North Devon Integrated Diabetes Service

Project Team Notes

Friday 3 November, 9am to 11am

	Description
	Introductions & apologies **Present: Glen Allaway (GA), Sharon Bates (SB), Andrea Beacham (AB), Stephanie Johnson (SJ), Karen Murray (KM), Gayle Richards (GR), Lindsay Stanbury (LS), Michelle Stevens (MS), James Szymankiewicz (JS), Jonathan Wilkins (JW)** **Apologies: Alastair Watt (AW), Nic Harrison (NH), Clare Shanley (CS), Pat Doran (PD), Claire Morgan (CM)** **Finance** AB highlighted that it was proving difficult to spend a full year's allocation of clinical backfill funding in 7 months. This was particularly the case for the primary care allocation. This funding is managed between the CCG and GP practices so it was suggested that the full funding is allocated to Year 1 and transferred to the GP Provider Group which has been set up to be able to be a vehicle of this nature for 'cluster' funding arrangements. Need to supply a clear rationale for changing how the funding is spent. If this could be agreed, it would set a precedent and allow funding to be spent over 2 years. The need has previously been identified for a post to co-ordinate and support the eight projects and this has been allocated within the project support budget. It had been suggested that this role could extend to maintain the new service delivery model of integrated primary and secondary care. The team felt that this was not necessarily required as long as the project co-ordinator is tasked with completing the exit strategy for the primary and secondary care integration which should include how the service should be maintained and developed in future. **Actions:** AB to update finances accordingly. **Project updates** <u>Making every consultation count</u> GR went through her project highlight report with the team. A discussion took place about PAMS. Apart from the reluctance of PNs due to the extra time this would take the question is what to do with it once the patient has been scored. GA said it would

	be useful to target advice dependent on score but there's not much in the way of evidence that the patient score can be improved. It feels like the score just tells you where they are but not why or what to do about it. It was suggested that a half day training session should be arranged to understand some of these issues using the backfill funding. Organise a training session and go out to all practices to ask for volunteers to pilot it. Spec to be developed about what we're asking them to do and output requirements. Questions raised are "Does a certain score determine why they are there and highlight those that need more input? Can we shift someone from one score to another?" It's also important to understand if there is long term funding for licences. AB advised that licences last the lifetime of the patient but that did not answer the question of how long new licences would continue to be issued. Question for Kim Hopkins who is leading implementation across Devon: "What is being done about the why the patient is at that level and what is likely to happen regarding funding after the two year project period comes to an end?" Could this become a LES to work up a trial for GPs to offer longer appointments or pay for a LES to get practices to implement PAMs post trial. **Actions:** GR will advise what the initial reaction is when she goes out to practices. AB/CS to investigate training session and invite all those who have expressed an interest in PAM in order to test use. MS to raise questions with Kim Hopkins <u>Evaluation:</u> The team reviewed NH's highlight report. Data gathering process but now trying to define what elements are useful. We now have practice level data but it has not been fully interrogated as yet to make sure it tells us what we need to know or gives a useful baseline. Peter Nolan who is leading on the STP evaluation has asked AB to ask GP practices for their comments. **Actions:** AB to take results to practice visits for their comments about whether the data is useful in terms of providing a clear baseline and understanding need. <u>Podiatry</u>: The team reviewed LW's highlight report. The new podiatrist posts paid for by the Transformation Fund have been approved and are currently out to advert with 18 month contracts. <u>Place Based Wellbeing</u>: The team reviewed Hannah McDonald's highlight report. The first wellbeing club has taken place and was considered very much a success from the Fremington GP practice perspective. The feedback from all the practitioners in attendance was that it had been valuable to attend but this was not the case for the DSNs as the practice had only invited pre-diabetic patients which meant there was nothing the specialist team could bring that the practice nurse couldn't offer. Patient feedback was that they feel more informed and better able to manage when they came away. Next one in Ilfracombe will be held at the Lantern Centre. It was suggested that Lynton & Braunton practice patients should be invited to the Ilfracombe venue. JW asked to be advised of

