

# HEALTH AND WELLBEING BOARD

29 JULY 2014

<b>Title: Progress on the Diabetes Actions from the Health and Adult Services Select Committee Scrutiny Review</b>	
<b>Report of the Director of Public Health</b>	
<b>Open Report</b>	<b>For Decision</b>
<b>Wards Affected: All</b>	<b>Key Decision: No</b>
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<b>Sponsor:</b> Matthew Cole, Director of Public Health	
<b>Summary:</b> <p>This report updates the Health and Wellbeing Board on the progress of implementation of the recommendations of the Health and Adult Services Select Committee in 2012/13.</p> <p>Collaborators and stakeholders have worked in a very positive manner to start to achieve change. There is still work to be done but there is now a strategic group (the Diabetes Sub-Group of the Planned Care Steering Group) that can take forward the ongoing work that needs to focus on identifying diabetics within high risk groups in primary care and elsewhere together with the need for NHS England to address the problem of some underperforming GP practices.</p>	
<b>Recommendation</b> The Health and Wellbeing Board is recommended to agree that the Diabetes Action Plan has been completed (table 1) and is fit for return to the Health and Adult Services Select Committee.	
<b>Reason(s)</b> The Health and Wellbeing Board is overseeing the Diabetes Action Plan from the Health and Adult Services Select Committee. Whilst some changes were easily actioned others require more integrated working, defined governance structures and a shared vision. The Health and Wellbeing Board can both define the issues and work through how to improve collaboration in order to improve the delivery of population health outcomes.	

## **1. Background and introduction**

- 1.1. Barking and Dagenham has one of the highest rates of Diabetes in London and high rates of complications including kidney failure and amputations. Disease control measures including sugar levels are variable with patients at some practices having excellent results and others having significant room for improvement.
- 1.2. The actions suggested by the Health and Adult Services Select Committee concerning diabetes have been worked upon for a year and most areas show significant improvement.
- 1.3. In addition, the review of local diabetes services especially in the Integrated Diabetes service has identified some subtle but important discrepancies from best practice which could be worked upon by NHS Barking and Dagenham Clinical Commissioning Group's commissioners.

## **2. Additional progress to date and recommendation**

- 2.1 The Diabetes Action Plan been completed (table 1) and been embedded in the Barking and Dagenham, Havering and Redbridge Integrated Care Coalition Five Year Strategy. Apart from the progress outlined in table 1, the action plan has resulted in general improvements in communication, collaboration and pathways:
  - NHS Barking and Dagenham Clinical Commissioning Group (CCG) has prioritised diabetes clinical teaching and training for Practice Nurses and GPs from the allocated Public Health Grant.
  - The CCG has appointed a Director of Primary Care Improvement (Sarah See) which should improve aspects of performance and organisation.
  - The CCG has formed a Primary Care Improvement Group. Diabetes has been made a priority in the group's 2014/15 Forward Plan based on recommendations from the Director of Public Health Annual Report 2013
  - The Barking Havering and Redbridge group of CCGs has initiated a pathway redesign project to improve the diabetes pathway and rationalise costs.
- 2.2 The Health and Wellbeing Board is recommended to agree that the Diabetes Action Plan has been completed and is fit for return to the Health and Adult Services Select Committee.

Table 1- Progress on Diabetes Action Plan for The Health & Adult Services Select Committee

Number	HASSC recommendation	Responsible Officer:	Time Frame	R	Progress:
				A	
				G	
1	The Select Committee recommend 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.	Matthew Cole	Completed Jan 2014	G	The JSNA 2012/13 has been updated for accuracy and is currently being refreshed for 2014/2015.
2	The Select Committee recommend 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.	Matthew Cole	Completed 2013	G	A significant number of undiagnosed diabetics are identified routinely through the NHS Health Check programme.  Proactive screening occurring in General Practice around high risk groups Gestational Diabetes and morbid obesity
3	The Select Committee recommend 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.	Sharon Morrow (CCG) via Dr Kalkat and Primary Care Improvement Group.	Completed September 2013	G	Diabetes patient booklet has been produced and distributed to practices and community services to share with all diabetic patients/carers.

