public domain so you will be able to read about it.

More information is needed. There isn't information for people to find about it.

The B&D Diabetes Support Group run a stall once per month in Queen's Hospital and provide pamphlets. We get about 50 odd people during the day and are often asked how people know if they will get diabetes.

When first diagnosed, my GP specialised in diabetes but said that if I kept doing what I was doing I'd know more than GP. A GP gets ½ day on average of training in their career on diabetes.

Good Practice Session

Date of Session: 12 December 2012

Organisations: Diabetes UK
South West Essex Community Diabetes Service (SWECS)

Diabetes UK

Diabetes UK is the UK's leading diabetes charity and provides an on-line one-stop-shop for patients and carers which give information about living with and managing diabetes as well as signposting services and training programmes at a national and local level. Their presentation focused on the national picture of diabetes, as well as preventive activity and campaigns. The presentation gave the Select Committee ideas to what the Borough could be doing in regards to local campaigns and diabetes provision.

Notes from presentation by Diabetes UK
Of Type 2, 90% remain undiagnosed and people can have it for 8-10 years before being diagnosed and usually as a result of being tested due to another condition e.g. heart attack.
Type 1 can develop at any age but generally before 40.
A report was published last week which stated that people with diabetes had a 48% higher risk of cardiac arrest/death.
B&D are in the bottom 25% in respect of patients having 5 of 9 of the annual tests.
Healthcare Essential is the key thing all patients should have annually. Survey's often ask whether patients have the 9 health checks but since many people don't know what they are they have no baseline *[Note: the Patient & Carer survey does ask people to indicate each health check they have annually]*
The key message to people is that there is no such thing as mild diabetes.
All health care professionals need to have a good understanding of diabetes not just GPs and diabetic nurses.
The NHS has an 18% target for diagnosing diabetes in the undiagnosed; this is quite low and reflects the failure of health services to do so.
Children's Campaign started on 14 November and will last for 5 years. Need to raise awareness

among GP's of the importance of diagnosing diabetes in children quickly as it can develop and progress very suddenly.

Q&A SESSION NOTES

How can B&D link up to national campaigns?

NHS Foot Profile is a good example of what B&D could do. Diabetes UK figures for B&D reflect the expected numbers.

Middle-age to older people tend to get Type 2 but it is progressive and slower and is often overlooked due to age. Need to encourage people who are over 40, Black/Asian, family history of diabetes or overweight to get risk assessed.

Why is there is often no information in GP surgeries?

Diabetes UK do have a "Measure up" campaign and do regular road shows but if a person has had another medical condition, they are often automatically tested for diabetes without being advised.

What are the key components to good practice?

The population of individual boroughs requires a different approach. Generally, everyone should have annual checks and their needs to be support and help to keep health to a good level and a multidisciplinary foot care team to help reduce unnecessary amputations.

Is there anything else a person can do other than use medication?

Type 1 must have insulin and watch their diet. Type 2 can be managed by diet/exercise alone although some have oral medication. A third go on to take insulin as Type 2 is progressive.

What are the main issues coming through for patients?

Diabetes UK recently did a survey around foot checks as many GPs did not do them properly. GPs are getting paid but the level of the check is poor.

Emotional/psychological support is also necessary as diabetics have a higher rate of depression generally. Severe mental issues are higher due to diabetic needs.

How can we improve our services in B&D to work with Diabetes UK?

Need to meet with the area manager to talk about what can be done. Make sure that the "Healthcare Essentials", "10 Steps to Healthy Feet" and children's posters are available in schools and surgeries.

CCG Response:

The CCG are keen to improve services in B&D and met with a diabetes forum this week. The CCG are keen to receive feedback from HASSC.

GPs in the local area need awareness of health checks being done properly. If feedback from the Diabetes UK survey can be provided it will be used as we are CCG are keen to make a change/improvements.

South West Essex Community Services (SWECS)

SWECS are a newly commissioned model for the delivery of community diabetes services in South West Essex and have been identified as good practice by the North East London Foundation Trust (NELFT). As NELFT are one of our community service providers, it was thought that this community-level organisation would be able to give Members a focus as to what the facets of a good diabetes service delivery model should look like and to shape some of the questions that they may ask local providers during site visits and future HASSC sessions.

Notes from presentation by SWECS
Area covers Purfleet to Wickford.
York and Humber found that 6.2% of people have diabetes in B&D and 6.6% in Thurrock which is what is expected based on the population levels.
In Thurrock in 2011 a scoping exercise took place and the Community Diabetes Service was commissioned to enable care to be delivered closer to home.
The service includes 3 consultants from Basildon Hospital and a specialist diabetes dietician. There are no outpatients at Basildon any more.
Patients are usually referred by their GP and triaged at the Hub at Orsett. There are 13 outreach clinics plus Orsett and patients are able to choose where they want to be seen once they have been triaged. Run the DESMOND (Type 2) and DAFNE (Type 1) courses at all outreach clinics. Also run Group Carbohydrate sessions and recent evaluation indicates that it has been well received by patients who seem to prefer the group sessions. The group aims to dispel the myths around diabetes. There is an Insulin pump clinic (for Type 1) for people struggling to use insulin and a recent audit shows that it has done very well over the 18 months it has been running.
Nurses undertake visits to people in their own homes/care homes. They work closely with ambulance staff who report repeat offenders to them (people often don't want to say anything in case they get into trouble with their GP for not looking after themselves) and refer people to the Hub so that nurses can make a visit. Nurses will see patients if they receive urgent calls from GPs or Basildon Hospital.

They run an annual conference for all staff in their patch and a forum every 3 months.

Nurses work in GP practices to help with the shortfall in expertise and resources.

Since the service was set up there has been a marked reduction in unplanned hospital admissions.

Q&A SESSION NOTES

What are the 2 or 3 key things that you think makes a service work well?

No Barriers – something is always done.

Large group of nurses means that there is a lot of expertise and support amongst each other.

Good relationship with acute colleagues.

What is the difference between an insulin injection and an insulin pump?

The injection lasts as long as the insulin should last, the pump sits under the skin and gives little shots and can be increased/ decreased as required.

Which carbohydrates should diabetics cut out?

There are sugar and starch in all carbs including rice, potatoes. A typical day involves a carb-heavy diet e.g. cereals for breakfast, bread at lunch, rice/potatoes for dinner, crisps for snacks. However, fruit also contains high levels of sugar. A better snack option would be nuts.

A dietician is very helpful at getting people into good eating patterns.

Do you have links to other services such as local IAP team for therapeutic interventions?

In SWECS there are links to the South East Partnership (SEP). Also a specialist nurse in SE Essex who works for the mental health team.

Why is SWECS working so well and yet Porters Avenue (which has similar services) is not

as successful? Whey has there been no crossover of learning?
Michelle Stapleton advised that she will contact her counterpart at Porters Avenue to begin discussions about information and best practice sharing.
What other options do patients have? What are the waiting times? What are the levels of care and intervention by GPs? Is the service showing value for money? Do you run a GPwSI Service?
The GP with a Special Interest (GPwSI) Service was decommissioned when the new service was started. Month on month figures are going down – 900 have been diagnosed this month. Blood glucose strips were expensive and costs have been reduced by 5% in this area alone. MS advised that clinical staff made a case to work with the acute trust and predicted savings around decommissioning approx £1m. Patients are being moved through the pathway quickly.
People often go to A&E because they can't get GP appointments or have no way of getting advice after hours.
Urgent cases are seen by the Hub although they do not have the medical history but they get a GP referral and access it this way. They would love to have an out of hours/walk-in services.
What are you doing in terms of preventing diabetes?
This is not part of the service remit but is a public health remit although it makes sense to be part of the service. Need a public health remit attached to a diabetes service.

Service Provision Session

Date of Session: 31 January 2013

Organisation: Clinical Services
Low Vision / Retinopathy Services
Community Nursing
Mental Health Services
Integrated Diabetes Service

Clinical Services
Works out of King George and Porters Avenue, previously Redbridge and GPwSI Service at Havering.
There are less and less referrals to hospitals as most patients are referred to Porters Avenue. Of all the referrals who come to hospitals only 10-15% of them are diabetics.
Cases are quite complex. After 3 consultations patients are usually discharged back to community services where despite new medication being prescribed in hospital the local GP often changes the medication. This is often due to changes in the NHS and hit and miss management.
Porters Avenue works reasonably well although it is not cheap to run. Patients get referred and are able to see everyone under one roof except retinopathy services. It is a very good services and a recent questionnaire to patients show an outcome of 98% satisfaction with the service.
Need to look at training of GPs with a special interest (GPwSIs) to ensure a direct result on outcomes for patients.
The GPwSI service started 3 years ago.
The prevalence of diabetes is increasing. In 2005 there were 5.4% of people known to have been diagnosed with diabetes, now that figure sits at 6.2% although it is more likely to be nearer 8% due to lifestyle and ethnicity changes in the Borough population.
80% of patients are treated in community practices. Some GPs are not interest or trained in diabetes and training should be ongoing. GPwSIs are a good model but not value for money as new standardized payments can vary across the country.

Low Vision Services / Retinopathy
Offer a service for people with learning disabilities to ensure that they receive appropriate eye care. The service is part of the Community Learning Disability Team.
Generally, people with learning disabilities have poorer health and there are approximately 550 known to the team.
People with Type 2 diabetes can develop sight loss via diabetic retinopathy.
There is a vision strategy group in the Borough which looks at issues associated with people with disabilities.
A Low Vision Service is available at Porters Avenue. There are moves to make it a more enhanced service by providing specialist services through opticians. The new service was recently approved by the Health & Wellbeing Board.
Diabetics should have annual retinol eye screening tests.
Not many people know the difference between a retinol screening and a standard eye test and this is one of the main problems in B&D. People used to get a full eye check which included a check for different diseases (including diabetes retinol screening) but in 2009 this changed and retinol screening became an independent test from the standard eye check. The service has found that many people who have the retinol test do not have a standard eye check so often miss being diagnosed with issues such as glaucoma. As a diabetic, people are not receiving the service they should be.
There is currently no link between opticians and retinol screening services so it is difficult to easily track whether a patient has had both tests.
There are 12 practices in Havering which carry out an enhanced service already, it works very well and this is the model B&D used until 2009. In Havering a patient can choose where they have their sight test done received the combined standard eye test and retinopathy test at the same appointment.
It was noted that there are some accessibility issues to the current service as it not commissioned as part of Porters Avenue.
The commissioning issue should be referred back to the commissioners.

This is similar to the Catalyst Scheme set up with opticians. There are potentially 600 people who could use this service but only approximately 140 have taken it up. It was suggested that the enhanced service was not doing very well in the Borough and this is often because the optician will need to see someone on 2-3 separate occasions because the tests can be quite frightening (e.g. eye drops and flashing lights).

Community Nursing

There are exclusion criteria around this service and that service users must have a learning disability (this excludes people with substance issues).

There are at least 7 people with learning difficulties at the Support Group which enjoy attending sessions but find it hard to understand what is being discussed and this can make things difficult for people with diabetes where they are required to understand issues around medication and self-management. As a result they often end up in and out of hospital.

A nurse attends the Support Group meetings and advised that this matter is a big concern. A diabetic nurse from Porters Avenue also attends the sessions and ensures that any service users are referred to Porters Avenue.

If a patient is required to go to a day centre their blood sugar levels are not monitored as there are no policies or training around this in the day centres. Staff at the day centres liaises with Porters Avenue to arrange staff training and look at what is being done for the service user.

Services try to take a person-centred approach and try to ensure that staff at the day centres understands that where a service user is displaying challenging behaviour that it may be due to the fact that they are diabetic and have low blood sugar levels.

A DES (Direct Enhanced Service) scheme is in place to provide training for GPs to enable GPs to provide an annual health check for people with learning disabilities. Those signed up must achieve their targets as part of the Health Action Plan (HAP).

For people who are living independently, some chose to have their annual checks and it is difficult to identify whether they have been until they have their annual HAP review. It would be useful to get a report of all people who have had tests to date.

