DIABETES
All Party Parliamentary Group

Meeting

The prioritisation of diabetes for Government and the NHS

Thursday, 28th February 2019

Committee Room 15, Houses of Parliament

2:15 – 4:00pm

More people than ever have diabetes. More people than ever are at risk of Type 2 diabetes. If nothing changes, about 1 in 12 people will have diabetes in the UK by 2025, increasingly at risk of developing devastating and costly complications.

Yet, recent polling found that amongst the national population less than 20% of people think of diabetes as a condition with serious impact on health and life. Diabetes is not taken as seriously as it should.

We were pleased to see a continued commitment to diabetes care and Type 2 prevention in NHS England' Long-term plan, announced in January. If followed, there is a real potential to make a difference in the lives of people with diabetes.

But getting these commitments in place was not without considerable work and pressure. And turning the plan into reality will not be an easy task.

To continue to ensure diabetes remains a priority for Government and the NHS, we must understand the challenges ahead and how to beat them:

- In the next phase of the plan, local areas will put together their own plans for how they will implement the commitments. How can we prevent a postcode lottery from taking place and ensure diabetes is a local priority too?
- Are there areas where the plan did not go far enough? What more needs to be done?
- What future challenges are there to diabetes and the health system that could threaten the delivery of the plan? What impact might a 'no deal' Brexit have on the NHS and people with diabetes?

The meeting will be chaired by The Rt Hon Keith Vaz MP, Chair of the APPG for Diabetes. Attendees included Lord Brooke of Alverthorpe.

Speeches:

Prof Jonathan Valabhji and Dr Partha Kar, NHS England

Prof Jonathan Valabhji started by saying the last nine months had been exciting for diabetes. He spoke about the announced 20 billion increase for the NHS and the production of the NHS Long-term Plan. "We managed to get almost all we wanted for diabetes in the plan."

Prof Valabhji spoke about the NHS Diabetes Prevention Programme and its role in assuring the sustainability of the NHS. "I think we are not alone in England and in the UK on wanting to focus on diabetes and mainly prevention of Type 2 diabetes", he said. He mentioned the high referral numbers and uptake of the programme, and how England became the first country in the world to offer this type of service, at this scale, for people at risk of Type 2 diabetes. Due to this achievement, NHS England announced in November 2018 that they will double the capacity of the NHS Diabetes Prevention Programme.

Another topic Prof Valabhji covered was the concept of Type 2 diabetes remission. “It really came into focus when Prof Roy Taylor published its Randomized Controlled Trial”, he said, which is why NHS England has started a Type 2 remission trial with 5,000 people following a low calorie diet. “We decided to trial what has the best potential of impact. We will publish the results and see how best to move forward.”

Prof Valabhji also spoke about the investments made through the Diabetes Transformation Fund and how the commitment has been continued on the NHS Long-term plan. “It is not only to improve care, but also understand how investments in care can lead to savings in the long-term. This is a new and important way to think about care”, he said.

Prof Valabhji explained how the burden of diabetes sits within complications. “If there are improvements in the achievement of treatment targets, access to diabetes education and access to specialists in foot care and diabetes hospital care, you can see a reduction in complications”, he said. He explained how funding for a second phase of the Diabetes Transformation Fund has been guaranteed in the NHS Long-term plan to prevent a ‘fall face’. “There will be tampering down, because that was the deal. But for areas like education, where it takes much longer to see results, there will be a tampering down over the next 10 years.”

Dr Partha Kar spoke about NHS England’s priorities regarding Type 1 diabetes and their focus on improving patient care. He explained some of the resources developed for people with Type 1 diabetes, including Language Matters and the Diabetes Technology Pathway. He highlighted the commitment NHS England made in regards to Flash Glucose Monitoring, which will be centrally funded from April 2019. “We cannot fund everyone, but we have made a big commitment that hopefully is appreciated.”

Dr Kar also quickly mentioned the economic work conducted by Helen Murphy as an example of how research should influence policy; the recent NHS England Diabulimia announcement; the NHS Apps Library; and the Mental Health work conducted with Diabetes UK that will start on March 11th.

