Children and Young People Committee: Inquiry into Childhood Obesity Additional Evidence

February 2014

WLGA • CLlLC

INTRODUCTION

1. The Welsh Local Government Association (WLGA) represents the 22 local authorities in Wales, the three national park authorities and the three fire and rescue authorities.

2. It seeks to provide representation to local authorities within an emerging policy framework that satisfies the key priorities of our members and delivers a broad range of services that add value to Welsh Local Government and the communities they serve.

3. Following the WLGA evidence session with the National Assembly for Wales Children and Young People Committee on the 15th January 2014 the Committee was keen to receive additional written evidence on a number of issues relating to childhood obesity. This report contains the information requested by the Committee.

The All Wales Obesity Pathway

4. Please see the attached case study on the use of the All Wales Obesity Pathway.

Child Measurement Programme

5. The WLGA is currently awaiting information on examples of interaction between health visitors who work at part of the Flying Start programme and their use of the child measurement programme. The information in the child measurement programme is however, used as a key indicator in the Welsh Government early years plan, Building a Brighter Future.

Change4Life

6. Wales, as far as the WLGA is aware, does not participate in the Start 4 Life programme, initiatives aimed at the under 7s in Wales are channelled through the Flying Start Programme.

Appetite for Life

7. Local authorities in Wales monitor the take-up of school meals in order to effectively plan for provision. Information on the take-up of schools meals as a whole is currently not collated at a national level. Information is collected in relation to the number of

pupils who are eligible for and who take-up a free school meal. In 2012/2013 the total number of children in Wales eligible for free school meals was 83,498, the total taking up free school meals averaged 79% on the school census day.

8. A proportion of the funding for obesity programmes is retained within grants provided by the Welsh Government which have to date been relatively unaffected by recent budget constraints. There are some exceptions, for example, MEND funding will be looked at as part of the full review on public health programmes undertaken in 2013. The schools budget has been subject to protection in line with the First Minister's commitment and local authorities are now delegating over 82% of funding directly to schools to which can be used to fund school-based programmes such as Wales Healthy Schools Programme.

9. As the Committee will be aware all local authorities in Wales are seeking to make budget savings following an average 4% reduction in the funding that they receive from Welsh Government through the Revenue Support Grant (RSG). Authorities are considering a range of measures to ensure that the best value is being made of public money whilst fulfilling statutory functions.

Creating an Active Wales

10. All local authorities in Wales have developed their own strategy, for example, Creating an Active Cardiff. These plans are created in partnership with Sport Wales and include local authority physical activity plans that are then funded by grants from Welsh Government and the lottery, e.g. 5 x 60 Dragon Sport. The level of resources provided through Sport Wales has remained consistent up until 2014, however final budgets for the next financial year have not yet been set but there is a likelihood of a reduction of approx 4.5%.

11. There are a number of ways in which the Creating an Active Wales plan is monitored and evaluated. At a strategic level, there is a cross-departmental Welsh Government group in place to oversee the implantation of the action plan. At a local authority level, specifically in relation to physical activity and sport, the Chief Leisure Officers in Wales and Sport Wales have developed a results based accountability approach which focuses on key indicators to monitor progress, using information such as the number of children who can swim by age 11. All local authorities also produce annual Local Authority Physical Activity Plans. The plans are closely monitored and evaluated by Sport Wales through an annual return on achievements within the plan.

12. The level of financial pressures being faced by local authority leisure services is unprecedented. In order to address these issues local authorities have looked to alternative methods of delivering their leisure services, including external trusts, internal trusts, contracting out to the private sector, community partnerships with the 3rd sector and local community management. There will however, be instances where centres or facilities close due to a combination of factors beyond just the revenue costs. Such factors include condition of the building, present low use of the facility and new facilities replacing the old.

13. The Active Travel (Wales) Act 2013 comes into force in mid-2014 and requires councils to create a network of routes for walking and cycling. This legislation will be implemented, monitored and evaluated. The legislation requires local authorities to identify and map the enhancements that would be required to create a fully integrated network for walking and cycling, and develop a prioritised list of schemes to deliver this network. This requirement presents an opportunity to develop safe routes for children to use to and from school.

14. Many local authorities already employ strategies to encourage more children to walk or cycle, such programmes might include:

    - Introducing traffic calming measures and/or 20mph speed limits around schools;
    - Development of footpaths and cycle paths on key routes, for example under the Safe Routes in Communities Programme;
    - Cycling training or cycle loan schemes to ensure that children have access to a bicycle and are able to cycle safely and confidently;
    - A 'walking bus' led by parent volunteers, is a cost-effective solution to help children get to school safely on foot.

15. The legislation also enables local authorities to develop safe environments where children can play in the evenings, weekends and holidays. Through this legislation, there is an opportunity to achieve positive outcomes for children's health via planning mechanisms. Consideration of programmes and initiatives aimed at reducing childhood obesity should be taken into account early on in any discussions.

MEND

16. The MEND programme is managed by Public Health Wales and delivered by many local authorities. The programme has been reviewed by Public Health Wales and through its National Health Improvement Review it was determined that Public Health Wales and the Welsh Government would work together to identify a way forward. The WLGA and local authorities through its collective experience of delivering the National Exercise Referral Scheme and operational areas within MEND, have offered to work with Welsh Government and Public Health Wales to develop a way forward.

17. The WLGA feels strongly that there needs to be a targeted but also more universal drive to reduce the levels of young people with obesity and would wish to see a continuation of funding specifically for this age group but with clearer alignment with the National Exercise Referral Scheme on the continuation of funding for the MEND programme.

Future developments

18. The WLGA in its recent work with the Effective Services for Vulnerable Groups (ESVG) (which reports to the Public Service Leadership Group), supported the view that health considerations should be an important part of planning considerations. This approach however, will only be successful if combined with strategies to educate children and young people about making healthy choices.

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Hearty Lives Torfaen: Schools Prevention programme

Torfaen CBC in partnership with Aneurin Bevan Health Board and Public Health Wales, were awarded £1.5m through the British Heart Foundation (BHF) Hearty Lives funding stream. This funding facilitated the development of an "obesity pathway" which enabled the joint working of clinical treatment services and community prevention activities, to deliver a new and innovative way of reducing health inequalities related to Cardiovascular Disease (CVD) by tackling obesity as a co-morbidity of CVD.

The approach taken in developing the various elements of the 'Obesity Pathway' was fully in-line with:

- The Welsh Assembly Government model and framework for the management of chronic conditions in Wales (WAG 2008) including pathway development and provision of interventions in-line with tiers of population need from prevention through to complex condition management.

- The National Service Frameworks for older people, diabetes and Coronary Heart Disease, all of which contain standards relating to the prevention of ill health through primary prevention and effective secondary prevention of disease through risk factor reduction and health promotion.

The National Institute for Health and Care Excellence (NICE) guidance on the prevention, identification, assessment and management of overweight and obesity which identifies the need for effective intervention across the health, social and community interface.

School Prevention Strand Methodology

He schools prevention programme targeted school aged children with the aim of increasing awareness and knowledge, and improving attitudes and behaviours in relation to diet and exercise to prevent obesity and reduce risk of CVD.

The schools prevention strand focused on delivering a cascade of training to teachers, LSA's and other professionals who worked directly with children and young people. A lead teacher from each school 'cluster' took responsibility for school prevention development, and undertook training in the use of BHF resources, these lead teachers would then deliver training to other teachers within the cluster, mentor, supervise and coach them to ensure quality standards of delivery in heart health promoting activities were maintained.

A variety of BHF resources were available to schools, all of which focused on healthy eating and physical activity, with the exception of the BHF Heartstart programme, which focused on Essential Life Saving Skill (ESL), was already delivered in the Community in Torfaen, but was identified as valuable resource to be rolled out in schools, with age appropriate ESL being delivered from Primary level through to Adults. The Heartstart programme, amongst other BHF resources, was ideal for 6th pupils who, as part of their 'Good Citizenship' programme at school and as part of

the Welsh Baccalaureate community work experience, could use these resources to enhance their learning and skill set by having the ability to support teachers in their delivery to younger pupils. 6th form pupils were trained to support and cascade training to younger pupils throughout schools.

Other BHF children and young people's resources enhanced the curriculum delivery within Torfaen schools. The lead teachers took responsibility to train other teachers in how to utilise available BHF classroom resources, and therefore adopted a sustainable and successful model across Torfaen, which also supports the Healthy Schools Scheme.

Schools Prevention Strand - Outcomes

More than 800 teachers, learning support assistants and sixth form pupils were trained to utilise BHF resources as part of their curriculum delivery or provision. Through the schools prevention strand of the Hearty Lives Torfaen programme, 48,846 contacts with children were involved in activities and curriculum-based learning about heart health, healthy eating, physical activity and healthy weight, in addition to

TCBC staff delivered a range of school-based activities on heart health, BHF awareness and promotion of healthy lifestyles in a number of different ways including, during PSHE sessions and additional workshops but importantly embedding this work through existing after-school activities and using BHF resources throughout the core curriculum, during each school term by the project development workers and trained teaching staff.