Mental Health Services

S75 agreement for Mental Health Services includes general population and older adults with learning and psychological issues.
Physical and mental health is complex especially among Type 2 diabetics including staying connected, exercise, lifestyle and stress. There is no easy typology for depression as there is for other mental disorders such as schizophrenia but people with mental health issues are twice as likely to have Type 2 diabetes. Someone with Type 2 diabetes is twice as likely to suffer from depression due to the range of complex psychological needs associated with their condition.
There are a range of treatments in community services and in the Integrated Services to be able to detect and work with people with different psychological requirements including different people from ethnic backgrounds.
NELFT have a specialist psychological IAP service and works with GPs with less specialism in diabetes and a combined approach to physical and mental health with multi-disciplinary teams.
Integrated Diabetes Services
There are more sessions to work with people from BME which provide interpreters. Work with the voluntary sector to increase awareness at mosques and temples.
The Complex Care Clinic is a good way to look at all issues associated with a patient to reduce acute admission.
Increased confidence as a result of the DAFNE and DESMOND education programmes as well as a user group for patients.
There are also strong links with B&D Support Group who helped structure the services at Porters Avenue when the service was first set up.
Work with GPs to help improve diagnosis and identify people at risk.
The Integrated Care management service works with community teams to look after people with Type 2 diabetes.
Flexible clinic times (e.g. before and after work) help to improve accessibility.

General Comments
Need to support Public Health and health promotion strategies. The CCG need to improve diabetes management. NELFT should look to having a more generic team with a single access point to help reduce the need for referral.
The B&D Support Group would like to see more service progression and education of GPs and people generally. They also noted that they are grateful for the service and support provided by Porters Avenue to the B&D Support Group. They also believe that diabetics need a holistic package which includes physical, mental and clinical help as well as support groups.
Links with the CCG are essential as services should be developed with clusters.
There needs to be a focus on early intervention/detection as people can't work on self-management unless they know they have a condition.
The same applies for identifying diabetics in depression cases. Support is also needed for carers.
Education in care homes and for nurses in residential nursing homes/people with learning disabilities required.
On 30 January a representative from the B&D Support Group spoke at the Barking Job Centre to the disability advisers to help them understand about the impact of diabetes and how it affects patients and carers for example if someone misses an appointment because a family member had a diabetic episode it is a real issue for the carer.
There is a high risk group (people with learning disabilities) who need help cooking and are currently enrolled on college courses to gain cooking skills. Some also have diabetes but they are being taught to bake cakes. Educators need to change their way of teaching. Colleges also sell junk food but they should be helping people make healthier choices. Colleges give a different message to the client group than the community nursing teams.
Need to encourage GPs to send people to a DESMOND/DAFNE programme.
Need to think about how we get the message across to the broader population: • People at risk need a targeted approach • Social care – carers education

- Awareness of looking after people with alziehmers/dementia

Q&A SESSION NOTES

How we can improve links between services? Do we need an investigation into how we can improve the communications issue?

There is no holistic approach/communications between services. For example, although there is a retinopathy screening service at Porters Avenue the pictures are not sent to hospital staff if a hospital referral is made.

Advised that Havering have a computer system which allows them to do this.

What improvements need to be made? What are the next steps?

Things have improved having a health psychologist on board as it is important to help 'change behaviour'. Need to grow this service alongside other mental health teams.

Nursing/residential homes require staff training (and resources) for working with the elderly population to ensure they are getting the care they need.

Intervention is essential but also need to work with carers and train them to be able to give insulin injections in the future so that clients aren't required to wait in for a district nurse.

If someone has a problem but can't get hold of a GP they ring the emergency doctor who advises them to go to A&E. Help lines, especially for people living independently are necessary even just for advice.

Why is the Retinopathy Service at Porters Avenue is not as good compared to Havering?

The main issues are access/IT issues rather than the service itself.

Patients give good feedback about the retinol scan but it's more the issue of having to get the results from the patients or ringing the GP if the patient is referred.

Are there any GP's or anyone else it would be useful for HASSC to meet?

Dr Kalkat and Dr Goraparthi look at broad level service, possibly retinol screening personnel.
There are ways in which service could be improved. People do see that the work is being done properly but the issues around accessibility remain. Havering have a rate of 5% of people not taking up the Service, this is higher in B&D. She felt it worked better pre-2009.
Some patient's prescriptions get changed or take a lot of medication – who assess medication?
At hospital specialist take a holistic point of view as it diabetes affects different parts of the body different so different medications are recommended for each issue. Doctors recommend a biannual check up for medication for patients not on insulin and three times annually if the patient is on insulin.

Service Provision Session

Date of Session: 16 February 2013

Organisations: GP with Special Interest (GPwSI)
Retinopathy Services
Pharmacy Services

Pharmacy
Greater role for patients to take on responsibility for their own care.
Pharmacies and voluntary organisations could work together to provide more help to patients.
Pharmacists can help with lifestyle, management of minor ailments (Minor Ailments Scheme in B&D).
No difference between PG and Pharmacists in terms of dealing with long term medication.
Other areas for contribution could include providing education, self-care skills, benefits advice, care plans (these always end at surgery level) as well as what can be done in terms of preventing and support and communications.
Need to develop new skills to support patients locally. There is regular training available and up to 150 pharmacists attend regularly. But there is a need to ensure Continuing Professional Development (CPD).
There is a stage on medicines. Pharmacists try to look at reducing hospital admissions. They have looked at respiratory ailments and diabetes will be next.
Patients often have loyalty to the same Pharmacy/Pharmacist as they develop a relationship, especially those with long-term conditions.
Joint work between GP and Pharmacists needed. Each pharmacist can carry out up to 400 medication reviews each year. Pharmacists go through the disease and treatment as well as lifestyle choices.
Pharmacist can help with sign-posting services as they look at all of the patient's conditions.

Good practice examples e.g. weight management and vaccination at Tower Hamlets and Newham.
Need to publicise what pharmacists can offer.
No integrated system between the newly diagnosed to help them find their way around health and social care systems. Need to find a model to help people use the system effectively as well as working with carers and voluntary organisations and develop links with these groups.
There is a fundamental need to identify why people waste medication. It is largely down to support around changes in a healthy lifestyle and help with educating patients to self-management and self-care.
Patient satisfaction feedback from pharmacists indicate that more work is needed around repeat prescriptions and making the system easier for patients.
There is a role for pharmacists in terms of diabetes prevention. Access is not an issue as most people live within a 20 minute walk from a pharmacist and there are usually good opening hours including weekend services.
Pharmacists could help with screening diabetes patients.
Some pharmacists put up posters on a voluntary basis. The PCT has been asked to circulate information about reviews and new meds service – these will go out in the next few weeks. Some pharmacists also do prick tests for diabetes.
Retinopathy Service
Screen diabetics for eye problems, the sooner conditions are picked up the easier it is to treat them.
B&D and Havering had a diabetic eye screening programme with closed as the service had an uptake of only 47%.
The Homerton is in Hackney and a centralised fixed site at Porters Avenue.
A patient experience survey was undertaken at Porters Avenue in November 2012.

GP with a Special Interest (GPwSI)
Unhealthy eating habits as a child can cause an increased risk especially if the family has unhealthy habits. Made worse by obesity and lack of exercise.
If screening is done early on many could get diagnosed before the symptoms start.
Cycle of diabetes care: Diagnosis ⇨ look at lifestyle ⇨ refer to special education programme ⇨ medication ⇨ increase meds as diabetes progresses ⇨ complications (secondary care)
Public Health needs to help reduce diabetes prevalence especially in children and family units through school education and an increase in sports at school.
Need to ensure that we screen people early as age is a strong risk factor (40-74) for developing diabetes. People should be screen in this age group regularly but B&D do not screen enough. Should be using the pharmacies to help with the screening process. Last year pharmacists attended a mosque to carry out a screening event. Similar activities could be carried out in supermarkets/car parks. It is difficult for GPs to screen effectively but this activity could be commissioned in collaboration with surgeries/pharmacies.
There needs to be some work done around advertising to people that they need to be screened and reinforce the symptoms of diabetes.
There is a big variation relating to what happens in different GP surgeries e.g. some surgeries have a higher prevalence of diabetes but the practice is not doing a good job. This could be down to demographics, organisation of surgeries, and education of GP/practice nurses. Commissioners need to understand why there is such a variation in this area.
It is important to manage blood pressure and cholesterol levels. Patients need to be advised that there have double the risk of a heart attack and kidney problems if they have diabetes. We need to be reinforcing the seriousness of the disease and explaining the different issues. Providing leaflets to support and reinforce this would help as people only hear the first two points after receiving bad news. Dr Kalkat said that there is not enough money to do this but patient-friendly information and language issues in printed material need to be addressed.
Reinforce the DESMOND and other training programmes among patients as not enough people are being referred. Many patients don't realise they are entitled to attend.

People do not understand what to expect from GP/Nurses especially in annual reviews. EG feet checks should be done properly and the review should include reviewing footwear but due to time pressure this does not always happen which is unfortunate as foot problems are hard to treat.

Training sessions across the PCT (cluster-based) is already offered but is mostly based on medications and not enough education is given about providing holistic care and patient interview techniques. GPs need to know how to work with a patient's lifestyle to help them develop suitable self-management techniques.

Internet resources, email etc… are possible options especially an on-line user forum but there are confidentiality issues associate with this. Patients also need to understand what services are available before we could consider doing something like this.

Community Care - less than 5.5% of patients come to the clinic. Need to see a bigger impact in B&D and work closer with GPs and cluster practices. All services need to be more seamless so that all health professionals understand how to access the service.

Self Help is important as people are more likely to take their medication properly and be more prepared in their annual health review.

Additional comments sent by Dr Goriparthi after the HASSC meeting

Obesity epidemic - we need Public Health to:

a. help manage this problem and to work to reduce unhealthy dietary habits and inactivity in children and adults
b. work with schools to provide healthy meals, encourage healthy living lessons, and increase time for physical activity
c. work with family units to help with healthy habits if children are noted to be overweight
d. help poorer population to have affordable fruits and veg and sports centre passes etc
e. advertise healthy living messages at schools, pubs, parks, holy places etc

Pre-diabetes - make available intensive dietary physical activity courses to:

a. help people delay the conversion into full blown diabetes
b. GPs/practice nurses need to explain clearly the importance of healthy living to delay Diabetes and reduce complications in this group

Diabetes diagnosis - prevalence of Diabetes is increasing but still several people with

diabetes remain undiagnosed. GPs need to actively screen people with risk factors for diabetes early and we need to consider about other ways of screening people for diabetes e.g. at supermarkets, pharmacies, holy places, parks to catch people who do not routinely go to GP Surgeries.
Diabetes management - once diagnosed a good explanation from GPs/ Nurses needs to take place on more than one occasion to help patients understand Diabetes. We need to make available information booklets to give to patients so that they can read and understand further about what they discussed. All patients need access to proper education courses like DESMOND and all patients should be offered exercise referral.
Medication - GPs should make sure that the medication that they prescribe is working by repeating the blood tests appropriately and stopping medication if not effective regular audits to help this process.
Annual reviews - GPs/nurses have to explain to the patients about the purpose of the annual review and what to expect. Booklets to explain what happens in the annual reviews are essential as significant no. of people do not seem to understand what to expect. Locally we are very low in the percentage of people getting annual reviews and there is significant variation across different practices. We need to better understand why this is so, and we need to encourage patients to attend and encourage GPs to make sure that they maximise the no. of annual reviews that they do.
More **seamless pathway** for the patients across the different Tiers of service is essential. It would be better for more patients to be managed within their GP surgeries. The CCG is looking into GPwSIs and DSNs are considering how to work more closely with practices to support them.
Special groups - we need to identify people who would require a different type of service that routine service will not be able to provide. People who are housebound or with Learning difficulties or with palliative care needs and we need to work closely with the teams looking after these people to better identify their needs and improve the support that Diabetes services can provide people with significant medical problems like Kidney or Heart need. More closely working across different department's people with significant language barriers will need to have easy access interpreting services -already available and working people need services outside the normal working times. Diabetes affects young working people and needs several appointments over the year. It is hard for people to keep taking significant time of work to attend these day time appointments.
CCGs already looking at how to use peer-led education support and pressure to help reduce variation and improve the service offered by the GPs.

No. of GPwSIs - I have conflict of interest so, I am not the right person to discuss this but it would be important for the members to consider what the role of GPwSI would be in the future is the role is to see and manage patients at Tier 2 level (higher than usual GP care) like we are doing now or is the role in the future to work more closely with practices, train local GPs/Nurses to help them manage their Diabetic patients at Tier 2 Level.

Consultant/Secondary care support - we would need more consultant time and support to help oversee the local services for Clinical Governance some other areas had more consultant input and have shown that this can help create closer links between primary and secondary care and helped reduce the need for patients going to hospital.

Special GPs – Work closely with the LD team and outbound patients or where English is not the first language as approach needs to be different. Working people require extended surgery hours including late nights and weekends to increase access to services.

Other Issues

Member comment: We need to make sure that the report states that the survey is not representative of all diabetes patients.

