North Devon Integrated Diabetes Service

Project Team Notes

Wednesday 7 February, 12.30 to 2pm

	Description
	1. Introductions & apologies Present: Annika Palmer (AP), Sharon Bates (SB), Andrea Beacham (AB), Stephanie Johnson (SJ), Gayle Richards (GR), Lyndon White (LW), Melanie Hucker (MH), Lindsay Stanbury (LS), Nic Harrison (NH), Amy Williams (AW), Sheree Southworth (SS), Chris Thomas (CT), Kerry Burton (KB), Chris Thomas (CT), Nic Harrison (NH) Chris Bowman (CB) Apologies: Glen Allaway (GA), Katherine Allen (KA), Clare Shanley (CS), Michelle Stevens (MS) Pat Doran (PD) 2. Notes and actions from meeting held on 8 December 2017 Previous actions: PAMS Plan is to test in Bideford and Wallingbrook. AB & AW met with Clinical Pharmacist Karen Acott in Wallingbrook who led on a national PAMS project, so AW will meet up with Karen and Caroline Sanford Wood the PM at Bideford who also has some experience in PAM to agree the way forward. **Action**: AW to meet with Karen Acott and Caroline Sanford-Wood to discuss possibility of a PAMs test Practice data Waiting to get data updated by Pete Nolan. Will be included in Nic Harrison's work. Primary care budget AB to discuss finances/spending with Michelle Roe. AB said she will update on this in Finance item. Training for Eclipse CS – action complete, Eclipse training took place with 20 participants Diabetes UK AP confirmed Diabetes UK will not be charging for leaflets. Virtual Clinic AB to circulate latest virtual spec – action complete SB said element to discuss cases highlighted by practices was very important to include within

the spec.
Need to ensure we record activity that arises as a result of the support visits – ie telephone advice, work shadowing etc.
Action: AB to plan with project team how recording practice support activity will happen

Ilfracombe Wellbeing Club
AB action complete. AW to update in that agenda item.

3. Project overview –

Amy Williams has joined the team to support the clinical leads in 5 of the 8 projects. She is meeting with each of those leads and teams separately. Chris Thomas has joined the team as the representative for community nursing and Karen Acott has joined the team as representative for community pharmacy.

Overall STP highlight report submitted (brought forward by STP a week so out of step with project meeting). AB thanked the leads for getting their reports completed so that she was able to submit within earlier deadline.

Action: **AB** will circulate the STP report.

4. Project updates –

Integrated Primary and Secondary Care:

AB advised that contact has been made with Richard Paisey, a retired diabetes consultant from Torbay who continues to have a role in improving diabetes services within the SW cardiovascular network about covering the diabetiologist role within the project (not the clinical diabetes work that is ongoing within the current diabetes service which is currently being covered by a locum but we are looking to fill two substantive posts).

Next practice visits are Caen (22 Feb 11am-1pm) and Hartland (14 March 2-4pm). Once Litchdon has been visited this will be the 6th design visit and then it will be taken to the GP forum to be rolled out.

Action:
SB to check the next available date of forum.
AB to send SB virtual spec to get thoughts. AB circulated yesterday and asked for comments.
SB said element to discuss cases very important.
LW said the offer of 'sitting in' foot clinics would also be helpful. Important to have flexibility to meet individual practice needs.

Project team agreed we would sign the STP Practice Support visit spec with the North appendix that had been circulated subject to GP and NDHT sign off.
Action: LS will take report (within appendix) to Tri-U in NDHT and CB will take to Execs.

CT asked if community nurses could be there as may be looking after more complex patients. This is included in the spec. LW said need to discuss how we support community nurses. CT asked for list of dates when circulated.
CT asked for list of dates when circulated.
Action: AB to send dates to CT

Podiatry/MDFT:
LW gave an update:
Lots of overlap with MDFT. Looking at digital equipment (shared with MDFT). A rep is visiting on 8 February to explore. 5 new staff recruited who start on 19 February. Did practice nurse update (promoting FRAME) at Park Hotel. Received very positive feedback. Diabetes Foot Admin will be chasing people about FRAME (e.g. keep record of who has done the training).
Action: LW to include in project highlight report – details of when and to whom FRAME has been promoted & numbers who have completed the FRAME training. Also include this in the training table that CS has circulated.

Currently have no way of tracking patients between podiatry and other disciplines to identify if seeing within timescales should be seeing them?
Action: LW is meeting with IT and NH to look at how this can be done.

Potential to use diabetic flag on Trakcare as no current register means manually adding. RD&E has retinal screening database which is best way to identify. Exploring inter-compatibility between this and Trakcare.
MH – also issue of measuring outcomes as we're not entirely sure if patients are following the right pathway.
Action: AW to attend MDFT clinics to help review patient flow
LPM – South Devon may have done screening on Diabetes passport – MH done on leg ulcers.
Action: Podiatry & MDFT Teams to articulate exactly what the issues regarding tracking patients are and agree plan for solving the issues.

MH – also issue about cover for vascular consultant from Taunton. AB has requested the service agreement between Taunton and NDDH but has been advised that this has only ever been in draft and the draft is now out of date as we are no longer providing vascular surgery at NDDH. AB had advised GT who was due to meet with the vascular commissioners.
Action: AB to raise with CB to understand who is picking this up.
Tony Layton is currently drawing up the spec.
Action: MH & LW to speak to Tony Layton & Gillian Taylor.

Wellbeing event in Ilfracombe went well from a podiatry point of view.
Continuing to look at foot assessment template to be used in primary care and embedding it into IT systems.
Action: LW to ensure this is linked up with the GR's template in the MECC project.
New education programme NAF questionnaire – based around new patients (newly diagnosed foot problems). Running a pilot currently doing this.
Action: LW to ensure this is linked up with the Patient Education project.