Finally, Dr Kar spoke about the Getting It Right The First Time programme, where NHS England is going to hospitals and sharing good practice. “It is not just about technology. We need the workforce in place to deliver it.”

“There is a lot of things happening. Lots of things moving”, finalised Dr Kar.

Robin Hewings, Head of Policy, Knowledge and Insight at Diabetes UK

Robin Hewings started by mentioning how Diabetes UK works closely with NHS England, and that he will not repeat what they already have said. “The prioritisation of diabetes has grown incredibly. The growth of the Diabetes Prevention Programme, the Diabetes Transformation Fund, and now the very comprehensive commitments in NHS England’s Long-term Plan are fantastic and exciting. I would not have think in past years that we would ever get here.”

Robin explained how in terms of what Diabetes UK wanted to get in the NHS Long-term plan, almost everything was there. “Taken together these changes have the potential to make a real difference. But turning the plan into reality will not be easy”. He explained how what was not in the plan relates to the wider system; the external environment which can present a big challenge to the commitments made to diabetes.

“The NHS is still under real strain. It is just one part of the health system alongside public health and social care. A reversal of cuts to public health, resources to get the NHS staff we need, and a way of paying for proper social care are all needed if we are to have a sustainable health system. The very welcome commitments in diabetes will only come about if there is a healthy NHS to deliver them. To pick one example, we are not going to get consistently good inpatient diabetes care without skilled and motivated staff to actually deliver it”, said Robin.

He finalised by mentioning the need to be mindful when scaling up the NHS Diabetes Prevention Programme, and be more conscious of the groups at risk we need to reach.

Andrea Beacham, Northern Devon Healthcare Trust

Andrea Beacham started by talking about the partnership approach to improving diabetes care that has been in progress in North Devon since January 2017, based on the premise that the best way to support people with diabetes to manage their health well is to create a framework where understanding is the catalyst for actions. "This focus on understanding applies at the level of the individual with diabetes, their healthcare providers and the healthcare system. Without this understanding, people with diabetes might not be given the support that is right for them, healthcare providers can be frustrated that their support is not as effective as they think it should be and the healthcare system has no opportunity to diagnose and address the real issues."

Andrea explains that early indications show the work of the North Devon Integrated Diabetes Service team is starting to make a difference, most noticeably demonstrated by a marked reduction in diabetes related lower limb amputations which had, for the previous decade, remained high.

According to Andrea, when we take the time to understand the issues from the perspective of everyone involved we "Understand what is really needed. Work out how to do what's needed with the people who will be doing it. And make the links that help us join up the pathway to provide a system solution", she said.

She explained the projects put in place 'STOP, LOOK and LISTEN' and 'TEST AND RESPOND', as well as their limitations, outcomes and further recommendations. You can read her full presentation here.

Andrea mentions that none of the interventions described above could be described as ground-breaking, and many take place across the country. "The model does however, provide a framework that can be replicated for taking a whole-system approach that uses understanding as a starting point for every stage of action. Because these changes to working practices were co-designed with those who will be delivering them based on the feedback of those who use them, the team is confident that they are they are moving in the right direction", she says.

Sarah Dunderdale and Caroline Cottingham, Lincolnshire STP

Sarah Dunderdale started by explaining how Lincolnshire is a large rural county with large pockets of deprivation and obesity. "We have 2 major hospital sites and a majority of patients have to travel over an hour to attend either". She shares how Lincolnshire has one of the highest constituency level diabetes prevalence in the country at 14.4% on the East Coast. "We started working on the issues in 2007 when it was predicted by 2027 there would be 50,000 people with diabetes in the county; we reached this level in 2017. The PCTs then became 4 CCGs each of whom had different priorities."

Sarah says the 2016 Diabetes Prevention Programme, followed by the Diabetes Transformation Fund, were what brought the focus back round to diabetes. According to her, the issues were:

- Huge variation in clinical care at practice level a post code lottery for standard services.
- Lack of patient support and education
- Silo working of services
- Large numbers of patient seen in inappropriate setting and traveling long distances to do so.
- Large DNA rate.

