Committee: Health and Wellbeing Board

Date: 28 November 2017

Wards: ALL

Subject: Diabetes Strategic Framework (Whole System Approach)

Lead officer: Dr Dagmar Zeuner, Director of Public Health & Dr Andrew Murray, Chair MCCG

Lead member: Councillor Tobin Byers, Cabinet Member for Adult Social Care and Health

Contact officer: Amy Potter, Consultant in Public Health / Barry Causer, Public Health Head of Strategic Commissioning & Dr Joanna Thorne, Clinical Lead, Planned Care, Merton CCG

Recommendations:

The Health and Wellbeing Board is asked to:

A. Consider the initial outline of a proposed 'whole system' strategic framework for tackling diabetes.

B. Agree, in principle, to develop and participate in the 'diabetes truth' programme through 2018, noting the fit with other planned activities with clinicians and communities to inform the development of the strategic framework.

C. Agree to support the process and governance structure, and commit representatives from their organisations to participate.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. The purpose of this report is to set out the approach to the development of a whole system approach to tackling diabetes. The aim is to take an innovative approach and to develop a supporting strategic framework to underpin our whole system approach, as we learn by exploring this complex issue.

1.2. This approach will build upon the excellent work already undertaken in Merton, for example on clinical management of diabetes and on a whole system approach to childhood obesity.

1.3. It will provide significant opportunity for the HWB to further refine system leadership skills, enable them to gain insight into what it is like to have diabetes and deepen the connection of the HWB to local communities, helping to shift balance of power and decision making in tackling diabetes.

2 BACKGROUND

2.1. In June 2017, the Health and Wellbeing Board agreed diabetes as a priority for 2017/18 and to adopt a whole system approach (WSA) across the life course. Rather than a focus on diabetes as a specific disease, the aim of this approach is to use it as an exemplar for a whole system preventative

approach because it lends itself to clinical, non-clinical and prevention approaches.

2.2. Diabetes is a 'complex' problem

Diabetes is an area where the traditional 'medical model' centred on specialist and hospital based care has been unable to curb the rise in diabetes cases, serious complications and spiralling costs, and despite evidence-based guidelines there remains considerable variation in hospital, primary and community services, and patient outcomes.

Where standard 'complicated' problems require expert analysis and a logical choice of solutions, truly 'complex' problems, such as tackling diabetes at scale across a population, need more experimental approaches. See Appendix 1 for a visual example of tackling a *complicated* problem (treating diabetes in an individual) compared to a *complex* problem (understanding and tackling obesity or diabetes at a system level).

Leadership theory suggests that for complex problems, new approaches need to be tried out to see how systems react, with the opportunity to safely probe, sense, respond and repeat, using learning from the results that occur to feed back into the next iteration.[1]

2.3. This approach suggests that solutions to diabetes as a complex problem will need to emerge from the HWB and the community itself rather than trying to impose them. As such, we are framing diabetes as a systems leadership challenge for the HWB, and one which requires the iterative development of a strategic framework rather than a more straightforward clinical strategy.

2.4. As part of this, we propose that the approach to developing a strategic framework will include listening to people experiencing diabetes, trying new ways of working and then learning from these, iteratively. Although solutions to complex problems cannot always be easily replicated at scale, as they often need to be bespoke, the aim of building a relationship with people experiencing diabetes is that over time we can build a movement and voice in Merton to support behaviour change at scale, with learning for the wider health economy about how best to do this.

