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 diabetes services. It therefore focuses on maximising efficiency and effectiveness, tackling variation in access and reducing inequalities in service provision across seven themes.

For each theme it sets out:

- Delivery expectations to ensure the right patient receives the right care at the right time
- Specific priorities for the three year period 2013 – 2016
- Responsibility to develop and deliver identified actions
- Assurance measures that will be used to ensure that the plan is delivered and effective outcomes are achieved.

There are remain a number of priorities and milestones to be achieved in Powys for the seven themes referred to above. These are described in detail in Section 6 of this plan, (Priorities for the Coming period)

2. The vision

For our population in Powys 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.
3. **The drivers**

Spending in Welsh hospitals in 2012-13 on diabetes was almost £90m\(^1\), this is an increase of 4% when compared to 2011-12. However NHS expenditure on diabetes related care in Wales is almost £500m a year\(^2\).

In 2013-14; 177,212 people over the age of 17 were registered with their GP as diabetic. This is 3,913\(^3\) more people than in 2012-13. There were 1,469 children and young people with diabetes under the age of 25 in Wales, almost all of whom have type 1 diabetes. Gestational diabetes is a type of diabetes that some women get during pregnancy. Between 2% and 10% of expectant mothers develop this condition, making it one of the most common health problems of pregnancy.

It is widely accepted that Wales is facing a significant increase in the number of people with diabetes. The number of adults registered with their GP practice with a diagnosis of diabetes has increased by just over 24,000 people in the last five years. Much of the increase is in type 2 diabetes, which is associated with an aging population and the increase in the numbers of people who are overweight or obese.

There is evidence to show that:
- The onset of type 2 diabetes can be delayed, or even prevented;
- Effective management of the diabetes increases life expectancy and reduces the risk of complications; and
- Supported self-management is the essential element of effective diabetes care.

People with diabetes have a substantially higher risk of serious illness, hospitalisation and premature death compared to the general population.

It is important to note that:
- Type 2 diabetes is more prevalent among less affluent populations.
- A child with HbA1c levels above 9.5%, according to the National Institute for Clinical Excellence, would be at risk of medical complications in the future.
- Obesity is the top risk factor for type 2 diabetes at all ages.

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\(^1\) NHS Expenditure Programme Budgets – Wales 2012 -13
\(^2\) Together for Health – a Diabetes Delivery Plan
\(^3\) Stats Wales
• It is estimated that there are around 2300 people with undiagnosed type 2 diabetes in Powys (extrapolating from national data).

• High blood pressure is an important risk factor for diabetes, and while 20%\(^4\) of adults are being treated for high blood pressure, it has been estimated that across the UK around half of people with high blood pressure are not receiving treatment\(^5\).

• Less than 8% of newly diagnosed patients in Wales received structured education in 2012-13. In Powys the figure was only 3.3% although steps are in place to address this issue.

• 60% of adults with type 1 diabetes and 33% of adults with type 2 diabetes are not having the annual tests and investigations associated with the national standards. Of those having the annual tests, 86% of type 1 diabetic patients and 65% of adults with type 2 diabetes do not meet the agreed treatment targets.

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\(^6\).

4. **ORGANISATIONAL PROFILE**

**Overview**

• Powys Teaching Health Board is responsible for providing and commissioning diabetes services for a population of 7499 people with diabetes. This equates to meeting the needs of 5.7% of the Powys population, as compared to an all Wales incidence of diabetes of 5.6%. This is forecast to increase to over 15,500 people in Powys by 2030.

• Specialist diabetes care is commissioned from five main acute secondary care providers: Shrewsbury and Telford Hospitals Trust, Aneurin Bevan University Health Board, Wye Valley NHS Trust, Abertawe Bro Morgannwg University Health Board and Hywel Dda University Health Board.

• Diabetes services in Powys are also delivered across seventeen General Medical Practices through a Local Enhanced Service agreement, and are supported by a range of community

\(^4\) Welsh Health Survey 2013, Welsh Government Statistics released September 2013


services, including nine community hospitals, community pharmacies and community multidisciplinary teams.

- For children, the majority have Type I diabetes and they are treated by Paediatric Diabetologists within specialist secondary care services. Paediatric Diabetic Community nursing is provided on an ‘in-reach’ basis from specialist secondary care.