	Also doing some work around staff competencies and input into wards. Action: LW/MH to add detail of this in highlight report and also to include in staff training table (as previous action) LW & MH highlighted the risk around decommissioning of transport for some podiatry patients AB asked LW/MH to describe a situation where this might impact as we have not so far been able to explain what the impact or potential impact is. LW & MH said it has potential to affect the patients who are most likely to result in poor foot outcomes. **Action:** AB to re-instate in risk register. LW & MH to describe the potential risk to a patient and monitor to see if this risk occurs. KB said that funding was requested in the bid for domiciliary podiatry visits. LW said it is possible to do joint visit with DN's. **Action:** LW to confirm what the pathway for patients with diabetes who are homebound but have an at risk foot. RCA training Need to rename as investigation training and currently developing a tool that is consistent with national best practice that would be beneficial to roll out across primary care also. Invites have gone to primary care. NH offered any help around data translation and support. **Actions:** SB to re-circulate the invites. <u>Healthy Lifestyle Support:</u> LPM updated that not able to have second meeting yet but the first meeting was very productive. The group developed an outline of training that could be delivered flexibly and identified some lifestyle referral pathways. Not anticipating any major delays. MH advised that a good forum to access all practice nurses is the CEPN – half day shut down. There are also separate forums for HCAs. **Action:** MH to put LPM in contact with Lucy Wood who leads the CEPN. <u>Making every contact count:</u> GR updated: Breaking it down into smaller pieces – starting with first appointment after diagnosis (working with Bideford Medical Centre). Looking to send some communications to patients before first face-to-face contact. Signposting to web-based resources and pack left at reception prior to appointment. KB asked what the outcome of the Informatics project was. SB advised that the stumbling block was the time it took for the Path Lab to do the work needed. Whilst it had good results in Litchdon it would have been a lot more work if it had been rolled out across North Devon. SB said it would be possible to do similar on System One. Now thinking about HbA1c, cholesterol and blood pressure but opportunities also to include signposting etc. KB asked if it is worth going back to Tom to see if things have moved on – GR to contact. RiO may also be able to do graphs.

Action: GR to contact Tom Lewis for his views.

Diabetes care at home
First meeting of Chris Thomas' project is scheduled. SJ agreed to be part of project team.

Place-based offers:
AW updated:
Wellbeing Club in Ilfracombe attended by around 150 people and 14 staff. As patients left tried to catch to complete evaluation sheets. Planning next one in Torrington on 5 March. Most people came because they had a text that morning. Torrington Health Centre do not have this service. The event will be advertised in Torrington Crier. Two retired diabetes nurses attended who were keen to be involved. Evaluation of Ilfracombe event being completed by Hannah McDonald.

5. Project Finance Update -

SS updated:
Have billed CCG for up to Q3 and billed Q4 around what was planned. Happy that some of the funding will be spent in Q1 next year. Asked that all keep records of expenses claim forms etc.
Budgets SS circulated spend claimed for – Budget Code is 53498.
AB advised that primary care funding was being dealt with separately and the STP had not had agreement for this to be used over the two years. Therefore plan of action is to agree dates for Practice Support visits with all practices and get them to invoice in advance for these in this financial year to protect the funding.

6. STP Update -

AB advised that one of the actions across the STP was to establish a Diabetes Clinical Forum in each locality. It was agreed that this project team acts in that role for the duration of the project and then continues in a form that includes monitoring and evaluation and ongoing service development into the future.
Action: Andrea to update the milestone accordingly.

7. Issues and Risks Log -

Issues and risks added to log from this meeting with mitigating actions:

Issues:

- Capacity of the project team to carry out the work within the STP timescales required. Project support capacity has been increased (see 3. Project Overview)
- Primary care funding (see 5. Project Finance action)
- Vascular pathway (see 4. Project Update – Podiatry/MDFT action)
- Consultant availability for Practice Support visits (see 4. Project Update – Integrated Primary & Secondary care action)
- Virtual Clinic/Practice Support spec (see 4. Project Update – Integrated Primary & Secondary care action)
- Keeping stakeholders updated (see 8. Communications – action)

Risks:

- Loss of patient transport for some podiatry patients (see 4. Project Update – Podiatry/MDFT action)
- Not recording activity related to the practice support service (see 2. Previous Actions – Virtual clinic action)

8. Communications Plan -

AB asked team if they felt it would be a good idea to create an IDS newsletter for primary care that could include updates, information, opportunities and requests in one package. If so, should this be monthly, quarterly? SB thought it would be a good idea and could be done monthly and could be done as a link to the 'Friday email' sent out by Sharon Hobbs.

LW said some of our group emails sometimes people get missed off. GR also think about diabetes news for patients. LW asked if communications around Alastair had gone out. AB said no, but they are planned to go NDHT and GPs at the same time.
Action: SB to send to primary care & AB to send to Jess Newton to go in Chief Execs Bulletin.
Action: AB to schedule in monthly IDS update for primary care and patients

9. Project modelling -

NH updated:
Ambitious idea to support project using modelling for patient pathways, tracking how disease progresses. We can then turn various projects on and off and how this impacts – hoping to show whole is better than sum of parts. This will help with business cases etc.

Need projects leads/reference group to determine pathways and assumptions, to design the model. Aim to meet in about a month's time. Also planning to add to next project group meeting and needs to include each project.
Action: NH to liaise with AB about what's needed to progress. Also need someone from primary care.

10. Next Steps

Not discussed.

11. AOB -

There was no other business discussed.

12. Date of next meetings -

Friday 2 March from 9-11am, Wednesday 4 April 12-2pm; Friday 4 May 9-11am.