Overall this strand aimed to build a sustainable approach through leadership in partnership with schools and other education providers enabling TCBC staff to support capacity development (providing skills, knowledge and resources) to continue to deliver this work. Positioning of this strand within the TCBC was crucial to the change agreed to by the schools in training and delivery amongst their busy schedule – including education authority wide ESTYN inspection (the statutory education and training inspectorate for Wales).

Schools were allowed the autonomy of how they introduced the resources to their curriculum, to ensure they fitted with their schemes of work. Process evaluation information was collected from Teachers and through focus groups, the results of which enabled continual improvement which increased the scope of the HLT programme within schools by allowing programme more flexibility.

Training in the use of BHF resources was flexible and appropriately pitched, to enable teachers to come together collectively, share ideas and best practice and also to "up-skill" teachers who required some additional knowledge around the subject area

The specific elements of this strand of the programme included:

1. **Jump Rope for Heart (Schools)**

Encouraging physical activity through skipping, there is a resources pack including materials, equipment and teaching support which the schools can also use to raise money for the BHF and/or for their schools. 527 teachers, 6th formers and other play and youth service staff were trained. Lead teachers in secondary schools developed and monitored skipping activities within schools and across school clusters. Training took place during routine INSET and planned workshop sessions. Practice sessions for school children were delivered through physical education and Personal Health and Social Education (PHSE) lessons with jump rope activities being embedded into curriculum delivery across 28 schools in the borough.

2. **Dodgeball (Schools)**

An event-led fund-raising package which also contained tips on how to run a dodgeball tournament within the school setting. 527 teachers, sixth formers and other play/youth staff were trained. Lead teachers in secondary schools developed and managed ball activities within schools and across school clusters. Training took place during routine INSET and planned workshop sessions. Practice sessions for school children were delivered through physical education and PHSE lessons with dodge ball activities being embedded into curriculum delivery across 28 schools. Many Secondary Schools within Torfaen have adopted Dodgeball as part of their PE curriculum delivery.

3. **Active Club**

Aimed at Primary Schools and Comprehensive Years 7, 8 and 9 /Key stage 2 and 3. This pack contains a range of physical activity ideas and resources for out of school settings. 527 Teachers, 6th formers and other play/youth staff were trained to deliver the BHF Active Club package and deliver as part of an after-school programme and during breaks and lunchtimes in schools. This programme also utilised resources such as ‘Let’s get physical pocket play pack’.

4. **Heart Start (Schools)**

Provides an opportunity for pupils to learn simple emergency skills which can save a life, the pack provides a comprehensive guide and materials to implement it in school setting. 802 teachers were trained along with 6th formers. The programme was cascaded through school clusters by the trained teachers. Training for key staff took place during routine teacher training days (INSET) and twilight sessions. Training for 6th formers who also supported delivery of Heartstart took place as part of schools ‘good citizen’ programme and Welsh Baccalaureate, with additional workshops run as part of the PHSE curriculum. Key Staff delivered training and support (with development workers) to other staff members throughout their own schools and within their cluster schools. 6th form pupils supported delivery of workshops and sessions with younger children throughout their own school and worked with children in feeder schools to deliver training at an age appropriate level.

5. **Big Food Challenge**

Enhancing food knowledge in “learning through play” as part of the Foundation Phase curriculum with games and activities as well as clear teachers notes to incorporate in to lesson plans and delivery (Key stage 2). As part of PSHE 123

teachers and LSA's were trained and also agreed to deliver the resources to be used to enhance the core curriculum; Artie Beat Packages (Key stage 1) The Big Heart Exploration (Key stage 2).

In total, 28 out of 32 schools in Torfaen "signed-up" to become Hearty Lives Torfaen (HLT) Schools during the lifespan of the programme. The four schools who did not take part were the three Welsh medium schools (the programme was unable to provide all school based resources in Welsh) and one school which underwent relocation and major building works during the programme period.

Evaluation Data

There was a large amount of activity within this strand in terms of numbers trained and the numbers of children-contacts from the training. In summary, to date the HLT programme has achieved:

- **48,846** children (contacts) have utilised BHF resources through curriculum delivery in Torfaen Schools
- 527 Teachers/Learning Support Assistant's (LSA's)/ Play/Youth Staff trained to deliver BHF resources
- 802 Teachers, LSA's and 6th Form pupils trained in Heart Start

Knowledge and Awareness of Heart Health amongst Primary School Children

Pre & post questionnaires were completed within some school clusters during the academic year 2011/12 to gage the children's understanding and awareness of heart health & healthy lifestyles, before and after the implementation and this data was compared against the Torfaen average. It is acknowledged that due to the nature of the population and the self reported results it is difficult to attribute meaningful changes to the intervention. The individual school reports are available on request and the Torfaen aggregated results are presented below.

The survey was administered with primary school years four, five and six (children aged 8 to 11 years) in 13 primary schools in Torfaen. The questionnaires were administered in two phases in November 2011 and April 2012 to 1,291 and 1,365 pupils respectively.

Although the majority of the children (87%) surveyed in Torfaen Primary Schools perceived themselves as being very or quite healthy, 47 percent and 37 percent of the children self reported that they are not currently achieving the national guidelines in relation to physical activity and nutrition respectively. This information suggests that in order to benefit heart health, there is a need to increase their levels of physical activity and improve their diets (particularly in relation to intake of fruit and vegetables) to enable them to establish lasting healthy diet and physical activity levels. In fact in phase two 61% of children indicated they were getting a healthy amount of physical activity – a very important increase.

Whilst there was little change in knowledge and attitudes between pre- and post-evaluation in many of the parameters measured as part of the evaluation, there was

a 30 percent increase in children reporting getting adequate physical activity to benefit their health.

Conclusion

In conclusion; it was widely acknowledged by all partners in the Hearty Lives Torfaen programme that the schools prevention strand was a very successful element of the overall programme and the model adopted would provide an excellent blueprint for the national Healthy Schools Scheme across Wales.

Briefing Paper – BHF Hearty Lives Torfaen

BHF

British Heart Foundation is a medical research charity that aims to play a leading role in the fight against disease of the heart and circulation so that it is no longer a major cause of disability and premature death.

Hearty Lives

In December 2008, BHF launched a multi-million pound 'Hearty Lives' award Programme. This new funding programme was specially created to fund innovative and collaborative initiatives that seek to address health inequalities due to Cardio Vascular Disease (CVD). In Wales, 3 local authorities applied to the fund and Torfaen was successful in being awarded £1.5 million to fund a joint bid between the Local Authority, ABHB and Public Health Wales.

Torfaen Data

The project is targeted at the management of obesity in adults who are more at risk of developing major risk factors for CVD. Welsh Health survey (WHS) data (2005/2007) show that **at 26% Torfaen has the highest adult obesity prevalence** of all local authority areas in Wales. This equates to just over **19,000 obese adults**

Torfaen also has high levels of morbid obesity. WHS data (combined 2003/04, 2004/05, 2005/06), suggest that between 1.3 and 2.8 per cent of the Torfaen population aged 16 and over have a BMI of 40 or more. This equates to between **900 and 2000 adults and ranks Torfaen second for morbid obesity in Wales**

Whilst rates of obesity in the borough increase with age, there is **little difference between men and women**. There are estimated to be significant variation in obesity based on a variety of determinants which are strongly related to material deprivation.

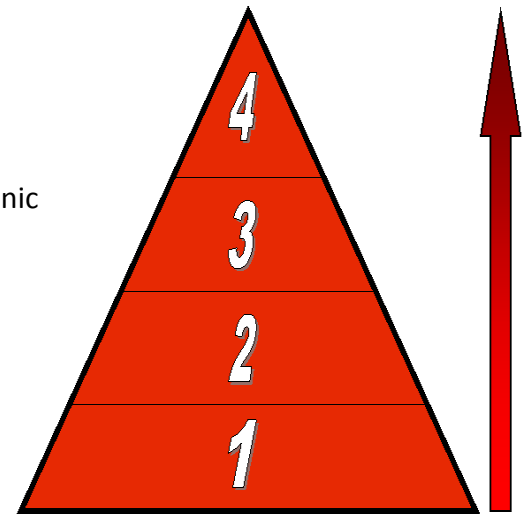
The Torfaen Approach

The approach taken in developing the various elements of the bid is fully in-line with:

- The Welsh Assembly Government model and framework for the management of chronic conditions in Wales (WAG 2008) including pathway development and provision of interventions in line with tiers of population need from prevention through to complex condition management.
- National Service Frameworks for older people, diabetes, CHD and children's and women's. all of which contain standards relating to the prevention of ill health through primary prevention and effective secondary prevention of disease through risk factor reduction and health promotion
- NICE guidance on the prevention, identification, assessment and management of overweight and obesity which identifies the need for effective intervention across the health, social and community interface.

Stratified Obesity Management

- Bariatric surgery
- Intensive (Multidisciplinary Team) obesity clinic
- General Practice based obesity service
- Health promotion and primary prevention



The Torfaen award consists of **4 Project Strands:**

Strand 1: Childhood Obesity - Managed by Aneurin Bevan Health Board
Strand 1 focuses predominantly on children and young people:

'Obesity in Gwent School Children'
25% of Torfaen children, weighed at school entry, were overweight or obese (data from an audit undertaken by Dawn Slade, Paediatric SpR).