**Overview of Local Health Need and Challenges for Diabetes Services**

- The benefits of a prompt diagnosis of diabetes are significant. The challenge is to increase public awareness of the risks posed by delayed diagnosis or treatment. Access to appropriate specialist advice is also strongly supported.

- Patient supported self care is a priority; structured education programmes are central to patient confidence in self managing their diabetes on a successful diabetes pathway. There is a need to work with our key partners within and outside the NHS to ensure key priority areas such as lifestyle advice and education links to external lifestyle support programmes in Powys’ communities.

- The challenge of delivering formal structured education programmes across Powys remains a key consideration and is addressed in this delivery plan.

- PTHB’s vision is to manage the majority of Type II Diabetes provision within primary care. This will ensure people of all ages have a minimised risk of developing Type II diabetes. Where type II diabetes does occur, patients can be confident, that through a single primary led Diabetes Care pathway, education programmes self management and access to specialist advice, can optimise their chances of living a long and healthy life. Patients with Type I diabetes will be largely managed in specialist secondary care services, supported by primary care and community services.

5. **Development of Powys Teaching Health Board local delivery plan for diabetes**

In response to the “Together for Health – A Diabetes Delivery Plan” (2013), health boards in Wales are required, together with their partners, to produce and publish a detailed local service delivery plan to identify, monitor and evaluate action needed within specified timescales. ‘Together for Health – A Diabetes Delivery Plan’ requires
health board lead directors for diabetes to report progress formally to their respective Boards, against milestones in the local health board diabetes delivery plan; and to publish these progress reports on the public health board website at least annually.

The Powys Diabetes Planning and Delivery Group has reviewed and assessed the progress against priorities and has reviewed how service provision will change. Actions have been identified to be undertaken during the period of the national delivery plan and in particular actions and outcomes to be achieved this year. In addition to this, lead clinicians will be tasked with assessing what we are currently doing, to look at what we can do differently or collectively and to set priorities for 2016-17 within this plan.

6. **Priorities and Actions for the coming period**

The Together for Health Diabetes Delivery Plan sets out action to improve outcomes in key areas.

For 2016-17 the following **NATIONAL PRIORITIES** have been agreed:

1. **Eye Care**
   - Ensure 100% referral rates from primary care to Diabetic Eye Screening Wales.
   - Measure times from referral by Diabetic Eye Screening Wales to review by an ophthalmologist.
   - Ensure suitable local infrastructure to support new Diabetic Eye Screening Wales clinic model.

2. **Insulin Pumps**
   - Provide NICE compliant insulin pump therapy service by improving expertise and annual training updates, meeting safety standards and providing patients with a choice of devices.

3. **Health Care Professional Education**
   - Ensure all inpatient staff and staff caring for people living with diabetes have adequate knowledge and training to safely manage diabetes

4. **Pregnancy**
   - A preconception awareness campaign to be developed and implemented across Wales, supported by a
preconception film (various languages) and health care professional on line education module

These crucial national priorities are part of the local plan, and in addition to these national priorities, Powys Teaching Health Board highlights the following aims and priorities for 2016-17 which reflect the needs of the local population.

The following pages look to show how the variety of actions being pursued locally are linked back to the overall ambition of the National Delivery Plan

The Driver diagram on page 6 to 9 are an attempt to show this visually and the detailed actions are contained at pages 10 to 22.

The attached Action Plan outlines the agreed priority areas, the actions that are required, the measure of success and an action owner with an agreed timeline.

A national refresh of the Together for Health plan is underway and local plans for 17/18 onwards will be refreshed to account for this.
Diabetes Driver Diagram

Aim
The delivery of high quality Diabetes services

Primary Driver
People of all ages to have a minimised risk of developing diabetes.
Where diabetes does occur, people have an excellent chance of living a long and healthy life.