3 DETAILS

3.1. Strategic Framework: A Whole System Approach to Diabetes

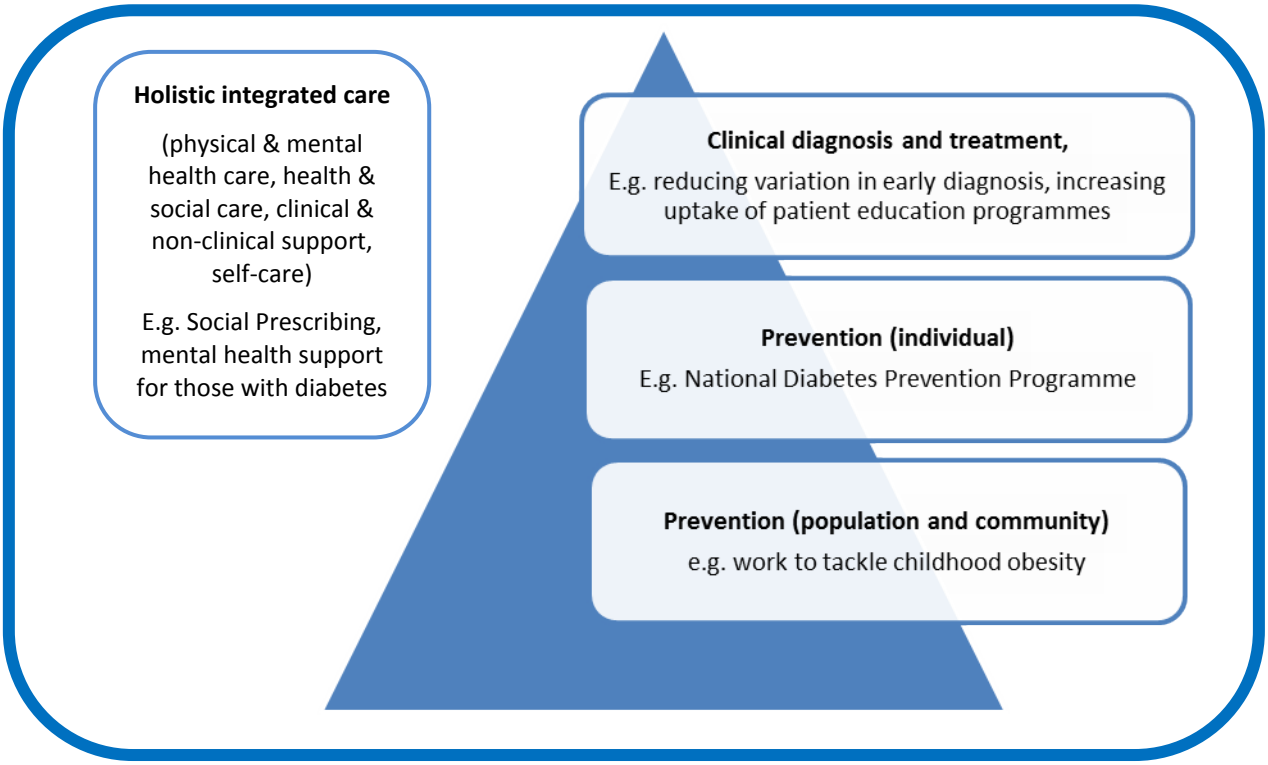
The Diabetes Strategic Framework will build on the work already undertaken in Merton to tackle diabetes. Building on the HWB work on childhood obesity and social prescribing in 2016/17, the framework will take a life course approach, span the whole health and care system, and focus on prevention and tackling health inequalities including those linked with poverty and ethnicity. It will aim to deliver behaviour change at scale, as well as improve early diagnosis and holistic integrated health and care in the community.

The strategic framework will look at where we are now, and where we want to be in terms of outcomes that matter to individuals at risk of or already with diabetes, to their families, and to the health and care system (from clinical

[1] Snowdon, DJ and Boone, ME (2007) A Leader's Framework for Decision Making. Harvard Business Review, Nov; 85 (11): 68-76, 149. https://hbr.org/2007/11/a-leaders-framework-for-decision-making

measures such as HbA1c and reduced inequalities in uptake of services, through to outcomes that the community itself defines as success measures), and how we can get there. The diagram below (Figure 1) gives a suggested outline of the different facets of a whole system approach to diabetes, but will be developed and refined over time, with the first input being the learning from the proposed leadership work of the HWB to hear from community members with diabetes, set out in this paper (Section 3.2.1).

Figure 1: Example facets of a whole system approach to diabetes



3.2. <u>Proposed approach to developing the Strategic Framework</u>

The process for the development of the framework will be an intervention in its own right, making explicit use of the different skills, experiences and roles of the member of the board as clinicians, community representatives, council officers and politicians, as well as a broader range of officers, clinicians and place shapers in the local area.

Currently, there are three main programmes of proposed work that will feed into the development of the strategic framework, and learning about 'what works', particularly thinking at scale:

- Work with HWB and individuals on a 'diabetes truth' programme: 'buddying up' with individuals with diabetes
- Work with diabetes community connectors in the South Asian community
- Work with clinicians to encourage new ways of thinking about a whole system approach to prevention, using diabetes as an exemplar

These are discussed in more detail below. Over time, as we build the learning from these pieces of work into the development of the framework, we may develop other work areas.