Pre-diabetes, patients have a slightly elevated blood sugar level. We need to identify how we can organise a co-ordinator programme for pre-diabetes patients.

Q&A SESSION NOTES

Pharmacists do a good job and there is a good link between pharmacists and patients. The relationship building element has gotten better and they are very helpful and friendly. We would like to see better integration between pharmacists and GPs.

The patient repeat prescription service makes it more complicated for patients to get a repeat prescription especially if the medication is not in good supply and they have to wait for it to be ordered.

Pharmacists could also do things such as peak flow tests and check that the condition is being controlled. There has been a 60% increase in prescriptions over the past 10 years and there is a strategy to train technicians and a contract with Barking College for an apprentice scheme (the aim is to get 200 people onto the apprentice scheme) to increase

the number of pharmacists.

IAP leaflets: Work has started to trial this and it has gone very smoothly. All pharmacists are trained to give proper support to patients as well as giving out leaflets and sign-posting people to the correct place.

Need to strategically review the care pathway to ensure that all the relevant players (including pharmacy) are included and understand how pharmacists can offer support through pathways (e.g. new meds service, meds use reviews. Because work is not co-ordinated between the GP-Pharmacist-Patient, activities appear to produce no real outcome. Should advise the patient to get a med use review from the pharmacist before a request for a repeat prescription is made.

Member Comments

Member Question about Results sharing

Response: There is a national stand to report results to patients within 3 weeks and to cc the GP. There is an 87% achievement rate for this target in B&D.

Member Comment: It is nice to see B&D have a high achievement rate for sharing retinopathy screening results. At the last meeting it was indicated that our service does not perform as well as Havering. It was also said that pictures were not sent to Queens as this was not possible with the current system.

Response: This is not true as there is a web-based programme that any doctor can request a login for to obtain the pictures. Every diabetes patient is advised to see an optician annually but if urgent action is required they are automatically referred to an ophthalmology department.

Member Question: What is the difference between annual optician and retinopathy service tests?

Response: In the previous service, opticians did the diabetes test as well as the standard eye test. Opticians now just do the general eye health check and sight test. Retinopathy is not done as part of the standard check as there are different standards for retinol screening. There are double checks I the retinopathy screening service to ensure quality assurance.

Member Question: It is important that exercise and healthy living are part of the self-management process. What can GPs do to promote this?

Response: GPs ask how much patients currently engage in but more could be done to

explore this issue with the patient. In 2010 there was a booklet of exercise schemes across the borough which was sent to GPs and was helpful when GPs gave advise to patients. However, this book hasn't been updated so it's difficult to sign-post services without knowing what's still available.

Member Question: The Adult College could do out-reach work in PA or at the new Ripple Road Centre. Could be used to do some of this work?

Response: It would be good to see a central telephone number which patients could ring to understand choices and services available.

Member Question: Is there any rationalisation of medication?

Response: Sometimes medications are no longer effective. There was an audit carried out last year to look at effectiveness of medication after 6 months or at least at the point of the annual health review.

Member Question: Where there are side-effects do GPs advise patients of the most serious or common ones?

Response: Yes they do.

Meeting with Chairs of the Barking & Dagenham Clinical Commissioning Group and Health & Wellbeing Board

Date of Session: 6 March 2013

Representatives: Cllr Maureen Worby, Chair of the Health & Wellbeing Board
Dr Waseem Mohi, Chair of the Barking & Dagenham Clinical Commissioning Group

Q&A SESSION NOTES
How high is diabetes on the Health & Wellbeing Board's (H&WB) list of priorities?
There is no special priority per se as the approach of the Health & Wellbeing Strategy is based on life stages and diabetes will have a role to play in each of those stages. The H&WB Board welcomes the focus of HASSC and money has been put aside to look at diabetes, although not as much as HASSC would like to see. It is important not to let diabetes slip through the net. The H&WB Board will wait to see a more detailed action plan.
With a predicted increase of 50% in the prevalence of Type 2 diabetes, what improvements will H&WB make?
H&WB need to get the processes right. Promotion and prevention work to catch it early on and ensure that people take diabetes seriously. The Board hopes to tackle some of the causes of Type 2 diabetes such as obesity/age-related issues/smoking. There needs to be joined up thinking around prevention work which will have a knock on effect of reducing Type 2 diabetes prevalence.
The CCG has signed up for health improvement plans to identify gaps in 2013/14. An audit, led by Dr Kalkat, is already underway to investigate this. There has been no improvement in care despite commissioning a community service. Detection and early treatment of diabetes is important and we need to make sure that people get the message early. Patient education in GP practices and community services needs to be smarter and the CCG will work with the H&WB Board to identify how we can better target information.
The health picture for the borough is changing rapidly and we need to understand the scale of the problem. Detection and prevention during childhood is increasing. We need to be able to identify groups of people via primary health care teams and look at ways of improving the health of these groups. Health checks in some practices are very advance

although poor in others especially around the nine annual diabetic health checks. A peer review scheme has been developed to look at practices which are underperforming and providing training for GPs and practice nurses as part of the continuous review of process.

There is a lack of posters in GP practices and hospitals which raise awareness of early diagnosis. Is there also any automatic testing for diabetes in the same way people are automatically tested for HIV?

Patients over 14 years old are entitled to free health checks, and this includes a screen for diabetes. There is a need to get the message to young people as although a majority of people diagnosed with Type 2 diabetes are over 40 years old, a small number of patients are as young as 16.

Recent work has been done in collaboration with the Barking and Dagenham (BAD) Youth Forum. This group may be able to advise how to get the message to a young age group. IT might be worth considering commissioning BAD to do some work for us around lifestyle advice.

People are not routinely tested for HIV whenever they provide a blood sample. Only people donating to a blood bank or using maternity services are routinely tested.

Can the CCG confirm that they are committed to funding literature?

Literature is already available on computer for GPs to print off in the surgery. Packs of literature on diabetes are also delivered by Pharmaceutical companies.

The current packs are being reviewed at present to ensure the information is up to date as they were designed 4-5 years ago. 10,000 packs were distributed 2 years ago.

The B&D Support Group found that despite GPs having high stocks of the packs, none of their members were ever offered one. The group has also never been asked to participate in a focus group with the CCG.

A recent survey revealed that there needs to be better work with patients and the CCG is looking at membership of the Health Improvement Partnership as part of this.

What work is being done to target people with mental health issues who have diabetes?

A lot of work is being done with GPs to ensure people with mental health issues have

annual health checks.
General practices target all mental health patients to ensure that they have annual health checks as well as the diabetes health checks as medications can often cause diabetes. IAP services are also accessible for diabetic patients due to high levels of depression.
We need to understand what the baseline is in order to better gauge how to target groups. How do we target specific groups and deliver services to those groups?
What can we do to improve services? How can we help get information to the newly diagnosed?
The H&WB Board do not deliver services directly. The CCG is responsible for delivering and commissioning services. H&WB Board can try to influence what the CCG commissions and it can monitor performance and hold the CCG to account.
Diabetes is a recognised problem for community services and there are also other issues which affect the health economy of patients and this affects what the system can do. Health checks can be advertised along with the range of services we can offer. Maintaining quality of care is important and the CCG are looking at prescribing efficiency across ONEL and to ensure that good use is being made of the DESMOND programmes as well as improving patient/public engagement about diabetes.
There remains an issue of an out-of-hours service as many people are told to go to A&E when they phone for support.
Diabetes underpins the integrated case management strategy and is fundamental to the strategy going forward. Diabetes needs to be dealt with in an integrated way in order to keep people out of hospital.
Maintenance of diabetics within the community is essential as if a patient goes to A&E they will be admitted to hospital. Reacting to diabetic patients is critical.
The committee has heard evidence from patients and GPs that the 9 annual tests are not all carried out well for example foot checks. They also found that a patient's ability to take in information when they are first told that they have diabetes is limited. The CCG need to look into this and consider how this will be tackled in future work. A report will go to H&WB Board to consider this as part of the priorities for 2014 so there is some time to undertake further investigations into this issue.

Routine MOT health checks can help to detect diabetes. At a national level, only 50% of diabetics are shown to receive the 9 annual diabetic health checks. In a recent review, many GP practices were above this figure but there are also a lot falling below it. This information has been shared with GPs in a league table in order to encourage peer reviews.

Appendix 2 Diabetes Survey

We are reviewing the diabetes services across Barking and Dagenham and we would like you to tell us about how you manage your diabetes, what services you use and what else you think we should be offering. Your response will help us make recommendations to the Council's Cabinet about how services could be improved.

We would really appreciate it if you would take 10 minutes to answer a few questions.

Everything you tell us will be kept completely confidential, and will only be used as part of this review.

To thank you for completing the survey, you will have the chance to enter a prize draw to win an iPod Shuffle. The competition will close on the 4 January 2013 and the winner will be presented with their prize at Barking Town Hall during January 2013.

To enter, please provide your name and contact telephone number below and tick the box to confirm that you would like to enter the draw.

☐ Please tick if you would like to enter the prize draw

Name: .....

Contact Number: .....

If completing it on paper, please hand your survey back to the surgery reception

If you would like to complete this survey on-line please go to the following link:

http://www.lbbd.gov.uk/DiabetesSurvey

For office use	
Ref.	

London Borough of Barking & Dagenham

1. How are you affected by diabetes? *(tick all that apply)*

☐ I have diabetes ***(Please jump to Section 1 below)***

☐ I look after someone with diabetes ***(Please jump to Section 2 on page 5)***

Section 1

2. How long have you had diabetes?

☐ 0-2 years
☐ 3-5 years
☐ 6-10 years
☐ 11-15 years
☐ 16-20 years
☐ 21 years and over

3. What type of diabetes do you have

☐ Type 1
☐ Type 2

4. How do you manage your diabetes? (tick all that apply)

☐ Insulin
☐ Physical Activity
☐ Medication
☐ Other (Please indicate
☐ Diet

……

5. If you selected "Medication" in Question 4, please state which medication you take

……

6. How helpful was your GP when you were first diagnosed?

Not helpful	Not very helpful	Helpful	Very Helpful
☐ My GP gave me no explanation or information	☐ My GP didn't give me very much information	☐ My GP gave a brief explanation	☐ My GP took time to explain diabetes to me

7. When you visit your GP do you:

	Never	Almost never	Sometimes	Fairly often	Very often	Always
Prepare a list of questions for your GP?	☐	☐	☐	☐	☐	☐
Ask questions about the things you want to know?	☐	☐	☐	☐	☐	☐
Ask questions about the things you don't understand?	☐	☐	☐	☐	☐	☐

8. Who gave you information about your diabetes? (tick all that apply)

- ☐ GP
- ☐ Hospital
- ☐ Family/Friend
- ☐ Nurse
- ☐ Local Diabetes Support Group
- ☐ Other *(please specify below)*

.....

9. What sort of information did they give to you? (tick all that apply)

- ☐ Information about diabetes
- ☐ Dietary information
- ☐ How to manage my diabetes
- ☐ Other *(please specify)*
- ☐ Information about diabetes medication
- ☐ How to live with diabetes
- ☐ Long term health impacts of diabetes

10. Was this information helpful? (Please circle the one which applies)

☐ Not at all helpful ☐ Not very helpful ☐ Fairly helpful ☐ Very helpful

Please tell us what was helpful or unhelpful about the information you received?

.....

.....

.....

11. Have you developed more health issues as a result of your diabetes?

☐ Yes ☐ No ☐ I didn't know that might happen

12. If you answered "Yes" to Question 12 please say what health problems you have developed

- ☐ Vision problems
- ☐ Circulation
- ☐ Other problems *(please specify below)*
- ☐ Kidney problems
- ☐ Liver problems

.....

.....