Welsh Health Survey 2007
36% of children were classified as overweight or obese, including 20% obese

This is comparable to data for England from the Millennium Cohort Study 2007:

- *23.7% of 3 year olds are overweight or obese*
- *Almost a third of children age 2-10 are overweight or obese*
- *More than a third of children aged 11-25 (31.5%) are overweight or obese*

Without intervention, these children are at high-risk of long term health problems later in life. The NICE guidelines on obesity underlines the importance of ensuring that the prevention and management of obesity remains a priority for adults and children and the need for a broad approach on a number of levels involving multiple agencies.

The project will target the 5 Communities First areas of Torfaen. A children's community dietician will be appointed to deliver the programme which will interface with 'Flying Start/Health Visiting Services' to enable families to adopt healthier lifestyles.

- To support the work of Flying Start and Sure Start staff with families in communities first areas
- To promote and engender healthy eating from early years onwards
- To be a source of expert guidance and training providing nutrition education and resources for staff of other disciplines and organisations as well as for families
- To work with women and girls of childbearing age to avoid excessive weight gain in pregnancy, promote breast feeding and healthy weaning/ family diet.
- To work with families providing of direct intervention
- To coordinate the delivery of MEND and mini MEND programmes, contributing the dietetic input/ theory lead

Designed by child obesity experts; the MEND and mini MEND programmes are family based with mandatory participation by parents/adult carers; their aim is to gain positive and sustainable lifestyle improvements for the child and other family members.

MEND 2 – 4 focuses on families with children aged 2 - 4 years and is aimed at prevention and management of obesity. Research shows the child who becomes obese under-5 years of age has a strong likelihood of going on to be an obese adolescent and adult with all the attendant health risks.

MEND 7-13 focuses on families with children aged 7 – 13 and seeks to inculcate healthier eating and physical activity behaviours at the age when children are receptive

Project Objectives

- Short term - to empower socially disadvantaged members of the community, at increased risk of CVD due to overweight or obesity, to access locally based information and effective services to promote a healthier community (evidenced by reduced waist circumference and improved cardiovascular fitness in participants).

- Medium term - to increase the organisations' awareness of effective interventions for childhood obesity and gain commitment to on-going funding for a sustainable service in the future, thereby actively manage risk factors relating to or associated with the development of heart disease

- Long term – to see a halt (ultimately a reduction) in the prevalence of children and young people in Torfaen classified as overweight or obese (sustained reduction in waist circumference/ increased activity levels in children and young people).

Strand 2: Schools Prevention – Managed by Torfaen County Borough Council

- Targets school aged children to increase awareness, knowledge, attitude and behaviours in relation to diet and exercise to prevent obesity and reduce risk of CVD.
- Focuses on a cascade of training approach, already adopted and successful within the local PESS programme. A lead teacher from each school 'cluster' to take responsibility for school prevention development. Lead teachers will deliver training to other teachers within the cluster, mentor, supervise and coach them to ensure quality standards are maintained.
- Heartstart – Already delivered in the Community in Torfaen – can be rolled out in schools – 6th formers could, as part of their 'Good Citizenship' programme at school or as part of the Welsh Baccalaureate community work experience. Pupils can be trained and cascade training to younger pupils throughout school
- Other BHF resources will enhance the current curriculum delivery. The 'mentor' teachers will train other teachers how to utilise available BHF classroom resources.

Strand 3: Obesity Pathway - managed by Aneurin Bevan Health Board

- Development of an obesity pathway aimed at reducing CVD inequalities
- Support for all general practices to manage people at greater risk of CVD due to overweight and obesity
- Specialist Multi-disciplinary service for people classified as morbidly obese and at high risk of developing CVD
- Implementation of the agreed and locally negotiated Obesity pathway with evidence based protocols for the management of overweight and obese people, utilizing expertise from the multi-disciplinary team
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- Training and education of primary care staff, providing resources for the management of overweight and obese adults, information for the management of overweight and obese children into the BHF Hearty lives schemes
- People seen in all parts of the service will be enabled to move up or down the pathway, into services that are appropriate for their needs taking into account their readiness for change.

Strand 4: Community prevention - managed by Torfaen County Borough Council

- Targeting adults who are 'at risk' of CVD.
- Targeted GP referral programme, which enables GP's and Health Care Professionals to refer patients who will benefit their health by losing weight.
- Provides an 8 week educational and mentoring weight management programme that enables patients/community members to access appropriate support to change behaviour in relation to their nutritional intake and physical activity levels.

- Involves delivery of 1:1 lifestyle, and group sessions focussing on diet, exercise and health behaviour changes.
- Offer practical support, information and sign-posting to existing and new health promoting community activities
- Post Intervention follow-up sessions and support for 12 months following completion

Adult Community Prevention Weight Management Strand - Total Health 2 programme

Torfaen CBC in partnership with Aneurin Bevan Health Board and Public Health Wales, were awarded £1.5m through the British Heart Foundation (BHF) Hearty Lives funding stream. This funding facilitated the development of an "obesity pathway" which enabled the joint working of clinical treatment services and community prevention activities, to deliver a new and innovative way of reducing health inequalities related to Cardiovascular Disease (CVD) by tackling obesity as a co-morbidity of CVD.

The approach taken in developing the various elements of the 'Obesity Pathway' was fully in-line with:

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- The National Service Frameworks for older people, diabetes and Coronary Heart Disease, all of which contain standards relating to the prevention of ill health through primary prevention and effective secondary prevention of disease through risk factor reduction and health promotion.

The National Institute for Health and Care Excellence (NICE) guidance on the prevention, identification, assessment and management of overweight and obesity which identifies the need for effective intervention across the health, social and community interface.

Total Health 2, Programme Methodology

The major determinants of obesity are physical inactivity and energy dense diets resulting in a positive energy balance over several years. In addition to their impact on obesity which in turn adversely affects the other risk factors and hence CHD, the independent or direct effects of a healthier diet and, particularly, appropriate physical activity on the other risk factors as well as CHD is clinically important, statistically significant and consistently documented.

The Hearty Lives Torfaen programme consisted of four programme strands of work, which aimed to tackle obesity throughout the life course, one of which is the TCBC managed Total Health 2 (TH2) programme. TH2 content was developed by the TCBC Health Improvement Team, in collaboration with ABHB Dietetics service and the Public Health Team, and was fully in-line with NICE guidance for weight management and behaviour change. TH2 is a unique programme, developed to tackle a growing need in Torfaen. Combining everything we know about nutritional needs, physical activity and behaviour change theory in relation to improving people's health outcomes.

TH2 was established as both a GP referral and self referral programme, to maximise its reach on the Torfaen population. A GP referral route was established, as it was identified through our primary care partners, that there was a gap in provision for prevention of ill health in patients who required support to lose weight. These patients were deemed "not in need" of clinical treatment, however without intervention these patients would be more likely to go on to have an increased risk of severe health problems and would eventually progress to becoming 'in need' of clinical services. In light of this a programme within the community which would tackle both inactivity and poor diet was identified as a need.

People were also encouraged to self-refer to TH2, as it was identified that people with weight issues can often be reluctant to visit their GP or clinician for support or advice for their fear of being "judged". Therefore it was agreed that TH2 would best serve the population of Torfaen and be more accessible if it was delivered within community settings across Torfaen.

Based on these identified needs the TH2 programme was developed and implemented across Torfaen to offer targeted weight management support.

TH2 is fundamentally an eight week weight management programme, which provides on-going support for a 12month period to individuals to support the maintenance stage of their behaviour change.

Mechanism for monitoring impact on population health

TH2 incorporates National Institute for Health and Care Excellence (NICE) guidelines which offer a robust evidence base on which Total Health has been formulated. This programme also provides a robust framework for weight management and currently forms a programme approach to provide a pathway into clinical, treatment age appropriate weight loss services that are needed. Total Health 2 offers a clinical, evidence based approach to achieving and sustaining weight loss amongst the target population, whilst also complimenting a full range of community learning and education programmes that already exist for health promotion.

The Total Health programme has a robust evaluation framework in place which has been designed in collaboration with Public Health Wales, Torfaen Locality and incorporates previously validated health and lifestyle monitoring questionnaires.

Participants are assessed and monitored pre and post intervention to enable positive changes and programme successes to be robustly recorded.

As TH2 is “unique” in its approach and delivery model, it was crucial to fully evaluate the outcomes, as it is the only programme of its kind that combines nutritional educational and physical activity in a “whole” programme approach. There is a strong evidence base to using this type of model and this is advocated by NICE Guidance as the best approach to long term health and weight management (good diet and regular physical activity).

Programme Outcomes:

The programme aimed to target adults that were sedentary and a have poor diet. The target population were those perceived to be ‘at risk’ from overweight and obesity, and developing CHD/CVD.

By the end of the programme they would;

1. increase their knowledge and awareness (Short-term)
2. make positive changes in their attitude (Medium-term)
3. report improved access to local facilities (Short-term)
4. make positive changes in their behaviour towards healthy eating, physical activity and smoking (Long-term)

Since the Hearty Lives Torfaen programme commenced in 2010/11, 523 people have contacted the TH2 service, 442 of these were assessed for their suitability and readiness to change, of which 379 people were registered to attend TH2 and 259 people went on to complete the full TH2 programme.