3.2.1 *Part one - Diabetes Truth Programme.*

The idea of a 'diabetes truth' programme is to develop the HWB's behaviour as systems leaders in addressing a complex problem, using diabetes as an example. Through insight into what it is like to experience diabetes (and what influences the behaviour that will prevent or improve conditions for people with diabetes) board members will be able to understand the true costs to those people living with diabetes, and the trade offs that they are willing to make for improved diabetes outcomes.

Funding for the programme has been secured from the Leadership Centre Local Vision to provide expert facilitation to the HWBB (by Mari Davis with whom the Board is familiar). The initial thinking is that each Board member consider 'buddying up' with a named individual, who is living with diabetes or at risk of diabetes, with the potential to form a longer-term relationship and connection with people, initially over a year. The intention is that this learning is then fed into the emerging diabetes framework and governance process.

This will help the HWB members to get a deeper understanding of the lived experience of diabetes and therefore the vulnerabilities that others might feel, the link to poverty and also how HWB and senior professionals might work with people and communities differently. What it might mean to be community led around the prevention and treatment of diabetes and how the HWB, through its organisations and teams, might mobilise people with diabetes to take action around their own health.

3.2.2 *Part two – diabetes community connectors in the South Asian community*

A further funding application has been submitted to the NHS In Place Leadership Innovation Fund. The outcome of this bid is imminent and, if successful, this work aims to broaden the connection specifically to the South Asian community to develop movement building skills to tackle diabetes (further details in supporting documents – *In Place Leadership Innovation Fund EoI - MERTON*).

3.2.3 *Part three – development workshop for clinicians*

It is also proposed, if possible within funding available, to plan development sessions with clinicians to encourage new ways of thinking about diabetes prevention, learning from the success of the LGA Prevention matters workshop in September 2017 with local Councillors and GPs.

3.2.4 There may be opportunities through this work to work with the local Academy of Public Health[2] to develop an approach (e.g. a manual or toolkit) to operationalise complex leadership challenges at work at scale.

3.3. Proposed governance for Diabetes Strategic Framework/WSA

The governance for complex problems such as a Whole System Approach to diabetes is not straightforward. Rather than introducing new governance

[2] Health Education England (HEE) Academy of Public Health for London and the South East: https://www.hee.nhs.uk/hee-your-area/north-central-east-london/our-work/working-together-across-london-south-east/academy-public-health-london-south-east

arrangements, we want to make best use of existing knowledge and structures across Merton, the LDU, SWL and pan-London. We want to make sure that there is accountability and oversight of the approach, but that there is also freedom to experiment. We propose a small steering group and inclusive reference group with HWB oversight, but appreciate the support of HWB to help us to think this through.

3.4. See Section 6 for a proposed timeframe

4 ALTERNATIVE OPTIONS

Not to develop a strategic framework to tackle diabetes.

Not to work with HWB and communities to better understand diabetes.

5 CONSULTATION UNDERTAKEN OR PROPOSED

Proposals are being developed with partners and are planned to involve partners and the community (Section 3.2).

6 TIMETABLE

Table 1: Proposed for development of Strategic Framework for WSA to Diabetes

Activity	Date
Discussion of approach at HWB	28 November 2017
HWB Focal topic – WSA Diabetes	January 2018
Launch of Whole System Approach - workshop	January 2018
Part 1: Diabetes Truth programme (Leadership Centre Local Vision)	Dec 2017 to Dec 2018
Part 2: Diabetes Community Connectors ('In Place' NHS Leadership Innovation Fund bid)	Dec 2017 to Mar 2018
Part 3: Diabetes Whole System Approach development workshop with clinicians	Early 2018
Draft Strategic Framework for Diabetes	April 2018
Implementation of a Whole System Approach	Iterative and ongoing

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

Leadership Centre funding secured is specifically for HWB facilitation support

8 LEGAL AND STATUTORY IMPLICATIONS

None

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

The Strategic Framework is specifically aimed at tackling health inequalities.

10 CRIME AND DISORDER IMPLICATIONS

None

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

None

12 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

12.1. APPENDIX 1: Examples of complicated and complex problems

12.2. APPENDIX 2: Current work underway on diabetes

12.3. APPENDIX 3: HWB paper (20 June 2017) Proposal for diabetes to be adopted as a HWB priority 2017/18

13 BACKGROUND PAPERS

13.1. In Place Leadership Innovation Fund Expression of Interest - MERTON

13.2. Snowdon, DJ and Boone, ME (2007) A Leader's Framework for Decision Making. Harvard Business Review, Nov; 85 (11): 68-76, 149. https://hbr.org/2007/11/a-leaders-framework-for-decision-making

APPENDIX 1: Complicated vs. Complex problems[3]

'Complicated' problems require probing, analysing, and then responding with an appropriate expert solution, compared to 'complex' problems which tend to need more experimental approaches and iterative feedback loops. Complex problems tend to have the following characteristics: large number of interacting elements, interactions are non-linear, the system is dynamic, and solutions are not effective if imposed rather than emerging from the circumstances. We propose that a whole systems approach to diabetes is a *complex* rather than a complicated problem.