13. Do you think they could have been avoided if you had received better advice and information about diabetes?

- ☐ Yes — If I had understood the consequences I would have managed my diabetes better
- ☐ No — I don't manage my diabetes
- ☐ Don't Know

14. Which of the following services have you heard of (tick all that apply)

Heard of	Used this service	
☐	☐	Porters Avenue Integrated Diabetes Service
☐	☐	Barking & Dagenham Diabetes Support Group
☐	☐	Diabetes UK

15. Which of the following programmes have you heard of (tick all that apply)

	Heard of	Have attended	Not heard of
DAFNE (Dose Adjustment for Healthy Eating)	☐	☐	☐
DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed)	☐	☐	☐

16. If you have attended did you find these programmes useful?

	Not at all helpful	Not very helpful	Fairly helpful	Very helpful
DAFNE	☐	☐	☐	☐
DESMOND	☐	☐	☐	☐

17. If you haven't attended a programme please indicate why not?

☐ The time/day was inconvenient
☐ The location was inconvenient
☐ Nobody offered it to me
☐ I do not like group training
☐ Other reason – please state

18. Do you have annual check-ups for your diabetes? (tick all that apply)

Check up	Annually	Sometimes	Never been checked	Didn't know I should
Blood pressure	☐	☐	☐	☐
Cholesterol level	☐	☐	☐	☐
Eye check	☐	☐	☐	☐
Leg and feet check	☐	☐	☐	☐
Kidney check	☐	☐	☐	☐
Weight check	☐	☐	☐	☐
Support for smoker	☐	☐	☐	☐
Personal health and care plan	☐	☐	☐	☐

Section 2 – Only complete this section if you look after someone with diabetes

19. Have you received any emotional support or counselling as a carer of someone with diabetes?

	Heard of	Used this service	Not heard of
Porters Avenue Integrated Diabetes Service	☐	☐	☐
Barking & Dagenham Local Involvement	☐	☐	☐
Patient Advice and Liaison Service (PALS)	☐	☐	☐
Barking & Dagenham Diabetes Support Group	☐	☐	☐
Diabetes UK	☐	☐	☐

20. Do you think you have been given enough information about looking after someone with diabetes

	None	Too little	About right	Too much
Amount of information received on diagnosis	☐	☐	☐	☐
Amount of information received since diagnosis	☐	☐	☐	☐

21. Do you feel confident in administering medication for the person you are caring for?

Not at all confident	Not very confident	Fairly confident	Very confident
☐	☐	☐	☐

22. Please add any other comments below:

.....

.....

.....

Thank you for completing this diabetes survey.

We can make much better use of the information if we know a little about you. Please could you take a minute to answer the 'about yourself' questions on the next page?

If you would like to receive more information about the DAFNE or DESMOND programmes or would like to know more about the services offered at the Porters Avenue Integrated Diabetes Service please contact Porters Avenue on:

Tel: 020 8522 9826

e-Mail: diabetes.bdchs@nhs.net

Please tell us a little about yourself

(a) How old are you?

Under 20		40 – 59	
20 – 39		60 – 74	
		Over 75	

(b) What is your ethnic group?

WHITE	
English/Welsh/Scottish/ Northern Irish/British	
Irish	
Gypsy or Irish Traveller	
Any other White background	
MIXED	
White & Black Caribbean	
White & Black African	
White & Asian	
Any other Mixed/ multiple ethnic background	
ASIAN or ASIAN BRITISH	
Indian	
Pakistani	
Bangladeshi	
Chinese	
Any other Asian background	
BLACK or BLACK BRITISH	
Caribbean	
African	
Any other Black/ African/ Caribbean background	
OTHER ETHNIC GROUP	
Arab	
Any other ethnic group	

(c) Gender

Male		Female	

(d) Do you consider yourself disabled?

No	
Visual impairment	
Speech impairment	
Wheelchair user	
Mental health issues	
Hearing impairment	
Restricted mobility	
Learning difficulty	
Other hidden impairment (please specify)	

(e) Are you a carer?

Yes		No	

If Yes, do you care for….

Disabled person in your family	
Older family member	
Child/ren under 14 years	

(f) What is your sexual orientation

Heterosexual	
Gay man	
Lesbian	
Bisexual	
Other (please specify)	

(g) Do you identify, or have you ever identified, as "Transgender"?

Yes		No	

(h) What is your religion?

No religion	
Christian (all denominations)	
Buddhist	
Hindu	
Jewish	
Muslim	
Sikh	
Other religion (please specify)	

(j) Is English your first language?

Yes		No	

(k) What is your level of fluency in English?

	1 = Poor				5 = Fluent
Reading	1	2	3	4	5
Speaking	1	2	3	4	5

(i) What is your postcode

THANK YOU FOR COMPLETING THIS DIABETES SURVEY

For office use	
Ref.	

Appendix 3 Findings from the Patient and Carer Survey

1.1 Who Took Part in the Patient and Carer Survey?

The survey was aimed at people with Type 2 diabetes and carers of people with diabetes. Responses from LBBD staff were also accepted, but are not the main focus as they may not be residents in the Borough

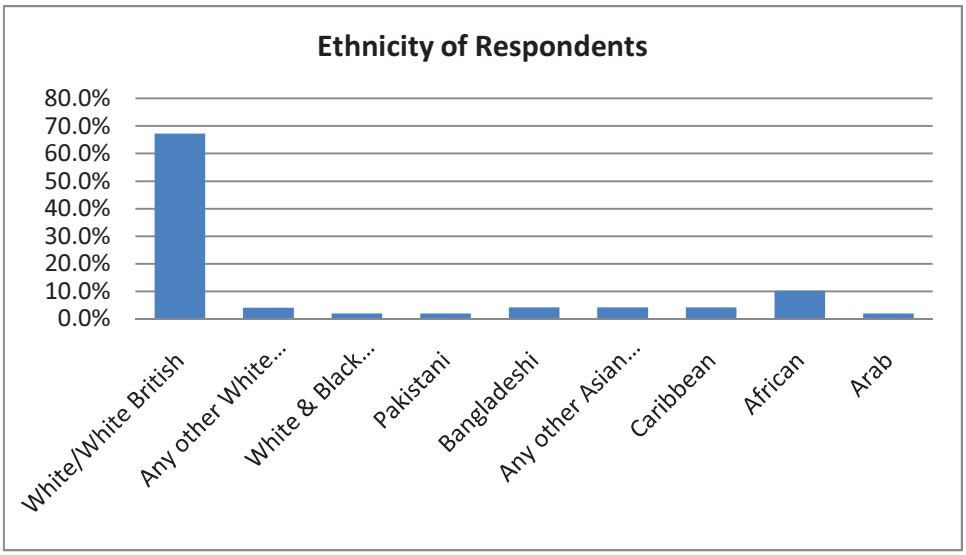
1.2 Patients

1.21 Age and gender

The age range of the respondents was between 40-59 (44%) and 60-74 (38%) which is in line with the expected age range of people most likely to develop Type 2 diabetes. There were very few respondents under 40 (12%). A majority of the respondents were female (40%).

1.22 Ethnicity

A large proportion of the respondents were White/White British (67.3%). The ethnic groups which are most likely to develop Type 2 diabetes (Black Caribbean, Black African and Asian) were not well represented among the respondents as indicated in the chart below:

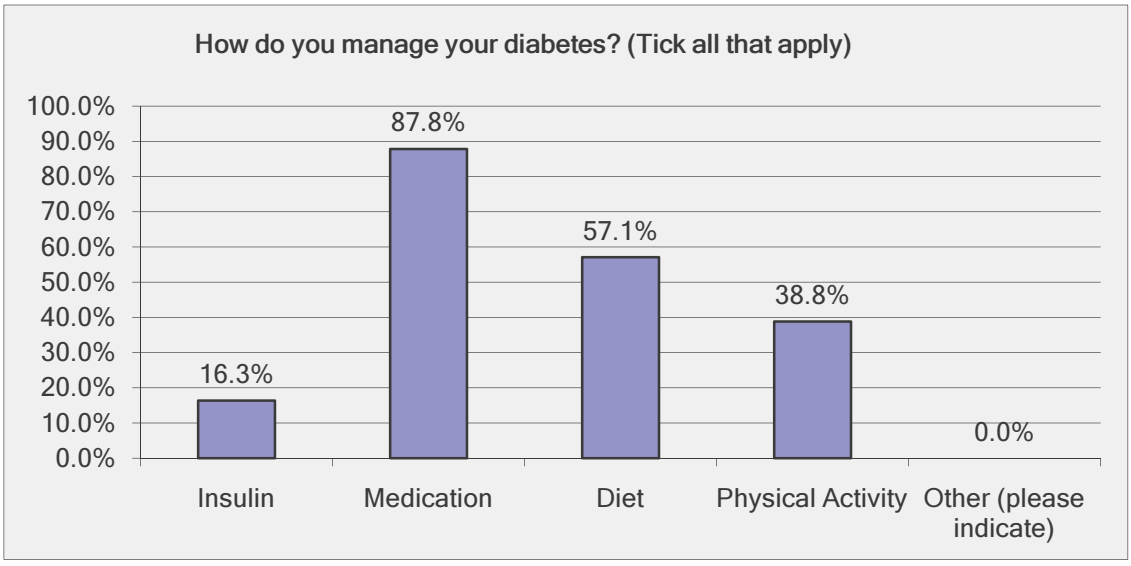


1.23 How long have you had diabetes?

The majority of the respondents have had their diabetes between 6-10 years (36%) with only a small proportion of respondents who participated in the survey being diagnose over 21 years ago (4%). It is interesting to note that during the patient perspective session many of the respondents attending had been diagnosed between 15-20 years ago and the information available to them at point of diagnosis was markedly different to those diagnosed 10 years ago or less which leads Members to conclude that the quality of information has improved over the past 10 years.

1.24 Type of Medication

87.8% of the respondents indicated that they were taking medication for their diabetes and at least 84.2% of these were taking Metformin, although some are taking a combination of diabetes drugs such as Meformin and Sitagliptin.



1.25 Annual Check ups

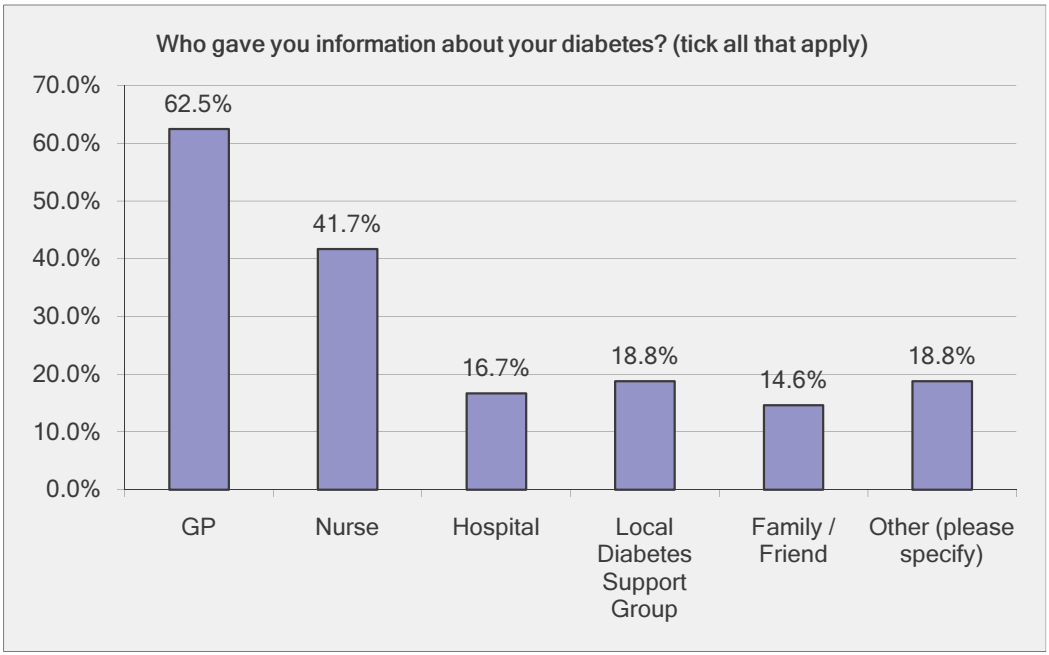
The resonses for annual check ups among respondents was fairly good especially for retinol screening (98%). Only 71.4% had annual feet checks which was identified as an area of concern by Diabetes UK. Also very low, was the number of respondents having an annual care plan review (26.5%). Care plans was identified by Pharmacists as one of the key areas in which support could be offered to people living with Type 2 diabetes as this was one of the ways in which patients could improve self-management of their condition.

1.26 How helpful was your GP when first diagnosed?

At the patient perspective session representatives indicated that they did not receive very positive support and information from their GP. Those attending the session were generally diagnosed between 15-20 years ago. The survey indicated that this trend has now changed and that people generally feel that their GP is very helpful (38.3%) or helpful (40.4%) with only 8.5% saying that their GP was not helpful.

1.27 Who gave you information about your diabetes?

In contrast to the patient perspective session, many of the respondents 62.5% said that they got their information about diabetes from their GP. However, one of the areas of concern from service providers was that while there is good quality information available through GP surgeries, there are not enough leaflets provided to surgeries. Members suggest that commissioners may wish to review the quantity of information provided.



What is also worth noting is that GP surgeries are also working with patients on issues such as dietary information (66%), managing their condition (78.7%) and the long term health impacts of diabetes (53.2%)

1.28 Development of further health issues

41.7% of the respondents had developed further health issues, mostly relating to neuropathy and foot conditions. Only 2.1% of respondents did not realise that long-term complications were possible which indicates that a majority of patients are aware of the importance of managing their condition to prevent further health issues.