For Sarah, the funding streams enabled county wide focus, which highlighted the sheer scale of the issues. "Diabetes is now a key priority for the STP, our focus is on tackling the issue", shares Sarah. "The NHS Rightcare Pathway and the Long Term plan strengthened the case to make change and ensure that this time it will be done". They have plans to integrate the diabetes teams during 2019/20, with all four CCGs committed to making it happen.

"The NHS Long-term Plan really cemented what we want to do. We want to make sure we have it all available", she says. Sarah mentions how relationship building has been key in navigating the inpatient care network,

integrated health systems and infrastructure changes. “It is key to have the clinicians on board. Having people pick up the phone and have those conversations”. But Sarah highlights that these relationships take time, despite all the NHS support to help sent them on the path they needed.

Sarah explains what she believes could be done better for diabetes care:

- Longer term funding to embed change;
- Funding for integration projects which enable long term sustained transformational change rather than short term specific project;
- Identification of synergies across funding streams e.g. mental health IAPT and diabetes.

Discussion

Keith Vaz MP mentioned the need for a larger prioritisation of education for people with diabetes. “I think it has gone wrong in England. We have given a lot of money to companies who are not doing what they are supposed to be doing in the field. I am shocked to see the amateurish service being offered by companies receiving a lot of money from the NHS”, he says. Nigel Gainer agreed with the Chairman and, after sharing his own challenge accessing diabetes education, asked NHS England why Dafne courses were not offered across England. Dr Kar responded by mentioning how there are often patients who do not attend Dafne courses, despite being offered them. He explained how the reality is that a lot of people cannot even attend, due to not obtaining time off work. He highlights the importance of giving people with diabetes options.

Keith Vaz MP also highlighted the issue with data and how information might not be ‘hold centrally’, a response he received to many WPQs raised. “It is important to continue to ask these questions to continue to pressure government and show that we are watching”. Lord Brooke of Alverthorpe agreed with the Chairman and shared his experience of failing to obtain answers, highlighting the disaggregation of data due to funding cuts. Prof Valabhji responded to these questions by mentioning the Health and Social Care Act, and how when something is commissioned locally, the data remains locally. He notes, however, the diabetes data NHS England has is better than anywhere in the world. He also explains the issues with delay in obtaining data and how, as the NHS will start to report quarterly, their capacity to respond to WPQs will improve. Finally, he clarifies how there are things NHS England cannot realistically ask clinicians to respond. “Our response rate with GPs is 15%”

Dan Parker asks what king of support the 5,000 people going through the low calorie trial will receive to get back to eat normally. A member of the audience asked whether NHS England is aware of data in the US presenting evidence for low carbohydrate diet and Type 2 diabetes remission. Prof Valabhji responded by explaining the importance of Randomised Controlled Trials (RCTs) and its difference to anecdotal evidence. He also highlights an increase in interest for lifestyle change interventions, mentioning the NHS Diabetes Prevention Programme and the importance of addressing social-economic components that impact any dietary intervention. “That is our main challenge”. Finally, he answered that NHS England has met with the aforementioned US company and saw their data, explaining that an RCT had not been conducted and there were concerns over the increased levels of LDL cholesterol. “It may work, it may not, we just do not know. There is not yet enough data.”

Maggie asked NHS England on what service model they were going to use to ensure all pregnant women with Type 1 diabetes will have access to CGMs, as promised on the NHS Long-term Plan. Dr Kar responded by informing NHS England has built a working group to plan how the service will work.

Keith Vaz MP asked NHS England what are their five priorities on diabetes and why, on terms of prioritisation, diabetes has not reached the stage of cancer. Prof Valabhji answered the priorities are Type 2 prevention (highlighting T1 prevention is currently being researched), structured education, achievement of treatment targets, preventing amputations and inpatient care. Dr Kar responded that, if all datasets are compared, England does better on diabetes than on cancer and cardiovascular diseases. “The issue is that there is a media rethoric around cancer that is different to diabetes. We need to shift the narrative. Patient voice has a lot of power and we need to see more of it.”

