APPENDIX TWO

ABMU Diabetes Delivery action plan 2015-2016					
Priority	**Actions**	**Expected outcome**	**Risks to delivery**	**Timescales**	**Lead**
Develop a Diabetes delivery plan Annual report	Using Welsh Government template populate Delivery plan with updated information and actions to date. Agree content in DPDG Agree content through Health Board Agree and Publish agreed Annual Report on Health Board Intranet.	Diabetes Delivery Plan will be submitted to Welsh Government within deadline DPDG will agree actions going forward. Health Board agrees proposed actions in the Diabetes Delivery plan Annual report is developed to demonstrate what has been achieved and agreed and published.	Engagement of DPDG Health Board does not agree the proposed actions Information may not be available to populate the Annual report.	April 2015 April 2015 May 2015. 30th June 2015	*CV/ DPDG* *ALL* *SHG/CV* *CV/SHG*
Paediatric Diabetes Peer review Actions	Address workforce deficits • Dietetics • Paediatrician (appointed x 1) • Paediatric diabetes specialist nurses (appointed x 0.8) • Psychological support Address MDT deficits • Cover arrangements • Sufficient MDT clinics • Skills update/ communication • Engagement with families • Out of hours advice	Staggered investment over 3 years resulting in increase in dietitian hours, psychologist and PDSN hours (£100k in 2015/6 IMTP) Ability to provide all key members of MDT (doctor, PDSN and dietitian) at every clinic for every patient Further progress towards a single, integrated service for ABMU Ability to refer patient to psychologist when required	Inability to recruit to posts Challenges of co-ordinating multiple job plans across multiple sites to facilitate integrated working and appropriate cover arrangements Inability to recruit to post	July 2015 Sept 2015 Dec 2015	*ABMU Paediatric Diabetes management group*

APPENDIX TWO

		Parent / patient engagement including representation at Diabetes management meetings Develop OOH telephone advice as part of network Formalise and develop link nurse role and skills Develop business case for insulin pump costs including personnel	Challenge of engaging parents / children in management process Requires network co-ordination Ability to release nursing time No additional funding for this	Sept 2015 Sept 2015 July 2015 Dec 2015	*ABMU Paediatric Diabetes management group*
Focus on Improving outcomes in paediatric care for Children with Type 1 diabetes	Understanding our baseline Obtaining accurate data/information locally Assess areas for prioritisation and focus on improvements needed Engage with patients / families to identify what they want as outcomes	Annual NPDA report. Reporting tool for in-patient admissions. Use of Twinkle.net to track HbA1c data Iterative work plan to be reviewed continuously Develop forum for parents / children to engage.	Lack of data staff to support data tracking Challenge of engaging parents / children in management process	Dec 2015 Sept 2015	*ABMU Paediatric diabetes management group* *M Thomas* *C Bidder*
Prevention of Diabetes – evidence review and supporting General Practice	Obtain Information locally on number of pre diabetic patients or diet controlled diabetics that are on surveillance Work with staying healthy and public health to use every opportunity to promote healthy eating, diet and exercise Obtain GP information on high risk		Local information may not be robust. Information held by	Sept 2015 Sept 2015	GP clusters/ DPDG GP Clusters /

	patients (pre diabetic) and focus on education and self management with structured education. Work with AWDIG on developing further opportunities for screening at community pharmacies etc including identification of potential pilot sites.		practice may vary and may not be complete. Ability to rollout nationally agreed practice in ABMU Localities.	 December 2015	DPDG SB/CB/DPDG
Improving Structured education and Self Management	Work with Primary care to utilise all opportunities to sign post and refer people for structured education programmes. Assess needs in each of ABMU areas and identify resources in IMTP. Work with AWDIG to examine "information Prescriptions" for people at risk of developing diabetes. Work with AWDIG to implement All Wales structured Diabetes Education packages.	*All patients within ABMU Health board are aware of services and are able to receive structured education programmes* *Information prescription should be available to all patients who require them to achieve good glycaemic control* *All patients living with diabetes will have good clear standardised information to help them self manage their condition*	Resources available to each cluster Information prescriptions are produced but use and distribution by GP practices may require further discussion Inconsistency within the health board of the training packages in use.	September 2015 September 2015 December 2015	GP clusters/ Localities and DPDG CV/DPDG DPDG
Introduce an All Wales Patient Information management System	Continue to engage with NWIS and All Wales Diabetes Implementation group in agreeing a useable information management system. Work closely with AWDIG to finalise the business case and implementation plan.	*A management system is agreed and put in place that can capture robust data and be able to compare to other health boards and provide national intelligence on diabetes services.*	Decision is delayed further and the system is not rolled out leaving gaps in information.	December 2015	DPDG/ AWDIG

APPENDIX TWO

Focus on foot care for inpatients	Review baseline data on foot care. Integrate structured education at every opportunity to promote good foot care.	*To review and steer where improvements are needed* *Improved knowledge of self care for patients living with diabetes and early detection and prevention of further complications*	Establishment of baseline data and regular reporting structure Providing evidence that structured education has been provided.	December 2015	SB/DPDG
Focus on Inpatient Insulin management.	Review baseline data on inpatient Insulin management and identify specific shortfalls. Work with Ward based staff to address the shortfalls including regular checks/titration of insulin as per prescribed regime. Work with Other Health boards and AWDIG to identify and agree resources needed to roll out the "Think Glucose" programme across ABMU.	*Regular reports of insulin management issues to learn from and inform where change and improvements in safety need to be made.* *Roll out the "think Glucose" programme across ABMU as best practice to improve the service to the patients*	Quarterly reporting to DPDG now in place. Engagement of ward managers and cascading of information. Education and resource to deliver this across ABMU	April 2015 Ongoing December 2015	AC/ DPDG SB/DPDG/RF
Continue to participate in the National Diabetes Audit (NDA)	Ensure there is a quarterly review of audit information to discuss at DPDG Address any shortfalls in information Ensure any audit is communicated to Health Board annual audit plan.	*To review and steer where improvements are needed* *Information will be robust to be able to monitor service and manage improvements*	Clinical engagement in National Diabetes Audit (NDA)	September 2015	DPDG

APPENDIX TWO

All diabetes patients should be offered all 9 key annual health checks	Review Baseline data to identify any deficits Assess needs locally and identify potential resource shortfalls. Develop IMTP submissions and work with AWDIG to develop prudent strategies to tackle this	*This will highlight areas where we need to achieve improvement* *Working both locally and nationally to improve the widespread offer of all annual health checks for our patients*	Information deficit Ability of clusters to be able to demonstrate the level of monitoring and delivering the scale of checks.	September 2015 December 2015	GP Clusters / DPDG GP Clusters / DPDG
Obesity & Fitness	Work with a broad range of partners to deliver local strategies and services to prevent obesity, improve fitness and offer support for those wishing to diet and exercise. Ensure timely referral to the National Exercise Referral Scheme (NERS), designed to increase the long-term adherence in physical activity of patients.	*More people pursue a healthy diet and achieve a healthy weight*	Poor public engagement Need for education and training of staff Lack of capacity in dietetics	2016	TBC