Theme 1 - Clinical oversight and service improvement. Lead org: CCG

Vision*:* Merton delivers evidence based services, providers and commissioners actively seek out opportunities for service improvement and share learning and uses data to identify areas of best practice and variation.

In order to deliver this vision, we will

Action 1) develop a 'diabetes dashboard' to monitor outcomes and use data to identify variation and empower practices to improve services, **Action 2)** keep services and pathways under review & use patient views to identify and secure improvements in existing and future projects, **Action 3** provide access to training for staff to ensure that they are up to date with clinical guidelines, evidence based management and emerging approaches e.g. very low calories diets**, Action 4)** approach commissioning of diabetes services in a manner that empowers and supports quality improvement across two levels; at a federation level and in individual practices, **Action 5)** increase access to and uptake of evidence based and highly effective structured education programmes e.g. Desmond and DAFNE and deliver culturally specific programmes e.g. DoSA.

Theme 2 - Holistic Individual Care. Lead org: LBM & CCG

Vision: Merton takes a holistic care approach to diabetes and delivers what matters to residents, uses local assets and takes a partnership approach to increasing the uptake of NDPP and the wider digital prevention offer.

In order to deliver this vision, we will

Action 6) roll out social prescribing at scale and consider wider opportunities to connect residents to services, **Action 7)** increase resilience of communities and residents by ensuring that diabetes services are linked to mental health services, **Action 8)** produce a Directory of Services e.g. Adult Education and cooking classes that support residents at risk of or living with diabetes, **Action 9)** develop a network of 'connectors' to enable the community as a whole to take action to prevent diabetes, **Action 10)** increase uptake of the NDPP and deliver wider prevention programmes, **Action 11**) promote the wider Merton digital prevention offer, **Action 12)** actively engage communities and residents living with diabetes (T1 and T2) in service design and improvement.

Theme 3 – Healthy Place. Lead org: LBM

Vision: Merton as a place to live and work encourages people to be more active and make healthier choices.

In order to deliver this vision, we will

Action 13) work in key settings to ensure they support healthy lifestyles e.g. delivering Healthy Workplaces across Merton in (a) organisational members of the HWB and (b) external businesses, **Action 14)** create a healthier food environment in Merton by working with partners and businesses, **Action 15)** increase and promote opportunities to be physically active**.**

Merton Tackling Diabetes Action Plan

THEME 1: Clinical oversight and service improvement.						
Vision:-	Merton delivers evidence based services, providers and commissioners actively seek out opportunities for service improvement and share learning and uses data to identify areas of best practice and variation.					
Actions:-	**To achieve this vision, we will deliver the following actions:-** **Action 1)** We will develop a 'diabetes dashboard' to monitor outcomes and use data to identify variation and empower practices to improve services. **Action 2)** We will keep services and pathways under review & use patient views to identify and secure improvements in existing and future projects. **Action 3** We will provide access to training for staff to ensure that they are up to date with clinical guidelines, evidence based management and emerging approaches e.g. very low calories diets**.** **Action 4)** We will approach commissioning of diabetes services in a manner that empowers and supports quality improvement across two levels; at a federation level and in individual practices. **Action 5)** We will increase access to and uptake of evidence based and highly effective structured education programmes e.g. Desmond and DAFNE and deliver culturally specific programmes e.g. DoSA.					
Actions	**Tasks**	**Lead responsibility**	**Monitoring indicators /targets**	**Timescale**	**Lead Officer responsible**	**Progress**

1) We will develop a 'diabetes dashboard' to monitor outcomes and use data to identify variation and empower practices to improve services.	**1.1)** Use the NDA to develop and strengthen the diabetes dashboard as a tool to reduce variation, and expand to cover a NDH register and annual recall.	CCG Federation	• Dashboard developed and used by practices, localities and LDU Steering Group.	June 19	Kemi Eniade Ruben Reggiani	TBC
	1.2) Identify variations in NDA to improve achievement of the NICE recommended treatment targets (HbA1c, cholesterol and blood pressure) and drive down variation between East & West and between GP practices	CCG Federation Practices	• Individual Practice action plans.	June 19	Kemi Eniade Practice leads	
	1.3) Develop projections for NDH and T2 diabetes for next 10 years.	PH	• Projections and ROI modelled.	May 19	Mike Robinson	
2) We will keep services and pathways under review & use patient views to identify and secure improvements in existing and future projects.	**2.1)** Consider the needs of particular target groups e.g. patients with learning disabilities and the protected characteristics in service design and improvement.	CCG	• Key target groups identified and plans to tackle underperformance identified. • Equalities Impact Assessment of services completed. • PSED report published	Sept 19	Kemi Eniade Fiona Gaylor Equalities	TBC
	2.2) Deliver a Public Health profile on the Protected Characteristics and diabetes.	PH	• Profile published.	Sept 19	Mike Robinson	
	2.3) Gain insight on patient perspective of gaps and opportunities to secure service improvement.	CCG	• 'You said, we did' account published in PSED.	Dec 19	Kemi Eniade Fiona Gaylor Equalities	