1.29 Services and Support

69.6% of the respondents had either heard /and or used services at Porters Avenue, which included education programmes such as DESMOND with 52.9% of those who said they attended saying that it was very helpful. 54.3% of the respondents used the B&D Diabetes Support Group which offers support for people living with diabetes of 50+.

1.3 Carers

1.31 Support and Counselling

16.1% of the respondents cared for someone with diabetes and of that number none had received support or counselling and under half had received information about diabetes since diagnosis of the person they cared for.

1.32 Administering Medication

One of the concerns carers who attended the patient perspective session had was they did not always feel confident in administering medication because they had received little advice about doing so. The survey indicates that 28.6% of carers who responded did not feel very confident and only 57.1% feeling fairly confident.

Members suggest that some further work around information/education for carers may be required.

1.4 Conclusions from the Survey

Members found that the survey suggests that on the whole, those who responded were satisfied with the information they received at diagnosis and from their GP although commissioners may wish to consider increasing the amount of printed information available in GP surgeries.

Patients and GPs also appear to be very poor in terms of reviewing care plans annually, although it is not clear if this is because the GP did not include this as part of the review process or if patients are not aware that it should be reviewed annually.

There also needs to be a review of the information and support offered to carers. This was raised during the patient perspective session and the survey indicates that carers are receiving very little education particularly around administering medication.

Appendix 4 Overview of the National Standards Framework for diabetes

The National Service Framework for Diabetes includes standards, rationales and key interventions which should be taken into account when planning services. The standards are summarised below.

Prevention of Type 2 diabetes

Standard 1
The NHS will develop, implement and monitor strategies to reduce the risk of developing Type 2 diabetes in the population as a whole and to reduce the inequalities in the risk of developing Type 2 diabetes.

Identification of people with diabetes

Standard 2
The NHS will develop, implement and monitor strategies to identify people who do not know they have diabetes.

Empowering people with diabetes

Standard 3
All children, young people and adults with diabetes will receive a service which encourages partnership in decision-making, supports them in managing their diabetes and helps them to adopt and maintain a healthy lifestyle. This will be reflected in an agreed and shared care plan in an appropriate format and language. Where appropriate, parents and carers should be fully engaged in this process.

Clinical care of adults with diabetes

Standard 4
All adults with diabetes will receive high-quality care throughout their lifetime, including support to optimise the control of their blood glucose, blood pressure and other risk factors for developing the complications of diabetes.

Clinical care of children and young people with diabetes

Standard 5
All children and young people with diabetes will receive consistently high-quality care and they, with their families and others involved in their day-to-day care, will be supported to optimise the control of their blood glucose and their physical, psychological, intellectual, educational and social development.

Standard 6
All young people with diabetes will experience a smooth transition of care from paediatric diabetes services to adult diabetes services, whether hospital or community-based, either directly or via a young people's clinic. The transition will be organised in partnership with each individual and at an age appropriate to and agreed with them.

Management of diabetic emergencies

Standard 7
The NHS will develop, implement and monitor agreed protocols for rapid and effective treatment of diabetic emergencies by appropriately trained health care professionals. Protocols will include the management of acute complications and procedures to minimise the risk of recurrence.

Care of people with diabetes during admission to hospital

Standard 8
All children, young people and adults with diabetes admitted to hospital, for whatever reason, will receive effective care of their diabetes. Wherever possible, they will continue to be involved in decisions concerning the management of their diabetes.

Diabetes and pregnancy

Standard 9
The NHS will develop, implement and monitor policies that seek to empower and support women with pre-existing diabetes and those who develop diabetes during pregnancy to optimise the outcomes of their pregnancy.

Detection and management of long-term complications

Standard 10
All young people and adults with diabetes will receive regular surveillance for the long-term complications of diabetes.

Standard 11
The NHS will develop, implement and monitor agreed protocols and systems of care to ensure that all people who develop long-term complications of diabetes receive timely, appropriate and effective investigation and treatment to reduce their risk of disability and premature death.

Standard 12
All people with diabetes requiring multi-agency support will receive integrated health and social care.

Overview of the National Standards Framework

Newly diagnosed patients should receive the following from their diabetes care team:

- A full medical examination.
- An agreed care plan.
- An appointment with a diabetes specialist nurse (or practice nurse) to explain what diabetes is and discuss individual treatment and the equipment needed.
- Agreed named healthcare professional to contact for support, advice or more information, if needed.
- An appointment with a state registered dietitian, to discuss usual diet, advice on how to match diet with diabetes - a follow-up meeting should be arranged for more detailed advice.
- Discuss the beneficial effects of a healthy diet, exercise and good diabetes control.
- Discuss the effects of diabetes on work, driving, insurance, prescription charges, and if the patient is a driver, whether they need to inform the DVLA and insurance company.
- Provide regular and appropriate information and education, on food and footcare for example.
- Refer to a structured education programme meeting national criteria.
- Provide information about Diabetes UK services and details of local Diabetes UK voluntary group.
- Refer to a psychologist should the person need to discuss how to cope with the diagnosis/condition.

If treated by insulin injections patient should:

- Have frequent visits demonstrating how to inject, look after insulin and syringes and dispose of sharps (needles). Also how to test blood glucose, test for ketones and be informed what the results mean and what to do about them.
- Be given supplies of, or a prescription for the medication and equipment needed.
- Discuss hypoglycaemia (hypos): when and why they may happen and how to deal with them.

If treated by tablets the patient should:

- Be given instruction on blood or urine testing and have explained what the results mean and what to do about them.
- Be given supplies of, or a prescription for the medication and equipment needed.
- Discuss hypoglycaemia (hypos): when and why they may happen and how to deal with them.

If treated by diet alone the patient should:

- Be given instruction on blood or urine testing and have explained what the results mean and what to do about them.
- Be given supplies of equipment needed.
- Be offered nutritional advice.

Once the diabetes is reasonably controlled, the person should:

- Have access to their diabetes care team at least once a year - to discuss how diabetes affects them as well as diabetes control.
- Be able to contact any member of the diabetes care team for specialist support and advice, in person or by phone.
- Have further education sessions when they are ready for them
- Have a formal medical annual review once a year with a doctor experienced in diabetes.

On a regular basis, the diabetes care team should:

- Provide continuity of care, ideally from the same doctors and nurses.
- Work to continually review the care plan, including diabetes management goals
- Ensure the person shares in decisions about treatment or care.
- Enable the patient to manage thier own diabetes in hospital after discussion with the doctor, if they are well enough to do so and that is what you wish.
- Organise pre and post pregnancy advice, together with an obstetric hospital team, if the person is planning to become or already are pregnant.
- Encourage a carer to visit with the person, to keep them up to date on diabetes to be able to make informed judgements about diabetes care.
- Encourage the support of friends, partners and/or relatives.
- Provide educational sessions and appointments.
- Give advice on the effects of diabetes and its treatments when the person is ill or taking other medication.

Appendix 5 - Site Visit 'Menu of Involvement'

Site visits to the following locations were organised for Members as part of the diabetes scrutiny review.

ORGANISATION	ORGANISATION DETAILS	DATE	TIME	LOCATION	EVENT	EVENT DETAILS	ATTENDING MEMBERS
B&D Diabetes Support Group	The B&D group was set up in 2003 and provides an opportunity for people with diabetes and carers of people with diabetes to meet to discuss issues relating to medication, diet and long term issues associated with diabetes. The group specifically deals with diabetics over the age of 50. There is regular attendance by health care professionals who provide advice and information.	11-Feb-13	8 to 9.45pm	Dagenham and Redbridge Football Club Victoria Road Dagenham RM10 7XL	Foot and leg ulcers – complications and impact	Meet with patients and carers to discuss some of the different issues faced by diabetics and carers of people with diabetes.	Cllr Alasia Cllr McKenzie Cllr Wade
Integrated Diabetes Service	The team helps patients to develop their knowledge and understanding about diabetes, controlling long-term condition. Includes patient education programme (DESMOND) and 3 clinics: Complex Care Clinic, Individual Patient Support and Intervention Clinic, diabetic Retinopathy Screening Clinic.	19-Feb-13	11:30-2pm	Porters Avenue	Complex Care Clinic Individual Patient Support and Intervention Diabetic Retinopathy Screening Clinic	Meet with service providers about the different clinics and programmes being offered to patients with diabetes.	Cllr McKenzie Cllr Salam

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Diabetes Action Plan – from Health & Adult Services Select Committee May 2013

Number	HASSC recommendation	Process Involved	Responsible Officer	R / A / G	Progress
1	It is recommended that a future iteration of the Joint Strategic Needs Assessment (JSNA) provides a clearer account of the source of competing data and the 'best estimate' that the borough is using to monitor its progress and identify the challenge it faces in addressing undiagnosed diabetes.	Next JSNA clearly defines current prevalence, estimated actual prevalence in terms of percentages and numbers including referencing from whence come the figures. Clearly identify the target that is being used to monitor progress and trends. Provide definitions and simple explanations.	Matthew Cole	A	In the plans for next iteration of JSNA. Refresh section when next tranche of annual diabetes data released.
		Identifying the challenges in finding people with undiagnosed diabetes. Increasing diagnosis is a complex process involving public awareness, unique patient factors and healthcare related factors.		G	Will need an evidence based plan to be written and tasks to be apportioned.
2	It is recommended that a programme of proactive screening opportunities is established, linked to improved entry routes to an integrated diabetes care pathway, with more medical professionals seeking opportunities for the proactive identification of diabetes in their patients and service users, and for GPs to take a more pro-active role in diagnosis.	Programme for proactive screening is established.	Dr Sue Levi	G	Diabetes diagnosis included in the NHS Health Checks programme. Audit number of newly diagnosed diabetics annually as have been doing (36 diagnosed in 2012/13) Promoting Health Checks via volunteer networks and Health Champions.

3	Specifically, it is recommended that action is taken to improve patients' understanding of the annual diabetes health checks, what they should expect to receive, and their importance in preventing complications.	Example: Ensure B&D Diabetes Support Group and other diabetes patient engagement fora receive regular refresh on 'What they should expect from Medical Care'.	Diabetes Long Term Conditions service at NELFT to include small public awareness function. CCG write in contract	R	
4	It is further recommended that the CCG takes steps to ensure that all clinicians are familiar with the NICE recommendations for the Annual [Diabetes] Health Check and have arranged the provision of high-quality interventions, with associated processes for prompt arrangement of patient appointments and their reminders.	Encourage all GPs to refer people with newly diagnosed diabetes. Attend patient education sessions (DAFNE or DESMOND) within 6 months of new diagnosis. Ensure commission sufficient capacity of DAFNE and DESMOND courses.	Sharon Morrow (CCG) via Dr Kalkat & Primary Care Improvement Group. Include and monitor via diabetes Long Term Conditions service	R	
		It is further recommended that the CCG takes steps to facilitate clinician familiarity with the NICE recommendations for the Annual (diabetes) Health Check and awareness of best practice on performing checks, subsequent interventions and follow up.	Sharon Morrow (CCG) via Primary Care Improvement Group	R	
		Continued defining of CCG powers to influence practice performance. Enrolling Clinical Champions and Primary Care Improvement Group to produce incremental improvements in care.	Dr Sue Levi / Primary Care Improvement Group	A	Ongoing process

		Director of Public Health (DPH) to write to the Quality and Outcomes framework administrators and NICE in official capacity to attempt to move remuneration onto annual checks rather than 15 monthly checks.	Dr Sue Levi / Matthew Cole	R	
		DPH to write to NHS England to highlight problems in Primary Care diabetes performance and invite comment on how performance management might be improved.	Dr Sue Levi / Matthew Cole	R	
5	For the longer term, it is recommended that the data is improved and the baseline for understanding uptake of the nine health checks is brought up to date, with on-going robust monitoring thereafter	Chief Operating Officer (COO) of CCG to ensure that H&WB sees aggregate data of National Diabetes Audit as soon as available in next round. COO of CCG to investigate if feasible and/or desirable via Health Analytics.	Sharon Morrow	A	National survey with annual retrospective publication. The data is not held locally and extraction would be complicated and involve confidentiality issues as well as have resource implications.
6	The Committee recommends that the whole range of information provided to people already diagnosed and people newly diagnosed with Type 2 diabetes is reviewed, ensuring that it gives them what they need to know to improve self-management of their diabetes and their understanding of long-term complications.	Patient consultation via Healthwatch to define exactly what information is required beyond the diabetes booklet, 1 to 1 clinical attention and public domain sources.	Healthwatch / Sharon Morrow	A	Diabetes booklets have been revised and distributed to practices. Still need to promote their use in practices, pharmacies and community services.