Figure 2: Example 'complicated' problem – a linear NICE Pathway requiring expert analysis and appropriate intervention

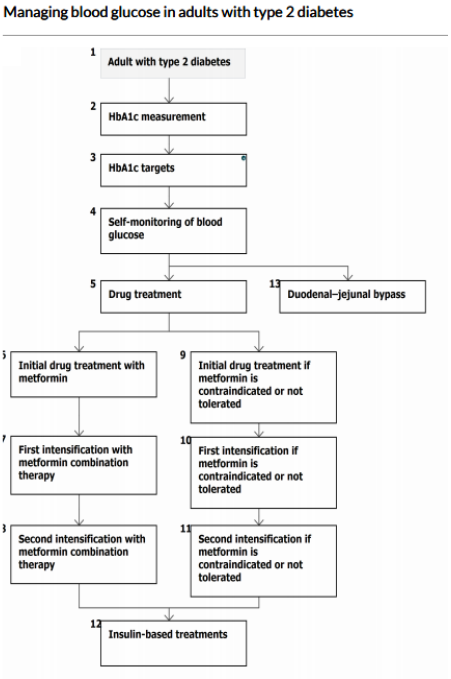
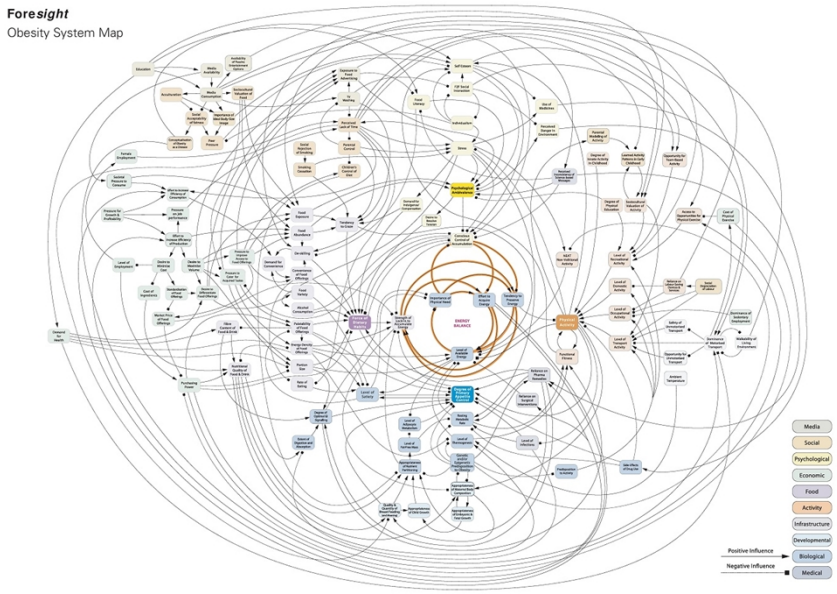


Figure 3: Example 'complex' problem – Foresight Report on Obesity 2007 (a similar picture could be drawn for a Whole System Approach to Diabetes) – making systematic change to a complex problem requires iterative experimental approaches and learning at different points across a system



[3] Snowdon, DJ and Boone, ME (2007) A Leader's Framework for Decision Making. Harvard Business Review, Nov; 85 (11): 68-76, 149. https://hbr.org/2007/11/a-leaders-framework-for-decision-making

APPENDIX 2: Current work underway on diabetes

Currently there is work underway on multiple levels, from the individual GP practice or group of GP practices, Merton Primary care level, Merton and Wandsworth Primary Care Level, and on a full SW London level. There is also work ongoing between the CCG and individual hospital trusts, so this summary is a small flavour.

Prevention (population and community)

Merton and Wandsworth Local Delivery Unit (LDU) are working in partnership with St Georges Hospital to develop a pre-diabetes pathway for patients who have been identified as a risk with 'borderline' diabetes. The pathway aims to support clinicians with giving patients good advice and directing them on to support services to try and prevent them progressing to diabetes, and also to encourage patients to engage with NHS health checks and be proactive about their health.