	the date as he's not seen any invites yet. The evaluation needs to be more refined than the first event. Ask people what they have learned that they didn't know before and what they would change. Could then follow up to see if the change has been made. Proposal to ask people to think about three things at the start of the meeting. Fremington are taking this forward and are planning regular wellbeing clubs, although not necessarily diabetic focused. **Actions:** Lynton & Braunton patients, invite JW, update evaluation to include the above. Primary care team access: Needs a project lead. Three practice visits are booked for the 8th November with a further 3 practices on hold. Need to have a plan B as it's not clear how long AH will be unavailable. Funding is at risk if nothing implemented. Options discussed are fund a locum for 2 days a week. West are going for a locum 3 days a week to cover their consultant doing the practice visits. Will try and tap into the locum they are recruiting. George Thomson has offered to do the visits alongside Gayle and Lyndon. Or use the locum to undertake the visits. Take up George's offer on the first three visits and then review. Key outcomes as discussed plus a hearts and minds review. Leicester CCG has identified funding to develop specialist GPs to support their service. JW proposed taking the specification to the provider group for discussion. GA said that the service in North Devon would still remain vulnerable. The current Mutual Support Agreement only covers an emergency scenario for a period of three months. Is a longer-term solution being worked on? Chris Bowman has offered to help step in to cover AW's role with George Thomson taking the clinical diabetes role. The group appreciated this but felt the clinical leadership in the interim should come from existing team members. JS and GA offered to share this responsibility together. The team felt it was a good message to have project clinical leadership from primary care as the SRO is George Thomson and this is a co-produced project. **Action**: AB to speak to George Thomson and Chris Bowman about JS and GA acting as clinical leads for the project. Virtual Clinics content was agreed to be an hour open to all staff to provide an overview of the project (ten minutes) and then a clinical Q&A. Review of a few complex cases; obtain an overview ahead of time to allow visiting team to work through. Two hour session around design of the following three items, patient management using advice and guidance facilities, practice education sessions and practice audit and RCAs. Responsibility for the patient remains with the GP unless the consultant takes over the patient's care. It hinges on whether a referral has been made or not. JW has discussed this with the Medical Protection Society and they have been very clear on this. MDU, MPPS letter to be framed if it becomes an issue. Give surgeries the option of how they access the advice and guidance. Should it just be Eclipse, or then e-mail, letter or phone call. Email doesn't integrate into either clinical system. The Trust's new PAS system can attach documents. Identify 6 areas to try out during the initial visit and then at the follow up visit use it to see how it works. **Action:** MS to make Elaine F aware that Consultants in Secondary care are unable to log on to Eclipse then this could be used in preference to the DRSS service. MDFT: Mel is currently on leave so there is no update. Ensuring same standard of diabetes care at home

	Karen Murray explained that she has a role across the STP to ensure care homes are signed up to the FRAME foot education tool. The majority of people she has come across had not previously heard of this tool. It was agreed that Karen needed to be linked to this work. <u>Improving access to healthy lifestyle support:</u> There is a sum of £38k for improving access to healthcare support. Dietetic support has been discussed as a potential for using this and following Workshop 4, Tim Burke did some work to identify drug costs which would be reduced according to the evidence Ellie put forward at the workshop. Lyn Palmer also provided evidence about the benefits of Health Coaches. There has also been discussions about the need for clinical psychologists attached to the diabetes service. All of this is not affordable and JS suggested that, if we are to provide a sustainable lifestyle support service, that is universal and continues beyond the life of the project, an education programme is developed to upskill primary care in dietetic support, etc. SB had previously made this suggestion and the team agreed it would be the only way of improving universal access to support. The resource would be for lifestyle support to include dietetics, health coaching, psychological etc and JW proposed upskilling HCAs and peer support groups as well. The use of free apps should also be considered. **Action:** AB/CS to update the lead for this project once identified. <u>Patient Education</u> JS is leading the project but it has so far been difficult to find a mutually convenient time for the team to meet. SH is currently trying to get a date. Takeda support documentation discussed. They also provide a patient app and something that could be screening in the waiting room. JW's impression is that an app would only be useful to those patients already motivated as it is a very low level intervention. If there is no funding, then it was proposed to fund specialist dietetic time to provide training to HCAs and providing local peer support groups using a hub and spoke model, continuing training to a cohort of local practitioners.