Secondary Driver
- Children and Young People
- Reducing the risk of developing type 2 Diabetes
- Detecting Diabetes Quickly
- Delivering Fast, Effective Care
- Supporting Living with Diabetes
- Improving Information
- Improving Research
Diabetes Driver Diagram

Secondary Driver
- Delivering Fast, Effective Care
- Supporting Living with Diabetes

Priorities
- Consider the establishment and trial of a pan Powys Diabetes Care Delivery Team
- Support Practices to improve QOF targets of relevance
- Commissioning of adult secondary care
- Ensure compliance with the diabetes LES requirements
- Out of hours and emergency services treatment pathways
- Inpatient care in Powys Community Hospitals
- Review & develop educational programmes and support services
- Support for patients and carers groups
- Support for community pharmacists and care workers
- Improve uptake of flu vaccination rates

Actions

Please see Diabetes Action Plan 2016/17
Diabetes Driver Diagram

Secondary Driver

Improving Information

Effective sign-posting to information and advice
Ensure there is comprehensive and accessible provision of information

Improving Research

Improve access to education programmes
Link into larger research projects relevant to Powys
Encourage patients to participate in research activity

Actions

Please see Diabetes Action Plan 2016/17
## 1. Children and Young People

<table>
<thead>
<tr>
<th>Priority</th>
<th>Actions required</th>
<th>Outcome / Success Measures</th>
<th>Lead Name</th>
<th>Job Title</th>
<th>Due Date</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Continuation of commissioning of paediatric primary &amp; secondary care</td>
<td>Have clear Long Term Agreements with providers for specialist services which can be audited to ensure quality, including timely access to diagnosis and treatment</td>
<td>Agree LTAs with providers and report progress, developments, issues to Diabetes Planning and Delivery Group (DPDG)</td>
<td>Andrew Cresswell</td>
<td>Locality General Manager</td>
<td>April 2016 – March 2017</td>
<td>PTHB’s Commissioning Assurance Framework enables contracts to be managed on quality as well as financial performance.</td>
</tr>
<tr>
<td></td>
<td>Quality standards included in LTA/contract negotiations</td>
<td>Quality standards included in LTA/contract negotiations</td>
<td>Julie Richards</td>
<td>Women and Children’s Service Manager</td>
<td>April 2016 – March 2017</td>
<td>Long Term Agreements with secondary care require providers to meet WG standards</td>
</tr>
<tr>
<td></td>
<td>Develop report &amp; present outcomes to DPDG</td>
<td>Develop report &amp; present outcomes to DPDG</td>
<td>Angela Lewis</td>
<td>Commissioning Manager (N)</td>
<td>April 2016 – March 2017</td>
<td>Activity for commissioned services is reported.</td>
</tr>
<tr>
<td></td>
<td>Included in LTA /contract negotiations &amp; reviews</td>
<td>Included in LTA /contract negotiations &amp; reviews</td>
<td>Cath Quarrell</td>
<td>Finance &amp; Performance Manager (N)</td>
<td>April 2016 – March 2017</td>
<td>LTAs support provision of Insulin Pumps. Confirmation of compliance with NICE guidance to be undertaken.</td>
</tr>
<tr>
<td></td>
<td>As above</td>
<td>As above</td>
<td>Peter Richards</td>
<td>Commissioning Manager (S)</td>
<td>April 2016 – March 2017</td>
<td></td>
</tr>
<tr>
<td></td>
<td>As above</td>
<td>As above</td>
<td></td>
<td>Finance &amp; Performance Manager (S)</td>
<td>Sept 2016 – March 2017</td>
<td></td>
</tr>
</tbody>
</table>
### 1.2 Transition to adult services

<table>
<thead>
<tr>
<th>Compliance with NICE guidelines for transition from paediatric commissioned services to adult services</th>
<th>Provider reports confirming compliance</th>
<th>Andrew Cresswell, Julie Richards, Angela Lewis, Cath Quarrell, Sally Ann Jones, Niamh Cottrell, Eleri Evans, Jenny Jarvis, Cath King, Trisha Powell</th>
<th>Locality General Manager (N) Commissioning Manager (S) Diabetes Specialist Nurses</th>
<th>April 2016 – March 2017</th>
<th>Commissioning managers to request from specialist secondary care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Produce annual register of young people aged 15-18 with type 1 diabetes</td>
<td>Register produced in conjunction with Practice Managers</td>
<td>As above</td>
<td>Diabetes Specialist Nurses</td>
<td>January 2017</td>
<td>To commence January 2017</td>
</tr>
<tr>
<td>Monitor / assess drop out during transition and ensure equity of handover procedures across all providers</td>
<td>Monitor &amp; report on attendance / contact / drop out of patients on register</td>
<td></td>
<td>Diabetes Specialist Nurses</td>
<td>January 2017</td>
<td>To commence January 2017</td>
</tr>
</tbody>
</table>