As previously mentioned the TH2 programme has a robust evaluation framework in place, which aimed to capture primary outcomes related to weight for health, secondary outcomes of health improvement and health behaviour change and tertiary outcomes of changes to the processes of behaviour change, such as self-efficacy or confidence. Participants were assessed and monitored pre and post intervention, and again at 3months, six months and 12months to enable positive changes and programme successes to be robustly recorded.

Evaluation

A formal evaluation was conducted by Public Health Wales. Carried out on 161 course participants with an age range from 16-78 years of age. The average age was 53 years.

A range of measures were used including clinical outcomes, physical and mental

health and wellbeing scores. A range of measures and evaluation tools were used to evaluate the impact of the programme. Self-efficacy assessments, weight efficacy lifestyle score, IPAQ (Physical Activity Questionnaire), and a set of standard questions from SF36v2.

The key highlights from the formal evaluation report are:

The physical summary component score at baseline is 46.9, below the Welsh average (48.8) and the Torfaen average (47.7). Post intervention this improved (48.7) to above the Torfaen average and in-line with the Welsh average. At 6 months follow-up this increased to (50)

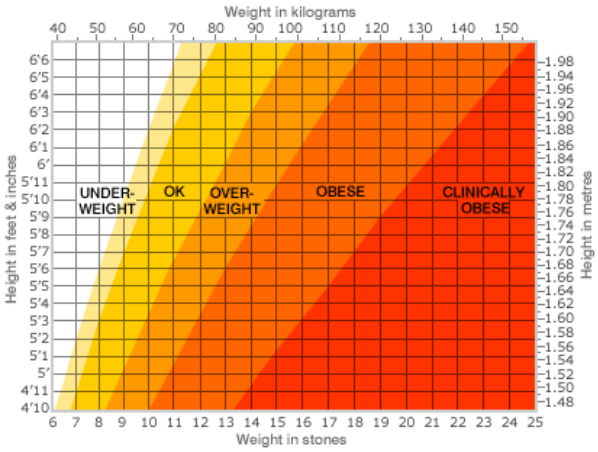
The mental health summary component score at baseline is 44.9, considerable lower than the Torfaen and Welsh averages of 49.8 and 49 respectively. (WHS, 2010, 2011). Post intervention this improved to (49.7) in-line with the Torfaen and Welsh average. At 6 months, this improved to 49.8.

The improvement in mental and physical health component scores is consistent with the average clinical weight loss achieved by participants. The data was subject to a paired sample analysis and both physical activity and mental health component scores are statistically significant at the 95% level.

Qualitative data was collected using the International Physical Activity Questionnaire, short version (IPAQ) to compare pre and post intervention data with a categorical variable which relates to the UK Chief Medical Officers recommendations for aerobic / healthy physical activity (150 minutes of moderate level intensity or 75 minutes of vigorous intensity physical activity per week). Post intervention, 70% of participants reported physical activity at a level to benefit health. In summary, the analysis carried out with the IPAQ questionnaire indicated that post programme 70% of TH2 participants were achieving enough physical activity to benefit their health.

The clinical evaluation outcomes are as follows:

Participants BMI ranged from 23.6 to 48.5 with an average of 33.7. Healthy BMI range is 18 to 25.



Of 157 participants with recorded BMI at pre-post intervention, 135 (86%) had lost weight post intervention. 7 people maintained their weight, no change. 15 had gained weight. Amongst those who lost weight, the average weight loss 3.17kg.

The evaluation data show that weight measurements at baseline and follow-up intervals that weight loss is not only maintained but participants continued to lose weight over time. At 6 month follow-up weight loss has increased to 5.8kg and at one year further increases to 8.5kg compared to baseline weight. As the post intervention period increases, the numbers for follow-up decreases at 6 months and 12 months and therefore the confidence interval widens from:

- Post intervention 95% CI, -2.7 to 3.6.kg
- 6 months 95% CI, -4.6 to -6.9.kg
- One year 95% CI, -4.9 to -11.9kg

The above statistical information indicates that the number of participants reduced at 6 month and 12 month follow-up, however, even with the reduced attendances at follow-up, the results are still statistically significant at the 95% level. This level of confidence indicates that if TH2 was delivered in a similar population it would have the same impact and success in terms of health outcomes.

Conclusion

The formal evaluation, conducted by Public Health Wales; Locality Team, states that "*Total Health 2 is a very successful community weight management programme for people with overweight to moderate obesity. The data shows that the participants lost a statistically significant and clinically important amount of weight, lowered their BMI and reduced their weight circumference. Participants' general health, physical and mental health components improved in addition to improving their physical activity levels. The changes were observed up to one year follow-up and self efficacy an important cognitive determinant of behavior change and maintenance of healthy behavior also increased with respect to both physical activity and diet".*

ANEURIN BEVAN UNIVERSITY HEALTH BOARD

TOGETHER FOR HEALTH – DIABETES DELIVERY PLAN

LOCAL DELIVERY PLAN

A Delivery Plan up to 2016 for Aneurin Bevan University Health Board and its Partners

SECTIONS **PAGE**

1 Welsh Government Policy & Strategic Direction

"Together for Health – Diabetes Delivery Plan" was published by the Welsh Government 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 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.

There is a focus on high quality health care for the people of Wales, with increased levels of personal responsibility for lifestyle choices that increase people's risks of developing chronic diseases, such as diabetes.

Welsh Government's 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 with a commitment to a quality-driven NHS that provides services that are:

- Safe
- Effective
- Accessible
- Affordable; and
- Excellent User Experience

What Does The Welsh Government Want to Achieve?

The Welsh Government aim for Wales to have diabetes incidence rates, and health care outcomes, comparable with the best in Europe. The following population outcome indicators will be used 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

These aims build on the Welsh Government policy set out in the Programme for Government and Together for Health to deliver real and measureable improvements in Diabetes through an ambitious programme for health and health care in Wales.

To achieve this ambitious programme the Welsh Government has set out evidence based actions in its *Diabetes Delivery Plan* to improve outcomes, between now and 2016, in the following key themed areas:

- **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.

- **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.

- **Detecting Diabetes Quickly**
  Diabetes is detected quickly where it does occur.

- **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.

- **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.

- **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.

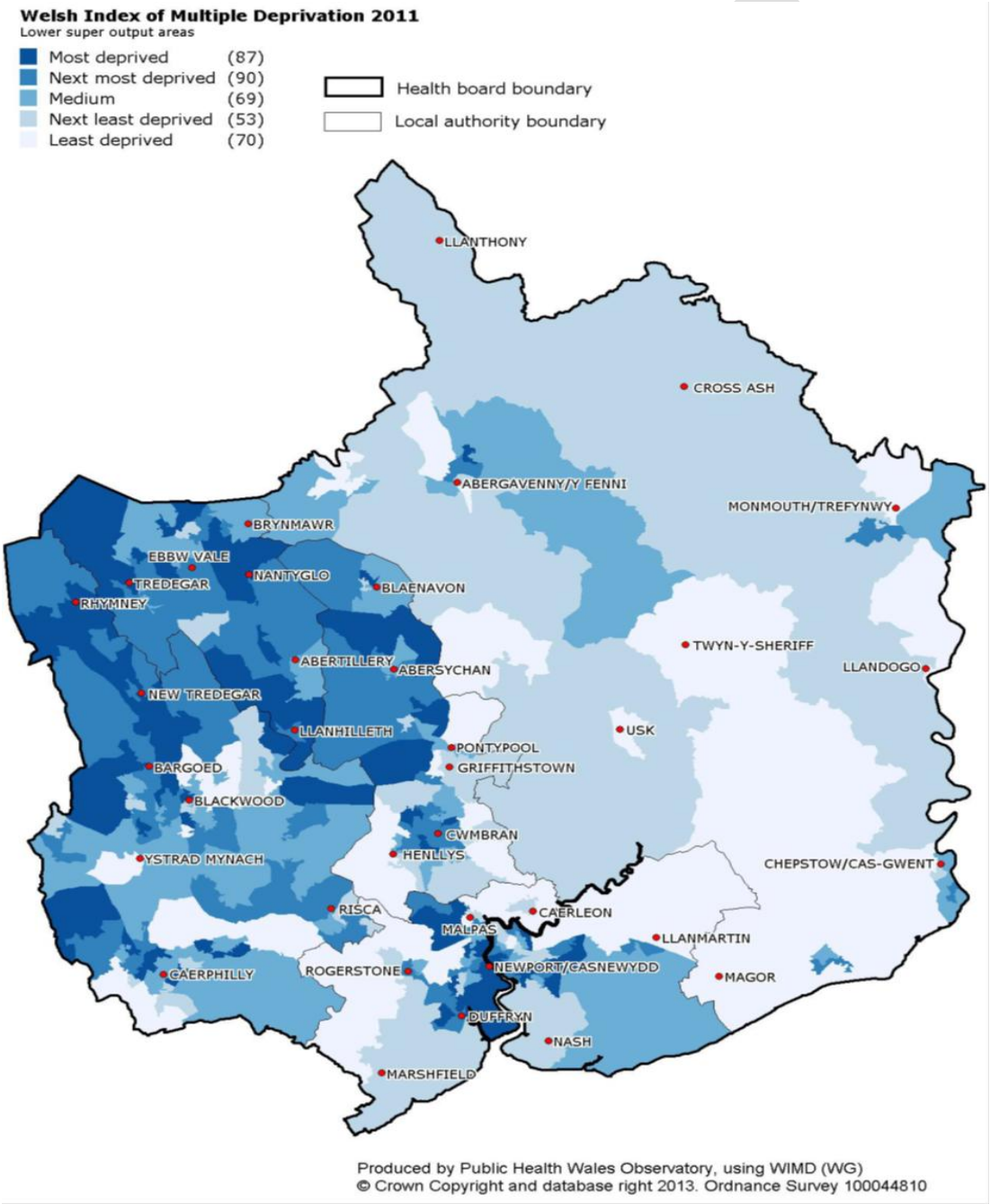
- **Targeting Research**
  Access to research can lead to better outcomes for patients. The NHS must promote research and ensure appropriate access to clinical trials.

