Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board

ABERTAWE BRO MORGANNWG UNIVERSITY HEALTH BOARD

TOGETHER FOR HEALTH - A DIABETES DELIVERY PLAN

OUR DELIVERY AND IMPLEMENTATION PLAN

OUR IMPLEMENTATION PLAN

1. BACKGROUND AND CONTEXT

"Together for Health – a Diabetes Delivery Plan" was published in 2013 and provides a framework for action by Local Health Boards and NHS Trusts working together with their partners. It sets out the Welsh Government's expectations of the NHS in Wales in delivering high quality critical care ensuring the right patient has the right care at the right time. It therefore focuses on maximising efficiency and effectiveness, tackling variation in access and reducing inequalities in service provision across 5 themes.
The All Wales Diabetes Implementation Group (AWDIG) Has also identified a clear set of priorities to be taken forward nationally and these will inform and steer the priorities for ABMU Health Board as part of the 2015-16 and 2016-17 Integrated Medium Term Planning (IMTP) process.

For each theme it sets out:

- Delivery expectations to ensure the right patient, in the right care and the right time
- Specific priorities for 2013 – 2016
- Responsibility to develop and deliver actions
- Assurance measures that will be used to ensure that this plan is delivered and effective outcomes achieved.

The vision:
The aim for Wales is to have better health for all and reduced inequalities in health. Any action we take that reduces the impact of diabetes on the lives of people in Wales will contribute towards this objective. Reducing diabetes incidence rates, complications linked with diabetes and improving health care outcomes in people with diabetes making us comparable with the best in Europe is a challenge which could reap significant benefits for the health of our population in the future.

For our population we want:

- People of all ages to have a minimised risk of developing diabetes through adopting healthier lifestyle approaches.
- Where diabetes does occur, we want to educate people and provide the greatest possible opportunity for them to live a long and healthy life, wherever they live in Wales.

We will use the following population outcome indicators to measure our success:

- Incidence of type 2 diabetes per 100,000 population
- Circulatory disease mortality rate under age 75 per 100,000 population
- Age group specific diabetes mortality rate under age 75 per 100,000 population
- Variations in incidence of complications of diabetes by geography and deprivation

The Drivers:
Around 7%[1] of adults in Wales are being treated for diabetes, 16% of those over 65. The incidence of diabetes is increasing as the prevalence of obesity is rising; diabetes among adults in Wales is predicted to rise to 10.3% in 2020 and 11.5% by 2030[2]

Services for diabetes already account for 10% of all NHS expenditure in the UK[3] and in 2009-2010 this amounted to £500 million in Wales. The current rate of increase in spend on diabetes is totally unsustainable, so action must be taken now to address this, focusing on prevention and condition self management.

Funding must be spent effectively for the benefit of people at risk of, or with, diabetes and managed within budgets that reflect increasing financial constraints.

Type 1 diabetes is not linked to lifestyle behaviours and is one of the most common chronic diseases in childhood, with a significant impact on health, lifestyle the future economy and life expectancy. Whilst prevention is not possible, the active management of care can help prevent complications and ensure children and young people with type 1 are able to lead full, active lives.

Poor diet and a sedentary lifestyle are major contributors to obesity and many cases of type 2 diabetes. The proportion of adults not maintaining a healthy body weight is increasing in Wales and, despite stabilising in children, remains too high, as in many other countries. Lifestyle interventions promoting moderate weight loss together with an increase in physical activity can result in a more than 50% reduction in the risk of type 2 diabetes amongst at risk individuals[4].

To improve individual health outcomes and ensure the sustainability of our health and social care services, it is essential that people take responsibility for their health and well being and attention is given to the environmental factors that can assist healthier lifestyles. Improvements in health have not been achieved equally for all people; people living in areas a few miles apart may face a 10-year difference in life expectancy and very different chances of developing and dying from complications caused by poorly controlled diabetes.