North Devon Integrated Diabetes Service

NHS
Northern Devon Healthcare
NHS Trust

The understanding cycle: a framework for building local commitment and ownership of improvement in diabetes care

ALL PARTY PARLIAMENTARY GROUP FOR DIABETES - 28 FEB 2019

A partnership approach to improving diabetes care has been in progress in North Devon since January 2017, based on the premise that the best way to support people with diabetes to manage their health well is to create a framework where understanding is the catalyst for actions. This focus on understanding applies at the level of the individual with diabetes, their healthcare providers and the healthcare system. Without this understanding, people with diabetes might not be given the support that is right for them, healthcare providers can be frustrated that their support is not as effective as they think it should be and the healthcare system has no opportunity to diagnose and address the real issues.

Early indications show the work of the North Devon Integrated Diabetes Service team is starting to make a difference, most noticeably demonstrated by a marked reduction in diabetes related lower limb amputations which had, for the previous decade, remained high.[1]

This paper describes our approach, the key learning, limitations and recommendation.

Key learning:
When we take the time to understand the issues from the perspective of everyone involved we:

- Understand **what** is really needed
- Work out **how** to do what's needed with the people who will be doing it
- Make the links that help us **join up** the pathway to provide a system solution

This requires:

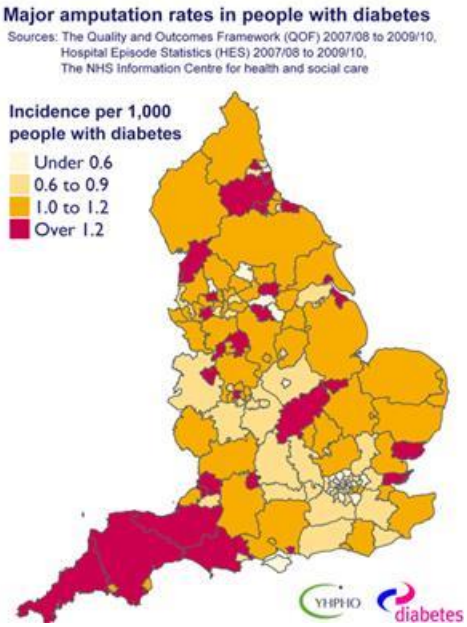
- Recognising the value and allocating time for 'understanding'. We followed a process of 'stop, look, listen, test, respond'
- Designing new ways of working with the people who are delivering the service and those that are receiving it (moving away from remote design) alongside commissioners
- Working as a system at community level including GP practices ,community nursing teams, mental health, podiatry and local voluntary groups
- Specialists spending time out of the hospital supporting primary care where the majority of people with Type 2 diabetes are supported

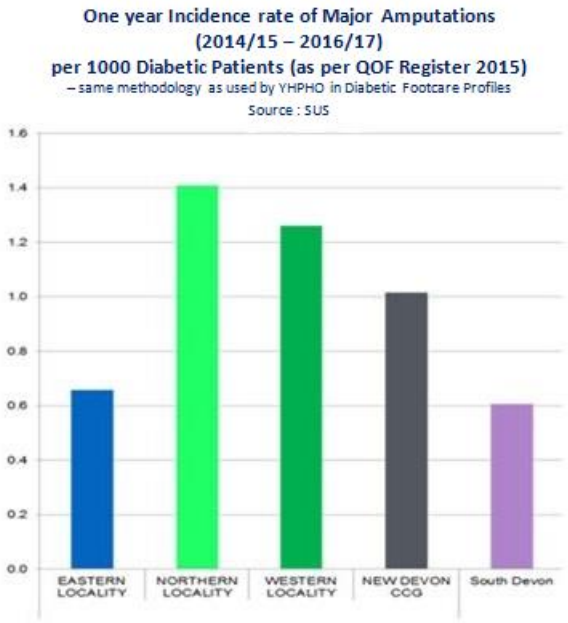
BACKGROUND:

[1] Secondary Uses Service (SUS) data, 2018

North Devon has a population of around 162,000 people and a slightly higher than average incidence of diabetes at 7.5%. However, variation exists with areas of affluence alongside pockets of high deprivation where prevalence is higher and there are some stark health inequalities with a life expectancy gap of 14.6 years[2].

The South West has a higher than average age profile and historically a higher than national rate of diabetes related limb amputations, an indicator of poorly controlled diabetes. North Devon consistently had the highest rate in Devon.