Each of the above themes is supported by specific priorities to deliver them.

2 Demographic and epidemiology profile of diabetes in Aneurin Bevan University Health Board Area.

This Section presents the demographic and epidemiology of diabetes within the population of Aneurin Bevan university Health Board. It provides a summary of the contributing factors towards developing Type 2 diabetes and the links with the high levels of deprivation across the area.

A higher percentage of Aneurin Bevan University Health Board population live in deprived areas compared with the national population (Figure 1).



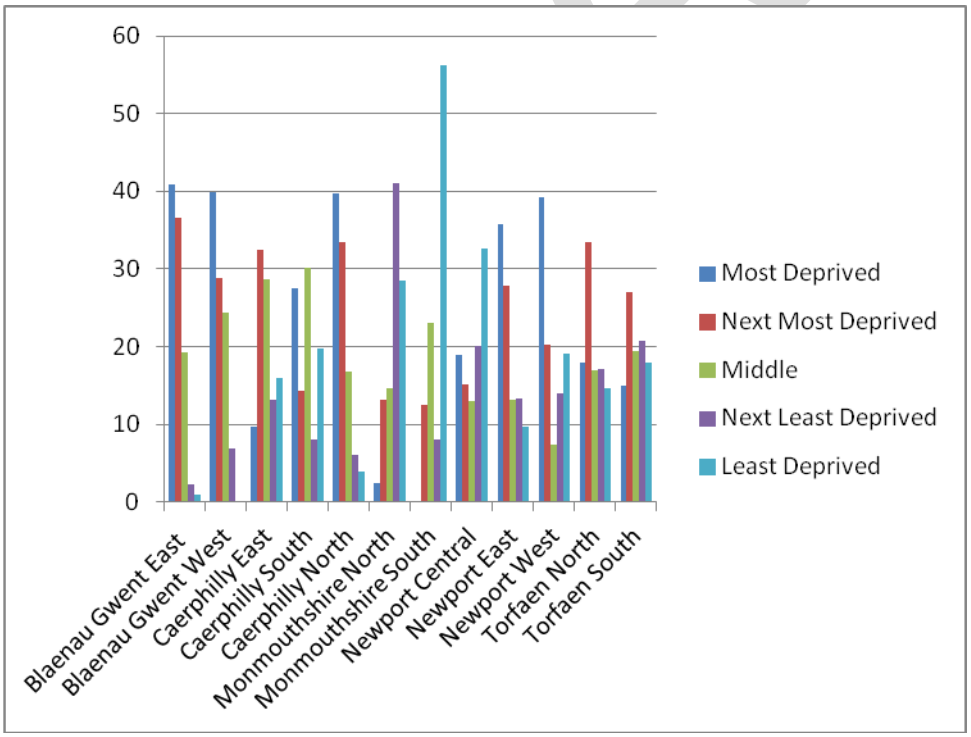
Deprivation

The link between deprivation and poor health is well recognised. People in the most deprived areas have higher levels of mental illness, obesity, hearing and sight problems, and long-term conditions, particularly chronic respiratory diseases, cardiovascular diseases and arthritis. Diabetes in Wales is almost twice as high in the most deprived areas compared to the least deprived.

Within the Health Board there are areas of deprivation, particularly in the valley areas of Blaenau Gwent, Caerphilly and Torfaen. 88 out of the 369 Lower Super Output Areas (LSOAs) in the Health Board (24 per cent) are among the most deprived fifth in Wales with 72 (20 per cent) in the least deprived fifth. However, within less deprived areas there are often pockets of hidden deprivation. Graph1 shows the deprivation levels across the 12 Neighbourhood Care Networks.

BME groups experience higher levels of Type 2 diabetes, Newport has the largest BME group with significant pockets of deprivation.

Deprivation levels across the 12 Aneurin Bevan Health Board Neighbourhood Care Networks



(Source: Public Health Wales Observatory 2013)

Obesity

In the 2011-12 Welsh Health Survey, 58 per cent of Welsh adults reported a weight and height classed as being overweight (BMI of 25 or greater) or obese (BMI of 30 or greater). In Aneurin Bevan Health Board population, 61% of adults are overweight or obese, and 25% are obese. This is significantly higher than the Wales average.

Related statistics show low levels of fruit and vegetable consumption (used as a proxy for a healthy diet) and of physical activity, reflecting the two main behavioural determinants of weight gain.

Within the Health Board area, these factors tend to be more prevalent in the more deprived areas. However, the recent analysis of obesity and overweight in children (measured in school at age 5) shows that Blaenau Gwent has a lower than expected level of child obesity, similar to the Wales average.

From 2011-12 Welsh Health Survey – Local Authority level data in adults aged 16+ (-/+ = significant difference re Wales)

	% who ate five portions of fruit and vegetables yesterday	% who are active for at least 30mins on at least five days in past week	% overweight or obese	% obese
Caerphilly	29 (-)	28	64 (+)	27 (+)
Blaenau Gwent	27 (-)	31	62 (+)	27 (+)
Torfaen	30	26 (-)	63 (+)	28(+)
Newport	35	30	56	19 (-)
Monmouthshire	30	27	60	23

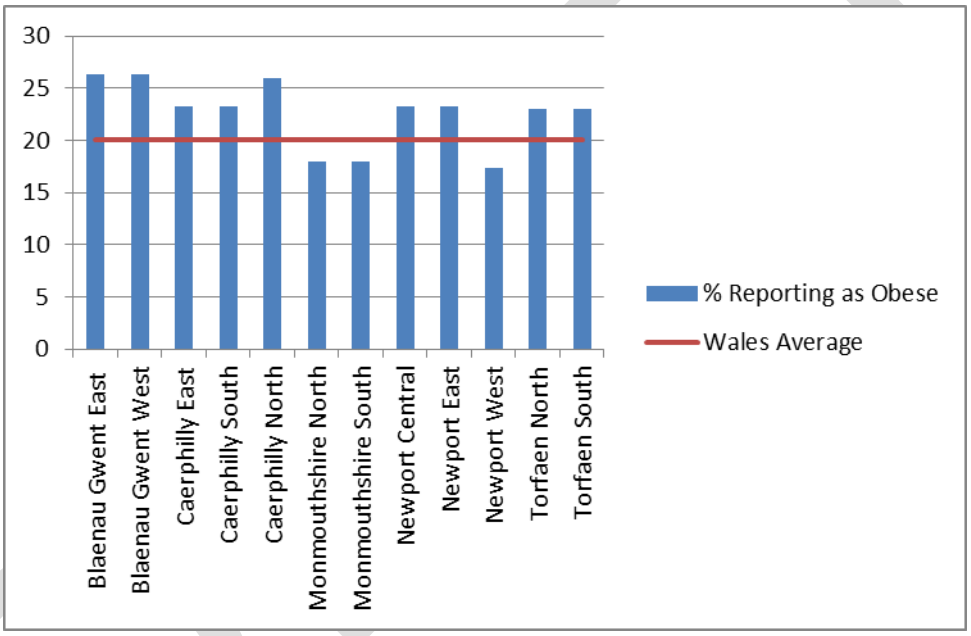
Poor diet and sedentary lifestyle are major contributors to obesity and many cases of type 2 diabetes. The proportion of adults not maintaining a healthy body weight is increasing in Wales and, despite stabilising in children, remains too high, as in many other countries. The Welsh Health Survey in 2011-12 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.

Lifestyle interventions prompting 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.

Across Wales the average levels of obesity were report at 20%. Graph 2 shows where the obesity levels are higher than the Welsh average across the 12 Neighbourhood Care Networks (NCNs). The areas where they are higher is clearly reflective of the levels of deprivation within these areas as shown in Graph 1 above.