### 1.3 Education (Supports National Priority 3 Health Care Professional Education)

<table>
<thead>
<tr>
<th>Identify health professionals that would benefit from training and deliver appropriate level of education to them</th>
<th>Mapping exercise to identify appropriate professionals. Agree in PDP for appropriate staff as agreed with their manager</th>
<th>Julie Richards</th>
<th>Women and Children’s Services Manager Diabetes Specialist Nurses</th>
<th>September 2016 – March 2017</th>
<th>To commence in community children’s services in September 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver annual training to school nurses on diabetes within ‘protected learning time’</td>
<td>Completion of training &amp; evaluation report produced</td>
<td>Sally Ann Jones, Niamh Cottrell, Eleri Evans, Jenny Jarvis, Cath King, Trisha Powell, Julie Richards</td>
<td>Women and Children’s Service Manager</td>
<td>September 2016 – March 2017</td>
<td>To commence in school health nursing services in September 2016</td>
</tr>
<tr>
<td>Implement updated WG guidance on the management of diabetes in schools</td>
<td>Audit of schools given training &amp; compliance</td>
<td>Julie Richards Helen James</td>
<td>Women and Children’s Service Manager Head of Children’s Public Health Nursing</td>
<td>January 2017</td>
<td>To commence January 2017</td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>1.4 Peer support groups</td>
<td>Explore feasibility of implementing peer support groups</td>
<td>Feasibility report completed and presented to DPDG</td>
<td>Jenny Jarvis Sally Ann Jones Cath King Trisha Powell Mike Griffiths Jason Harding</td>
<td>Diabetes Specialist Nurses Planning Manager Deputy Director, Diabetes UK</td>
<td>September 2016</td>
</tr>
</tbody>
</table>
## 2. Reducing the Risk of developing Type 2 Diabetes

<table>
<thead>
<tr>
<th>Priority</th>
<th>Actions required</th>
<th>Outcome / Success Measures</th>
<th>Lead</th>
<th>Due Date</th>
<th>Progress</th>
</tr>
</thead>
</table>
| 2.1 Identify population at risk of type 2 diabetes | Use of risk stratification tool  
Patients offered lifestyle interventions (e.g. exercise, weight management, smoking cessation)  
Identify individuals within specific target groups at risk and provide appropriate advice & support (e.g. long term use of steroids & antipsychotics)  
Raise awareness of Diabetes through locally delivered activities | Feedback from GP clusters  
Number of patients offered intervention and reported outcome from this. WG scorecard data for obesity, physical activity and smoking  
Target groups identified and number of individuals provided with advice & support  
Living with Diabetes Day delivered on 29/6/16 (north Powys) & evaluated  
Subject to demand and resource, further day delivered in south Powys | Sally Ann Jones  
Sally Ann Jones  
Sally Ann Jones  
Jason Harding Mike Griffiths | March 2017  
April 2016 – March 2017  
April 2016 – March 2017  
Clinical lead for diabetes appointed July 2016.  
Clinical lead for diabetes appointed July 2016.  
Completed. 200 Powys citizens with Type II diabetes attended in June 2016. Consideration of running the day again in South Powys. |
### 2. Reducing the Risk of developing Type 2 Diabetes

#### 2.2 Empower staff to promote healthy lifestyles and support behaviour change.
- Implementation of the Invest in Your Health programme
- Support national public health initiatives that supports reducing the risk of developing diabetes
- Support the Wellbeing at Work programme across Powys

<table>
<thead>
<tr>
<th>Activity</th>
<th>MECC training audit</th>
<th>Pain Management Service</th>
<th>Public Health Wales Practitioners</th>
<th>Public Health Wales GPs Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PHW update</td>
<td></td>
<td>April 2016 – March 2017</td>
<td>April 2016 – March 2017</td>
</tr>
<tr>
<td></td>
<td>Report from HR on attendance / involvement</td>
<td>Planning Manager Human Resources</td>
<td>April 2016 – March 2017</td>
<td>April 2016 – March 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mike Griffiths</td>
<td></td>
<td>On track for delivery from September 2016</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Due to report in September 2016</td>
</tr>
</tbody>
</table>

