Diabetes Action Plan Progress Report (November 2013)

Number	HASSC recommendation	**Processes Involved**	Responsible Officer:	R A G	Progress:
1	The select committee 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.	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	Matthew Cole	G	JSNA 2012/13 has a large diabetes section which covers this material and is available at http://www.barkinganddagenhamjsna.org.uk/ Feedback is welcomed by Public Health.
		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.		A	NHS Health Checks already progressing well and has a diabetes detection component. Other awareness raising, unique patient issues and other healthcare related factors will need to be coordinated.
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 GP's 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 Check programme. Audit number of newly diagnosed diabetics annually as have been doing (75 in 2011/12, 36 diagnosed in 2012/13).

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.	Diabetes handbook to be produced for practices and community teams to give to all diabetic patients which will contain lifestyle advice including importance of annual health checks.	Sharon Morrow (CCG) via Dr Kalkat and Primary Care Improvement Group.	G	Diabetes patient booklet has been produced and distributed to practices and community services to share with all diabetic patients/carers.
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 six months of new diagnosis. Continue to commission DESMOND and DAFNE programmes and to raise awareness of these to practices, patients, and providers.	Sharon Morrow (CCG) via Dr Kalkat and Primary Care Improvement Group.	A	Continued primary care care training programme to ensure GPs and nurses include patient education as part of diagnosis and annual review.
		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	A	Training bid secured from HENCEL to develop primary care management of LTCs which will include following NICE recommendations.
		Using the locality model to support improved primary care management of patients with diabetes. Enrolling Clinical Champions and Primary Care Improvement Group to produce incremental improvements in care	Sharon Morrow (CCG) via Primary Care Improvement Group	A	The Primary Care Improvement Group has rolled out feedback and peer influencing sessions via the cluster structure. The locality management paper sets out the role of the CCG in influencing primary care improvements through the cluster model.

		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	G	Remuneration has been changed to requiring annual checks (rather than 15 months). Starts in 2013/14 so expect improvement to be 'visible' from late 2014/early 2015.
		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	G	Quality and Outcomes framework has been altered for 2013/14 to raise the threshold for maximum payment on many indicators. Hence, remuneration structure should improve performance.
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	Public Health to provide the CCG and HWB with intelligence on outcomes relating to diabetes through public health profiles and other available datasources to support commissioning devisions	Dr Sue Levi/Matthew Cole	A	Currently, there is 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
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	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 to lead on this.	A	Surveys have been developed and sent to all families who attend the children's diabetes service. Report will be available end of October 2013.

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 & Wellbeing Board.		Health Watch – Marie Kearns.	A	Initial meeting to be held on 11th November with the diabetes support group. Final Report to be available end of November 2013.
9	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.	Barking & Dagenham Public Health will work with NELFT to understand the evidence of what actions in relation to the NELFT commissioned service are most likely to impact on patient outcomes. NELFT wishes to emphasise that access to and quality of Primary Care will have significantly more impact than any direct interventions that are under the remit of NELFT.	Dr Steve Feast (MD at NELFT) to provide measures of different performance and Public Health will support him in this review	R	Approach being finalised so as to get the most valuable measures
10	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.		Sharon Morrow/ Sarah D'Souza	A	The planned care steering group is in place covering BHRUT and CCGs and is establishing a diabetes project group that would support pathway redesign. Workshop convened for October 2013