What do we want to achieve?
The ABMU Health Board Delivery Plan sets out action to improve outcomes in the following key areas between now and 2016:

- A greater focus on improving outcomes in paediatric care for Children and young people with Type 1 Diabetes
- Prevention of diabetes
- Improving Structured Education and Self Management

[1] Welsh Health Survey

[2] APHO Diabetes Prevalence Model - these figures include estimates for undiagnosed prevalence. http://www.yhpho.org.uk/default.aspx?RID=81090

[3] Hex N, Bartlett C, Wright D, Taylor M, Varley D: Estimating the current and future costs of Type 1 and Type 2 diabetes in the UK, including direct health costs and indirect societal and productivity costs. *Diabet Med 2012*

[4] Prevention of type 2 diabetes mellitus by changes in lifestyle among subjects with impaired glucose tolerance: Tuomilehto et al 2001; Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin: Knowler et al 2002

- Work towards introducing a single diabetes ICT system for Wales
- Focus on foot care for inpatients
- Focus on inpatient insulin management

2. ABMU HEALTH BOARD PROFILE

ABMU Health Board Overview

The Abertawe Bro Morgannwg University Local Health Board provides services to approximately 600,000 people, primarily serving the populations of Bridgend, Neath Port Talbot, Swansea and the Western Vale of Glamorgan and their respective communities. In addition, the LHB provides a large range of regional and sub-regional services, including Burns and Plastics, Cardiac Surgery, Forensic Mental Health and Learning Disability Services. A range of community based services are also delivered in patients' homes, via community hospitals, health centres and clinics.

The Health Board has close links with Swansea University, College of Medicine and is fortunate to have state-of-the-art research facilities within close proximity to Singleton Hospital, we also have a Professor of Diabetology. In late 2015 the Health Board will be restructuring and moving towards a structure of 6 Delivery units giving an opportunity to really tackle the issues locally while still maintaining the overall priorities of the Health Board.

The Health Board has a budget of £1.3 billion and employs over 16,000 members of staff), 70% of whom are involved in direct patient care.

In 2014/2015 we set out our six strategic aims. We want to achieve:

- Healthier Communities
- Excellent patient outcomes and experience
- Sustainable and accessible services
- A fully engaged and skilled workforce
- Strong partnerships
- Effective governance

Everything that we do will be aligned back to these six strategic aims. Achieving these aims will be a significant challenge within the resources available to the Health Board but we have already made significant progress against each of these aims as set out in the introduction section of the ABMU Integrated Medium Term Plan.

In the summer of 2014 the Health Board held a series of staff, carer and patient engagement events including:

These events demonstrated in a change in the focus towards listening to our patients and learning more about what they want to see the future shape of services to be. Based on these listening events, the UHB has created our values:

Our Integrated Medium Term Plan

As required by Welsh Government, ABMU Health Board has prepared its IMTP for 2015-17. Critical to this process is ensuring that specialty specific delivery plans are aligned with the Health Board's priorities and the NHS Wales Planning Framework 2015-2016. This is our opportunity to reshape how we plan services and activities and places quality and safety at the heart of everything we do. Directorates and Localities have prepared plans based on addressing a range of issues, including quality and safety issues, achieving targets, delivery plans and financial constraints, including improving diabetes care. Where funding is required for actions within this and other delivery plans, these are being prioritised alongside all the other actions identified across the organisation as necessary.

Changing for the Better Programme

http://howis.wales.nhs.uk/sites3/page.cfm?orgid=743&pid=49925

In "Together for Health" (November 2011) Welsh Government described unprecedented challenges ahead, it called upon health boards to create services that are safe, sustainable and comparable with the best anywhere. In ABMU a strategic change programme, Changing for the Better Programme was developed and is ABMU Health Board's response to that challenge.

Some of the projects within the ***Changing for the Better*** programme have particular importance in the implementation of improved diabetic care, and an outline of these areas are detailed below:

Staying Healthy

The Staying Healthy project based its priorities on the outcome of the Strategic Health Needs Assessment completed in October 2013 which set out the health needs of the population by life course. This showed that Obesity levels are rising and obesity in children aged 4-5 is higher across the Health Board that across Wales and much higher than England. Obesity is a major risk factor for the biggest cause of premature death and also a major risk factor for long term conditions including diabetes.

Specifically in relation to the preventative focus on diabetes is the 2015 -16 priority of reducing unhealthy eating.

ABMU Health board has set out a plan to:

- Start specialist antenatal clinics for obese pregnant women as part of a maternal obesity care pathway.
- Commence a targeted level 2 community weight management service to be implemented for adults with a BMI of 30 or over.
- The establishment of a specialist multidisciplinary level 3 weight management team for adults with sever and morbid obesity.

- Increase vaccination and immunisation rates to target levels (the flu jab in particular is pertinent to good glycaemic control as the flu can reduce the effects of medication for people living with diabetes.)

Primary Care
Primary Care and community services are the most frequently used part of the heath care system and is the foundation of all that we do. Most of the care and monitoring for diabetic patients is delivered out of hospitals and it is only by improving access to a wide range of services in these settings that we will improve the health of our population and support peoples independence living with diabetes at home. In 2015 – 2016 one of the priorities will be to focus on commissioning the further roll out of diabetes education across all networks and clusters.

There will also be a greater emphasis on detailed care planning for "at risk" individuals within clusters who would benefit from greater care coordination to prevent hospital admission.

Ambulatory & Rapid Access Services
This project has developed the model of an ambulatory care unit at Singleton Hospital, and this will include aspects of diabetic care. It includes the provision of rapid access diagnostics and specialist advice access for GPs in primary care has been established in a number of areas which can help to manage patients safely in the community rather than adopt a default position of admitting a patient to a hospital.

Hospital Services
ABMU Health Board is working towards having one major acute site to serve the populations of Swansea and Neath Port Talbot, with services to be provided for Bridgend residents under consideration through the South Wales Collaborative process. This means that in Swansea and Neath Port Talbot acute services will in future be centralised at Morriston Hospital with Singleton and Neath Port Talbot Hospitals being developed as centres for Ambulatory Care and Outpatients. As part of this work, it is important to ensure that Diabetes care is developed both to care for the low level of acute admissions for patients with acute diabetic exacerbations at Morriston as well as to support the high number of admissions to other specialties by patients with diabetes.

Improving Diabetes Care
Ensuring we deliver the best evidence based care and the highest level of patient safety are key priorities for the Health Board going forward. People with diabetes are twice as likely to be admitted to hospital as the general population, and length of stay can be up to twice the average as a direct result of diabetes associated morbidity.
Work on current standards of diabetic care has highlighted differences in staffing and processes across sites. Consequently nursing audits have been carried out in June and December 2013 with educational sessions delivered

by Diabetic Specialist Nurses in between. This raised some concerns over care standards which has resulted in the following actions being proposed for prioritisation for funding through the IMTP process:

- Implementation of "Think Glucose" (which is a hospital ward based education programme) to systematically improve the care of those individuals with diabetes as a secondary condition, ensuring these patients return home safer, fitter and faster.
- Implementation of Diabetes Inpatient Facilitator Tool Kit (from admission to discharge) – a teaching framework for ward based staff.

Work has already commenced on standardisation of intravenous insulin infusion chart, documentation of hypoglycaemia and Health Board wide diabetes meetings across ABMU.

In addition for health professional structured education there are primary care education sessions facilitated for GPs and practices in Swansea and Neath Port Talbot and there is also a multi-professional MSc course run from Swansea University or in Hywel Dda Health Board.

Structured Patient Education expert courses are run from Morriston, Singleton and Neath Port Talbot. In Bridgend the "Desmond" education tool is used.

Women, Children & Families

This project is focused on ensuring women, children and families receive safe, high quality integrated and sustainable care, delivered by a workforce that is trained to the highest standards. Specifically within this and of relevance to diabetic care is the intention to:

- Review and redesign services provided within the community for children and young people and set out the framework for the implementation of a children and young people service model.
- Ensure age appropriate care is provided including managing the transition of children with long-term conditions to adult services.

National Diabetes Priorities

As part of the All Wales Diabetes Implementation Group, ABMU has signed up in principle to the actions prioritised from this group, as follows:

<u>Focus on improving outcomes in Paediatric care</u>

- Establishment and rollout of a formal paediatric diabetes managed network with a dedicated Network Coordinator and Clinical Lead.
- Mandatory participation in a quality assurance programme. (Peer review which has taken place in 2014)
- Development of a structured education programme with trained educators and resources; structured education for CYP and families from diagnosis, tailored to their learning needs, with updates and refreshers as they grow older and move into transition. Education

programmes for staff within schools particularly primary school age group – consider across county/borough level (long term benefits – less complications, better quality of life for longer). This has been cross referenced in the Primary care cluster plans and has been prioritised for 2015-16.

Preventing Diabetes

- Preventing diabetes in our population is crucial and the best ways to achieve this are complex. Further discussions with the Directors' of Public Health representative on the group will be held, with further proposals brought to the second meeting of the Group. Health board plans will need to reflect local approaches to preventing diabetes.

Introduce a Patient Management Information system

- It has been agreed that an All Wales Diabetes database will be developed or commissioned, and NWIS will oversee implementation across Wales. This is currently being scoped.

Improved Structured Education and Self management

- Developing comprehensive and consistent Structured Diabetes Education across Wales is vital to help people manage their own care to the best of their ability, prevent the onset of complications and reduce the requirement to use NHS resources. As mentioned this is now a priority for 2015-2016 for Primary care GP clusters and will build on the education that is currently provided.

- Foot Care – the whole patient journey for foot care will be considered, utilising existing tools eg Putting Feet First, Think Glucose and ensuring education for both patients and healthcare professionals.

Focus on inpatient insulin management

Other Issues

Links with the Pharmaceutical Industry

- The AWDIG will consider how to best link with the pharmaceutical industry to ensure we are able to grasp any opportunities to link with new innovations and develop the best models of care in partnership.

Communications

- There are opportunities to work with the media to develop press campaigns particularly about healthy lifestyle changes to support this work, and the AWDIG will take this forward, advising Chief Executives of any upcoming events/opportunities.

Appropriate funding required for some of these priorities has been identified and then considered alongside all other priorities identified across the

organisation as part of the IMTP process. These will now form part of a detailed action plan for the forthcoming year.

ABMU Local Health Need and Diabetes Challenge

The Diabetes Delivery Plan requires each Health Board to carry out local population needs assessments to prevent and treat diabetes, review their services in the light of that assessment, identify gaps between need and current provision and identify where service provision needs to change to meet demand.

The full population needs assessment for ABMU Health Board is contained within a separate report:
http://howis.wales.nhs.uk/sites3/docopen.cfm?orgid=743&id=325420
The key headlines from the needs assessment are included below.

ABMU HB covers three local authority areas: Swansea, Neath Port Talbot (NPT) and Bridgend and is home to around 522,390 people, 17 per cent of the population of Wales. It is one of the most densely populated health boards with 466 persons per square km.

Current projections will see a rise in the older population (75 years and over) from 45,368 (9 per cent of total population) in 2006 to 75,986 (13 per cent of total population) by 2036. The increase in the number of older people is likely to lead to a rise in chronic conditions such as circulatory and respiratory diseases and cancers. Analysis is being undertaken to try to understand the potential impact of this demographic change.

The population of the Health Board is predominantly white British with 18,700 or 3.9% coming from a black and minority ethnic background (Swansea 6%, Bridgend 2.2% and NPT 1.9%), which is lower than the Welsh average of 4.3%.

Health inequalities have increased across ABMU HB over the last 10 years with the life expectancy gap increasing from 9.1 to 10.4 years for men and 6.6 to 7.3 for women between the least and most deprived communities across the HB.

- Diabetes prevalence is projected to more than double by 2030.
- The majority of diabetes (85%) is type two, strongly associated with being overweight and having sedentary lifestyles.
- It is estimated that many people with type two diabetes are not diagnosed and so are currently not identified to the appropriate support services.
- People with diabetes have around twice the risk of developing a range of cardiovascular diseases, compared with those without diabetes.
- Tackling risk factors for cardiovascular disease and particularly obesity will also help reduce impacts of diabetes.
- 23% of ABMU Health Board residents over 16 report smoking. Neath Port Talbot has the highest rate of smoking across the HB at 26%,

although this is not significantly higher than the Wales average. There is a marked relationship between smoking and deprivation and a two-fold difference in self-reported smoking prevalence between the community networks.

- Only 31% of the ABMU HB population report eating 5 portions of fruit and vegetables a day, the lowest being Bridgend at 28%.
- Only 28 per cent of adults report meeting the recommended guidelines for being physically active across the ABMU HB.
- There is a marked relationship between obesity and deprivation, with levels ranging from 6% in the least deprived areas to 14% in most deprived areas.
- Across the HB 44% of adults admit to drinking above recommended limits on at least one day and 29% binge drinking on at least one day a week. Recent trends show reported prevalence of excess drinking and binge drinking is increasing in older age groups. Hospital admissions due to alcohol and drugs are more common than in Wales as a whole, with particularly high levels found in Swansea.

3. DEVELOPMENT OF ABMU HEALTH BOARD DELIVERY AND IMPLEMENTATION PLAN FOR DIABETES

Implementation Plan Development

The ABMU Diabetes Implementation Plan has been developed in response to "Together for Health – A Diabetes Delivery Plan" (2013). It supports the progressive implementation of the Diabetes National Service Framework, and the priorities as outlined in the Welsh Government's Diabetes Delivery Plan and NHS Planning Framework 2015-2016.

The development of the ABMU plan has been led by the Director of Strategy for ABMU supported by the Clinical Lead for Diabetes and multi disciplinary members of the ABMU Diabetes Planning and Development Group (DPDG). Workshops have been held with presentations on the IMTP and key projects from the ***Changing for the Better*** programme. One workshop focused on adults with diabetes and the other on children and young people. These workshops with DPDG members, led by the Executive and Clinical Leads, and with representation from Corporate Departments, Directorates and Localities, have agreed the priorities within this implementation plan.
In addition the publication of the NHS Planning Framework 2015-2016 refreshes the priorities for the forthcoming year to be included and taken forward by each Health Board in their IMTP.

Progress against the Plan will be reported to the Board twice a year and an Annual Report on progress will be produced annually in line with timescales set by Welsh Government.

Members of the ABMU Diabetes Planning and Delivery Group are identified in the following table.

Members of ABMU Diabetes Planning & Delivery Group

Name	Job Title / Role

Professor Stephen Bain	Clinical Lead, Diabetology, ABMU
Alan Clatworthy	Clinical Effectiveness & Formulary Pharmacist
Andar Gunneberg	Consultant Chemical Pathologist
Andrew Crowder	Diabetic Retinopathy Screening Services Wales
Ashok Rayani	GP
Carol Milton	Head of Nutrition & Dietetics
Charles Beaverstock	Clinical Nurse Specialist
Chris Hudson	Consultant Physician & Clinical Director
Christine Williams	Acting Director of Nursing
Christopher Bidder	Consultant Paediatrician
Colin Rennie	Lay Member
Dai Williams /Jason Harding	Diabetes UK
Mrs Sian Harrop-Griffiths	Director of Strategy ABMU HB
Carl Verrecchia	General Manager of Strategy
David Price	Consultant Endocrinologist
Geraldine Phillips	Clinical Nurse Specialist
Heather Mogford	Clinical Nurse Specialist
Helen Griffiths	Head of Professional Standards
Ian O'Connor	GP
Jane Harrison	Assistant Medical Director – Primary Care
Jeffery Stephens	Professor of Medicine
Joanne Davies	Assistant Director of Planning
John Langdon	Lay Member
Judith Vincent	Clinical Director for Integrated Pharmacy
Kevin Duff	Head of Planning, NPT Locality
Lawrence Cozma	Consultant Physician
Louise Platt	Senior Nurse Integrated Medicine
Lynette Jenkins	Senior Specialist Nurse
Paul Westwood	GP
Richard Chudleigh	Consultant Physician
Richard Tristham	Clinical Director Primary Care (Swansea)
Rohan Mehta	Clinical Director (Bridgend)
Sally Bloomfield	Head of Podiatry & Orthotics
Sean Young	Associate Medical Director – Primary Care
Sharon Miller	Head of Primary Care & Planning
Silas Benjamin	Consultant Physician
Stephen Allen	Lay Member
Steve Lennox	Consultant Physician
Zoe Wallace	Acting Head of Primary Care & Planning

