Herefordshire Diabetes Network

Terms of Reference and Network Launch Information

Purpose

Herefordshire Diabetes Network is responsible for overseeing a whole system approach to local Diabetes care and support for adults, children and young people. The group represents a county-wide network of stakeholders who will collaborate as a single team along the entire diabetes pathway.
The over-arching goal is to improve outcomes for people with or at risk of diabetes

Strategic aims:

- Support local commissioning and design of diabetes services that reflect Herefordshire's population needs using Diabetes Patient Involvement and feedback, JSNA (created in collaboration with the Health and Wellbeing Board), Public Health and National Diabetes Audit Information.
- Raise awareness about Diabetes Prevention across public and professionals
- Raise the quality of diabetes care in Herefordshire, improving outcomes and quality of life for people living with diabetes. This includes children and young people affected by diabetes and their parents and carers
- Act as local "diabetes champions" committed to improving clinical outcomes and patient experience through involving local people with diabetes in commissioning and service planning and redesign processes
- Deliver a local model of care which facilitates self-efficacy, anticipatory care and personalised care planning
- Monitor local Quality and Performance Information to ensure patient safety and cost effectiveness are maximised
- Nurture a local culture of openness and transparency to maximize patient safety, enhance patient experience and harness opportunities for learning across stakeholders and care environments
- Influence the criteria essential in developing and sustaining effective diabetes services including workforce planning, clinical pathways, targets, compliance, data management and reporting mechanisms

- **Objectives**

- Actively engage people with diabetes in planning, implementation and evaluation of local diabetes services.
- To produce an annual work plan that reflects local diabetes population need, national guidance and priorities (objectives timelines and targets).
- To steer and support collaboration across local stakeholders in continuous quality improvement and ensure learning and good practice is shared.
- Identify and target areas of improvement or system failures to achieve goals and relevant targets
- Improve national diabetes prescribing metrics
- Receive and monitor local trends on diabetes related incidents and near misses making recommendations to guide actions in the interest of safety and quality outcomes. Where appropriate support local commissioners and providers with significant event analysis (SEA)
- Provide clinical leadership and advice in redesigning specific services and Pathways where evidence demonstrates a need for improvement, in conjunction with local diabetes patients.
- Maximise use of monetary, clinical and system resources to support aims of the network.
- Consider workforce, both capacity and planning to ensure requisite skills for delivery of best practice across diabetes services.
- To facilitate communication between Herefordshire local practitioners and other networks for mutual support, sharing of good practice and peer-learning
- Engage and participate in local, regional and national level audit and research
- Lead in planning a programme of education (including via existing diabetes forum) tailored to local priorities and needs

Outcomes

In line with Herefordshire CVD work plan priorities:

Implementation of local Transition Service (Pathway and Policy to support implementation)

Engage with NHSE/PHE National Agenda and Programme for Diabetes Prevention. Lead and support local strategies to support embedding prevention agenda across local health economy

Monitor provision of 8 care processes and agree strategies to support reduction in local variance (Local Dashboard)

Monitor BP control in people with diabetes (qof)

Monitor Cholesterol control in people with diabetes (QOF)

Reduce polypharmacy in elderly patients

Develop and implement local Diabetes Pathways via Map of Medicine including: Diabetes and CVD, Hypoglycaemia, and Diabetes Footcare Pathway

Reduce amputations (West Midlands Strategic Clinical Network Priority 2013/14)

Promote and monitor smoking cessation in people with diabetes

Enhance patient and carer experience:

- Provide Information and education at time of diagnosis
- Provide accessible on-going education
- Maximise Patient confidence in the management of their diabetes – (continue to embed Herefordshire Patient Held Record)

Governance and Meeting Administration

- The Group will meet Quarterly
- Network meeting administration will be provided by Diabetes UK Regional Diabetes Network Manager
- Minutes and a summary of key actions will be recorded.
- The agenda will be circulated at least one week in advance with minutes of the previous meeting circulated no more than three weeks from the date of the meeting
- The Network will prepare an annual work plan and progress report and where relevant interim reports to HCCG Service Transformation and Innovation Group.
- The Group may put in place some task and finish groups to take specific actions forward
- Terms of Reference will be reviewed April 2015

Quorum

The Network will be considered quorate with the following as minimum:

Chair or vice Chair and

- Representative from HCCG
- Clinical Service Lead/Senior clinical or operational representation from Adult and Paeds Service areas
- Patient Representation
- One other member

Linked Groups and key relationships

- Herefordshire Clinical Commissioning Group Service Transformation and Improvement Group &Clinical Outcomes and Service Transformation Team)
- Primary Care including 24 GP practices and other local health care providers
- Herefordshire Diabetes Education Forum
- Medicines Optimisation Team
- Wye Valley NHS Trust Diabetes Team (Adult and Paeds)
- Quality (including patient experience feedback) Groups across stakeholders
- West Midlands Strategic Clinical Network
- West Midlands Paediatric Diabetes Network;
- Local Diabetes UK support Group