#### 2.3 Adoption of the Welsh Government online over 50 health check programme (Add to Your Life)
- Increase awareness and encourage Participation.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Link on website &amp; encourage clinicians to promote to patients</th>
<th>Public Health Wales GPs Practitioners</th>
<th>April 2016 – March 2017</th>
<th>On line service available. Public Health Wales asked to report to DPDG on awareness campaign.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Public Health Wales GPs Practitioners</td>
<td>April 2016 – March 2017</td>
<td>Due to report in September 2016</td>
</tr>
</tbody>
</table>
### 3. Detecting Diabetes Quickly

<table>
<thead>
<tr>
<th>Priority</th>
<th>Actions required</th>
<th>Outcome / Success Measures</th>
<th>Lead NAME</th>
<th>Lead Job Title</th>
<th>Due Date</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Early access to diagnosis and treatment</td>
<td>Health checks offered to the public in community pharmacies Raise public awareness of the signs and symptoms of diabetes</td>
<td>Availability of health checks in at least 50% of community pharmacies. Information available in Primary Care settings DUK ‘Know Your Risk’ roadshows delivered</td>
<td>Jason Carroll Sally Ann Jones Mike Griffiths Tin Wheeler</td>
<td>Medicines Management Diabetes Clinical Lead Planning Manager Communications Manager</td>
<td>June 2016 June 2016</td>
<td>On track Due to report September 2016 DPDG</td>
</tr>
</tbody>
</table>
4. Delivering fast, effective treatment and care

<table>
<thead>
<tr>
<th>Priority</th>
<th>Actions required</th>
<th>Outcome / Success Measures</th>
<th>Lead</th>
<th>Job Title</th>
<th>Due Date</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Consider the establishment and trial of a pan Powys ‘Diabetes Care Delivery Team’.</td>
<td>Undertake feasibility study for initial consideration by DPDG.</td>
<td>Feasibility study presented to DPDG to identify if a ‘Diabetes Care Delivery Team’ should be implemented</td>
<td>Sally Ann Jones Andrew Cresswell Mike Griffiths</td>
<td>Diabetes Clinical Lead Locality General Manager Planning Manager</td>
<td>December 2016</td>
<td>Due to report December 2016</td>
</tr>
<tr>
<td>4.2 Support Practices to improve QOF targets of relevance</td>
<td>Monitor QOF returns and discuss at annual visits</td>
<td>Audit of current performance as part of annual visit</td>
<td>Andrew Cresswell Jayne Lawrence</td>
<td>Locality General Manager Head of Primary Care</td>
<td>April 2016 – March 2017</td>
<td>Completed. Embedded in QOF process.</td>
</tr>
<tr>
<td>4.3 Commissioning of adult secondary care</td>
<td>Have clear Quality agreements with providers for specialist services which can be audited to ensure quality, including timely access to diagnosis and treatment</td>
<td>Performance reports / reviews Timescales</td>
<td>Andrew Cresswell Angela Lewis Greg Chambers Cath Quarrell Peter Richards</td>
<td>Locality General Manager Commissioning Manager Finance &amp; Performance Manager Commissioning Manager (S) Finance &amp; Performance Manager (S)</td>
<td>April 2016 – March 2017</td>
<td>Commissioning Assurance Framework in place.</td>
</tr>
<tr>
<td></td>
<td>Agree and adopt WG quality standards for diabetes in contract negotiations</td>
<td>Agreed contract / compliance</td>
<td>As above</td>
<td>As above</td>
<td>April 2016 – March 2017</td>
<td>Complete providers must meet WG quality standards.</td>
</tr>
</tbody>
</table>
### 4. Delivering fast, effective treatment and care