	2.4) Explore opportunities for enhancing pathways and services e.g. behaviour change opportunity at diabetic retinal screening.	CCG PH Federation Practices CLCH	• Examples of enhancements published.	Sept 19	Kemi Eniade Barry Causer Ruben Reggiani Practice leads Sam Kelly	
3) We will provide access to training for staff to ensure that they are up to date with clinical guidelines, evidence based management and emerging approaches e.g. very low calories diets**.**	**3.1)** Horizon scanning for areas of potential service improvement and new guidance e.g. NICE Quality Standards on physical activity.	LDU Steering Group	• Merton participating in emerging practice.	July 2019 (and on-going)	Kemi Eniade Barry Causer	TBC
	3.2) Deliver and monitor uptake of appropriate training to front-line staff e.g. Cambridge Diabetes Education Programme, behaviour change and 'structured conversations'.	CCG PH	• Training for front-line staff developed and uptake monitored.	Sept 2019	Kemi Eniade Barry Causer	
	3.3) Develop leadership for clinical leaders through regional and national programmes e.g. Clinical Physical Activity Champions.	CCG PH	• Evidence of leadership development • Physical Activity Champion attending CEPN meeting.	Dec 2019	Kemi Eniade Barry Causer	
	3.4) Make for the case for Merton to participate in pilots of emerging practice e.g. very low calorie diets or digital tools.	LDU Steering Group	• Merton participating in emerging practice.	Sept 19	Kemi Eniade	

4) We will approach commissioning of diabetes services in a manner that empowers and supports quality improvement across two levels; at a federation level and in individual practices.	**4.1)** Include outcome based KPI's in the LIS that drive improvements in service delivery, education and pathways.	CCG	• Key LIS KPI's monitored.	April 19	Kemi Eniade Jo Thorne	TBC
	4.2) Reduce variation in outcomes and practices to provide better care across the 9 care processes.	CCG	• Practice performance across the 9 diabetes care processes.	Sept 19	Kemi Eniade Jo Thorne	
	4.3) Deliver the 'test-bed' programme and use lessons learnt to deliver service improvement.	SWL	• Performance data from test bed programme. • Lessons learnt report.	Ongoing	Chris Gumble	
	4.4) Review the LIS on a quarterly basis and feedback performance to appropriate groups e.g. LMC and LDU Steering Group.	CCG	• Notes of performance management and minutes of LMC and LDU Steering Group.	Quarterly	Kemi Eniade	
5) We will increase access to and uptake of evidence based and highly effective structured education programmes e.g. Desmond and DAFNE and deliver culturally specific programmes e.g. DoSA.	**5.1)** Develop communications to GP's and patients to promote **https://www.diabetesbooking.co.uk/**	CCG SWL Diabetes Team	• Comms materials developed. • Performance figures on usage of the site.	April 19	Kemi Eniade Chris Gumble	
	5.2) Increase the referrals and uptake of the structured education across Merton.	SWL CCG	• Performance data for structured education, including referrals, uptake and completion.	Sept 19	Chris Gumble Kemi Eniade	TBC
	5.3) Commission evidence based culturally sensitive structured education.	SWL CCG	• New service in place. • Performance data for structured education,	Sept 19	Chris Gumble	

			including referrals, uptake and completion.		Kemi Eniade	

THEME 2: Holistic Individual Care

Vision:-	Merton takes a holistic care approach to diabetes and delivers what matters to residents, uses local assets and takes a partnership approach to increasing the uptake of NDPP and the wider digital prevention offer.
Actions:-	**To achieve this vision, we will achieve the following actions:-** **Action 6)** We will roll out social prescribing at scale and consider wider opportunities to connect residents to services. **Action 7)** We will increase resilience of communities and residents by ensuring that diabetes services are linked to mental health services. **Action 8)** We will produce a Directory of Services e.g. Adult Education and cooking classes that support residents at risk of or living with diabetes. **Action 9)** We will develop a network of 'connectors' to enable the community as a whole to take action to prevent diabetes. **Action 10)** We will increase uptake of the NDPP and deliver wider prevention programmes. **Action 11**) We will promote the wider Merton digital prevention offer. **Action 12)** We will actively engage communities and residents living with diabetes (T1 and T2) in service design and improvement.