7	That the Health & Wellbeing Board facilitates consideration of how young people with diabetes (either Type 1 or Type 2) could be supported in the Borough, inviting the participation of the health group of the Barking & Dagenham Youth Forum.	[Note diabetes is uncommon in children so may need to go via healthcare route to identify families]	Healthwatch / Erik Stein, Group Manager Engagement.	R	
8	That the Diabetes Support Group participates in a short review of the support needs of younger adults developing Type 2 diabetes, and how they may be met from a service user led group, led by an agency to be identified by the Health and Wellbeing Board.	Healthwatch to conduct a review and make recommendations to the Health and Wellbeing Board.	Healthwatch	R	
9	That the Health and Wellbeing Board ask Public Health professionals to work with commissioners and North East London NHS Foundation Trust to understand the reasons why services which are on the face of it similar appear to be linked to different outcomes for patients, and to capture the lessons for future local commissioning.	As part of the agreed work programme to provide public health advice to commissioners. Public health will work with the CCG's planned care steering group in their review of the diabetes pathway to ensure this recommendation is built into the pathway development. Dr Steve Feast (Medical Director, NELFT) to provide measures of different performance and Public health will support him in this review.	Dr Sue Levi / Sharon Morrow	R	The planned care steering group is in place covering BHRUT and CCGs and is establishing a diabetes project group that would support pathway redesign.
10	That the Health and Wellbeing Board oversees a review of the care pathway to ensure that all opportunities for joint working are being harnessed and that the flow of patients between services is effective.	The CCG reports back to the Health and Wellbeing Board on its recommendations for improving the diabetes pathway in line with best practice and evidence of effectiveness.	Sharon Morrow / Sarah D'Souza	R	The planned care steering group is in place covering BHRUT and CCGs and is establishing a diabetes project group that would support pathway redesign.

HEALTH AND WELLBEING BOARD

4 June 2013

Title:	**Draft Engagement Strategy**
Report of the Corporate Director of Adult & Community Services	
Open	**For Comment**
Wards Affected: None	**Key Decision:** No
Report Authors: Mark Tyson, Group Manager Service Support and Improvement	**Contact Details:** Telephone: 020 8227 2875 E-mail: Mark.Tyson@lbbd.gov.uk
Sponsor: Anne Bristow, Corporate Director of Adult & Community Services	

Summary:

The Health & Wellbeing Board occupies a central position in facilitating the integrated planning of health and social care services. As such, it is essential that its discussions and decisions are informed by the views of those who use services, those at the front line of providing them, and the wider public. Healthwatch has a core role on the Health & Wellbeing Board in this respect, but there is a wider piece of work to be undertaken to ensure that the right information is being used to inform decision-making, and that engagement activity across partner agencies is being 'joined up' effectively.

This report begins a discussion about the development of an engagement strategy to support the work of the Board, setting out some principles to underpin the work and proposing some immediate actions to be taken to begin to shape the future strategy.

Recommendation(s)

- To note the contents of the report, comment on and shape the emerging thinking about a community engagement strategy.
- To agree the specific proposals at 3.1 concerning the way forward for developing the strategy in the short term.

1 Introduction

1.1 As a democratically-led focus for the whole health and social care economy, the Health & Wellbeing Board has a critical role in ensuring that plans for the development of health and social care services are both integrated and founded on the views and experiences of service users, carers and the general public. The position of Healthwatch as a statutory core member of the Board reflects this role.

1.2 However, Healthwatch cannot be the sole conduit for information and views on the future direction of services and the Board must ensure that it is engaging with the views of a wide cross-section of service users, residents, carers and frontline health and care workers. It is proposed, therefore, that the Board develop an engagement strategy.

2 Approach to developing the strategy

2.1 Having established a sub-structure, and to ensure that any future engagement strategy is grounded in the existing work of service providers, community organisations and commissioners, it is proposed that the development of the strategy is directed through the substructure. Details for this are described below.

2.2 As a sound starting point, the Learning Disability Partnership Board (LDPB) has established a set of three 'forums' to guide its work, and to promote the involvement of service users, carers and providers/professionals respectively. The forums will identify representatives to join the LDPB's discussions, and to channel information and views in both directions. As a starting point, this model is encouraged for other subgroups (mental health, integrated care/older people and children/maternity in particular), with adaptation to take account of existing work and structures or to fit with the particular priorities that the subgroups are pursuing on the Board's behalf. As a particular example, the Council, working with partners, has established comprehensive mechanisms for the engagement of young people in both service development and enhancing civic responsibility.

2.3 However, it is important that the Board set some overall principles to guide this work. The Board is invited to comment on or amend the following proposed direction to the sub-groups in thinking through their approach to balancing their strategic priorities (identified through the strategy), and shaping their work to deliver them, with the views of residents, service users and frontline professionals:

a) **Balance of strategic focus and responsiveness**
The work of the Health & Wellbeing Board and subgroups should be directed by the evidence gathered through the JSNA, and the priority setting which is undertaken at Board level, but should also be responsive to further shaping by those who will ultimately deliver the services (providers/professionals), and those who will use them (service users or carers), or expect them to be provided to an excellent combination of quality and value for money (residents). Therefore, there should be a balance struck between allowing those engaging with the group to shape the agenda, but maintaining a clear strategic purpose that has been established through the Board and as part of the Health & Wellbeing Strategy. How this balance is struck for each area of Health & Wellbeing Board business is to be determined by the relevant subgroups of the Board.

b) **Proactive communication is fundamental**
In terms of the focus of engagement, This will mean that proactive communication will be a priority, in order to ensure that the aims of the Board and the subgroups are well-understood by those working with the group.

c) **A range of methods and opportunities to influence**
The engagement mechanisms chosen should provide a range of methods by which people can engage (and so should not provide only formal meetings of representative groups). Online methods are to be considered, but not at the risk of creating or reinforcing a 'digital divide' by excluding those without access.

d) **Engagement that fosters the richest conversations**
The focus of engagement should bridge gaps between service users, carers and providers/professionals in order to promote more robust and innovative solutions to the issues that are being explored or tackled.

e) **Making sure the information is channelled and properly deployed**
Chairs of subgroups, and those supporting them, will need to be proactive in ensuring that feedback received 'on the job' (as opposed to through particular engagement exercises) is fed back up to the Board to inform its discussions and business, and to Healthwatch to support it in its lead role around promoting the patient, service user and carer voice in local service development.

2.4 As well as the work of the sub-groups, the Health & Wellbeing Board itself will need to establish methods of engagement that can support it in its activities. The principles that underpin this work (on which the Board is invited to comment) will include those above, but additionally might include:

a) **Minimising duplication**
A recognition that the partner agencies have a multitude of established and developing programmes for engaging people in their work, and that the detailed work on programmes that come under the Health & Wellbeing Board's remit, is invariably taken forward by one or more agencies individually or working together. Therefore, its engagement needs to use and strengthen these existing mechanisms, not bypass them. This will include use of the Council's social media outlets for developing conversations about the development of health and social care services locally.

b) **Distilling the information to key, well targeted messages**
The time available for discussions at the Board is relatively limited and that, therefore, those contributing reports will need to be able to present a succinct summary of views expressed on proposals, drawn from a range of sources. This information will become increasingly important in guiding decisions as the Board becomes more secure in its role and takes on a more central role in the shaping of the local health economy.

c) **Conflict to be expected, and will require management**
Conflicting views are to be expected, and that the Board will need to become adept at sifting and judging competing interests where there is an inevitable lack of consensus in the feedback provided.

3 Specific proposals for development of the Engagement Strategy

3.1 To pull together a high level set of proposals around engagement, the following specific actions are proposed:

a) That sub-groups have engagement as an early item (first or second meeting), specifically to review how they link to existing forums, what gaps they have, and what tools and techniques they intend to deploy to ensure their work is grounded in the views of those affected;
b) This work to be collated into an engagement strategy 'map' showing the connections, information flows, and early specific plans for events, consultations and web developments;
c) That Healthwatch, the Health & Wellbeing Board support team and the CCG Operations team join together - with others who may be keen to contribute - to shape how the Board itself can use information being gathered through the emerging strategy, including online, written and face-to-face methods, and the expectations on how reports are crafted to include reference to feedback from residents and service users;
d) That the Health & Wellbeing Board support team pull together an overview of how the Council's social media channels and the website may be used by the Health & Wellbeing Board, with input from the Corporate Communications team, in order to feed this into the developing strategy.

3.2 A report is proposed to come back to the November meeting, providing the draft Engagement Strategy for approval, with an interim progress update in September.

HEALTH AND WELLBEING BOARD

4 June 2013

Title: Chair's Report	
Report of the Chair of the Health and Wellbeing Board	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision:** No
Report Author: Mark Tyson, Group Manager Service Support & Improvement	**Contact Details:** Tel: 020 8227 2875 Email: Mark.Tyson@lbbd.gov.uk
Sponsor: Councillor Maureen Worby, Chair of the Health and Wellbeing Board	
Summary: This report draws the attention of Board Members to the SEN Green Paper and Healthy Schools London Project. Also included is an item on a recent government announcement on integration and urgent care, international recognition for our Integrated Care Coalition and a summary of the Social Care Bill which the Queen raised as part of her annual speech. The report also includes updates on measles, Hear to Meet and Sign Translate following the April Chair's Report.	
Recommendation(s) The Health and Wellbeing Board is recommended to: (i) Note the contents of the Chair's Report and comment on any item covered should they wish to do so.	

1 Healthwatch

1.1 Councillor Reason, Portfolio Holder for Adult Services and HR recently attended the Healthwatch launch event on the 22 May 2013 at Harmony House which was an enjoyable and informative event.

1.2 Patrick Vernon OBE - Healthwatch England committee member - introduced the role of Healthwatch England as the national champion and how Healthwatch England fits with local Healthwatch. Elaine Clark, a Barking and Dagenham Healthwatch Board Member, gave a presentation on the progress of Healthwatch to date and discussed their role on the Health and Wellbeing Board and as local health and social care consumer champions.

1.3 For more information on Healthwatch, please contact Frances Carroll, the new Chair of Healthwatch and our new Health and Wellbeing Board member on 0208 526 8200.

2 Queen's Speech on care and support

2.1 In her annual speech for 2013 the Queen set out the government's proposed legislative programme for the year ahead including a Social Care Bill which will end the situation where people who have worked hard all their lives have to sell their homes to fund their care.

2.2 The Care Bill which was published on 10 May 2013 will take forward elements of the government's initial response to the Francis Inquiry and give people peace of mind that they will be treated with compassion when in hospital, care homes or their own home.

2.3 The Bill has three parts which will see:

- The introduction of a cap on the costs that people will have to pay for care as well as setting out a universal deferred payment scheme so that people will not have to sell their home in their lifetime to pay for residential care.
- Ofsted-style ratings for hospitals and care homes so that patients and the public can compare organisations or services and make informed choices about where to go, as well as a process to deal with unresolved problems with the quality of care more effectively.
- Health Education England (HEE) and the Health Research Authority (HRA) as statutory non-departmental public bodies giving them the impartiality and stability to carry out their roles in improving education and training for healthcare professionals.

2.4 A full copy of the Queen's speech including references to legislation around working parents and childcare, fairer society and economic growth can be found on-line: https://www.gov.uk/government/topical-events/queens-speech-2013

3 Government announcement on integration and urgent care

3.1 On 25 April 2013, the Health Secretary announced a major NHS review to consider the possibility of GPs taking back out-of-hours care. In a speech to the Age UK Annual Conference, Mr Hunt drew on perceptions that primary care was "inaccessible", with poor out-of-hours availability when highlighting the rising pressure on A&E departments. The review of emergency and urgent care will be conducted by NHS England's medical director Sir Bruce Keogh, of which GP working hours will form part of the review.

3.2 In addition to a review on urgent care, Mr Hunt also revealed his strategy for better management of the health of vulnerable elderly patients. The Department of Health plans to draw up a Vulnerable Older People's Plan which will look at levers in the system which prevents joint commissioning and stops people from getting joined-up care.

4 Urgent Care Board

4.1 I have recently been advised that after discussion with the NHS Trust Development Agency, NHS England and BHRUT, it has been recommended that Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups establish an Urgent Care Board.

4.2 The new board is in line with recommendations from the review of Mid-Staffordshire NHS Foundation Trust and will be responsible for leading strategic development and improvement of emergency/urgent care services.