There was recognition from clinicians that local pathways contained inefficiencies, duplications and missed opportunities for learning and effective communication between primary and secondary care.

STOP, LOOK and LISTEN

The project began informally with discussions between clinicians and a small team of people decided to take the lead in tackling these issues together. The group included representatives from primary care, diabetes specialists, podiatrists, dietitians, psychologists, commissioners and patients. At this stage, the work was unfunded and relied on the enthusiasm of the individuals to make time to attend.

The first step was to understand what works well, what doesn't and whether we were doing what matters. No suggestions at this stage were made about solutions.

We engaged people with diabetes, holding two patient focus meetings, 22 individual patient interviews, 163 patient questionnaires and attending 3 local diabetes UK meetings. We engaged with clinicians through eight GP questionnaires, three GP forums and four primary care workshops with 72 attending from 13 practices.

<u>What people with diabetes said</u>

[2] http://www.devonhealthandwellbeing.org.uk/jsna/overview/archive/starting-well/life-expectancy-at-birth/ Table 8.2, Shortest and longest average life expectancy in years (LE) at birth by ward, Devon local authority districts, 2009 - 2013.

People with diabetes told us that family support was one of the most important factors in managing their health; that one of the biggest struggles was maintaining a healthy lifestyle yet there seemed to be little out there to help them with the motivation and tools to do that; some felt judged by doctors and nurses because they hadn't improved their weight or targets; there was not enough recognition and support for the psychological impact of diabetes and they felt particularly overwhelmed when diabetes was only one of the long term conditions they were trying to manage. There was also a worrying variation in their experience of diabetes diagnosis and care depending on where they lived and which practice they attended.

Nearly all valued their relationship and review with their practice nurse but that this wasn't frequent enough to help them with day to day questions and those who attended peer support groups found it to be a lifeline.

What clinicians said

The diabetes specialist team recognised that they only saw a very small proportion of people with diabetes so their impact was limited with the majority of diabetes care and oversight being in the community. They were frustrated at having limited opportunities to offer advice or input into the wider services or prevention strategy.

GPs said they felt de-skilled as the practice nurses managed most of their diabetes care and they were less confident about prescribing now that there were such a wide variety of treatment alternatives. GPs and practice nurses said they would welcome increased opportunities to consult members of the specialist team about individual patients and also raised concerns about house-bound patients who they felt weren't receiving the same standard of care due to split responsibilities. There was general consensus that they needed better tools to help patients make needed lifestyle changes.

Podiatrists and vascular surgeons were concerned that people whose feet were at risk of ulceration were not being referred soon enough and that people were not as aware of the risks as they should be. All clinicians recognised the service would work better if it was joined up across the providers with more emphasis on supporting 'people' with diabetes rather than concentrating on their feet, eyes or HbA1c results. This was echoed by people with diabetes.

TEST AND RESPOND

After listening to these views, the team began working together to address some of the areas identified. At the same time, the Devon STP was awarded Diabetes Transformation Funding[3] which enabled the team to begin to test whether employing more staff would help in addressing some of the issues identified as well as enabling some dedicated project support.

Foot care

We wanted to test the hypothesis that if practice linked podiatrists were employed to work more closely with practices more people would be referred at the right time to the foot protection service. It was a two-fold approach of increasing understanding of patients and healthcare providers in the importance of foot checks, how to correctly assess risk and refer accordingly, followed by increasing the capacity of community podiatry to respond to the increase in referrals.

[3] Bringing together the plans of its four localities, Devon STP was awarded Diabetes Transformation Funding in June 2017. The Northern Locality was allocated c. £700k for two years to improve treatment targets and reduce amputations.

These podiatrists have been working with their practice cluster, providing education, shadowing and joint visits. By testing new ways of working together we get a better understanding of the detail of what can go wrong. In one practice, open discussion revealed that foot checks were not being carried out consistently. The podiatrist trained the HCAs to carry out this role meaning more time was now allocated to this important check. Another discovery was that practice nurses weren't always sure if the referrals they made to podiatry were appropriate, making them hesitate to refer. A letter is now sent after each referral comparing the level of risk found by the podiatrist to that found by the practice. This acts as an educational tool and reduces delayed referrals.