Actions	Tasks	Lead responsibility	Monitoring indicators /targets	Timescale	Lead Officer responsible	Progress
6) We will roll out social prescribing at scale and consider	**6.1)** Evaluate delivery of SP, including the impact on primary care, secondary care and individual health gain.	MCCG	• Performance data from SP, including referral numbers by practice, reason for referral and uptake of VCS activities.	Sept 19	Mohan Sekeram	TBC

wider opportunities to connect residents to services.			• CSU data report on impact. • LSHTM Student reports			
	6.2) Seek information from Frome and other places where SP already rolled out to identify impact on PWDs.	PH	• Lessons learnt report and notes of meeting. • Lunch & Learn in LBM and CCG.	June 19	Mike Robinson	
	6.3) Deliver digital social prescribing to compliment face to face offer and self-care access to VCS services (tier 0).	CCG PH	• Business case developed for tiered approach to SP. • Service goes live and key performance data.	March 20	Mohan Sekeram Barry Causer	
	6.4) Explore funding opportunities for social prescribing for young people and their families.	CSF	• Business case developed for YP social prescribing. • Service goes live and key performance data.	March 20	Barry Causer	
7) We will increase resilience of communities and residents by ensuring that diabetes services are linked to mental health services	**7.1)** Work with Merton Uplift (IAPT) to inform roll out of new tiered service, including sharing insight from diabetes truth programme, to deliver what matters to residents.	MCCG PH	• Insight from diabetes truth informs mobilisation of Merton Uplift service.	April 19	Barry Causer Patrice Beveney	TBC
	7.2) Performance manage Merton Uplift (IAPT) service to include core offer to patients with LTC inc T1 and T2 diabetes.	MCCG	• Performance data Merton Uplift service.	June 19	Patrice Beveney	
8) We will produce a Directory of Services e.g. Adult Education and cooking	**8.1)** Map wider prevention services and promote through single on-line portal which will support holistic care.	PH	• Map prevention services • Performance data from on-line portal (see theme 3).	Jan 20	Rebecca Spencer	TBC
	8.2) Link wider support activities and programmes to clinical pathways e.g. cooking classes.	CCG	• Evidence of pathway enhancement.	Dec 19	Kemi Eniade	

classes that support residents at risk of or living with diabetes.	**8.3)** Explore opportunities to assist carers to provide support to residents at risk of or living with diabetes.	PH	• Publish Carers Strategy	TBC	Dan Butler	
9) Develop a network of 'connectors' to enable the community as a whole to take action to prevent diabetes.	**9.1)** Map current connectors – across workplaces, VSC, primary care and commissioned services.	PH	• Map connectors across Merton.	June 19.	Rebecca Spencer	TBC
	9.2) Learn from Wandsworth diabetes champions model.	CCG	• Lessons learnt session taken place and notes used to inform Merton approach.	May 19.	Amrinder Sehgal	
	9.3) Develop a network of diabetes and diabetes prevention champions.	CCG PH	• Number of diabetes champions trained and supported to use Diabetes UK resources	June 19.	Amrinder Sehgal Barry Causer	
	9.4) Develop structured conversation training package, beyond MECC to support connectors and front line staff across health and care system.	CCG PH CEPN	• Training undertaken and training feedback.	June 19.	Fiona Gaylor Barry Causer Zehra Safdar	
	9.5) Develop links to local Diabetes UK branch, to access trusted resources which can be promoted.	CCG	• DUK invited to LDU Steering Group • DUK involvement in campaigns and outreach.	June 19.	Kemi Eniade	
10) We will increase uptake of the NDPP and deliver wider prevention	**10.1)** Establish recorded prevalence of NDH in each practice.	Federation	• All practices have completed baseline search of NDH.	April 19	Ruben Reggiani	TBC
	10.2) Increase the referrals and uptake of the NDPP across Merton, through coordinated and successful	PH Federation CCG	• Notes of meetings. • Performance data for NDPP, including referrals, uptake and completion.	On-going	Rebecca Spencer	

programmes	communications to make best use of existing capacity.				Ruben Reggiani Kemi Eniade	
	10.3) In-line with NHS LTP, submit business case for increasing the number of places for NDPP (subject to additional capacity being needed – see 10.2).	CCG	• Evidence of additional capacity and uptake of services.	TBC	Kemi Eniade	
	10.4) In-line with NHS LTP, explore evidence based alternatives to the NDPP, including digital opportunities e.g. digital test bed.	CCG	• Evidence of additional capacity and uptake of services.	TBC	Kemi Eniade	
11) We will promote the wider Merton digital prevention offer.	**11.1)** Co-create with residents and VCS partners key messages for services that are culturally appropriate, inc link to other programmes e.g. childhood obesity.	PH CCG	• Write up of co-creation and evidence of implementation.	Sept 19	Barry Causer Kemi Eniade	TBC
	11.2) Identify key online community support groups to actively promote via services and single point of access (covering T1 and T2).	PH	• Mapping and promotion in place.	Sept 19	Rebecca Spencer	
	11.3) Explore opportunities for self-directed digital self-care in key community venues e.g. use of 'know your risk tools' community libraries.	Libraries	• Libraries promoting self-care including 'know your risk' tools.	Sept 19	Anthony Hopkins	
	11.4) Promote digital tools that support prevention of diabetes including mental health e.g. Good Thinking.	PH	• Usage figures for good thinking.	June 19	Barry Causer	
	11.5) Deliver the diabetes digital test bed.	SWL	• Usage figures for test bed.	TBC	Chris Gumble	