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Outcome Summary</th>
<th>Lead</th>
<th>Start Date</th>
<th>End Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Report on performance to Diabetes Planning and Delivery Group</td>
<td>Outcomes summary report with successes &amp; areas for development / issues presented to DPDG</td>
<td>As above</td>
<td>As above</td>
<td>Dec 2016</td>
<td>On track. Led by Powys Clinical Lead Diabetes &amp; North Locality Planning Manager.</td>
</tr>
<tr>
<td></td>
<td>Ensure NICE compliant insulin pump therapy service (Supports National Priority 2 - Insulin Pumps)</td>
<td>Included in SLA / contract negotiations &amp; reviews</td>
<td>As above</td>
<td>As above</td>
<td>Sept 2016 – March 2017</td>
<td>LTAs support provision of Insulin Pumps. Confirmation of compliance with NICE guidance to be undertaken.</td>
</tr>
<tr>
<td>4.4</td>
<td>Ensure compliance with the diabetes LES requirements</td>
<td>Review at annual visits with each individual practice &amp; evaluation report to DPDG</td>
<td>Andrew Cresswell, Jayne Lawrence</td>
<td>September 2016</td>
<td>March 2017</td>
<td>Completed. Embedded in QOF process.</td>
</tr>
<tr>
<td></td>
<td>Monitor QOF returns and discuss at annual visits</td>
<td>Agree competences &amp; monitor compliance</td>
<td>Sally Ann Jones, Jayne Lawrence</td>
<td>March 2017</td>
<td></td>
<td>On track. Due to report in March 2017</td>
</tr>
<tr>
<td></td>
<td>Define and review the competences required to undertake LES</td>
<td>Availability of formulary/guidance on Powys intranet</td>
<td>Sally Ann Jones, Jason Carroll</td>
<td></td>
<td></td>
<td>On track. Due to report in March 2017</td>
</tr>
<tr>
<td></td>
<td>Development of diabetes formulary / medication guidance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.5</td>
<td>Out of hours and emergency services treatment pathways</td>
<td>Ensure reporting and follow up arrangements are in place</td>
<td>Sally Ann Jones, Niamh Cottrell, Eleri Evans, Jenny Jarvis, Cath King, Trisha Powell</td>
<td>March 2017</td>
<td></td>
<td>On track. Diabetes Clinical Lead appointed in July 2016. Due to report March 2017.</td>
</tr>
<tr>
<td></td>
<td>Review current management of hyper and hypoglycaemic episodes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 4. Delivering fast, effective treatment and care

#### 4.6 Inpatient care in Powys Community Hospitals

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Review and report on existing policy</th>
<th>As above</th>
<th>March 2017</th>
<th>As above</th>
<th>March 2017</th>
<th>As above</th>
<th>March 2017</th>
<th>As above</th>
<th>March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review current out of hours policy on insulin management</td>
<td></td>
<td>As above</td>
<td></td>
<td>As above</td>
<td></td>
<td>As above</td>
<td></td>
<td>As above</td>
<td></td>
</tr>
<tr>
<td>Review current reporting arrangements with WAST</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve safety of insulin prescribing &amp; administration through the use of the implementing insulin chart by prescribers / nursing staff.</td>
<td>Medicines Management ward audits identify that chart is in use and appropriately completed</td>
<td>Jason Carroll</td>
<td>Medicines Management</td>
<td>September 2016</td>
<td>September 2016</td>
<td></td>
<td>September 2016</td>
<td></td>
<td>September 2016</td>
</tr>
<tr>
<td>ThinkGlucose initiative is implemented across all in patient facilities in Powys</td>
<td>Audit / confirmation of training undertaken / packs issued</td>
<td>Sally Ann Jones</td>
<td>Diabetes Clinical Lead</td>
<td>September 2016</td>
<td>September 2016</td>
<td></td>
<td>September 2016</td>
<td></td>
<td>September 2016</td>
</tr>
</tbody>
</table>

4. Delivering fast, effective treatment and care

<table>
<thead>
<tr>
<th>4.7 PTHB to ensure 100% referral rates to Diabetic Eye Screening Wales (Supports National Priority 1 - Eye Care)</th>
<th>Ensure suitable local infrastructure to support new Diabetic Eye Screening Wales clinic model. Measure times from referral by Diabetic Eye Screening Wales to review by an ophthalmologist</th>
<th>Audit of current performance Report to DPDG</th>
<th>Andrew Crowder</th>
<th>Head of Programme, Diabetic Eye Screening Wales (DESW Diabetes Clinical Lead)</th>
<th>September 2016 – March 2017</th>
<th>Due to report at DSG in September 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardise use of Blood Glucose Monitors across the county</td>
<td>New equipment procured, obsolete equipment disposed</td>
<td>Sally Ann Jones Niamh Cottrell Eleri Evans Jenny Jarvis Cath King Trisha Powell Helen Kendrick</td>
<td>Diabetes Specialist Nurses Quality &amp; Safety Manager</td>
<td>September 2016</td>
<td>Due to report at DPDG in September 2016</td>
<td></td>
</tr>
</tbody>
</table>
## 5. Supporting living with diabetes