4 THE PRIORITIES FOR 2015-16

Following the workshops outlined above and further work as part of the 3 year planning process, the priorities for 2013-16 have been identified as:

Children and Young People – Led by AWDIP & C4B Women, Children & Families Project

The priorities for 2015–16 are:

1. Continue to Participate in the peer review programme that the All Wales Diabetes Implementation Group recommended.
2. Implement service improvements and actions as recommended from the Paediatric Peer review reports from November 2014. **(Attached as Appendix one)**.
3. Work with other Health Boards through the All Wales Diabetes Implementation Group to further develop and implement a formal Paediatric Diabetes Managed Network
4. Work with other Health Boards across Wales to further develop and agree a diabetes structured education programme for implementation with all children and young people with diabetes. The First step was to complete a review of current levels and types of "structured Diabetes education" across Wales and this has shown a significant deficit with around 5% of patients receiving structured education.
5. Ensure a phased improvement in the uptake of structured diabetes education.
6. Develop and achieve funding for a business case to deliver improved staffing (dietician and psychologist) to help with education and support.

Outcomes:

- Children & Young People with diabetes lead healthier and more active lives as a result of improved glycaemic control
- Reduction in the proportion number of Children & Young People with Diabetic (DKA) at diagnosis
- A reduction in the proportion of children and young people admitted for diabetes related complications (DKA and Hypoglycaemia)

Preventing Diabetes – Led by C4B Staying Healthy Project

The priorities for 2015 – 16 are:

1. Work with a broad range of partners including the All Wales Diabetes Implementation Group, Public Health Wales and partners to:
    - Raise awareness of healthy living including tackling obesity with diet, exercise and healthy living choices etc.
    - Promote better public awareness of the risk factors for, and dangers of, developing diabetes and the importance of early presentation to primary care
    - Signpost existing sources of information, advice and support relating to lifestyle change, particularly in the third sector
    - Deliver local strategies and services through the GP Clusters priorities to tackle underlying determinants of health inequality and risk factors for diabetes, particularly smoking cessation and obesity and focussing on patients with pre diabetes or those at high risk of getting diabetes

- Target resources in population areas of high risk (such as areas of deprivation) and areas of high impact (including early intervention actions with children to tackle prevention from outset of life)

2. Support and facilitate GPs, practice nurses, and community pharmacists to proactively:
    - Use every opportunity in primary care to promote healthy lifestyle choices and smoking cessation.
    - Ensure consistent provision of testing for diabetes and interventions for proactive management of risk factors.

Outcomes:

- Reduce incidence of type 2 diabetes
- Reduce inequality gap for incidence of diabetes across all age groups

Detecting Diabetes Quickly – Led by DPDG & C4B Rapid Access Project

The priorities for 2015 – 16 are:

1. Work with primary care and allied healthcare professionals to raise their awareness of the risks and symptoms of diabetes.
2. At diagnosis, provide all individuals with evidence based education for their type of diabetes, and signpost them to a ABMU-wide standardised, evidence based, Structured Diabetes Education Programme.
3. Provide rapid access and advice services for primary care to support them in caring for complex diabetic patients.
4. Achieve the QOF targets for the number of patients referred to Structured Diabetes Education within 9 months of diagnosis.

Outcomes:

- Increase the proportion of individuals who understand the affect of a new diagnoses of diabetes and start effective self-management of the disease

Delivering Fast, Effective Care – Led by DPDG, C4B Hospital Services Project and AWDIG

The priorities for 2015 – 16 are:

1. Participate in all aspects of the National Diabetes Audit (including the Pregnancy Care, Foot care and Patient Experience parts of the expanded audit programme) and take appropriate action to ensure continuous quality improvement.