Principles and Values

Herefordshire Network is

Patient Centred – Diabetes services need to be commissioned, designed and delivered with people at the centre. The network will champion patient involvement and have an active role in the above processes

Integrated and Transparent – All stakeholders will collaborate to commission, design and deliver diabetes care and support that is integrated and transparent

Supportive of the local health economy – to put policy into practice at local level, overcome challenges faced by the NHS, an arena to understand the local diabetes population health and support needs and what should be in place to fulfill those needs

The Network is framed upon five core features for successful network design and outcome:

All features are interdependent and their combined effect gives energy and momentum enabling quality improvement and learning across all stakeholders

- Common Purpose
- Co-operative Structure
- Critical Mass
- Collective Intelligence
- Community Building

(Reference below)

Stakeholders embrace the vision and principles set out by the NHS England in *Action for Diabetes* 2014:

Quality is at the core

Preventing people from dying early (prevention of type 2 and minimizing risk and impact of diabetes related complications)

Enhanced quality of life for people with diabetes

Helping people recover following episodes of ill health or following injury

Ensuring people have a positive experience of care

Treating and caring for people in a safe environment and protecting them from harm

Membership *(Deputy Chair to be agreed)*

Name	Role	Organisation
Sarah Harding	Chair Dietician	WVT
Jacinta Meighan-Davies	Vice-Chair Clinical Programme Manager	HCCG
Ainsley Rees	Paediatrics Diabetes Specialist Nurse	WVT
Dr Dave Jeffery	Primary Care Data Quality Lead	HCCG
Alison Rogers	Medicines Optimisation Team	HCCG
Alison Talbot-Smith	Head of Clinical Outcomes and Service Transformation	HCCG
Abby Maisey	Lead Diabetes Specialist Nurse	HCCG
Arif Mahmood	Consultant Public Health	Herefordshire LA
Cate Lamport	HCCG Practice Nurse Lead & Nurse Practitioner	HCCG/ Much Birch Practice
Claire Goodwin	Practice Nurse	HCCG
Dr Andy Jones	GP	Belmont Medical Centre

Dr Andy Watts	HCCG Clinical Leader/Chair and GP Sarum House	HCCG & Sarum House Surgery
Dr Ben Hall	GP Cantilupe Surgery	Cantilupe Surgery Hereford
Dr Crispin Fisher	GP	The Marches Surgery Leominster
Dr Hemanth Balehithlu	Transition lead for Paediatric Diabetes	WVT
Dr Ian Roper	GP IT Lead	HCCG Kingstreet and Bobblestock Surgeries
Dr Ian Tait	HCCG GP Lead for Quality & GP Nunwell	HCCG
Dr Janet Lloyd	Consultant physician	WVT
Dr Malik	Clinical Lead (Paeds and Young People)	WVT
Dr Richard Kippax	HCCG GP Lead Finance and Contracting	HCCG & Fownhope Surgery
Dr Ritesh Dua	Urgent Care GP Lead HCCG GP	Urgent Care GP Lead HCCG GP Weobley and Staunton Surgeries
Dr Sarah Newey	HCCG Primary Care Lead & GP	HCCG & Colwall Surgery
Gwenda Ellison	Commissioner for Health Improvement	Herefordshire Public Health/ LA
Hilary Heyes	Community Podiatry	WVT
Joanna Clutterbuck	Head of Dietetics	WVT
Joanne Hall	Paeds DSN	WVT
Jonathan Thomas	Specialist Podiatry	WVT

Karina Blunn	Nurse Practitioner/ Programme Manager (LTC)	Sarum House HCCG
Kathryn McNally		WVT
Marie Clear		
Mark Weston	Paediatric Diabetes Specialist Nurse	WVT
Mental Health		2GETHER
Mick and Roberta Jancey	Local DUK Support Group	Herefordshire Diabetes UK
Mr Alaric Smith	Ophthalmology Consultant/ Retinopathy Screening	WVT
Mr Iain Bissell	Clinical Director Orthopaedics	WVT
Nikki Marriot	Interim Director of Nursing	Taurus Healthcare
Peter Shorrick/Katy Cook	Regional Manager DUK/Influencing Manager DUK	DUK (Midlands Region)
Saran Braybrook	Medicines Optimisation	HCCG
Sarah Caldicott	Clinical Programme Manager	HCCG
Sue Vaughan	Clinical Pharmacist	WVT
Victoria Millward	Improvement Manager (Diabetes)	West Midlands Strategic Clinical Network

Members may send a substitute with appropriate delegated authority to attend on their behalf. Additional attendees will be at the discretion of the chair.