12) We will actively engage communities and residents living with diabetes (T1 and T2) in service design and improvement.	**12.1)** Deliver a programme) on a diabetes challenge e.g. lack of take up in structured education.	CCG SWL Comms	• Challenge identified and target programme delivered and evaluated.	TBC	Charlotte Gawne Fiona Gaylor	TBC
	12.2) Work with partners to develop an approach to patient engagement to actively engage with men, residents with a disability, from south Asian communities and families.	CCG	• Develop and review of EIA to inform priority groups. • Engagement plan includes specific diabetes workstream.	TBC	Aman Nathan	

THEME 3: Merton as a Healthy Place.

Vision:	Merton as a place to live and work encourages people to be more active and make healthier choices.
Actions:-	**To achieve this vision, we will achieve the following actions:-** **Action 13)** We will work in key settings to ensure they support healthy lifestyles e.g. delivering Healthy Workplaces across Merton in (a) organisational members of the HWB and (b) external businesses. **Action 14)** We will create a healthier food environment in Merton by working with partners and businesses. **Action 15)** We will increase and promote opportunities to be physically active**.**

Actions	Tasks	Lead responsibility	Monitoring indicators /targets	Timescale	Lead Officer responsible	Progress
13) We will work in key settings to ensure they support healthy lifestyles e.g. delivering Healthy Workplaces across	**13.1)** Develop a light touch framework for joint action inked to HWC London Excellence level.	PH	• Framework developed and available for use.	June 19	Mike Robinson	TBC
	13.2) Deliver healthy workplace programmes by organisational members of the HWB e.g. Merton Council, MCCG and MVSC.	HWB	• Organisational action plans in place.	Sept 19	Mike Robinson	
	13.3) Pilot and evaluate a programme of healthy workplaces in the 3 Business Improvement Districts in Merton.	PH	• Programme delivered and evaluation disseminated widely including via GLA.	March 20	Rebecca Spencer	
	13.4) Actively seek ops for joint work across health and care system e.g. mental health first aid.	PH CCG	• Examples of joint work and commissioning.	Sept 19	Dan Butler	

Merton in (a) organisational members of the HWB and (b) external businesses.					Nicky Bamford	
14) We will create a healthier food environment in Merton by working with partners and businesses	**14.1)** Implement the "School Neighbourhood Approach Pilot"(SNAP) and produce recommendations in response to the evaluation findings.	Child Healthy Weight Steering Group	• Evaluation response completed and recommendations implemented.	August 19	Julia Groom	TBC
	14.2) To support businesses that have achieved the Healthier Catering Commitment and explore ways to expand the number of businesses signed up to the Commitment in Merton.	Child Healthy Weight Steering Group	• Review of current arrangements completed and recommendations for future approach agreed and implemented.	May 2019	Julia Groom	
	14.3) To manage and monitor proposals for new fast food takeaways (A5 uses) located within 400 metres of the boundaries of a primary or secondary schools in order to promote the availability of healthy foods.	Child Healthy Weight Steering Group	• Proposals to manage and monitor A5 use category produced, agreed and implemented as part of Local Plan. • No. of applications for A5 use affected and outcome.	Ongoing	Julia Groom	
	14.4) To review existing approach to managing public events and implement a new approach to ensure the food and drink offered at council events are healthier, facilities are breastfeeding friendly and promote free drinking water.	Child Healthy Weight Steering Group	• Evaluation response completed and recommendations implemented.	Ongoing	Julia Groom	
	14.5) To review existing advertising and sponsorship policies and agree and implement a new policy that tackles unhealthy advertising and promotes wellbeing.	LBM Environment & Regen	• Review completed and new policy implemented.	TBC	James McGinlay	
15) We will increase and promote opportunitie	**15.1) T**he Active Travel and Transport Subgroup to develop an active travel action plan, including further consideration around parking policy.	AT&T Subgroup	• Task and Finish Group set up. • Work programme agreed.	Sept 2019	Mike Robinson	TBC

s to be physically active.	**15.2)** Deliver a 'Merton year of physical activity, with a different focus for each month e.g. Merton Mile, active travel, leisure centres, parks and open spaces, sport, strength and balance, family fun, active workplace, active schools, NHS, MECC and accessing funding.	PH London Sport	• Delivery plan for 'Merton year of physical activity.	June 2019	Barry Causer Shaz Avazzadeh	

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