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.