4	<p>The Select Committee recommend 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.</p>	<p>Sharon Morrow (CCG) via Dr Kalkat and Primary Care Improvement Group and Training Planning Group.</p> <p>Matthew Cole liaising with NHS England over GP performance.</p>	<p>Completed February 2014</p>	<p>G</p>	<p>Continued primary care training programme to ensure GPs and nurses include patient education as part of diagnosis and annual review.</p> <p>Training bid secured from HENCEL to develop primary care management of Long Term Conditions which will include following NICE recommendations. CCG developing clinical balanced scorecard to prioritise clinical improvement.</p> <p>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.</p> <p>The Primary Care Group has also selected Diabetes as a priority in their 2014/15 Forward Plan based on recommendations set out in the Director of Public Health Annual Report 2012, particularly around reducing variation in performance and care amongst GP Practices.</p> <p>The balanced scorecard and clinical champion programme will provide an infrastructure for improvement.</p> <p>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.</p> <p>The 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.</p> <p>Letter also written to NHS England about GP performance governance. CCG has appointed a Director Primary Care Improvement (Sarah See)</p> <p>Integrated Diabetes Service to develop and lead on structured education programme for practices, and to work with the CCG to develop and implement practice improvement plans. This needs to be prioritised in importance by all groups and develop closer working practices to improve attendance.</p> <p>The CCG, NHS England, The North East London Foundation Trust, The Local Medical Committee and GPs need to work together to focus on consistency in General Practice performance with plans to work with poorer performers.</p>
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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.	Matthew Cole	March 2014	G	The Diabetes Community Health Profile and National Diabetes Audit are now produced annually and 2012/13 became available in December 2103. Will be incorporated into next JSNA.
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.	Healthwatch	March 2014	G	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 and 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 and Dagenham Youth Forum.	Healthwatch	March 2014	G	Healthwatch Report completed, findings (Appendix A) being taken forward by the Diabetes Sub-Group of the Planned Care Steering Group.
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.	Health Watch – Marie Kearns.	March 2014	G	Report available from <a href="mailto:ross.kenny@lbbd.gov.uk">ross.kenny@lbbd.gov.uk</a>
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.	Dr Steve Feast (MD at NELFT) and Matthew Cole	March 2014	G	Report by Dr Sue Levi completed, findings (Appendix B) being taken forward by the Diabetes Sub-Group of the Planned Care Steering Group. Report available from <a href="mailto:ross.kenny@lbbd.gov.uk">ross.kenny@lbbd.gov.uk</a> .
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.	Sharon Morrow/Sarah D'Souza/ Matthew Cole	March 2014	G	The Diabetes Sub-Group of the Planned Care Steering Group is in place covering BHRUT and CCGs and the first workshop took place in October 2013. The purpose of the diabetes project group is to support pathway redesign.  Also, overlap with 9

### **3. Mandatory implications**

#### **3.1 Joint Strategic Needs Assessment (JSNA)**

The JSNA shows there are some problems with diabetes care and outcomes in the borough. Diabetes is a critical disease for improving overall mortality measures and decreasing hospital admissions for ambulatory care sensitive conditions.

#### **3.2 Health and Wellbeing Strategy**

The Health and Wellbeing Strategy says that the Board will focus on improving the quality of care and support for people living with diabetes in the second year of the partnership (2014/15)

#### **3.3 Integration**

Improving diabetes outcomes will be complex and difficult to achieve. It will need to involve improvements in commissioning, contract monitoring and liaison between NHS England, the CCG, the Local Medical Committee (LMC) and The North East London Foundation Trust. It will also need improvements by GPs as providers and changes in the Community Service. The Health and Wellbeing Board might be a suitable location for high level discussions and identifying how to work better together.

#### **3.4 Financial implications**

There are no specific proposals with financial implications arising from the review at this stage.

Implications completed by: Roger Hampson, Group Manager (Finance - Adults & Community Services)

#### **3.5 Legal implications**

There are no direct legal implications from this report. However, the author does highlight some deficits in the service and there is a limited risk of litigation if this results in poor outcomes for patients, particularly if the recommendations from this report are not put in place.

Implications completed by: Chris Pickering, Principal Solicitor - Litigation & Employment, Legal and Democratic Services

#### **3.6 Risk management**

The risk from this paper is that changes are slow or non-existent and the quality of care remains unchanged.

### **4. Background papers used in preparation of the report:**

The Health and Wellbeing Strategy 2012-2015

The Health and Adult Services Select Committee: Review of Type 2 Diabetes Services across the London Borough of Barking and Dagenham. The report can be accessed here:

<http://www.lbbd.gov.uk/CouncilandDemocracy/Scrutiny/Documents/Diabetes%20Scrutiny%20170413.pdf>

The Health and Adult Services Select Committee: Diabetes Action Plan October 2013.

## **5. Appendices**

Appendix A: Recommendations derived from the engagement of Young People and Younger Adults conducted by Healthwatch regarding HASSC recommendation numbers 7 and 8

Appendix B: Recommendations derived from the Service Review conducted by Dr Sue Levi regarding HASSC recommendation number 9: