Together for Health – A Diabetes Delivery Plan
A Delivery Plan up to 2016 for NHS Wales and its partners
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Foreword by the Chief Executive of NHS Wales

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Our aim is for the people of Wales to have every possible chance of minimising their risk of developing diabetes. When needed, they must have access to diabetes services of the highest quality regardless of where they live or whether these services are delivered in the community, in primary care or in hospitals.

Diabetes is a disease that impacts people of all ages, and type 1 diabetes is one of the most common chronic diseases in childhood. We want all children in Wales to have the best possible start in life and be given the opportunity to fulfil their potential. To achieve this, there needs to be a continued focus on improvement in care for children and young people with diabetes.

Around 175,000 adults in Wales are currently being treated for diabetes, with type 2 increasing at an alarming rate. It is nothing less than a ticking time bomb for the health service in Wales. Every effort must be made to positively influence people’s lifestyle choices if we are to reduce the number of people with type 2 diabetes. We, the population of Wales, also have a clear role to play in taking responsibility for our own health to reduce the risk of contracting diabetes.

Patient education is at the centre of this plan. It is a key component of patient empowerment leading to effective self-management of the disease. We aim to help people with diabetes by providing effective, structured education and the development of other, innovative, education strategies to effectively deliver the support needed to manage their own condition.

To establish a basis for long term improvements in diabetes care, the NHS in Wales will introduce a Diabetes Patient Management System. This will help enable fully joined up diabetes services and allow clinicians to deliver better healthcare for people with diabetes as they pass along their care pathway.

By January 2014, I expect Local Health Boards and NHS Trusts to have effective plans in place to prevent diabetes and reduce the risk of long term diabetic complications. This Delivery Plan for NHS Wales sets out new Welsh Government commitments to the public for diabetes care in Wales and will support the continuing delivery of service Standards established in the Diabetes National Service Framework (NSF), published in 2003.

Much has been made of the growing impact patients with diabetes are having on the NHS, this plan is our response. Focusing on supporting children, making education the priority and establishing an information system to underpin services are the ways in which we can improve services over the next three years. However, we must all take collective responsibility for driving down the increase in type 2 diabetes by leading lifestyles and making choices where we do not put ourselves at risk.
Foreword from David Sissling, Chief Executive of NHS Wales

It is vital Local Health Boards and Trusts deliver safe, sustainable, high quality diabetes care. This will be challenging particularly as the incidence of diabetes is increasing. Success will depend on effective action in many areas. We will focus on prevention, recognising the impact of poor lifestyle choices. We will ensure efficient detection and diagnosis. And we will mobilise high quality treatment supported by excellent patient information. There will be an emphasis on partnership working – across public services, the third sector and with individuals – to promote healthier lifestyles and to enable more self care.

This Delivery Plan will direct our work. It clarifies the main areas of work and sets out key outcomes. Welsh Government will work closely with the Welsh NHS providing support as necessary. The expectation now is of rapid, sustained improvement.
1. INTRODUCTION

This Diabetes Delivery Plan provides a framework for action by Local Health Boards (LHBs), NHS Trusts and their partners in Local Government and education. It sets out the Welsh Government’s expectations of the NHS in Wales to tackle diabetes for people of all ages, wherever they live in Wales and whatever their circumstances. The Plan is designed to enable the NHS to deliver on its responsibility to meet the needs of people at risk of, or affected by, diabetes.

If we are to sustain, and further develop, high quality health care for the people of Wales, there needs to be increased levels of personal responsibility for lifestyle choices that increase people’s risk of developing chronic diseases, such as diabetes.

The Welsh Government will be issuing a public health white paper to take forward our proposals to support improvements in lifestyle changes. The people of Wales need to fully engage in this debate if we are to achieve a healthier country, which is served by an effective and sustainable health service.

2. STRATEGIC CONTEXT

The Welsh Government’s Programme for Government and its 5 year NHS Plan, Together for Health, introduced an ambitious programme for health in Wales so that:

- Health will be better for everyone
- Access to care and patient experience will be better
- Better service safety and quality will improve health outcomes

Achieving Excellence: The Quality Delivery Plan for the NHS in Wales for 2012-16 describes a journey to consistent excellence in service. It outlines actions for quality assurance and improvement. We commit to a quality-driven NHS that provides services that are safe, effective, accessible and affordable, and that come with an excellent user experience.

3. OUR VISION

The Programme for Government states the overall population outcomes we want to achieve: better health for all and reduced inequalities in health. Reducing the impact of diabetes on the lives of people in Wales will contribute significantly to achieving these outcomes.

For our population we want:

- People of all ages to have a minimised risk of developing diabetes
- Where diabetes does occur, an excellent chance of living a long and healthy life, wherever they live in Wales
Our aim is for Wales to have diabetes incidence rates, and health care outcomes, comparable with the best in Europe. We will use the following population outcome indicators to measure 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

4. OUR DRIVERS

There are good reasons for tackling diabetes to be a key priority for NHS Wales. 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 accounts 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 significant impact on health, lifestyle 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. The Welsh Health Survey in 2011 shows over half the adult population, and around a third of children, are classified as overweight or obese. The Millennium Cohort Survey found more than one in five Welsh three year olds were overweight. It does not have to be this way. 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\(^4\).

\(^1\) 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
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 diabetes. LHBs need to focus their activity on narrowing the gap in healthcare outcomes between their most and least deprived communities in their local populations.

5. OUR JOURNEY SO FAR

We have better information on the incidence and outcomes of diabetes care than ever before. Every person in Wales with diabetes is being offered the opportunity to attend a Diabetic Retinopathy Screening Services screening and last year we reduced emergency admission for diabetes by 9%, length of stay by 0.8 days and emergency readmission by 21%. This situation will continue to improve as clinical audit is embedded within the health community and through the introduction of an NHS Wales integrated diabetes patient management system. This will enable full participation in the National Diabetes Audit (NDA) and facilitate detailed recording of planned outcome measures.

The Diabetes National Service Framework (NSF) established core standards for the delivery of improved diabetes care in Wales and much progress has been made towards achieving these. The Welsh Government remains committed to the successful implementation of the standards across Wales.

6. AIM OF THE DELIVERY PLAN

This delivery plan sets out key population outcomes and service outcomes to drive forward improvements in diabetes care for the people of Wales. To support the delivery of the plan it sets out how we will monitor progress.

This plan establishes:

- The population outcomes we expect
- The outcomes for patients we expect from NHS care
- Level of performance we expect set out as NHS Assurance Measures
- Themes for action by the NHS, together with its partners

This plan has high level actions that need to be delivered by all LHBs. These actions have been developed by identifying key aspects of the Diabetes NSF that have yet to be delivered and setting new initiatives essential for the improvement of diabetes healthcare in Wales.

It remains the responsibility of LHBs to deliver the core standards of the Diabetes NSF, which are basic requirements for improved services. LHBs must report on the status of their delivery of the Diabetes NSF as part of the monitoring and reporting structure.
The Welsh Government will monitor national progress against the plan as well as the 12 service standards established under the Diabetes NSF. LHBs, working with their local delivery groups, will be responsible for deciding on what additional actions they need to take locally to drive forward improvements in diabetes care. Each Local Health Board will be required to produce a local delivery plan to address progress against the outcomes and the actions, as well as continued implementation of the Diabetes NSF standards. An Implementation Group will provide strategic leadership at an all Wales level, as well as reviewing and assessing priorities as progress is made.

7. WHAT DO WE WANT TO ACHIEVE?

1. **Children and Young People**
   Ensure children and young people with diabetes have the best possible start in life and are given the opportunity to fulfil their potential

2. **Preventing diabetes**
   People are aware how to live a healthy lifestyle, make healthy choices that minimise their risk of developing diabetes and understand the consequences of not doing so

3. **Detecting diabetes quickly**
   Diabetes is detected quickly where it does occur

4. **Delivering fast, effective treatment and care**
   People receive fast, effective treatment and care so they have the best chance of living a long and healthy life, with patients taking responsibility for lifestyle choices that contribute positively to their treatment and care

5. **Supporting living with diabetes**
   People are placed at the heart of diabetes care with their individual needs identified and met and feel supported and informed, able to manage the effects of diabetes

This will be supported through:

6. **Improving Information**
   Patients, health professionals and service planners will have access to appropriate information to help them make informed decisions about care and treatment. The public, the NHS, the third sector and the Welsh Government will have access to information on the outcomes that result from NHS Care.
7. Targeting research

Access to research can lead to better outcomes for patients. The NHS must promote research and ensure appropriate access to clinical trials.

7.1 Children and Young People

Type 1 diabetes is one of the most common chronic diseases in childhood. A key factor in reducing the impact of diabetes is good control of blood sugar levels, without frequent hypoglycaemic events.

All children and young people (CYP) with newly diagnosed diabetes need a care pathway, which includes a structured education component to support and empower them and their families. All CYP must also receive all key care processes recommended by the National Institute for Health and Care Excellence (NICE).

To support the care for children with diabetes, healthcare staff, schools and family need to be educated to ensure that children have the best possible opportunity to fulfil their potential. Policies need to be put in place to support the management of diabetes in school.

A patient’s transition from paediatric to adult services should be agreed between those services prior to the move and involve a multidisciplinary team (as defined in NICE guidelines) tailored to the individual’s needs.

NHS services in Wales are changing. This reconfiguration process has special relevance to the future of paediatric services, and this opportunity must be taken to improve the structure and delivery of paediatric diabetes services across Wales.

**OUTCOMES**

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

**ACTIONS**

Local Health Boards will:

- Ensure that all children and young people with newly diagnosed diabetes are seen within 24 hours by a paediatric specialist; with their ongoing care delivered by a multidisciplinary team
- Ensure that children and young people with suspected diabetes have immediate same-day referral to a specialist paediatric diabetes team
- Implement all key diabetes care processes referred to in the National Paediatric Diabetes Audit
- Deliver diabetes structured education to all children and young people with diabetes
- Develop appropriate out-of-hours phone advice services to support CYP, their parents or guardians and clinical staff
- Ensure provision of an insulin pump service in line with NICE guidance
- Ensure that GPs, practice nurses and school nurses are aware of type 1 diabetes in children and young people and that they can identify the signs and symptoms
- Work with education authorities to ensure policies are in place to manage diabetes in schools and to develop management systems to support individual pupils to play a full part at school
- Develop a transitional care plan to ensure appropriate and seamless transfer of care from paediatric to adult diabetes services
- Through the Wales Paediatric Diabetes Interest Group (Brecon Group) establish a Quality Assurance Programme for paediatric diabetes services

### 7.2 Preventing Diabetes

A combined approach of promoting healthy eating and increased physical activity is essential, as these are key factors in the prevention of obesity and type 2 diabetes. This will require partnership between Local Government, schools, industry, employers, LHBs and the public. Health care services will need to identify ‘at risk’ groups and provide evidence based-support and advice to prevent progression to diabetes. This support and advice needs to be reciprocated by people taking personal responsibility for their lifestyle choices and people need to be made aware of the possible consequence their lifestyle choices may have on the benefits of any future care that they may receive.

There needs to be a particular focus on children and young adults, including women planning pregnancy. The school and workplace needs to support healthy behaviours and lifestyle changes. Education within schools about nutrition and the consequences of poor nutrition is essential. Working with families to bring about changes to the way they live their daily lives has the potential to improve the health of the whole family, individuals with diabetes and their ‘at risk’ relatives. Older adults can also be encouraged to adopt healthy lifestyles and the move into retirement is a key transition point when change may be more likely to succeed.

‘Fairer Health Outcomes For All: Reducing Inequities in Health Strategic Action Plan’ sets out our vision to improve health and wellbeing for everyone in Wales, supported by the ‘Framework for Supported Self Care’ providing a structure to help plan and organise current and future self care interventions more systematically and consistently.
The Welsh Government will introduce an over 50s health checks programme in the spring of 2014 to provide an online resource for people to assess their health and wellbeing. It will help identify risks to their health and provide advice on actions to reduce those risks and improve their health. It will also sign-post people to the most appropriate local support for changing lifestyle behaviours, and where appropriate direct them to seek advice from their GP, or other health professional.

**OUTCOMES**
- Reduced incidence of type 2 diabetes
- Reduced inequality gap for incidence of diabetes across all age groups

**ACTIONS**

**The Welsh Government will:**
- Encourage healthy environments through the promotion of the Healthy and Sustainable Pre-School Scheme, the Welsh Network of Healthy School Schemes National Quality Award and Healthy Working Wales
- Promote healthy lifestyle choices through the Change4Life public awareness campaign
- Introduce an over 50s health check programme

**Local Health Boards will:**
- Implement all levels of the Wales Obesity Pathway
- Work with partners to identify, audit, and implement local strategies, with clearly stated population outcomes and performance measures to prevent diabetes, as outlined in ‘Our Healthy Future’
- Promote better public awareness of the risk factors for, and dangers of, developing diabetes and the importance of early presentation to primary care
- Utilise the third sector to provide high quality reliable advice on how to reduce the risks of diabetes and what care to expect

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### 7.3 Detecting Diabetes Quickly

The benefits of a prompt diagnosis of diabetes are significant. Increased public awareness of the symptoms of diabetes and the risks posed by delayed diagnosis or treatment is needed. Local public health analyses should model the expected prevalence of diabetes utilising complete Primary Care Quality Outcomes Framework (QOF) registers. Boards should develop guidance, or share good practice strategies, to ensure that they effectively identify those at risk in all settings. Consideration should also be given to the identification of risk in those who do not attend NHS services.

A new diagnosis of diabetes presents an immediate opportunity to influence lifestyle changes that can positively affect the future health of the person diagnosed. The person diagnosed with diabetes should be educated about their type of disease, and
where appropriate referred to the National Exercise Referral Scheme and signposted to third sector organisations that can provide support.

Patient empowerment and effective self management of diabetes is best achieved through education. Every opportunity to provide this education needs to be grasped and a new diagnosis needs to be the starting point for this life long learning process.

**OUTCOMES**

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

**ACTIONS**

Local Health Boards will:

- Provide accessible educational and support services via local pharmacies, such as vascular risk assessment, lifestyle advice, and annual contracted “community pharmacy delivered” public health campaigns
- At diagnosis, provide all individuals with evidence based education for their type of diabetes, and sign post them to a Structured Diabetes Education Programme
- Achieve QOF targets for the number of patients referred to Structured Diabetes Education within 9 months of diagnosis
- Work with partners in Local Government, education, community programmes and the third sector to find innovative solutions to delivering diabetes education that links to lifestyle change support programmes in people’s communities; such as walking clubs, peer support and exercise referral
- Work with primary care and allied healthcare professionals to raise their awareness of the risks and symptoms of diabetes, and explore innovative approaches for early detection

7.4 Delivering Fast, Effective Care

The majority of diabetes health care is, and should increasingly be, delivered in the community, enabling people to stay in work and lead active lives. The aim is to improve the delivery of planned chronic disease management at a community level, through effective, local, integrated care, with timely access to specialist advice when necessary.

Diabetes can occur at any stage of an individual's life and care delivery needs to be designed to take account of this. Diabetes, particularly if poorly managed, can result in cardiovascular and cerebrovascular diseases, loss of vision, kidney disease and potential amputation of feet. It is important diabetes is identified and treated early in each of these areas to prevent further complications.

Improving management and outcomes of pregnancy in diabetes towards those seen in the general population
We want to ensure women with pre-existing diabetes and those who develop gestational diabetes have pregnancy outcomes comparable with the best worldwide. All women with diabetes need guidance and support to plan their pregnancy. Those who need to improve their glycaemic control prior to conception must have access to support to achieve this in a timely manner and they should be cared for by a multidisciplinary team led by a named obstetrician and physician, prior to and throughout pregnancy. There should also be careful monitoring of infants of mothers with diabetes after birth.

**Kidney complications (diabetic nephropathy)**
Diabetes is the most common cause of people starting renal dialysis. Identification of chronic kidney disease in someone with diabetes should result in treatment (especially blood pressure reduction) to slow the progression of renal disease and reduce cardiovascular risk. As early detection and treatment are key to improving care provision, there is a need for a clear patient pathway, emphasising the importance of primary care in monitoring patients with stable chronic kidney disease and limit secondary care involvement to those with accelerated progression.

**Foot complications**
All patients with diabetes must have an annual assessment of their feet to reduce the risk of ulceration and amputation. People with diabetes may have no assessment of their feet following admission, yet are more likely to develop severe complications (such as ulcers) whilst in hospital. To reduce foot ulcers and (ultimately) amputations, all people with diabetes should have an assessment of their feet on admission to hospital. All patients with a diabetes related foot problem should be referred to a multidisciplinary diabetic foot care team within 24 hours.

**Eye complications (diabetic retinopathy)**
The Diabetic Retinopathy Screening Service for Wales (DRSSW) is an all-Wales service designed to detect sight-threatening diabetic retinopathy at an early stage before visual loss occurs. The continued effectiveness of this service is key to improving treatment and care.

**Vascular complications**
Cardiovascular disease (CVD) problems are between 1.5 and 4.3\(^5\) times more likely in people with diabetes than the general population. Improved control of blood glucose, blood pressure and lipids will reduce the incidence of cardiovascular events.

**Inpatient Care**
As more preventative care and monitoring takes place in the community, hospital services in hospitals will need to focus on inpatients with diabetes. Management plans should be in place for all in-patients with diabetes. Emergency admissions with diabetes should be assessed by a multidisciplinary team within 48 hours of admission and their diabetes care should be overseen by the team. All hospitals should operate a systematic approach to recording of blood glucose levels.

**Modern medicines and technologies for the management of diabetes**
We want to see significant progress in patient access to intensive insulin (pump) therapy. Intensive insulin treatment reduces microvascular complications with emerging evidence of a later effect on large vessel complications when tight diabetes

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\(^5\) National Diabetes Audit 2011
control is achieved following diagnosis. Although pump therapy should now be considered as a mainstream therapy, the importance of multiple dose insulin treatment as an alternative to pumps should also be considered with patients.

**Seamless care delivered by motivated, highly educated and trained diabetes healthcare professionals**

All aspects of patient care should be underpinned by high quality professional education and training. Diabetes care already demonstrates a shift towards community provision requiring enhanced skills among health care professionals. Community diabetes teams with specialist nurses must be established to engage 'hard to reach groups', and support the shift towards diabetes management in the community.

**Equivalent outcomes for patients from minority & ethnic backgrounds**

People from black and minority ethnic groups are up to six times more likely to develop diabetes⁶. We must ensure that diabetes outcomes for people from black and minority ethnic (BME) communities are comparable to the general Wales outcomes by considering their linguistic and cultural needs when delivering services.

**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
- Reduction 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

**ACTIONS**

**Local Health Boards to:**

- Participate in all aspects of the National Diabetes Audit (including the Pregnancy Care, Footcare and Patient Experience parts of the expanded audit programme) and take appropriate action to ensure continuous quality improvement
- Fully implement National Diabetes Audit inpatient guidelines
- Provide pre-conception counselling for all women of childbearing age on diabetes registers
- Ensure that all healthcare professionals involved in diabetes care are educated in the management of diabetic nephropathy and recognition of non diabetic renal disease
- Inpatients with a diabetes related foot problem, or found to have one following initial assessment, should be referred to a multidisciplinary diabetic foot care team within 24 hours of admission

⁶ www.diabetes.org.uk
- Implement “putting feet first” pathway and quality standards set for prevention and management of diabetic foot disease
- Review and refresh Diabetic Retinopathy Screening Service Wales service to ensure that it achieves the best outcomes for all patients
- Inpatients with newly diagnosed diabetes should be assessed by a multidisciplinary team within 48-72 hours of admission and their diabetes care should be overseen by the team
- Establish and continue a rolling healthcare professional education programme, e.g. Think Glucose
- Ensure provision of an insulin pump service in line with NICE guidance
- Ensure culturally appropriate information is available to patients, families and carers in the appropriate language

### 7.5 Supporting Living with Diabetes

Diabetes education improves diabetes awareness and self management. A more informed and confident diabetes patient requires fewer unplanned primary care consultations, visits to outpatient departments, hospital admissions and a reduced length of stay in hospital.

The Quality and Outcomes Framework for 2013/14 has established an indicator for referral to a structured education programme within 9 months of entry onto the diabetes register. It is imperative that LHBs have structured education programmes in place to accommodate these referrals.

Alongside formal education programmes we must look at innovative ways of providing patients with information to support their condition that will include making use of local community based services and voluntary groups, such as Communities First activities.

Diabetes Specialist Nurses have a crucial role to play in delivering improved care to people with diabetes, both in the community and hospital, and an important educational role. Their availability needs to reflect local needs.

A diagnosis of diabetes sets individuals on a long term prevention pathway as they try to minimise complications through a combination of treatment and lifestyle change. Two factors that consistently predict better adherence to treatment and lifestyle change are social support and self efficacy\(^7\). Professionals supporting individuals with diabetes should be trained in psychological techniques which build self efficacy into their clients. Family based interventions around lifestyle change should be supported and encouraged as this can provide the vital social support for sustained change. Family based interventions have the advantage of simultaneously supporting the diagnosed individual and also their at risk relatives.

\(^7\) Self-efficacy is the measure of the belief a person has in their own ability to complete tasks and reach goals.
Each patient with diabetes will have an individualised care plan designed around their specific needs. The plan must be recorded and delivered in a co-ordinated and effective manner by primary care, the community and hospital (where secondary care is involved) in discussion with the patient. The patient and all care providers should have ready access to the individual’s health record and care plan in the desired format, which will also improve communications between the NHS and Social Services.

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<th>OUTCOMES</th>
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<tr>
<td>• Increase the proportion of people with type 1 and type 2 diabetes who achieve effective self-management of the disease</td>
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<tr>
<td>• Increase in the number of patients having well controlled blood sugar levels</td>
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<tr>
<td>• Reduction in number of glycaemic emergencies as a result of diabetes</td>
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<td><strong>Local Health Boards to:</strong></td>
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<tr>
<td>• Plan and deliver a recognised Structured Diabetes Education (SDE) service that meets the necessary recommendations for quality and audit, which is in line with NICE guidance</td>
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<tr>
<td>• All people with diabetes to have a personalised care plan in place</td>
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<tr>
<td>• All diabetic patients to receive all key indicator measurements annually as referred to in the National Diabetes Audit</td>
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### 7.6 Improving Information

NHS Wales Informatics Service (NWIS) will implement an integrated diabetes patient management system, providing timely access to accurate, current clinical information critical for the efficient and effective management of people with diabetes, as well as effective service planning and delivery within the NHS. This should be linked with the DRSSW database and benefit both services by cross referencing the names of all individuals with diabetes in Wales.

Clinical information from primary, community and secondary care services must routinely be added to the national diabetes patient management system. This will facilitate benchmarking of existing services and outcome measures, enable participation in National Audit, and identify areas requiring support or service redesign.

The National Diabetes Audit has developed key measures to assess the effectiveness of diabetes health care and participation in this audit is crucial in providing an accurate assessment of progress.

Information needs to be made readily available to patients in the appropriate format and language tailored to the individuals’ requirements. There are also a range of third sector organisations who can provide help, support and information to people with diabetes. These services need to be more co-ordinated and better sign posted.
LHBs will openly publish information on the performance of diabetes care in terms of safety, effectiveness and patients’ views.

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<td>• Public able to make effective choices about their care based on regularly updated information on the effectiveness of diabetes services</td>
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<th>ACTIONS</th>
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<tr>
<td><strong>The Welsh Government will:</strong></td>
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<td>• Publish an annual all Wales report on effectiveness of NHS diabetes services in Wales</td>
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<th>Local Health Boards to:</th>
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<tr>
<td>• Work with NWIS to implement national diabetes patient management system across Local Health Boards</td>
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<td>• Publish regular and easy to understand information about the effectiveness of their diabetes services</td>
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<td>• Work with the third sector to ensure effective signposting to sources of information and support.</td>
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7.7 Targeting Research

The Diabetes Research Network in Wales will promote, design and deliver high quality projects to attract funding from Wales and abroad. The network will support the new Academic Health Science Collaboration Initiative (Health Research Wales) to deliver fast-track, high quality pharmaceutical industry sponsored research in diabetes and related areas.

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<tr>
<td>• Increased and improved research activity resulting in improved healthcare outcomes for people with diabetes</td>
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<tr>
<td><strong>Local Health Boards to:</strong></td>
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<tr>
<td>• Work with Diabetes Research Network to secure research and development funding for Diabetes</td>
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<td>• Encourage more people with diabetes to participate in research activity</td>
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8. WORKING TOGETHER

All of us have a key part to play in our efforts to tackle diabetes.

The Welsh Government is responsible for strategic leadership through setting the health outcomes it expects for the people of Wales and holding the NHS to account.
The lines of accountability are via the Chairs of the LHBs and NHS Trusts to the Minister for Health and Social Services, with the Chief Executives of the LHBs and NHS Trusts reporting to the Chief Executive of the NHS Wales, who is also the Director General of the Welsh Government’s Department of Health Social Services.

The Welsh Government will review progress against the plan and continued progress against the Diabetes NSF standards. A national diabetes clinical lead role will be developed to support delivery of the plan. The national lead will need to work closely with the implementation group with a focus on working across traditional boundaries to deliver improvements in diabetes prevention and care.

**NHS Wales** is made up of 7 LHBs and 3 NHS Trusts. LHBs are responsible for planning, securing and delivering local services to help prevent diabetes and to diagnose, treat and care for people affected by diabetes. Each Local Health Board is expected to have a Diabetes Planning and Delivery Group; including Terms of Reference that establish clear and effective links between these groups and the Board.

To plan services effectively for their populations LHBs must build and lead coalitions with NHS Trusts, GPs, pharmacists, opticians, Local Government and the third sector voluntary bodies. These services need to be part of an integrated diabetes service.

Public Health Wales NHS Trust provides LHBs with information and advice to inform service planning, and is responsible for promotional activity aimed at reducing obesity.

**Local government** also has a vital role to play to prevent diabetes. To promote a co-ordinated approach, they need to work with LLHBs through Local Service Boards. This work includes the analysis of the evidence base and development of Single Integrated Plans showing how they can contribute to improving health outcomes, in areas such as obesity, nutrition and exercise.

**All Wales Diabetes Implementation Group** will be established to provide strong and joined-up leadership and oversight and to co-ordinate priorities in a strategic way. The Group will:

- Work in a co-ordinated way, at an all Wales level, to support LHBs to deliver the outcomes asked of them in a consistent way across Wales
- Agree how best to measure success
- Facilitate the sharing and implementation of best practice
- Identify constraints and solutions to common issues where a strategic approach is needed
- Review and assess Delivery Plan actions in light of progress and new developments

The **third sector** has an important role to play, both in providing services and acting as the voice of individuals.
**People** do not choose to develop diabetes. However, we can all choose to minimise the risk of acquiring type 2 diabetes through our lifestyle choices. Obesity increases the risk of diabetes. We all need to take action to ensure risks and harm related to obesity are decreased.

9. **MEASURING SUCCESS**

The Quality Delivery Plan sets out how we will monitor performance and progress in improving health and health care in Wales. An initial Outcome Indicator Framework will be developed during spring 2014.

The Quality Delivery Plan places requirements on NHS organisation to monitor a set of nationally specified performance measures and report them to the public, the Welsh Government, and their Boards at regular intervals. This Diabetes Delivery Plan now places a requirement on each organisation to publish an annual report on diabetes for the public of Wales to demonstrate progress.

Annex 3 sets out an initial set of national outcome indicators and NHS assurance measures. These will be refined in discussion with the NHS and its partners.

10. **LOCAL PLANS – LOCAL ACTION**

LHBs need to achieve full compliance with the Diabetes NSF, and this Diabetes Delivery Plan. LHBs will support their Diabetes Planning and Delivery Groups (DPDG) to review, update and publish detailed local diabetes delivery plans. The LHBs will support and enable the DPDGs to deliver the Diabetes plan, report progress, publish six monthly updates on their websites and contribute to the annual all Wales report to be published by the Welsh Government.

Whilst this plan sets out our expectations of the NHS, the delivery process which will follow is intended to be dynamic and flexible and able to demonstrate real improvement along the way. There are a number of strategic priorities identified throughout this document and these are set out in annex 2.
Annex 1 – The diabetes health care experience

This describes the characteristics of the services expected by 2016

Experience 1 - People are aware of and are supported in minimising their risk of diabetes through healthy lifestyle choices and medication where appropriate.
- more people are aware of the risk of diabetes from unhealthy lifestyles and the broader benefits of physical activity and healthy eating
- more people achieve a healthy weight
- more people are physically active as a natural part of their everyday life
- services to assess and manage people’s risk of diabetes and its consequences are easier to access, and are more co-ordinated and systematic

Experience 2 - Diabetes is detected quickly where it does occur
- easier access to primary care services
- more accessible information and support services provided through most appropriate local delivery channel(s)
- people at risk of diabetes have prompt evidence based management to minimise progression to diabetes
- greater awareness by primary care, schools and the general public of the symptoms of type 1 diabetes

Experience 3 - People with diabetes receive fast, effective treatment and care so they have the best possible chance of living a long and healthy life
- prompt and appropriate access to clinically and cost effective treatment
- people experience well co-ordinated services, which are compliant with national standards and guidelines and available as locally as possible
- equitable care outcomes for all diabetes patients
- diabetes care is delivered by a motivated, educated and trained work-force
- children and young people with diabetes and their families lead a full and active life
- young people receive smooth and co-ordinated transition to adult services
- timely access to appropriate multidisciplinary teams with care tailored to individual patient’s needs

Experience 4 - People are placed at the heart of diabetes care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of diabetes
- services are available as locally as possible
- people’s clinical and non clinical needs, as a consequence of diabetes, are assessed, agreed and recorded in a shared care plan
- care is given in the most appropriate place for the patient and not the service; increasingly this should be in primary care.
- communication links giving clinical staff fast, safe and secure access anywhere in Wales to the information needed to care for patients
- patients and carers are involved in the design of services and people’s views on services are sought regularly and acted on to ensure continuous improvement.
- transparently published information available on the performance of NHS
diabetes care in terms of safety, effectiveness and patients’ views.
- access to, and care and support from, co-ordinated primary care and community services
- people are empowered through access to structured diabetes education to understand their condition, what care to expect, what to look out for, what to do and which service to access should problems occur
- access to support in maintaining a healthy lifestyle from professionals with training in behavioural change techniques
- more accessible educational and support services provided through local pharmacies
### Annex 2

#### Strategic Key Actions

<table>
<thead>
<tr>
<th>Strategic actions</th>
<th>By Whom</th>
<th>By When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop a diabetes clinical lead role</td>
<td>Welsh Government</td>
<td>October 2013</td>
</tr>
<tr>
<td>Establish the all Wales Diabetes Implementation Group to provide strategic leadership and work at an all Wales level to support Local Health Boards’ service improvements</td>
<td>Welsh Government</td>
<td>October 2013</td>
</tr>
<tr>
<td>Establish an All Wales Integrated Diabetes patient management system to enable improved, efficient and effective healthcare provision which would include collection of information at Local Health Board and all Wales level for the outcome indicators and performance measures</td>
<td>Velindre NHS Trust through the National Wales Informatics Service</td>
<td>Timescale to be agreed by December 2013</td>
</tr>
<tr>
<td>Review current diabetes delivery plans and services against the expectations set out for 2016 and use the outcome to inform an updated local delivery plan to reflect activity under each of the themes for action; including addressing any gaps in the implementation of the Diabetes NSF service</td>
<td>Local Health Boards working in partnership through their Diabetes Planning and Delivery Groups with other Local Health Boards, NHS Trusts, Local Government and third sector</td>
<td>December 2013</td>
</tr>
<tr>
<td>Review and update delivery plans and milestones</td>
<td></td>
<td></td>
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<tr>
<td>Report progress against local delivery plan milestones on their website</td>
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<tr>
<td>Report formal progress against the delivery plans and NHS Performance Measures to Boards and Welsh Government</td>
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<tr>
<td>Publish annual All Wales report on effectiveness of NHS diabetes services in Wales, based on Local Health Board reports against Performance Measures</td>
<td>Welsh Government</td>
<td>October 2014</td>
</tr>
</tbody>
</table>
1. Outcome Indicators

Our population level outcome is:

_People have a minimised risk of developing diabetes and, where it does occur, an excellent chance of living a long and healthy life_

We will use the following outcome indicators to measure and track how well over time we are doing. Outcome indicators for measuring the health of the population of Wales more generally, such as the % of people who smoke or who are obese, have been set under our Programme for Government.

As we want to reduce inequalities in health, we will also examine how well we are reducing the gap between the most and least deprived parts of Wales and between age groups. We will also compare ourselves internationally wherever we can.

**OUTCOME INDICATOR: Incidence of type 2 diabetes per 100,000 population**

Population Group
People of all ages resident in Wales

Rationale
This is the population marker for the level of diabetes among the population and therefore a marker of the health of the population. It is a marker of effective health promotion, prevention, patient empowerment and service effectiveness.

**OUTCOME INDICATOR: Circulatory disease mortality rate under age 75 per 100,000 population**

Population Group
People resident in Wales

Rationale
This is the major cause of death in people with Type 2 diabetes and in Type 1 diabetes after 30 years age.

Mortality rates across deprivation quintiles are used here to describe variation in outcome for people with diabetes.

**OUTCOME INDICATOR: Age group specific diabetes mortality rate under age 75 per 100,000 population**

Population Group
People resident in Wales
**Rationale**
This is a marker of effective health promotion, prevention, patient empowerment and service effectiveness.

Excess death rate due to diabetes was 5.2% (National Diabetes Audit Mortality Analysis 2007-2008). Excess deaths were greater in young and middle aged adults (3-5 fold) than in elderly (1.5-3 fold). Diabetes related amputation predicts mortality rate of 13-40% within 12 months and 39-80% within 5 years.

**OUTCOME INDICATOR: Variations in incidences of complications of diabetes by geography and deprivation**

**Population Group**
People resident in Wales

**Rationale**
Vascular complications are higher in people with diabetes than in the general population, and continues to increase for cerebrovascular and end stage renal disease. We want to reduce inequalities in health in Wales.
2. NHS Assurance Measures

The following NHS Assurance Measures have been identified to measure how people receiving NHS diabetes care are better off as a result. These will form the basis of Local Health Boards’ annual reports on diabetes care.

Some NHS services aim to reduce risk factors associated with diabetes such as the number of people who smoke or who are obese. NHS Assurance Measures for those services are not included here as they are set out in Programme for Government and in the Welsh Government’s Performance Level Agreement with Public Health Wales NHS Trust.

These assurance measures are also linked to the high level diabetes health care experiences that are expected of the service, as set out in annex 1.

ASSURANCE MEASURE: % of children and young people achieving improved glycaemic control, defined as:

- A reduction of median HbA1c nationally by 11mmol/mol (1%) within 5 years and by 16mmol/mol (1.5%) within 10 years
- A year on year reduction in the number of children and young people with poor diabetes control (HbA1c >80mmol/mol (9.5%))
- A year on year increase in the number of children and young people with good glycaemic control (HbA1c <59mmol (7.5%))

What experience does this relate to?
Experience 3 - People receive fast, effective treatment and care so they have the best possible chance of living a long and healthy life

Patient Group
All children diagnosed with diabetes

Rationale
This is a marker of effective self care through patient education and empowerment, and effective NHS monitoring of people with diabetes for complications.

ASSURANCE MEASURE: % of children with diabetes achieving normal growth

What experience does this relate to?
Experience 3 - People receive fast, effective treatment and care so they have the best possible chance of living a long and healthy life

Patient Group
All children diagnosed with diabetes

Rationale
Appropriate growth in childhood is a marker of well being.
ASSURANCE MEASURE: % of children, young people and adults receiving Structured Diabetes Education within 12 months of diagnosis

What experience does this relate to?
Experience 4 - People are placed at the heart of diabetes care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of diabetes

Patient Group
People newly diagnosed with diabetes

Rationale
People newly diagnosed with diabetes who receive structured diabetes education are more likely to be empowered and able to manage the effects of diabetes and to stay healthy and out of hospital.

ASSURANCE MEASURE: Diabetic compared to non-diabetic: number of emergency admissions to hospital; readmissions to hospital; and average length of stay

What experience does this relate to?
Experience 3 - People receive fast, effective treatment and care so they have the best possible chance of living a long and healthy life

Experience 4 - People are placed at the heart of diabetes care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of diabetes

Patient Group
People of all ages with a diagnosis of diabetes

Rationale
We want to keep people with Diabetes healthy and out of hospital. This depends on the development of well coordinated services in primary and community care. The number of emergency admissions and readmission to hospital and average length of stay for diabetes are markers for this. These currently form part of Year 1 of the Annual Quality Framework delivery framework.

ASSURANCE MEASURE: % of people with diabetes related limb amputation

What experience in does this relate to?
Experience 3 - People receive fast, effective treatment and care so they have the best possible chance of living a long and healthy life

Experience 4 - People are placed at the heart of diabetes care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of diabetes

Patient Group
People diagnosed with diabetes
Rationale
This is a marker of effective self care through patient education and empowerment, and effective NHS monitoring of people with diabetes for complications.

ASSURANCE MEASURE: % of people with diabetes with sight threatening retinopathy or blindness

What experience in does this relate to?
Experience 3 - People receive fast, effective treatment and care so they have the best possible chance of living a long and healthy life

Experience 4 - People are placed at the heart of diabetes care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of Diabetes

Patient Group
People diagnosed with diabetes

Rationale
This is a marker of effective self care through patient education and empowerment, and effective NHS monitoring of people with diabetes for complications.

ASSURANCE MEASURE: % of people with diabetes with new foot ulcer

What experience in does this relate to?
Experience 3 - People receive fast, effective treatment and care so they have the best possible chance of living a long and healthy life

Experience 4 - People are placed at the heart of diabetes care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of diabetes

Patient Group
People diagnosed with Diabetes

Rationale
This is a marker of effective self care through patient education and empowerment, and effective NHS monitoring of people with diabetes for complications.

ASSURANCE MEASURE: % of people with diabetes reaching end stage renal disease or requiring renal replacement therapy

What experience in does this relate to?
Experience 3 - People receive fast, effective treatment and care so they have the best possible chance of living a long and healthy life
Experience 4 - People are placed at the heart of diabetes care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of diabetes

**Patient Group**
People diagnosed with diabetes

**Rationale**
This is a marker of effective self care through patient education and empowerment, and effective NHS monitoring of people with diabetes for complications.

**ASSURANCE MEASURE:** % of successful pregnancy outcomes in women with diabetes

**What experience in does this relate to?**
Experience 3 - People receive fast, effective treatment and care so they have the best possible chance of living a long and healthy life

Experience 4 - People are placed at the heart of diabetes care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of diabetes

**Patient Group**
Pregnant women diagnosed with diabetes

**Rationale**
This is a marker of effective self care through patient education and empowerment, and effective NHS monitoring of pregnant women with diabetes for complications.

**ASSURANCE MEASURE:** % of people with a diagnosis of diabetes who are satisfied with their personal care plan

**What experience does this relate to?**
Experience 4 - People are placed at the heart of diabetes care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of diabetes

**Patient Group**
People of all ages with a new diagnosis of diabetes

**Rationale**
Programme for Government includes a tracking indicator about people with long term conditions, such as diabetes, having a care plan. People with a diagnosis of diabetes who have their clinical and non clinical needs assessed, agreed with them, recorded in a care plan and then planned for and met, are more likely to feel empowered well supported and cared for, better able to self care effectively and to have a better experience of NHS care.
ASSURANCE MEASURE: % of people with diabetes having well controlled blood sugar levels

What experience does this relate to?
Outcome 3 - People receive fast, effective treatment and care so they have the best possible chance of living a long and healthy life

Experience 4 - People are placed at the heart of diabetes care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of diabetes

Patient Group
People diagnosed with diabetes

Rationale
This is a marker of effective self care through patient education and empowerment, and effective NHS monitoring of people with diabetes for complications.

ASSURANCE MEASURE: % of people experiencing a glycaemic emergency as a result of their diabetes

What experience does this relate to?
Experience 4 - People are placed at the heart of diabetes care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of diabetes

Patient Group
People of all ages with a diagnosis of diabetes

Rationale
Marker of patient education and empowerment, and service effectiveness including individualised glycaemic control.

ASSURANCE MEASURE: % people with diabetes who receive all key indicator measurements for diabetes

What experience does this outcome relate to?
Experience 3 - People receive fast, effective treatment and care so they have the best possible chance of living a long and healthy life

Experience 4 - People are placed at the heart of diabetes care with their individual needs identified and met so they feel well supported and informed, able to manage the effects of diabetes

Patient Group
People of all ages with a diagnosis of diabetes

Rationale
This is a marker of effective self care through patient education and empowerment, and effective NHS monitoring of people with diabetes for complications.