Graph 2: Percentage of Population across the 12 Aneurin Bevan University Health Board Networks who reported being obese

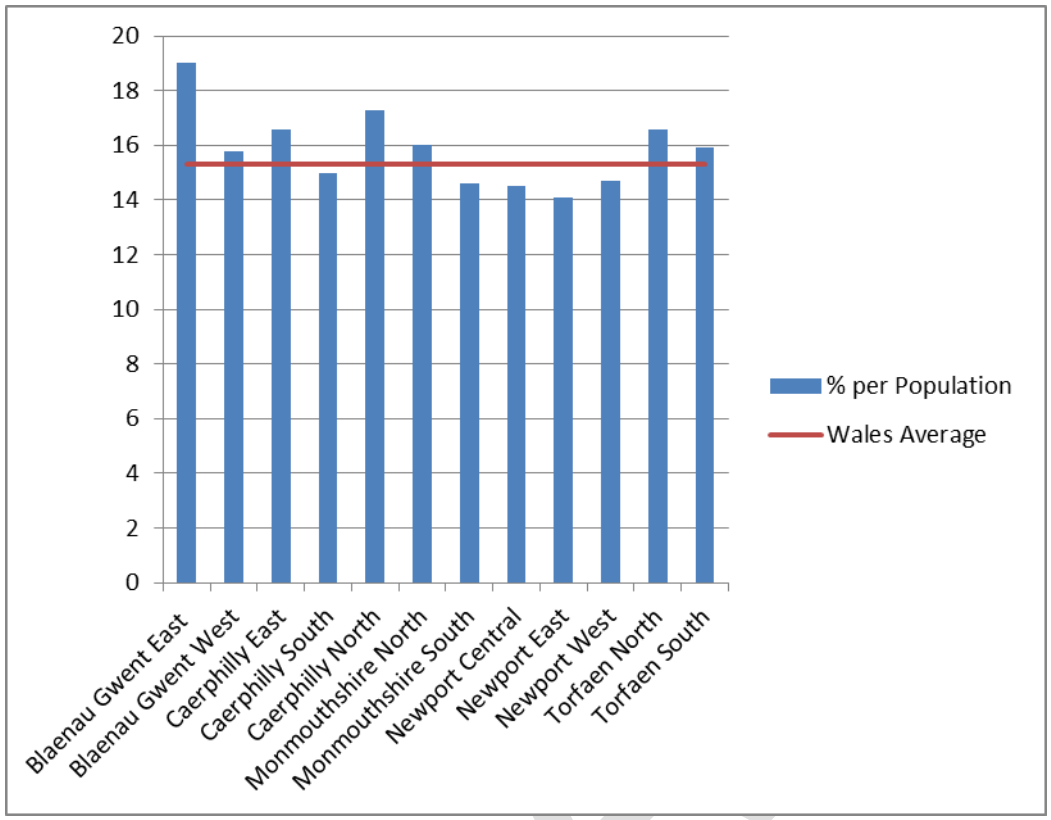


(Source: Welsh Health Survey 2011-12)

Hypertension (High Blood Pressure)

Hypertension is linked to diabetes and obesity. Measurement of hypertension is one of the 9 health checks which are carried out annually for people with diabetes. Graph 3 shows where patients across the NCNs have higher than the Welsh Average of hypertension. Blood pressure lowering in people with diabetes reduces the risk of macrovascular and microvascular disease.

Graph 3: Percentage of Population with Reported Hypertension across 12 NCNs

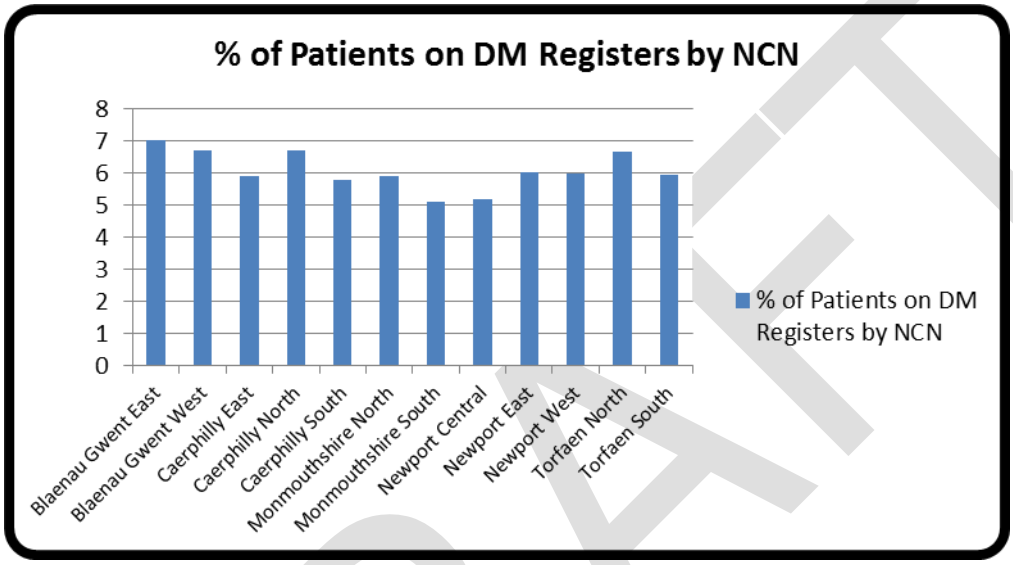


(Source: Welsh Health Survey Data 2011-12)

3 Aneurin Bevan University Health Board's Diabetes Incidence Rates

There are currently 36,323 patients on General Practice Registers across Aneurin Bevan University Health Board which equates to 6.07% of the practices population. Graph 4 below shows how these 36,323 patients are spread across Neighbourhood Care Network Areas and Table 1 shows the actual number of patients on Diabetes Registers.

Graph 4: Percentage of Patients on Diabetes Registry by NCN



(Source QOF Data 2012)

Table 1 Number of Patients on Diabetes Registers across NCNs

Neighbourhood Care Network	% of Patients on DM Registers	No. of Patients on DM Registers
Blaenau Gwent East	7.04	2695
Blaenau Gwent West	6.7	2348
Caerphilly East	5.9	3542
Caerphilly North	6.71	4620
Caerphilly South	5.79	3220
Monmouthshire North	5.92	3031
Monmouthshire South	5.1	2389
Newport Central	5.18	2505
Newport East	6.03	2888
Newport West	6	3131
Torfaen North	6.68	3252
Torfaen South	5.93	2702
Total		**36,323**

The above graph and table shows the variations in the incidence of diabetes across Neighbourhood Care Network with Blaenau Gwent having the highest proportion of people with diabetes. It should be noted that these variations are more significant at practice level, as these range from 4.10% in a practice in North Monmouthshire area and 10.22% in a practice in Newport West.

Management of Diabetes

HbA1c measurement is one of the other 9 health checks carried out in primary care. HbA1c levels above 75mmol/mol is an indicator of poor diabetic control and management.

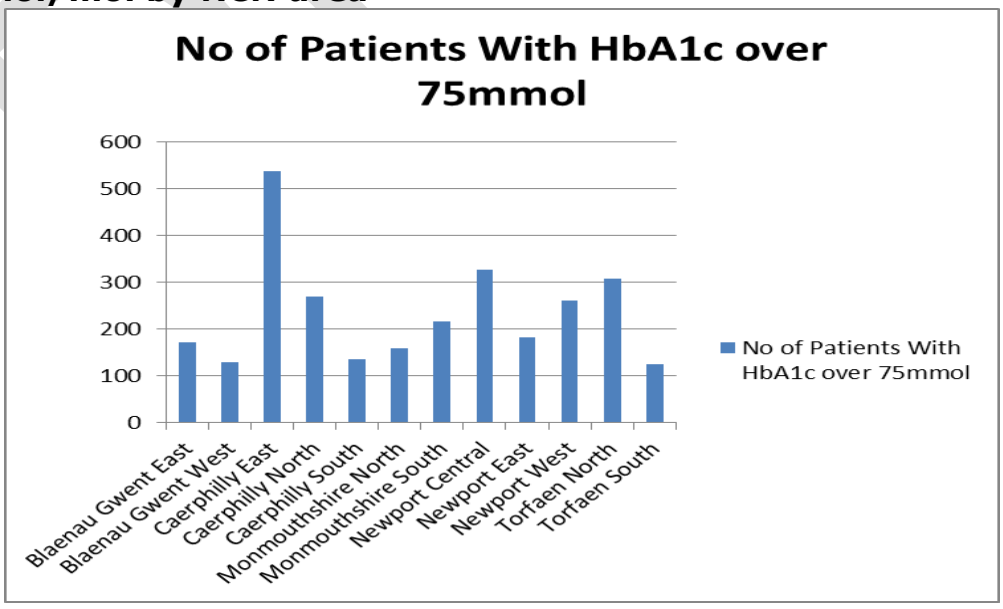
Across the NCN networks there are 4577 (12.6%) of the patient on the diabetes registers whose HbA1c levels are above 75mmol/mol. Graph 5 shows how these patients are spread over the 12 NCNs.

The term HbA1c refers to glycated haemoglobin. It develops when haemoglobin, a protein within red blood cells that carries oxygen throughout your body, joins with glucose in the blood, becoming 'glycated'.

By measuring glycated haemoglobin (HbA1c), clinicians are able to get an overall picture of what our average blood glucose levels have been over a period of weeks/months.

For people with diabetes this is important as the higher the HbA1c, the greater the risk of developing diabetes-related complications.

Graph 5: Number of People with diabetes with HbA1c > 75mmol/mol by NCN area



(Source: QOF Data 2012)

The management of HbA1c is primarily through good life style choices and appropriate use of medication therapies.