Other MDT or key committee members may be called to attend when appropriate e.g Quality and clinical Governance teams (CCG and WVNHST),Health and Wellbeing Board

Members of the network will lead on specific projects within the annual work plan. They act as the communication conduit disseminating information regarding improvement

plans to their organisation and wider network groups to ensure front line staff are kept advised of the work undertaken and where appropriate their views and feedback are sought to inform and support planning

Sub-groups

Time limited sub groups may be established to complete specific pieces of work set out in the Network's approved annual work plan. Each sub-group will have a chair who is a member of the Network. Membership of the sub-group will include wider local health and care professionals depending on nature of work to be undertaken. Products and output of the sub-groups will be shared with network members as deemed appropriate by the chair of the sub-group

Local information and supporting key documents for network members

Action for Diabetes NHSE 2014

Key reference document for network colleagues – a "one stop shop" bringing all the strands of work together in one place re action NHSE is taking for diabetes care over next few years. All relevant NICE documents are referred to. Focused on Adult services

Endorses and promotes the House of Care

http://www.england.nhs.uk/ourwork/qual-clin-lead/action-for-diabetes/

CCG Outcomes Indicator Set: March 2014 Health and Social Information Centre

Useful to support understanding of health related outcomes at local level

Aims to provide clear comparative information for CCGs and Health and Wellbeing Boards about the quality of health services commissioned by CCGs

Helps to understand where to focus efforts to improve services and outcomes

2014 release includes for the first time *People with diabetes diagnosed less than one year referred to structured education*

Complications associated with diabetes including emergency admission for diabetic ketoacidosis and lower limb amputation

http://www.hscic.gov.uk/catalogue/PUB13880

Transforming Participation in Health and care (NHSE 2013)

A guidance document for CCGs to involve patients and carers in decisions relating to their care and treatment and the public in commissioning processes and decisions

http://www.england.nhs.uk/2013/09/25/trans-part/

Effective networks for improvement Developing and managing effective networks to support quality improvement in healthcare A Learning Report The Health Foundation 2014 http://www.health.org.uk/publications/effective-networks-for-improvement/

Service Improvement and Delivery: Implementing Local Diabetes Networks

http://www.diabetes.org.uk/Implementing-Local-Diabetes-Networks

Provides guidance and support needed to create local diabetes networks that really can deliver high-quality, cost-effective care through the effective commissioning, delivery and monitoring of services.

Herefordshire Patient Engagement 2009/2010 Summary of key focus areas for service Improvement. (excel document). The word document provides a record of actual patient feedback captured via engagement workshops

DSUG Feedback report Nov 09 - VH jn

Diabetes Service User Engagement Eve

Diabetes Patient Held Record (Adult) Interim Evaluation Report December 2013 Abby Maissey, Jacinta Meighan-Davies in collaboration with Local DUK Group

patient held record report jmd.am 8.01.1

Herefordshire Clinical Commissioning Group Long Term Condition Strategy 2013 Our local strategy for commissioning and design of LTC services

Long term strategy for herefordshire 201

National Diabetes Audit 2011-2012 Report 1 Care Processes and Treatment Targets

Summary report for NHS Herefordshire CCG (Health and Social Care Information Centre January 2013

Is everyone with diabetes diagnosed and recorded on a practice register?

Care Processes – what % of people registered with diabetes received the 8 National Institute for Health and Care Excellence key processes of diabetes care?

Treatment Targets – what % of people registered with diabetes achieved NICE defined treatment targets for glucose control, blood pressure and blood cholesterol?

nda-audi-ccg-eng-he
re-11-12-rep1.pdf

Herefordshire CCG Outcome Benchmarking Report September 2013

2013-09 Sept
Herefordshire CCG O

West Midlands Strategic Clinical Network Programme and Contacts

WM SCN: Quality Improvement Team Contacts

NHS England

Cancer	Mental Health and Neurological Conditions	Cardiovascular Disease	Maternity and Children's
Awareness Raising and Education of GP	Dementia - appropriate and timely diagnosis – in Primary Care	Familial Hypercholesterolemia -	Community Asthma Services into Acute Care
	Supporting Carers of Dementia sufferer	Management of AF in Primary Care	Maternity
Survivorship and Rehabilitation	Reducing the use of anti psychotic drugs in Nursing homes	SSNAP adoption	Gastroenterology
	Reducing premature mortality in people with a serious mental illness	Renal review	Whole Service Review - Children's Surgical Acute (Emergency)
Network Site Specific Groups	Improving experience of healthcare for people with a mental illness	Lower Limb Amputations	Neonatal Transfers KIDS / NTS. KIDS Electronic Patient Record (EPR)
	Long term neurological conditions	GP Education Diabetes	Orthopaedic - Scoliosis
Cancer Peer Review and IOG	IAPT programme	Stroke Review	Palliative Care
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High quality care, now and for future generations

September 2013