The multi-disciplinary footcare team (MDFT) tested whether having a weekly forum to discuss patients of concern without bringing them into hospital would mean those at higher risk of amputation could be triaged sooner. North Devon is a predominantly rural geography and practice nurses explained that many in the farming community would not make appointments to have sores on their feet checked until problems were advanced. This 'virtual' forum is an opportunity to discuss and monitor patients and arrange appropriate investigations prior to face to face contact in the clinic. Using Transformation Funds, podiatrists were given iPads to share photographs of feet which could be triaged without patients having to travel long distances.

Specialist support to primary care

The team wanted to understand the best way to provide the specialist diabetes support that GPs and practice nurses had said would help, within the workforce constraints that funding would not resolve. A programme of support that would be beneficial but practical and achievable with the existing workforce was co-designed and tested with the diabetes consultant, diabetes specialist nurse and podiatrist in four GP practices across the locality. Practices are now scheduled to receive an annual support visit which brings together the practice team with the community and specialist team. During the visit they review practice processes and discuss up to ten patients that the practice has identified and a plan of action is jointly agreed. GPs felt that their knowledge and tools to provide dietary advice was lacking[4] so transformation funds have enabled these visits to now include a dietitian to help inform and equip practice staff to have discussions about diet and nutrition with their patients.

The discussion around practice processes has proven to be as valuable as the patient discussions as it has highlighted variation in delivery both between practices and within them. It is only variation in *quality* of practice that the team has been interested in, rather than the actual process which can vary according to patient list size or workforce as long as those carrying out the processes have the right clinical competencies. The team has been able to collect best practice examples from these visits and share them resulting in a body of learning that increases with each visit.

A template has been co-produced that can be added to all practice IT systems to deliver a consistent *and* personalised approach to agreeing a plan of action. After their diabetes review, people are able to take away these care plans that include graphs of their test results and the actions they've agreed to take.

In addition to the practice visits, the specialist team have tailored their communication channels to be available to discuss individual patients, introducing hotlines and email advice lines.

Personalised, place-based support

An issue that concerned both people with diabetes and their primary care team was how to make the lifestyle changes they understood to be necessary. It disheartened people that they didn't have the tools

[4] NHS Long Term Plan, Chapter 2, 2.19

they needed to sustain changes to their diet and activity levels and it frustrated healthcare providers that they weren't in a position to provide the necessary support.

There was a strong view from the clinical workshops that funding should not be used to put a new lifestyle support service in place that may not be sustainable, therefore tools would be provided to existing clinicians to work in partnership with individuals to make lifestyle changes. This begins with conversations with individuals to understand 'what matters' to them, their motivation level and preferences as well as the circumstances they live in that either help or hinder them. The hypothesis was that if diabetes reviews had three broad themes: Me, My Circumstances and My Diabetes, then a more personalised plan could be agreed together that would be more likely to succeed[5].

To embed this into working practice, the template for diabetes appointments includes this feature which promotes shared responsibility for health, a feature of the NHS Long Term Plan.[6]

An annual programme of training is now available to all practices to have motivational interviewing and lifestyle coaching by psychology and health coach professionals.

The next stage is to have options available to suit individual needs and preferences, such as education resources tailored to learning styles and introductions to local activities that interest the person and fit with their schedules.

Even before engagement took place, it was clear that people in North Devon prefer to stay local. There is a successful Diabetes UK group that runs in the largest town and those who attend it are effusive about how much it helps them manage their diabetes. However, very few people attend who do not live local to the group therefore 'place-based' opportunities needed to be encouraged. A variety of community activities have been tested such as exercise groups; practice support; peer support groups and 'Diabetes Wellbeing' events. These events bring together diabetes specialists, practice nurses, podiatrists, dietitans, psychologists, health, pharmacists and other wellbeing services and the local Diabetes UK group. Detailed local knowledge and links were important and transformation funds allowed the team to test working with a community partnership organisation to bring the local elements together. Feedback from the 600 + people who attended was that they valued the opportunity to ask questions of clinicians they would not normally have access to and find out what's available in their community. The events have generated new referrals and resulted in a further peer support group. There has been positive feedback from clinical staff and four wellbeing events are now scheduled to rotate across communities annually.

