AGENDA ITEM **
REPORT TO THE HEALTH AND WELLBEING BOARD

JANUARY 2018

REPORT OF Hartlepool and Stockton CCG and DIRECTOR OF PUBLIC HEALTH

Diabetes Update for Stockton Health & Wellbeing Board – January 2018

SUMMARY

This report has been developed for information to provide an overview regarding Diabetes-related work undertaken collectively by the CCG and Public Health across Stockton-on-Tees since a previous report was submitted in July 2017.

The report provides information regarding projects currently underway, relevant progress made against each area and the current status of such projects to provide members with an informed update.

The Health & Wellbeing Board is asked to

- Note the update on multiagency work on diabetes diabetes prevention, early intervention and treatment
- Support further collaboration and joint working of partners to improve diabetes prevention and care

RECOMMENDATIONS

1. Continue to joint working between partners to improve diabetes prevention in particular through the implementation of the NHS Diabetes Prevention Programme

2. Continue multiagency working including a joint action plan to prevent diabetes and improve diabetes care based on priorities identified in JSNA and previous report

3. Plan and conduct a joint consultation with patient and carers on diabetes related health and health care needs.

BACKGROUND

NHS Diabetes Prevention Programme

4. NHS England has commissioned 'The Healthier You: NHS Diabetes Prevention Programme' (NDPP). It was launched in 2016 with 27 areas covering 26 million people, and, in June 2017, 13 new areas of the country went live as part of Wave 2 of the programme. Wave 3 will be rolled out across the country by 2020, starting in April 2018 on an STP footprint. Stockton-on-Tees locality is part of wave 3.

5. The programme is a partnership between NHS England, Public Health England and Diabetes UK to deliver at scale, evidence-based behavioural interventions for individuals identified as being at high risk of developing Type 2 diabetes.

6. Rollout of the NDPP in the North East will be across Northumberland, Tyne, Wear, and North Durham STP and Durham, Darlington, Teesside, Hambleton Richmondshire and Whitby (DDTHRW) STP. The lead organisation for DDTHRW STP is Hartlepool and Stockton-on-Tees CCG and organisations included in the STP are:

    - Darlington Borough Council
    - Darlington CCG
    - Durham County Council
    - Durham Dales, Easington and Sedgefield CCG
    - Hartlepool Borough Council
    - Stockton-on-Tees Borough Council
    - Hartlepool and Stockton-on-Tees CCG
    - Middlesbrough Borough Council
    - Redcar and Cleveland Borough Council
    - South Tees CCG
    - North Yorkshire County Council
    - Hambleton, Richmondshire and Whitby CCG

7. 2.4 The procurement process has now taken place involving moderation panels for both STPs with the NHS England national team. The NDPP provider for each STP has been announced by NHS England on the 18th January. Implementation funding is expected to be known late January 2018 with a possibility of year two implementation funding, although this has not yet been confirmed.

8. 2.5 The communications strategy is being led by NHS England Communications team, linking with regional and national communication leads, Public Health England and Diabetes UK, to ensure a coordinated approach. Locally the communications team are meeting with stakeholders to develop a communications briefing and identify clear messages. Initial communication briefings for both GP practices and LA partners were circulated in December 2017.

9. 2.6 Trailblazer GP Practices are being identified across localities in each STP – these are GP Practices ready to make referrals to the NDPP from April 2018 to gain momentum from the start. It will be helpful for other practices to see what they have done to get ready and create a “ripple effect”.

10. Public health is working with practices and NECS to identify eligible patients through the NHS health checks and through practice systems; and to create and maintain electronic non-diabetic hyperglycaemia registers. This will support GP practices across Stockton to invite patients to the NHS Diabetes Prevention Programme and ensure universal access to the programme.

11. The NDPP behavioural intervention programme is underpinned by three core goals:
    Weight loss
    Achievement of dietary recommendations
    Achievement of physical activity recommendations

12. CCGs and public health local authority teams will roll out the programme working with regional teams and the national provider. CCGs and local authorities will work with general

practice, NHS Health Check providers and wider stakeholders to identify and refer individuals identified as having NDH.

13. The implementation of the NDPP follows the governance and reporting structure below.

14. HaST CCG leads the operational group for the south STP area and each organisation within the STP is represented at the group and representatives from lead organisations attend the Steering Group which is led by the Clinical Network.

15. The local assurance function for continued rollout and implementation of the diabetes programme (NDDP, Diabetes Treatment and Care, Diabetes Digital) is being devolved to NHS England (North) by NHS England North Regional team. A post holder has been recruited and is expected to take post early 2018.

Diabetes Prevention

16. Public Health works with partners to develop local infrastructure which promotes access to and uptake of physical activity e.g. cycling sessions at primary schools, active travel, club 55

17. Public Health commissions and works in partnership with a range of organisations to improve the diets of residents, including the NHS Health Check,Lite4life adult weight management service, the family weight management service, the men's healthy weight service, Change4life and schools based programmes, such as Phunky Foods.

18. The NHS health check programme has delivered 3,344 health checks in Stockton in 2016/17. 28% (n=1582) had a BMI of 30 or over and were therefore recommended to be tested for HbA1c. 5% of all patients receiving a NHS health check were found to be at risk of diabetes with an HbA1c of 42-47mmol/ml.

19. Public Health has commissioned DiaBeat it! a diabetes prevention initiative aimed at the BME community in Stockton. The pilot programme raises awareness, provides information and offers practical support and advice to people at risk of developing diabetes.

20. Research to understand the enablers and barriers to physical activity and healthy eating for people living in Stockton has been conducted including 701 structured interviews with adults across wards in Stockton.