The work from the childhood obesity strategy that looks at encouraging people to make healthier choices is very much aligned with what is needed to prevent diabetes.

Patients who are diagnosed as being 'borderline' are then entered into a recall system to ensure they are checked annually to see whether they have progressed to diabetes. Studies show that engagement with lifestyle services such as those provided by the NDPP can prevent patients from developing diabetes, and it is important that this 'borderline' stage is not thought of as an inevitable precursor; progression to diabetes and all the resulting complications and life impact can be prevented.

Prevention (individual).

Type 2 diabetes is a leading cause of preventable sight loss in people of working age and is a major contributor to kidney failure, heart attack and stroke.

Those patients who are found to have 'borderline' diabetes can be referred into the national Healthier You: the National Diabetes Prevention Programme (NDPP) which goes live in Merton in December, and offers a combination of education about preventing diabetes and information to help reduce their risk of diabetes that will include signposting to lifestyle services e.g. weight management, exercise classes, counselling etc.

If patients cannot engage with the full NDPP there are the other public health offerings around weight management, exercise and smoking cessation (via the One You Merton service).

To ensure hard to reach diabetic patients have access to education Merton CCG is piloting a new approach to diabetes structured education (evidence is that patients who have education around their condition are much better able to manage their condition). It combines education, supported behaviour change, and self-directed learning to empower people with type 2 diabetes (T2DM) to improve their health and develop self-management skills as per any standard course but this ois offered as a series of online modules that patients can complete at a time that is convenient to them. Identified patients will have access to a Diabetes Specialist Dietician and a range of self-study learning resources.

Clinical diagnosis and treatment.

Merton CCG is focussed on improving the care of Merton diabetic patients, using the NICE guideline 9 separate care processes that each person with diabetes should have review of as a marker for quality of care.

There are clear guidelines about levels to aim for in terms of treatment targets and Primary Care reports on these and the CCG has oversight.

Where patients are more complex and need specialist intervention Merton has commissioned Central London Community Healthcare to deliver a community based diabetes service. GPs have through this service access to rapid specialist advice and review from Diabetic Consultants and Specialist Diabetic Nurses to ensure their patients receive the most appropriate treatment to manage their condition.

A certain group of particularly complex patients require hospital based care and this is provided at the three local hospitals of St George's, St Helier and Kingston depending on patient choice.

The CCG has received additional funding from NHSE to improve access to patient self management structured education (usually delivered when people are first diagnosed, but now available at any point and for top up), foot health and in-patient care. The funding has enabled St Georges and St Helier Hospitals to recruit additional diabetic nurse capacity and provide training and mentorship in partnership with London South Bank University. This additional resource will improve treatment for diabetic patients admitted to these hospitals and on discharge to their GP**.**

There is also a SWL funding bid to improve access to specialist foot care for diabetes patients. The funding has meant an increase in the number of specialist podiatrists in the area as well as the establishment of a pathfinder podiatrist to be able to help care navigate for patients and a plan in the coming year to develop a 7 day service for diabetes foot care

Merton CCG is involved with Primary Care education, both that is commissioned on a South West London basis with local provision, and with specific local design facilitated by the local CEPN. The education supports GPs and Practice Nurses to identify and support their diabetic patients well, and also aims to give strategies and options specifically for their hard to reach diabetic patients.

There is now agreed clinical management pathways around diabetes that are easily available to Primary Care and education sessions have already been run in Wandsworth and are planned for Merton early next year.

Part of the aim of the developed pathways are to support patients to self-manage their diabetes, and with education to ensure that all members of the Primary Care and Community care teams are confident and able to deliver a good standard of care. This will help to significantly reduce diabetes as a hospital outpatient specialty, as well as have an impact on the complication rates from diabetes that result from poor control.

Merton CCG reports Primary Care outcomes via the GP 'Quality Outcomes Framework' (QOF) attainment, and although there is variation amongst practices overall the area does well compared to similar other areas of London.

Standard Primary Care diabetes care involves an annual check of feet, eyes, blood pressure, cholesterol, blood sugar reading and this happens more frequently if a patient's results are not within the guideline range.

Across SWL there is work under way to try and generally improve London diabetes care and there is further education and pathway work happening at this level.

Practices are also being encouraged to engage with the National Diabetes Audit, and looking at software options that enables GPs to identify their diabetic patients that do not receive all 9 diabetic care processes.

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