<table>
<thead>
<tr>
<th>Priority</th>
<th>Actions required</th>
<th>Outcome / Success Measures</th>
<th>Lead</th>
<th>Due Date</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Review &amp; develop educational programmes &amp; support services</td>
<td>Ensure that there is sufficient capacity to administer and deliver a rolling programme of structured education</td>
<td>Review of existing delivery levels across north and south localities, findings / proposals discussed at DPDG</td>
<td>Andrew Cresswell</td>
<td>June 2016</td>
<td>Capacity in clinical services to deliver Diabetes Xpert under review following appointment of Diabetes Clinical Lead.</td>
</tr>
<tr>
<td></td>
<td>Signpost newly diagnosed people to structured education sessions (for type 1 &amp; type 2)</td>
<td>No of sessions delivered / no of patients attending / waiting lists monitoring / evaluations Benchmark Powys data against WG Scorecard data</td>
<td>Sally Ann Jones Niamh Cottrell Eleri Evans Jenny Jarvis Cath King Trisha Powell Jeanne Nuttall Lorraine Haynes</td>
<td>Sept 2016</td>
<td>Information reported to DPDG in September 2016</td>
</tr>
<tr>
<td></td>
<td>Offer patients the opportunity to attend refresher courses</td>
<td>No of sessions delivered / no of patients attending / evaluations</td>
<td>Locality General Manager</td>
<td>Sept 2016</td>
<td>On track.</td>
</tr>
<tr>
<td></td>
<td>Patient and Carers Groups (reference groups) to be re established (north &amp; mid/south) to meet</td>
<td>2 x groups established / number of meetings held and individuals attending / completed evaluations</td>
<td>Mike Griffiths</td>
<td>June 2016 – March 2017</td>
<td>Completed. Reference groups established.</td>
</tr>
</tbody>
</table>

Information available from QOF data.

Diabetes Specialist Nurses
Head of Dietetics
Head of Podiatry
Practice Nurses
GPs
### 5. Supporting living with diabetes

| 5.3 Support for community pharmacists and care workers | Ensure access to information and advice as and when required | Promotion of new and existing initiatives | Jason Carroll  
Sally Ann Jones  
Niamh Cottrell  
Eleri Evans  
Jenny Jarvis  
Cath King  
Trisha Powell | Medicines Management  
Diabetes Specialist Nurses | September 2016 | Require update from medicines management in September 2016 |
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Support training programme for care workers</td>
<td>No of sessions / individuals attending / evaluations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Sally Ann Jones  
Niamh Cottrell  
Eleri Evans  
Jenny Jarvis  
Cath King  
Trisha Powell | Diabetes Specialist Nurses | September 2016 | To report in September 2016 |
| 5.4 Improve uptake of flu vaccination rates | Encourage patients who have diabetes to have vaccination | Vaccination rates & report | Public Health Wales Practitioners | September 2016 | Powys Flu Vaccination Campaign in development. Launch September 2016 |
| Support local flu vaccination campaign | Promotion through newly diagnosis groups, PTHB / CHC websites etc. |  | As above |  |  |
## 6. Improving information

<table>
<thead>
<tr>
<th>Priority</th>
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<th>Outcome / Success Measures</th>
<th>Lead</th>
<th>Due Date</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Effective sign-posting to information and advice</td>
<td>Work with third sector to ensure effective sign posting to sources of information and support</td>
<td>Evaluation report presented to DPDG with recommendations / actions</td>
<td>Sally Ann Jones, Freda Lacey, Mike Griffiths</td>
<td>Sept 2016 – Dec 2016</td>
<td>Due to report to Powys DPDG in December 2016.</td>
</tr>
<tr>
<td></td>
<td>Improve quality of info &amp; signposting on PTHB website</td>
<td>Update website gain feedback from Patient &amp; Carers Groups</td>
<td>Sally Ann Jones, Mike Griffiths, Tin Wheeler</td>
<td>May 2016 – June 2016</td>
<td>Completed, however further improvement required relating to accessibility.</td>
</tr>
<tr>
<td>6.2 Ensure there is comprehensive and accessible provision of information</td>
<td>Obtain feedback from patients as to the appropriateness of the information available</td>
<td>Evaluation exercise completed and resulting actions identified</td>
<td>Sally Ann Jones, Mike Griffiths, Tin Wheeler</td>
<td>Sept 2016 – March 2017</td>
<td>Feedback to be sought from the Diabetes Patient Reference Groups. Due to report March 2017.</td>
</tr>
<tr>
<td></td>
<td>Identify strategies so that ‘hard to reach’ groups access information and services</td>
<td>‘Hard to reach groups’ identified (e.g. housebound, in areas of deprivation, high risk groups, Strategy produced and implemented</td>
<td>As above</td>
<td>June 2016 – March 2017</td>
<td></td>
</tr>
<tr>
<td>6.3 Pregnancy preconception awareness campaign</td>
<td>Support national awareness campaign when developed</td>
<td>Coordinate completion of on line education module by health care professionals</td>
<td>Cate Langley</td>
<td>tbc</td>
<td>Head of Midwifery to confirm target date.</td>
</tr>
<tr>
<td><strong>(Supports National Priority 4 - Pregnancy)</strong></td>
<td></td>
<td>Promotion of preconception film</td>
<td></td>
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</tr>
</tbody>
</table>
### 7. Targeting research