Not all the place-based tests have proven successful – part of the cycle of learning process is to understand whether the whole intervention was not wanted or whether it was certain aspects that could be tweaked and re-tested.

Equality of care at home

Having listened to concerns that housebound patients were not receiving the same quality of care as those who could attend appointments, the team tried to find out more. It transpired that there was no consistent approach across the locality. Not everyone in the process had the correct competencies and communication between providers was not working well. In response, the diabetes specialist nurses have invited all nurses who care for people at home to become diabetes link nurses, with enhanced training in diabetes. 25 nurses from primary care, community nursing and care homes have been trained to undertake this role. Communication links are strengthened between primary and community nurses and their GPs during annual support visits.

[5] Developed with EasierInc

[6] NHS Long Term Plan, Chapter 1, 1.38.

SUMMARY OF ACTIVITY

None of the interventions described above could be described as ground-breaking, and many take place across the country. The model does however, provide a framework that can be replicated for taking a whole-system approach that uses understanding as a starting point for every stage of action. Because these changes to working practices were co-designed with those who will be delivering them based on the feedback of those who use them, the team is confident that they are they are moving in the right direction. The cycle of stop, look, listen, test and respond can be built into any programme and will result in experiential learning and a feedback loop that drives a continuous improvement cycle.

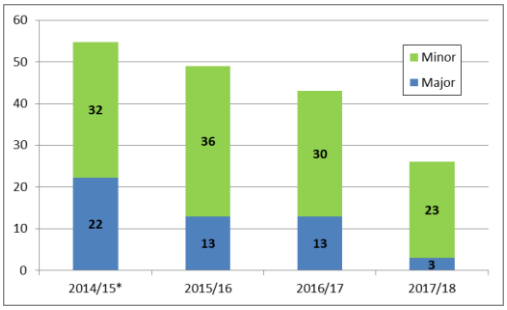
PROGRAMME LIMITATIONS

To date, the team has been unable to spend the time required to talk to people who do not fully engage with the current commissioned service. We hope to do some work in this area, as evidence shows that such people who are often 'exempted' from QOF targets, have the worst health outcomes[7]. We believe we may be able to test some adaptations to current processes when we are more confident that we understand the various reasons people don't engage.

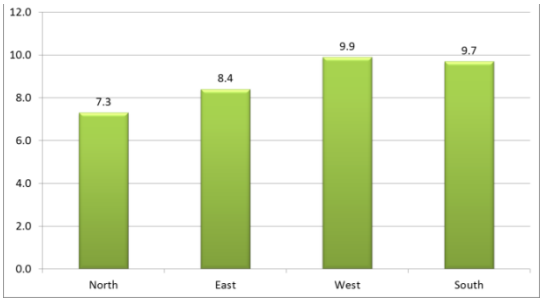
The personalised joint care plan template that has been created for diabetes appointments has yet to link fully with the non-medical community-based provision. The community infrastructure to include this is planned to be rolled out across North Devon by March 2020 but is so far only available in two localities. It is vital that these workstreams come together alongside social prescribing if this is to be achievable.

PROGRAMME OUTCOMES

To understand whether these interventions are succeeding, the team is monitoring whether fewer people need treatment for diabetes related complications. Early results are encouraging.



limb amputation rates in North Devon



Avg. length of stay for people admitted with active foot disease (days) 2018

Diabetes Lower

There are many factors that will have contributed to this improvement from all parts of the pathway from patient education to improving communication between primary care, podiatry and MDFT as well improvements to the vascular pathway and network arrangement. It is difficult to identify direct cause-effect but since the start of the programme there has been:

- Over 50% increase in referrals to podiatry for people with diabetes
- Despite this increase, average waits have reduced by 10%