Diabetes Treatment and Care Programme

21. HAST CCG applied for and was awarded national funding from the Diabetes Treatment and Care Programme to pilot and implement a Diabetes Inpatient Specialist Nursing (DISN) service.

22. The proposal to introduce a DISN service enables the provision of a dedicated resource to focus upon the following:

23. Support the “front door” services to facilitate timely assessment and treatment plans which could impact positively upon length of stay and could potentially avoid admission altogether.

24. Provision of early support and intervention to inpatients with diabetes across all hospital services both for those admitted due to their diabetes and those admitted for other reasons but who have diabetes. This would also include non-medical wards (pre and post-surgical support).

25. Education for inpatients, their carers and families with diabetes and those who are newly diagnosed during admission.

26. Education and training of ward staff (including medical clinicians) in the effective management of diabetes patients to improve continuity of care and to support the early recognition and escalation. Education for ward staff will be carried out on a structured basis with each ward staff able to participate at least twice a year.

27. Continued work with the consultant Diabetologist to review compliance against NICE guidelines and quality standards and the development of actions plans for improvement.

28. It is anticipated that the delivery of the DISN service will:

    - Reduce length of stay for patients admitted with diabetes
    - Reduce inpatient harms, including never events (insulin errors)
    - Improve systems and processes for management of inpatients with diabetes
    - Reduce time requirements on other clinical staff due to effective and efficient management

29. The additional DISN service will support the wider local diabetes treatment pathways from initial diagnosis within primary care through to inpatient treatment and care. Work is ongoing with primary care to ensure that the clinical team are aware of the additional service and able to refer patients to the correct pathway when required.

30. The new service will also enable the community service to operate at full capacity ensuring that patients are receiving the support they need to manage their condition in the community. Working in partnership with both the community specialist nurses and primary care will ensure that on discharge there is sufficient capacity and skills outside the acute setting to provide the care patients need. The inpatient nursing service will be able to more actively work with patients whilst in hospital to make sure they are aware of the services available to them, liaise with the community and primary care teams and facilitate timely discharge as the support needed can be put in place.

31. To enable release of the funding NTHFT were required to provide detailed milestones for each quarter to ensure delivery of the project as shown below

Milestones for Quarter 2 July – September 2017	• Continue to deliver the in reach model with the support of the community based teams • Commence the recruitment process to the posts to realise the full potential of the bid. • Develop dashboards with clear baseline measures including those extracted from the National Diabetes audit ensure robust data collection is developed

	• Develop a process to enable daily identification of in-patients who will require DISN input using TrakCare
Milestones for Quarter 3 October – December 2017	• Completion of the recruitment process including induction of staff into post and organisation (subject to notice period from current employment) • Development of appropriate local and clinical guidelines alongside the operational policy for the team • Ensure all training requirements for team are addressed • Produce a quarter end report to show progress against targets and milestone to be presented to project group
Milestones for Quarter 4 January – March 2018	• Set targets for improvement working alongside the clinical teams and continue to monitor on a monthly basis the define measures on dashboard • Develop a roll out plan, in conjunction with the Care Home Education Alliance, to support the delivery of diabetes education to care homes in order to support a reduction in hospital admissions/readmissions. Develop key performance metrics to measure outcomes. • Produce evaluation report at 6 months to be presented to project group

32. NTHFT has confirmed they are meeting these milestones, the recruitment process is complete and induction of staff into post is ongoing. The quarter end report to show progress against targets will also be shared with the CCG to provide assurance that the project is on track against all milestones.

Diabetes Community Services Remodelling

33. In September 2016 it was agreed by the Executive Committee of HAST CCG that plans could be worked up to remodel the current community diabetes service. The following key objectives were proposed:

- Identification of people with pre-diabetes allowing early interventions to take place to prevent the development of diabetes
- Change of pathway for patients diagnosed with Diabetes to focus the majority of care within primary care with a cohesive management plan, including self-management and clear contact information for any concerns / issues, agreed with the patient
- Ensuring more intensive support within the community service for patients with more complex needs
- Ensuring the flow of patients between primary, community and secondary care as required by ensuring that patients are able to step up and step down between providers as their needs change and their condition stabilises with the aim to return to primary care.

34. Plans were developed throughout 2017, working with the current community diabetes provider, NTHFT, to pull together a model, revise the service specification and agree next steps to implement the model.

35. It was identified that the project would require investment to be fully implemented and due to financial constraints highlighted within 2017, this investment was not available. Emphasis in year has switched to implementation of the NDPP and it is anticipated that the remodelling work will be reviewed and included as part of the planning cycle for 2018/19.

NEXT STEPS

In order to deliver the recommendations in this paper the Health and Wellbeing Board is asked to consider the following next steps

1. Establish a multiagency group with leadership from the CCG and membership from local authority and VCS including Diabetes UK to
2. Support the implementation of the NHS Diabetes Prevention Programme for TVHRW STP in Stockton ensuring universal and targeted access to the programme to prevent diabetes and reduce inequalities.
3. Plan and conduct a joint consultation with patients and carers on diabetes related health and health care needs and views on current services and proposed changes.

FINANCIAL IMPLICATIONS

The proposed recommendations will require funding from commissioning and providing organisations.

LEGAL IMPLICATIONS

There are no legal implications.

RISK ASSESSMENT

No specific risk assessment required.

COUNCIL PLAN IMPLICATIONS

The implementation of the recommended improvements will contribute to the aims of the Joint Health and Wellbeing Strategy.

CONSULTATION

No consultation at this stage.

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