5 SEN Green Paper

5.1 The SEN Green Paper *Support and aspiration: A new approach to special educational needs and disability* was published in March 2011. It sets out a reform programme aimed at supporting parents, the voluntary and community sector, early years settings, schools, colleges, health and social services and their partners in improving outcomes for children and young people with SEN or who are disabled and their families.

5.2 The key proposals outlined in the SEN Green Paper centre around:

- Changes to the current system for statutory assessment and statements of Special Educational Needs. The proposal is for a single Education, Health and Care Plan setting out all the services the child or young person will receive for their support;
- Statutory SEND provision to be extended to age 25
- Transparent funding for SEND based on a national banded framework
- Parents to have greater control over the services they and their family use.

- Those whose children have an Education, Health and Care Plan will be able to express a preference for any state-funded school and have the right to a personal budget for their support.
- Introduction of a single school-based category of SEN to replace the current 'graduated response' i.e. School Action, School Action plus and Statement of Special Education Needs.
- An indicator to be included in schools' performance tables showing progress of their lowest attainers.
- A requirement for Local Authorities to set out a local offer of the support available for children with SEND and their families.

5.3 Following the publication of the SEN Green Paper and its consultation, 20 schemes were introduced to test the reforms in different local authorities. A final report will be published by the Department for Education this summer on the progress made under these trials.

5.4 In February 2013, the Children and Families Bill was published, making changes to the law that is required for the green paper reforms. The bill sets out the duties for all the agencies involved in providing services for children and young people with SEN.

5.5 In Barking and Dagenham we have anticipated the proposed legislative changes and made some adjustments to the organisation of SEND services, these include:

5.6 For those families where children and young people had been eligible for borough transport we have initiated personalised budgets. The responsibility for this area now lies within the integrated disability team.

5.7 The School Improvement Service provides direct support, advice and challenge around specialist areas of SEN. There is a comprehensive professional development programme in place for school staff. This is enabling schools to increase their capacity to effectively meet the range of SEND in their schools.

6 Healthy Schools London

6.1 Healthy Schools London was launched in April 2013 and recognises the important role schools play in supporting the health and wellbeing of children and young and ensuring they make healthy lifestyle choices. The programme aims to support London's schools to provide an environment and culture that helps their pupils grow up to be a healthy weight, and support their wider health and wellbeing. Engagement with the new programme is optional however schools are strongly recommended to participate.

6.2 Healthy Schools London is based on an awards scheme sponsored by the Mayor of London that will recognise and celebrate schools that are making a difference for their pupils. Three awards are available to schools, bronze silver and gold. The

Healthy Schools London programme is website driven and aims to support schools as they work towards these awards via a network of London wide support networks, tools and guidance.

6.3 The national Healthy School Status programme ran from 1997 to 2011, during which time 100% of schools in Barking and Dagenham achieved National Healthy Schools Status. Provided that their health and wellbeing provision has been maintained, schools in Barking and Dagenham are automatically eligible to apply for the new Healthy Schools London bronze award.

6.4 A Personal Development Curriculum Advisor will be appointed from September 2013. The post-holder will support schools in working towards the available awards.

7 Integrated Care Report

7.1 A national collaborative has formed to focus on integrated care as a capital priority. The collaborative includes representatives from the Association of Directors of Adult Social Services (ADASS), Department of Health, Local Government Association, Monitor, NHS England and Public Health England.

7.2 The London branch of ADASS and NHS England (London region) have agreed a shared work programme and Elizabeth Comley has moved across from the Joint Improvement IP to the led by Jen Leonard at NHS England (London Region) to help facilitate the implementation of this programme.

7.3 Underpinning the team's work is a commitment to provide practical assistance in supporting London systems to provide high quality person-centred coordinated care for people with complex needs.

7.4 Initially, the programme will focus on the top 20% population (those who are calculated as being very high to moderate risk) the London team is promoting a particular emphasis of the needs of the frail elderly, people with dementia, one or more long term conditions or people nearing the end of their lives. This will also secure improvements well beyond the target group.

7.5 System leaders from across London had an opportunity on 24 April to test and influence the content of a common purpose framework (CPF). The CPF describes how the national partners will collectively support localities by creating the right conditions, which includes the removal of national barriers, to help good care become the norm.

7.6 More information about the these projects can be found on the Local Government Association Knowledge Hub: https://knowledgehub.local.gov.uk/group/healthandcareintegrationgroup

8 International Recognition for the Integrated Care Coalition

"Integrated care can only happen at the local level, and this needs outstanding local leadership to succeed" – Raj Verma

8.1 Further to the positive reception Barking and Dagenham's Integrated Care Coalition received at the Conference in Eastbourne earlier this year, our model of integrated care has been subject to further acclaim from international peers.

8.2 Raj Verma (Director of Clinical Program Design and Implementation, Agency for Clinical Innovation, New South Wales, Australia) visited East London on April 15th as part of a Community Insight event. The following aspects of the integrate care model were singled out for praise:

- Leadership and collaboration among Clinicians and Managers to develop local solutions
- A clear focus on the needs of the local population and targeting services to meet those needs
- Paying attention to the importance of long term conditions such as CoPD and Diabetes
- Commitment to improve systems and care pathways and having a co-ordinated service with a single point of contact.

9 Updates following the April Chair's Report

Hear to Meet

9.1 This year, during national Deaf Awareness Week (6 to 12 May), the Council hosted its annual information event to showcase services on offer to people who are deaf and hard of hearing. 100 people attended the event and found out more about some exciting new initiatives, including the launch of the new 'Hear to Meet' (H2M) project.

9.2 H2M is a partnership project between the Council, Action on Hearing Loss, and the Audiology Department at Queen's Hospital. The service will largely be run by volunteers, with the support of one paid coordinator.

9.3 The majority of people who are hearing impaired develop their hearing loss later in life and as they have previously been able to hear, this can be extremely traumatic; often leading to isolation, loss of independence and feelings of grief. Hearing aids can be tremendously helpful but generally do not restore hearing as people have previously known it and are difficult to use. As a consequence, many aids that are issued are never or rarely used.

9.4 The aim of the H2M service therefore is to support people in the bewildering position of having just been diagnosed with hearing loss; helping them to overcome isolation, make the best use of their hearing aid and access other equipment and services.

9.5 There are currently 540 hearing impaired residents known to the OT and Sensory Unit, but it is recognised that there are many more hearing aid users living in the borough who are not known to the service.

Sign Translate

9.6 Sign Translate is an online, real-time translation product for BSL (British Sign language) users, delivered by the healthcare charity Sign Health.

9.7 It is well known that Deaf people who rely on BSL face immense barriers when it comes to communicating their needs to professionals. Regrettably local Deaf people have told us that life in Barking and Dagenham is no easier in this respect. During consultation meetings BSL users complained particularly about their experiences of visiting their GP; reporting that they often had to wait 3 weeks for an appointment accompanied by an interpreter.

9.8 In February 2013 a Sign Translate licence was bought for the Council. Dialogue has subsequently taken place between the sensory service and officers responsible for reception areas at Civic Centre, BLC and Dagenham Library and the One-stop-shops. Discussions have also taken place between the sensory service, the Patient and Public Liaison Officer and integrated health and social care Cluster Managers; but, as yet the system is not being used by any local GPs or in any local NHS clinics.

9.9 To help promote the service, demonstrations of the software were provided at the BLC during Deaf Awareness Week. Unfortunately, no GP practices were able to attend the session to take advantage of the offer of a free webcam. However, further meetings with GP practices are being arranged. It should be noted that the service is free to set up, free to subscribe, and surgeries will receive a free webcam and 100 free minutes to help them get started.

9.10 I would ask relevant members of the Health & Wellbeing to promote the Sign Translate service among GP practices and advise them to contact Bill Brittain for further information (Bill.Brittain@lbbd.gov.uk, 020 8724 8373). Bill can also be contacted for more information on the Hear to Meet service.

Measles Update

9.11 As you are aware, there are increasing numbers of measles cases and local outbreaks being reported across England. In 2012 there were a total of 1,920 confirmed measles cases in England, the highest annual total since enhanced follow up of measles cases began in 1994. Measles activity has continued to remain high in the first three months of 2013, with a total of 587 confirmed cases reported across the country. Older children and teenagers have been particularly affected in the current outbreak as a result of the decline in MMR coverage at the turn of the century.

9.12 London is not in a measles outbreak situation currently. The majority of cases recently reported in London have been associated with particular ‘at risk’ communities and there is no evidence of spread to wider communities. There have been 68 confirmed cases in London during the first three months of 2013 although there have been no confirmed cases to date in Barking and Dagenham.

9.13 A national media statement was published supported by a local statement by the Director of Public Health on 25 April 2013 advising young people (and parents) of this increase and urging young people between 10 and 16 years of age who remain under or unvaccinated to get vaccinated. The highest priority groups are young people who are completely unvaccinated and have not received a single dose of MMR vaccine.

9.14 A National implementation plan has been announced to reduce the transmission and spread of measles and Public Health England and NHS England are developing a national implementation plan together with input from all partners including the Department for Education. The plan will have 3 essential components; namely:

- Offering MMR vaccine to children at risk;
- Improving and sustaining the current MMR programme;
- TI in May on the national plan.

9.15 NHS England (London Region) is now delivering the national GP led MMR Temporary Catch-Up Programme for 2013, specifically targeting the 10 to 16 year old cohorts who remain under-vaccinated due to the now discredited adverse publicity between 1997 and 2003. We consider the MMR coverage in the 10 to 16 year old cohorts to be higher in London than reported due to previous MMR catch-up campaigns. The Public Health Team and Public Health England presented to the GPs at their P Active identification of children at risk.

9.16 For more information on the measles outbreak, please contact Matthew Cole (Matthew.Cole@lbbd.gov.uk, 020 8227 3657).

HEALTH AND WELLBEING BOARD

4 June 2013

Title: Sub-Group Report	
Report of the Chair of the Health and Wellbeing Board	
Open Report	**For Information**
Wards Affected: ALL	**Key Decision:** No
Report Author: Glynis Rogers, Divisional Director, Community Safety & Public Protection	**Contact Details:** Glynis.rogers@lbbd.gov.uk 020 8227 2827

Sponsor:

Councillor Maureen Worby, Chair of the Health and Wellbeing Board

Summary:

Reports from sub-groups are a standing item on Health & Wellbeing Board agendas. At present, sub-groups are in the process of establishing themselves and this first report therefore includes only feedback on the Learning Disability Partnership Board (LDPB) Away Morning.

The Away Morning took place on Friday 10 May 2013 and was set up to discuss the role and membership of the LDPB, the outputs and deliverables of the group and how the LDPB would engage with service users, family carers and providers and professionals to inform their work in the future.

Should Board Members wish to have a more detailed conversation about the planned work of the sub-group and its vision, they can contact the Chair, Glynis Rogers, Divisional Director of Community Safety and Public Protection.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

(i) To note the contents of the sub-group report and comment on, or raise queries about, any issue covered should they wish to do so.

1 Introduction

1.1 The Learning Disability Partnership Board (LDPB) is a sub-group of the Health and Wellbeing Board as part of the substructure agreed by the Board in March 2013. The LDPB has been meeting in some form for a number of years on a bi-monthly basis, supported by Officers in the Council and chaired by a Senior Officer. On Friday 10 May 2013, an Away Morning was held to discuss and agree the way in which the LDPB would run in the future.

1.2 Over the last few years, the LDPB has been strong on its engagement with representatives, particularly with individuals from some of the service user groups and those who are family carers. The Away Morning celebrated some of the key achievements of the group, including:

- The work of the Advisory Partners;
- The creation of 'Sharkies', a social club run by, and for, people with a learning disability;
- The Safeguarding Action Group, run in conjunction with the Metropolitan Police, who put a voluntary database in place which resulted in the Police and Fire Service regularly visiting vulnerable adults, including those with a learning disability at home and offering them safety checks;
- The Carers Information Service and Friendship Map - a monthly drop-in service for Family Carers and an email support network;
- Giving input and feedback to various commissioning plans, strategies and policy documents.

1.3 However, the primary objective of the Away Morning was to discuss the transition of the Board from how it used to run, to how it would work within the new health landscape. Discussions at the Away Morning therefore focused upon:

- The role of the LDPB and its relationship with the Health and Wellbeing Board;
- The new 'task focus' approach of the LDPB, including the requirement for the LDPB to deliver the actions set out in the Winterbourne View Concordat and the relevant actions in the Health and Wellbeing Strategy, as well as shaping future Commissioning plans;
- The membership of the LDPB and how the group would widely and effectively engage with service users, family carers and providers in Barking and Dagenham to inform the work of the LDPB, and as such, the work of the Health and Wellbeing Board. It was proposed that a Service User Forum, Family Carers Forum and Providers and Professionals Forum is established to facilitate this engagement and that one or two members from each of the Forums would represent the Forums at the LDPB meetings.