2. Develop and agree a business case for additional recruitment of diabetic specialist nurses to address deficits in patient care.
3. Implement “putting feet first” pathway and quality standards set for prevention and management of diabetic foot disease and start to measure the outcomes.
4. Work with the Diabetic Retinopathy Screening Service Wales to pilot a fixed site option and rationalise their operations accordingly to achieve best outcomes for all ABMU patients.
5. Improve patient and carer engagement in service planning and delivery.
6. Establish and continue a rolling healthcare professional education programme based on Think Glucose across the Health Board.
7. Establish an insulin pump service across the Health Board in line with NICE guidance and measure effectiveness.

OUTCOMES

- Reduction in number of emergency admissions to hospital; readmissions to hospital; and average length of stay.
- Reduction in number of diabetes related eye, foot, kidney and vascular complications
- Improved successful pregnancy outcomes in women with diabetes
- Reductions in inequity gap for health care outcomes due to diabetes, with special emphasis on BME group
- Increase the proportion of people who have well managed diabetes as defined by NICE / All Wales targets for glycaemic control, blood pressure and lipids

Supporting Living with Diabetes – Led by DPDG

The priorities for 2015 – 16 are:

1. Commission and deliver a recognised Structured Diabetes Education service that meets the necessary recommendations for quality and audit, which is in line with NICE guidance (agreed to be XPERT for ABMU). This has been planned to be delivered in Primary care and is referenced in the IMTP as a primary care investment.
2. All patients with diabetes to have a personalised care plan in place. This element has also been referenced for particular “at risk” individuals in the Primary care section of the IMTP and will also be linked with Western Bay Programme work over the next year.

OUTCOMES

- Increase the proportion of people with type 1 and type 2 diabetes who achieve effective self-management of the disease
- Increase in the number of patients having well controlled blood sugar levels
- Reduction in the number of glycaemic emergencies as a result of

diabetes

Improving information – Led by AWDIG

The priorities for 2015 – 16 are:

1. Work with NWIS to implement a single national diabetes patient management system across Health Boards providing a clinical multi-disciplinary record with information that can be shared across primary, community and secondary health care settings.

OUTCOMES

- Public able to make effective choices about their care based on regularly updated information on the effectiveness of diabetes services
- Up to date Information will be readily available for health care professionals to be able to make informed decisions on treatments more effectively and to ensure this is recorded for others.

Targeting Research – Led by DPDG

The priorities for 2015 – 16 are:

1. Work with Diabetes Research Network to secure research and development funding for Diabetes.
2. Encourage more people with diabetes to participate in research activity.
3. Utilise links with Swansea University to see whether they can assist in localised targeted research into priority areas.

OUTCOMES

- Increased and improved research activity resulting in improved healthcare outcomes for people with diabetes

5. PERFORMANCE MEASURES/MANAGEMENT

The Welsh Government's Diabetes Delivery Plan (2013) contained an outline description of the national metrics that LHBs and other organisations will publish:

- Outcome indicators which will demonstrate success in delivering positive changes in outcome for the population of Wales.
- NHS assurance measures which will quantify an organisation's progress with implementing key areas of the delivery plan.

These measures / indicators as outlined in the 2014 Annual report are:

- Percentage of Children and Young People achieving improved glycaemic control.

- Reduced number of hospital admissions with Diabetic Ketoacidosis.
- Reduction in number of people with untreated hypertension and reducing the number of people with high levels of Blood Pressure.
- Increase in the number of people newly diagnosed with diabetes receiving structured education.
- Increase in the number of diabetic patients receiving all of the agreed care processes.
- Increase in the number of patients achieving the agreed treatment targets.
- Increasing the number of people with diabetes who have appropriate primary care checks.
- Reduction in emergency admissions for diabetic patients.
- Recruitment to diabetic National Institute for Social Care and Health Research CRP studies.

Progress against these outcome indicators will form the basis of the annual reporting on progress against the ABMU Diabetes Implementation plan each year. They will be calculated on behalf of the NHS annually at both a national and LHB population level.

Appendix Two is the Summary of progress against the Health and Social Care Committee's recommendations on the Diabetes National Service Framework which will also shape what we do as a Health Board in the forthcoming year.

The Challenges ahead are significant but as the prevalence of diabetes is increasing and the future health need is growing both demographically and economically, tackling this long term condition now is of paramount importance for our future population and health care delivery.