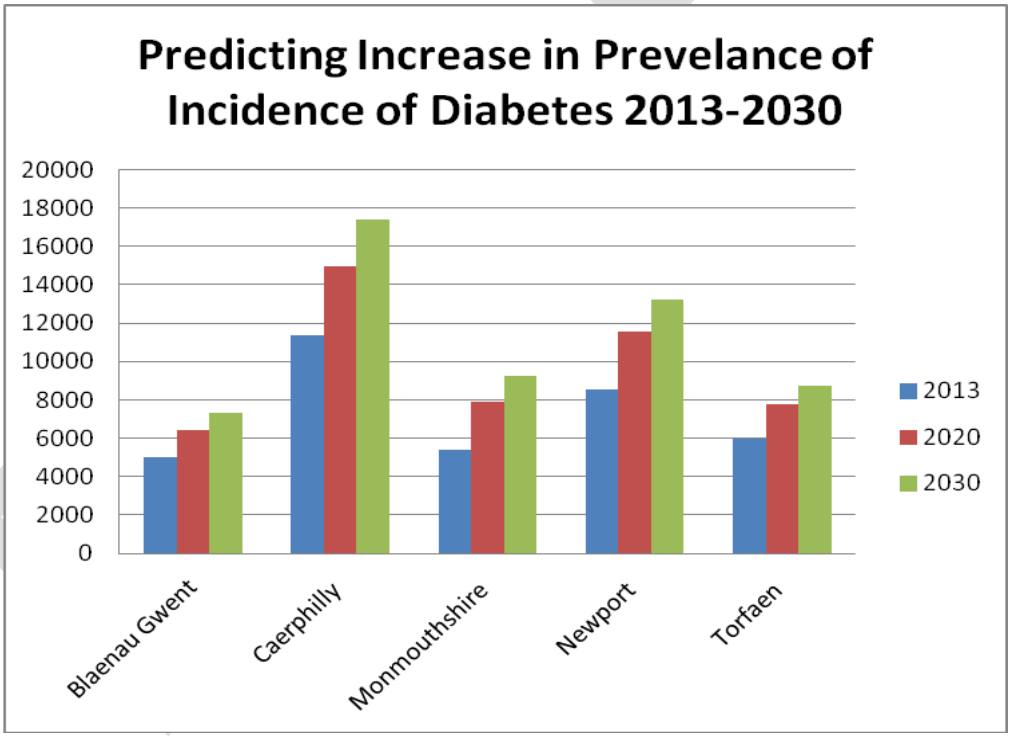
85% of the 36,323 patients receive their care in primary care settings.

All type 1 including children, young people and adults are managed in specialist services.

Predicting Diabetes Incidence Rates

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. Graph 6 and table 2 shows what that increase will look like for the Health Board.

Graph 6: Predicting Increase of Prevalence of Incidence of Diabetes in Aneurin Bevan University Health Board of the next 17 years



(source: Association of Public Health Observatories 2010)

Table 2: Number of Patients predicted to have diabetes in the next 17 years

Predicting Increase in Prevalence of Incidence of Diabetes			
Neighbourhoods	**2013**	**2020**	**2030**
Blaenau Gwent	5043	6,444	7,296
Caerphilly	11382	14,966	17,429
Monmouthshire	5420	7,891	9,232
Newport	8524	11,549	13,200
Torfaen	5954	7,788	8,730
Total	**36323**	**48638**	**55887**

These predictions are based on current patient list sizes and do not take into account any other variables other than the predicted increases as outlined above.

4 Aneurin Bevan University Health Board's Vision

Our Vision for diabetes care is aligned with the Welsh Governments for 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 the 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 healthier life, wherever they live in Gwent

Organisational Profile

Aneurin Bevan University Health Board (ABUHB) was established in 2009 as an integrated Health Board. The organisation is responsible for the planning and delivery of a wide range of primary, community and secondary care health services for the population of Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen. Together with an estimate of people living in South Powys and other areas that use the Health Board for acute services, the patient population served is close to 600,000. The Board serves a diverse range of population groups with different health needs and sizable inequities in health within and between localities. Service planning and delivery also has to take account of a mix across rural, urban, and valley areas, and a high proportion of elderly people. The Health Board employs approximately 14,000 staff.

On occasions primary care and acute services provide cross boarder arrangements for patients outside of the Aneurin Bevan University Health Board Area.

Clinical Futures Strategy

Following extensive local consultation Aneurin Bevan University Health Board's Clinical Future Strategy was launched in 2007. Clinical Futures sets out the Health Board's vision for the development of sustainable services that can provide appropriate access and excellent standards of care for patients. It is a plan that bridges primary, community and hospitals services, promoting services in or close to home, along with high quality hospital services available when needed. Hospital provision will be focused on a Specialist and Critical Care Centre, enhanced Local General Hospitals, Local General Hospitals and smaller community facilities. Primary and community services will be enhanced to re-balance care

between primary, community, secondary and tertiary services to ensure care is provided close to home where appropriate.

Current Diabetes Provision

The majority of people with diabetes (85%) are managed in primary care; meaning that currently about 15% would need specialist care due to the complex nature of their diabetes, or for management of the complications related to diabetes.

Children & Young People receive all their care from specialist diabetes services.

The National Diabetes Inpatient Audit has highlighted that 20% of hospitalised patients have diabetes. The majority (90%) of these are admitted for reasons other than their diabetes; but diabetes remains a significant co-morbidity in them, and about 60% of these patients will need input from the specialist diabetes team.

Table 3: Diabetes Services across Aneurin Bevan University Health Board

Level 1 - Primary Care	Level 2 - Local General Hospital	Level 3 - Specialist & Critical Care
• Prevention • Diagnosis • Care Planning • 9 Health Checks • Routine care clinics • Management of diabetes • Structured Patient Education	• In-Patient Beds & Specialist Clinics • Patients with complications • Rapid Access Clinics • Specialist Diabetic Team hub • Joint Ante natal - Diabetes clinics • Emergency care but not including Critical Care • Consultant hub • Transitional Clinics (Paediatrics – Adults) • Education • Care Planning • Diabetic Foot Care • Low eGFR/dialysis patients • Uncontrolled type1/adolescent diabetes • Insulin Pumps • CYP Diabetes Services	• In-Patient Beds • Renal Support • Intensive Care • Vascular Surgery • Critical care for patients with ketoacidosis • Diabetic Obstetrics • In-patient beds for CYP with complex diabetes and at diagnosis

Pivotal to the success of the Clinical Futures Strategy is the delivery of high quality and accessible primary care services. This is to ensure better access to and integration with primary and specialist services so we continue to shift resources from hospital to primary care services and preventative care.

Whilst it is essential that we develop and deliver care as safely and as locally as possible, it is a priority for the Health Board to ensure that there is a consistency and equity of service provision across the five local authority areas. Neighbourhood Care Networks are ideally placed to drive improvements in patient pathways as all patient care, with exception of emergency care, begins and ends in primary care. Across Aneurin Bevan University Health Board there are 89 general practices linked to the 12 Neighbourhood Care Networks.

Diabetes mellitus (DM) is one of the common endocrine diseases affecting all age groups with over one million people in the UK having the condition. Effective control and monitoring can reduce mortality and morbidity. Much of the management and monitoring of people with diabetes, particularly patient with type 2 diabetes, is undertaken by the GP and members of the primary care team.

Aneurin Bevan University Health Board aims to ensure that the resources of the 89 practices are utilised safely and effectively to deliver high quality care to people with diabetes in the community through up-skilling primary care staff through an integrated diabetes service model with access to specialist clinicians for advice and education.

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 expectance. 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.

5 Drivers for Change

The Welsh Government estimates that there are currently around 175,000 adults in Wales being treated for diabetes. This equates to approximately 7% of adults in Wales, 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. *(Together for Health – Diabetes Delivery Plan)*

Services for diabetes already account for 10% of all NHS expenditure in the UK and in 2009-2010 this amounted to £500 million in Wales. Applying this formula to Aneurin Bevan University Health Boards annual budget would equate to £99m being spent on diabetes care. 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. *(Together for Health – Diabetes Delivery Plan)*

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. The Health Board needs to focus their activity on narrowing the gap in healthcare outcomes between their most and least deprived communities in their local populations. *(Together for Health – Diabetes Delivery Plan)*

Strategic actions to prevent diabetes (type 2) and delay the onset of complications associated with diabetes by supporting people to live a healthy lifestyle and make healthy choices are set out in the Aneurin Bevan University Health Board Public Health Strategic Framework 2011-2015 'A Healthier Gwent for All' and include actions to:

- Reduce the percentage of adults who smoke
- Reduce the percentage of children & young people and adults who are obese
- Reduce the percentage of adults who report drinking alcohol above recommended guidelines
- Increase the percentage of children & young people and adults who are physically active
- Improving health literacy by equipping and empowering people with the knowledge and skills they need to navigate the health system and to take steps to improve their own health

6 Aneurin Bevan University Health Board's Approach to Tackling Diabetes

In response to the *"Together for Health – a Diabetes Delivery Plan"* (2013), the Health Board, together with its partners, has produced this detailed Local Service Delivery Plan to demonstrate a systematic approach to progressive implementation of the Diabetes National Service Framework and the Diabetes Delivery Plan.

Aneurin Bevan University Health Boards Diabetes Planning and Delivery Group

Aneurin Bevan University Health Board's Diabetes Planning & Delivery Group is the "Together for Health – Diabetes Transformation Group" which has been established in response to Delivery Plan.

This Group will build on the previous groups work and develop and oversee a programme of transformation to improve Diabetes Services across the whole pathway of care. The Group's objectives are set out to deliver Welsh Government requirements and to ensure links with the strategic objectives of partner organisations and the Welsh Government.