<table>
<thead>
<tr>
<th>Priority</th>
<th>Actions required</th>
<th>Outcome / Success Measures</th>
<th>Lead Name/Job Title</th>
<th>Due Date</th>
<th>Progress</th>
</tr>
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</table>
### 7. Targeting research

| 7.3 Encourage patients to participate in research activity | Identify research priorities for Powys people | Make patients aware of any opportunities to partake in research | Mike Griffiths  
Jason Harding | Planning Manager  
Appendix 1 - Powys Teaching Health Board’s Delivery Plan - Progress to date against the national delivery plan’s seven themes in 2015-16

Children and Young People

- Specialist paediatric nurses provide advice and information to schools where needed
- Continued to deliver the MEND programme which targets obesity in children.
- Developed guidelines to support transition for paediatric to adult diabetes services.
- Included Diabetes services as part of the contract negotiations for NHS secondary care service provision.

Preventing Diabetes

- Powys Tobacco Action Plan has been developed and implemented.
- Healthy Weights steering group established.
- Mind, Exercise, Nutrition, Do it! (MEND) programme targeted obesity in young people continues to be available in Powys.
- Healthy Schools programme rolled out across Powys.
- Invest in Your Health programme developed for roll out in 2015/16
- Substance Misuse Commissioning Strategy is being delivered and the services for adults, children and young people commissioned.
- Wellbeing at Work programme rolled out across PTHB.
- Diabetes measures discussed in annual Quality Outcome Framework visits to general practices.

Detecting Diabetes Quickly

- Diabetes checks offered to the public in community pharmacies.
- Awareness information available in general practices.
- Structured Education Programme for patients diagnosed with type 1 diabetes available and delivered across Powys.
- A diabetes Risk Stratification Tool has been adopted by some GP practices.

Delivering Fast, Effective Care

- Commissioned Specialist diabetes services from NHS secondary care providers. Long Term Agreement contracts were reviewed with provider organisations, and quality measures begun to be incorporated into these agreements during 2014/15.
- Developed and agreed a revised Local Enhanced Service agreement for diabetes with general practice.
• Agreement for a Powys Clinical Lead for diabetes to be established to take this work-stream forward.
• Diabetes Specialist Nurses delivered education programmes for Social Services carers and other ‘health’ clubs & groups (e.g. Leg Clubs).
• Diabetes Specialist Nurses have undertaken Think Glucose training.
• The podiatry ‘Feet First Pathway’ has been established and implemented
• Participated in the National Diabetes Audit.
• Improved communication between paramedics and GPs to reduce hospital admissions has taken place.

Supporting Living with Diabetes

• Supported patients with personalised care and self management plans through Specialist Diabetes Nurses.
• Improved Flu Vaccination uptake in at risk groups in 2014/15 on previous years, however the match between the influenza virus and vaccine in 2014/15 was not good.
• Developed a Multi Disciplinary Team approach to care includes Diabetes Specialist Nurses, Podiatrists, Tissue Viability Nurses and Dieticians.

Improving information

• Preliminary discussions have taken place regarding joint IT between Powys primary and community services.
• Diabetes Specialist Nurses work closely with voluntary groups to provide information and support.

Improving Research

• We have not advanced a research programme in 2015/16 other than to make a link with Aberystwyth University. This action has been deferred into 2016/17 when we intend to evaluate the locally developed Powys diabetes education programme in partnership with Aberystwyth University.