2 Feedback from the Away Morning

2.1 76 people attended the Away Day, including service users, family carers and providers and professionals from a number of different agencies.

2.2 After a scene setting discussion from Anne Bristow, Corporate Director of Adult and Community Services, attendees at the Away Day each had an opportunity to discuss the proposed Forums as outlined in paragraph 1.3 above.

2.3 Feedback from the groups was collated and the main points can be summarised as follows:

General

2.4 Some general points that came out of all three topics of discussion included:

- The importance of Forums being able to communicate directly with each other rather than relying on the LDPB as their main route of communication;
- The business of each of the Forums to be a standing item on the LDPB agenda;
- Forum chairs to receive some training in order to make their meetings effective;
- There was also widespread support for more accessible information for people with learning disabilities and for the use of social media, in particular making information available in video form. However, there were warnings that it should not be assumed that this was relevant for all individuals with learning disabilities.

Service User Forum

2.5 Discussions around involving service users emphasised the importance of making the Board's work accessible. It was thought that there should be an events newsletter, use of a telephone tree to keep in contact, and all information should be in an easy read format or even recorded as a video.

Service users also wanted to be more involved in wider decision making processes, including an expectation that reports would come to the Service User Forum on how Providers and Professionals are supporting people with learning disabilities.

There was also support for an election event to decide membership of the Board, and advocacy to support the involvement of service users provided that it complimented and did not replace the direct voice of service users.

Family Carers Forum

2.6 Discussions around family carers generally centred on supporting the voice of service users. Carers wanted to be able to speak directly to service providers, and to ensure that different age groups and disabilities would have a voice. It was

thought that Healthwatch could play a role in finding suitable members for the Family Carers Forum and also that there should be representation at the Forum for carers of people with learning disabilities who lived in residential facilities such as Winterbourne View.

Providers and Professionals Forum

2.7 The providers and professionals discussions made several recommendations to how the Forum could operate. It was suggested that organisations rather than named people should be members, and group priorities should be based around service users rather than commissioning issues. Service providers would also welcome a market position statement from the Council identifying services that are already provided and gaps in the market. It was also suggested that an online forum would aid information and resource sharing and that health professionals, including GPs, should be invited along to the Providers and Professionals Forum.

3 Next Steps

3.1 A number of people indicated their wish to be a part of the proposed Forums following the Away Day and provisional dates for the Service User Forum, Family Carer Forum and Provider and Professionals Forum have now been agreed. Officers will now work to contact interested individuals, organisations and groups and invite them to the Forum meetings.

3.2 The first Learning Disability Partnership Board meeting is also being organised and the provisional date for the first meeting will be on Wednesday 26 June, 2.00-4.30pm.

HEALTH AND WELLBEING BOARD

4 June 2013

Title:	Forward Plan (2013/14)
Report of the Chief Executive	
Open	**For Comment**
Wards Affected: None	**Key Decision:** No
Report Authors: Glen Oldfield, Democratic Services	**Contact Details:** Telephone: 020 8227 5796 E-mail: glen.oldfield@lbbd.gov.uk
Sponsor: Cllr Worby, Chair of the Health and Wellbeing Board	

Summary:

Attached at Appendix 1 is the Forward Plan for the Health and Wellbeing Board. The Forward Plan lists all known business items for meetings scheduled in the 2013/14 municipal year. The Forward Plan is an important document for not only planning the business of the Board, but also ensuring that we publish the key decisions (within at least 28 days notice of the meeting) in order that local people know what discussions and decisions will be taken at future Health and Wellbeing Board meetings.

The Executive Planning Group will own and maintain the Forward Plan on behalf of the Board - naturally seeking input from the wider membership of the Board as appropriate. However, to give Board Members maximum opportunity to influence the Forward Plan, it will feature as a standing item on agendas in the coming months.

Recommendation(s)

The Health and Wellbeing Board is asked to:

- Make suggestions for business items so that decisions can be listed publicly in the May edition of the Council's Forward Plan with at least 28 days notice of the meeting;
- To consider whether the proposed report leads are appropriate;
- To consider whether the Board requires some items (and if so which) to be considered in the first instance by a subgroup of the Board.

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Board Members should note that by law, Councils are required to publish a document detailing "Key Decisions" that are to be taken by executive committees, of which the Health and Wellbeing Board is now one. This means that the Health and Wellbeing Board will be publishing its key decisions as part of the Council's Forward Plan. This can be found here: http://moderngov.barking-dagenham.gov.uk/mgListPlans.aspx?RPId=180&RD=0 and is indicated on the Forward Plan below.

Tuesday, 16 July 2013 – 18:00 (Agenda publication date: 08 July 2013)							
Item	**Title**	**Board Sponsor**	**Author**	**Key decision**	**On Council Forward Plan**	**Report/Pres/Disc/ Brief**	**Links/comments**
1.	Services for 0 – 5 Year Olds	TBC	TBC			Report	Currently being scoped by Children's Services
2.	Maternity Services in Barking & Dagenham	Conor Burke	Sharon Morrow	Yes	Yes	Report	To be scoped at Children and Maternity Group
3.	North East and North Central London Health Protection Unit Annual Report 2012	Matthew Cole	Matthew Cole Public Health England rep	Yes	Yes	Report	
4.	Local Account 2012/13	Anne Bristow	Glynis Rogers	Yes	Yes	Report	
5.	Performance	Anne Bristow	Mark Tyson			Report and Proposed Dashboard	
6.	Domestic Violence Contracts Review	Matthew Cole	Matthew Cole	Yes	Yes	Report	

Tuesday, 16 July 2013 – 18:00 (Agenda publication date: 08 July 2013)							
Item	**Title**	**Board Sponsor**	**Author**	**Key decision**	**On Council Forward Plan**	**Report/Pres/Disc/ Brief**	**Links/comments**
7.	Sub-Group Reports: 1) Children & Maternity Group 2) Public Health Programmes Board	Councillor Worby	Sharon Morrow Matthew Cole			Report	
8.	Chair's Report	Cllr Worby	Cllr Worby			Report	To include: GP Profiles; Sign Translate update
9.	Winterbourne View Update	Anne Bristow	Pete Ellis			Report	To discuss targets that were set to be met by June 2013 (Bruce Morris and Sharon Morrow)
10.	Forward Plan	Cllr Worby	Glen Oldfield			Report	
Private business							
	None.						

Tuesday, 17 September 2013 – 18:00 (Agenda publication date: 09 September 2013)							
Item	**Title**	**Board Sponsor**	**Author**	**Key decision**	**On Council Forward Plan**	**Report/Pres/Disc/ Brief**	**Links/comments**
1.	Winter Planning	Anne Bristow	TBC	Yes	Yes		Scope to be discussed at Executive Planning Group
2.	GP Profiles	Matthew Cole	Matthew Cole Sharon Morrow				
3.	End of Life Care	Anne Bristow	TBC	Yes	Yes		To be scoped at Integrated Care Group
4.	Adult Social Care Funding	Anne Bristow	Glynis Rogers				For information and discussion
5.	Memorandum of Understanding between Public Health and the CCG	Matthew Cole	Dr Sue Levi	Yes	Yes		
6.	H&WBB Theme report: Protection and Safeguarding	TBC	TBC				
7.	Contracts: Substance Misuse Services	Anne Bristow	Glynis Rogers	Yes	Yes		Retender for Horizon & Recovery substance misuse services

Tuesday, 17 September 2013 – 18:00 (Agenda publication date: 09 September 2013)							
Item	**Title**	**Board Sponsor**	**Author**	**Key decision**	**On Council Forward Plan**	**Report/Pres/Disc/ Brief**	**Links/comments**
8.	Joint Strategic Needs Assessment	Matthew Cole	Dawn Jenkin	Yes	Yes		
9.	Pharmaceutical Needs Assessment	Matthew Cole	Dawn Jenkin	Yes	Yes		
10.	Contracts: Smoking Cessation Locally Enhanced Services	Matthew Cole	Matthew Cole	Yes	Yes		
11.	Sub-Group Reports: 1) Mental Health Group 2) Integrated Care	Cllr Worby	Various				
12.	Chair's Report	Cllr Worby	Cllr Worby				Sign Translate update
13.	Q1 Performance and Budget Report	Matthew Cole	Matthew Cole				
14.	Francis Report: Thematic issue	TBC	TBC				
15.	Forward Plan	Cllr Worby	Glen Oldfield				
Private business							
	None						

Tuesday, 5 November 2013 – 18:00 (Agenda publication date: 28 October 2013)							
Item	**Title**	**Board Sponsor**	**Author**	**Key decision**	**On Council Forward Plan**	**Report/Pres/Disc/ Brief**	**Links/comments**
1.	Children and Families Bill: Relevant Provisions	Helen Jenner	TBC		Yes		
2.	HWBB Strategy Review: Older People	Anne Bristow	TBC				
3.	Healthwatch – The First Six Months	Frances Carroll	Frances Carroll				
4.	Health Impact of Older Population	Matthew Cole	Matthew Cole				
5.	H&WBB Theme Report: Care and Support	TBC	TBC				
6.	Sub-Group Reports: 1) Children and Maternity Group 2) Public Health Programmes	Various	Various				
7.	Chair's Report	Cllr Worby	Cllr Worby				
8.	Q2 Performance and Budget Report	Matthew Cole	Matthew Cole				

Tuesday, 5 November 2013 – 18:00 (Agenda publication date: 28 October 2013)							
Item	**Title**	**Board Sponsor**	**Author**	**Key decision**	**On Council Forward Plan**	**Report/Pres/Disc/ Brief**	**Links/comments**
9.	Francis Report: Thematic issue	TBC	TBC				
10.	Winterbourne View Update	TBC	TBC				
11.	Forward Plan	Cllr Worby	Glen Oldfield				
Private business							
	None.						

Tuesday, 10 December 2013 – 18:00 (Agenda publication date: 02 December 2013)							
Item	**Title**	**Board Sponsor**	**Author**	**Key decision**	**On Council Forward Plan**	**Report/Pres/Disc/ Brief**	**Links/comments**
1.	Impact of Welfare Reforms	Anne Bristow	TBC				
2.	Contracts: Public Health Commissioning Intentions	Matthew Cole	Matthew Cole	Yes	Yes		
3.	H&WBB Theme Report: Prevention	TBC	TBC				
4.	Sub-Group Reports: 1) LDPB 2) Integrated Care	Various	Various				
5.	Chair's Report	Cllr Worby	Cllr Worby				
6.	Francis Report: Thematic issue	TBC	TBC				
7.	Forward Plan	Cllr Worby	Glen Oldfield				
Private business							
	None.						

Tuesday, 11 February 2014 – 18:00 (Agenda publication date: 03 February 2014)							
Item	**Title**	**Board Sponsor**	**Author**	**Key decision**	**On Council Forward Plan**	**Report/Pres/Disc/ Brief**	**Links/comments**
1.	HWBB Strategy Review: Working Age Adults	Anne Bristow	TBC				
2.	H&WBB Theme report: Protection and Safeguarding	TBC	TBC				
3.	Sub-Group Reports: 1) Mental Health 2) Children & Maternity	Cllr Worby	Various				
4.	Chair's Report	Cllr Worby	Cllr Worby				
5.	Q3 Performance and Budget Report	Matthew Cole	Matthew Cole				
6.	Winterbourne View Update	TBC	TBC				
7.	Francis Report: Thematic issue	TBC	TBC				
8.	Forward Plan	Cllr Worby	Glen Oldfield				
Private business							
	None.						

Tuesday, 25 March 2014 – 18:00 (Agenda publication date: 17 March 2014)							
Item	**Title**	**Board Sponsor**	**Author**	**Key decision**	**On Council Forward Plan**	**Report/Pres/Disc/ Brief**	**Links/comments**
1.	Director of Public Health Annual Report	Matthew Cole	Matthew Cole		Yes		
2.	Sub-Group Reports: 1) LDPB 2) Public Health Programmes	Cllr Worby	Various				
3.	Chair's Report	Cllr Worby	Cllr Worby				
4.	H&WBB Theme Report: Improvement and Integration	TBC	TBC				
5.	Francis Report: Thematic issue	TBC	TBC				
6.	Forward Plan	Cllr Worby	Glen Oldfield				
Private business							
	None.						

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