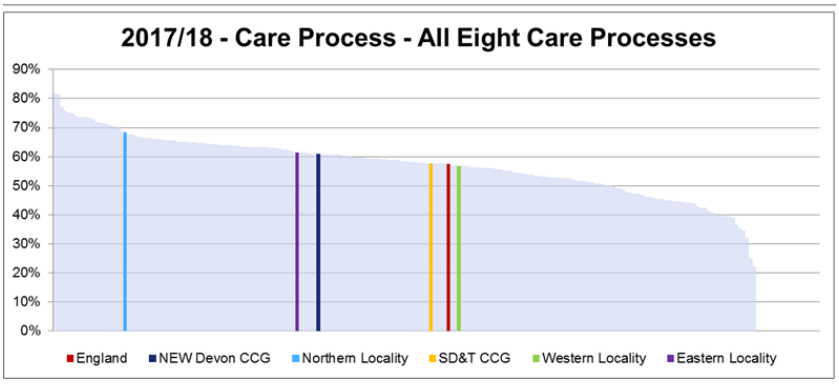
Prevalence of diabetes in North Devon has increased from 7.1% to 7.5% yet

- emergency admission into hospital for people with diabetes has reduced from 16% to 13%
- major amputations have dropped to 0.6 per 1000, a reduction of 77%, compared to 0.8 per 1000 in England[8]

[7] Associations between exemption and survival outcomes in the UK's primary care pay-for-performance programme: a retrospective cohort study, BMJ Journals, September 2016

[8] Public Health England, Diabetes Footcare Profile – 2011/12 – 2016/17 May 2018

Recent figures from the National Diabetes Audit show that there has been an improvement in all 8 care processes completed in primary care from 51.2% to 68.3% in North Devon compared to the England average of 57.6%. In particular there has been a 15% increase in foot surveillance which brings us slightly above the England average.



Although we have seen a small improvement in HbA1c and cholesterol levels, we recognise a lot more work needs to be done to improve treatment targets which still sit below national average.

Recommendation 1:

Funding for innovation and transformation is often awarded on the basis that commissioners and providers have a fixed plan to deliver improved outcomes with a set of outputs that will demonstrate delivery of the plan. This can result in assumptions being made and plans created that focus on doing what we currently do better, rather than considering whether we are doing the right things. It is difficult to 'test, learn and respond' with this approach and the steps of 'stop, look and listen' are often missed out altogether.

What works in one part of the country may not work in another where there is a different workforce, geography and public health profile but all areas can work to a framework that includes an 'understanding' phase where solutions to meet required outcomes are co-designed locally. This adds an initial stage into the timeframe but substantially decreases the implementation stage as the workforce is bought in and has designed something they know can be implemented. It should also reduce the amount of 'failure demand' which puts pressure on a system by not dealing with the real need.

It is recommended that these steps are built into future plans and funding packages in order to ensure that money is spent on what really matters.

Recommendation 2:

The best place to recognise fragmented, uncoordinated working is at the level of the individual and their family and following that, at the level of the community where often multiple initiatives compete for the time and attention of the same front-line staff.

The larger the geography and strategic the focus, the wider the lens and the less it is able to focus on the detail. The GP workforce in particular can feel overwhelmed by the number of overlapping and competing priorities that rain down on them. There has been a great shift towards systems working at an STP level and the same emphasis needs to be given to systems working at a community level where the size of the system is small enough to include a much broader partnership including the voluntary and community sector who have a big part to play in improving health and wellbeing.

Northern Devon is building a systems infrastructure (One Northern Devon) that brings strategies together such as those that overlap around out-of-hospital care, social prescribing, diabetes

prevention and local health needs assessment and brings them through one route into the community partnership systems it is helping to develop.

If diabetes is to remain a local priority, it is recommended that equal emphasis is placed on developing partnerships at community level where much of what's identified in the NHS Long Term plan will take place. Future measures of success could include how well any new group, work or service integrates into the rest of the system at a local level.

Recommendation 3

One size doesn't fit all and whilst everyone should receive high quality care, it should be recognised that this care can be tailored differently. If we are to tackle heath inequalities, local teams need the flexibility to be able to spend more time with those most in need of support to understand the person in context. Local support should be targeted in areas of high deprivation where the incidence of diabetes and co-morbidities is higher and people are less likely to travel to clinics or groups.

It is recommended that there is a specific focus on how to best support those with the most stark health inequalities including QOF exempt patients, people living in areas of high deprivation and people with severe mental illnesses (in line with the NHS Long Term Plan[9]).

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[9] NHS Long Term Plan, Chapter 2, 2.14 and 2.30