The ABUHB Diabetes Transformation Group aims to deliver improvements in the Three key areas set out in the Diabetes Driver Diagram (Appendix 1) as followings:

- Optimise Patient Management in Primary Care
- Appropriate Access to Specialist Support Services
- Improve Management of In-Patients with Acute Episodes

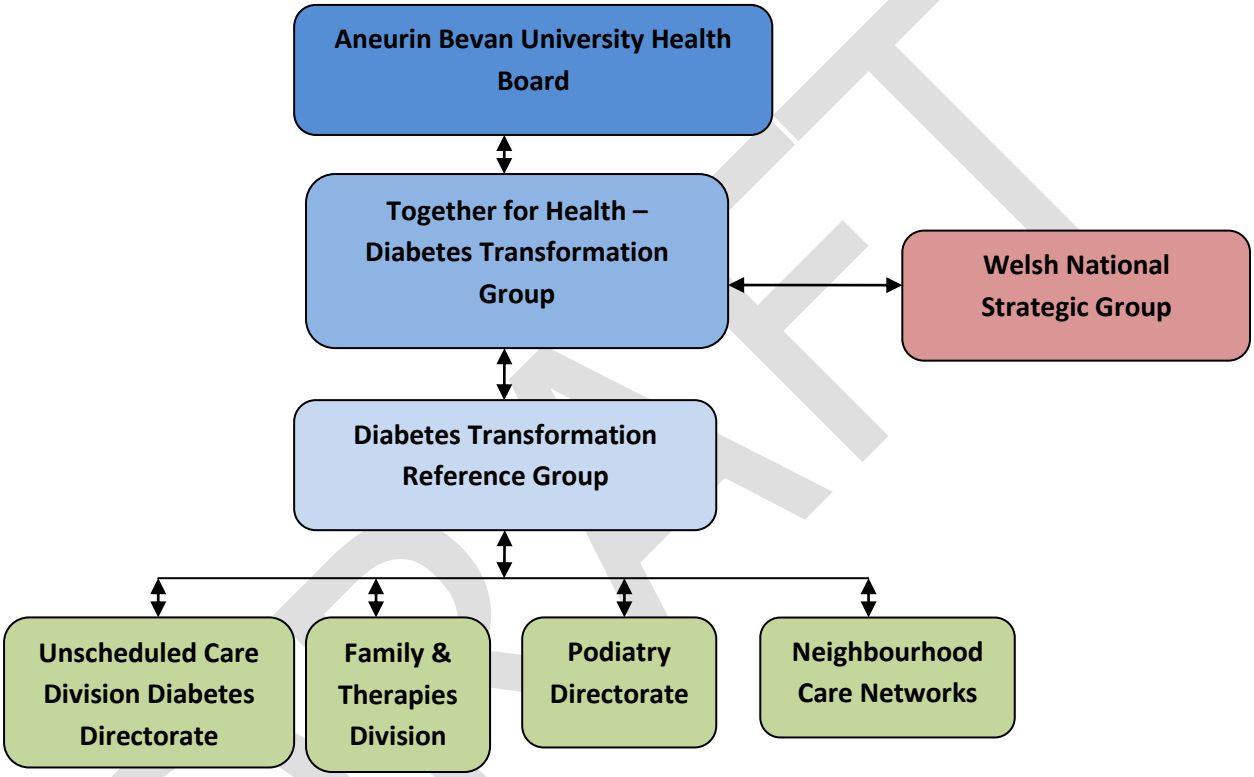
The oversight, development and implementation of the Diabetes Local Delivery Plan is an iterative process which aims to:

- Put effective plans in place to help prevent avoidable Type 2 Diabetes;
- Plan high quality, effective, person-centred care for anyone affected by diabetes
- Provide high quality detection and treatment in primary care and for diabetic complications in specialist services
- Improve health outcomes, quality of services and the individual's experience

Governance Structure

A programme of work has commenced to meet the Health Board's responsibilities under the Delivery Plan and the following Governance Structure has been established to support and monitor progress and implementation, as follows:

Governance & Delivery Structure:



The Together for Health Diabetes Transformation Group meet on a monthly basis and has representation from the Divisions:

- Primary Care & Networks – Primary Care & Medicines Management
- Unscheduled Care – Diabetes Directorate
- Family & Therapies – (Child Health), (Dietetics) and (Podiatry)
- Aneurin Bevan University Health Board/Gwent Local Public Health Team

The Diabetes Transformation Reference Group meets on a quarterly basis and has wide clinical, patient and Third Sector representations.

To support the implementation of the Delivery Plan a series of Task & Finish Groups will be set up according to priority. It is intended that these groups will have clearly defined task specific actions and will only meet two or three times to complete the action. This is to ensure timely delivery, leadership and maximise resources.

The Together for Health Diabetes Transformation Group has developed a Driver Diagram (Appendix 1 underpinned by a reporting framework (Appendix 2)) to measure performance of the Aneurin Bevan University Health Board Diabetes Delivery Plan (Appendix 3).

7 Performance Measures/Management

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

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

All of the Diabetes Transformation Group's plans incorporate all key performance outcomes, NHS Measures and actions for delivery to meet expectations of the *Together for Health – Diabetes Delivery Plan (2013).* Details of The Welsh Government's measures are shown in Appendix 4 attached.

Progress with these outcome indicators/measures will form the basis of Aneurin Bevan University Health Board's report on the Diabetes Delivery Plan. We will produce an initial progress report in March 2014 and a full Annual Report in March 2015 and March 2016.

We will also report progress against this Local Delivery Plan and its milestones annually to the public via our website.

8 The Priorities for 2013-2016

This Section provides a summary of the detailed Aneurin Bevan University Health Diabetes Delivery Plan which is shown in Appendix 3 attached. The framework for the summary has been developed against Aneurin Bevan University Health Board's Diabetes Driver Diagram (Appendix 1).

This Diabetes Local Delivery Plan includes actions for each of the priorities identified within the Welsh Government's Diabetes Delivery Plan (2013) and additional actions identified by the Diabetes Transformation Group.

The following tables summarise priorities and key actions against each Delivery Theme of the Diabetes Delivery Plan together with identified priority areas of the Diabetes Transformation Group.

It should be noted that the National Diabetes Strategic Group will also be identifying priority areas, indicative January 2014 which Health Board's will need to action. It is anticipated that our priority areas will mirror those of the Strategic Group.

Optimising Patient Management in Primary Care

Aneurin Bevan University Health Board's Vision:

- **Improved public awareness of the risk factors for, and dangers of, developing diabetes and the importance of early presentation to primary care**
- **To put patients first and to provide timely and quality diabetes management as locally as possible and in the most appropriate environment for the patient.**
- **Supporting patients to improve self-management of their diabetes through structured educational programmes**
- **To improve clinical outcomes and patient experience through having a skilled workforce in primary care to manage people with complex diabetes and improve timely access to specialist advice**
- **To deliver high quality and equitable diabetes services across Aneurin Bevan University Health Board to provide seamless care on the patients journey between primary care and specialist services**

Aims:

- Reduce incidence of Type 2 Diabetes
- Provide Diabetes Education to newly diagnosed patients and information for awareness raising of the risks of diabetes
- Every patient with diabetes will receive annual reviews against standard health checks
- Address actions around National Diabetes Primary Care Audit
- Optimise the use and management of medication
- Provide specialist support to Neighbourhood Care Networks
- Every diabetic patient to have a personalised care plan
- Implement Diabetes Integrated Service Model

WHAT ARE WE DOING IN PRIMARY CARE?

- Improved public awareness of the risk factors for, and dangers of, developing diabetes and the importance of early presentation to primary care.

- Implement all levels of the Wales Obesity Pathway.

- Progress with adult weight management services within the Health Board.

- Communities First areas are being supported by the dietetic service to provide 'Foodwise'.

- The BHF project in Torfaen has now ceased with the cessation of the fixed term grant, but the community programme 'Total Health 2' will be continuing to run until March 2014, and is being adapted to support young people not in employment, education or training as part of the three year LIFT project.

- Torfaen schools are continuing to use the BHF educational resources. A reconfiguration of adult weight management services across the whole of the Health Board has now been agreed and funded. This will change the way patients access services, with all patients entering services through a single point of access and assessment. This will then determine whether patients access level 2 (group education or a 1:1 specific dietetic programme) or level 3 (a multidisciplinary clinic involving a doctor, psychologist and dietician) services. The full service will be available from April 2014, when all staff are in post; but all patients referred to dietetics or the specialist weight management service will be following this pathway by that date, rolled out across each County Borough in turn, starting with Torfaen in December 2013. This new service will also continue the 'drop in' weight management support for pregnant women, complementing the obesity element of the new maternity services pathway.

- The Public Health team is also leading the development of a Gwent wide child obesity strategy, involving both the Health Board and other partners. Completion of this, with agreement by partners, is expected towards the end of 2014.

- The child obesity prevention and management programme 'MEND/My Time' is being reviewed by Public Health Wales, however a similar programme is expected to continue to be provided through the dietetic service and Local Authorities.

WHAT ARE WE DOING IN PRIMARY CARE? (Continued)

- Newly diagnosed individuals (Type 2 diabetes) will be referred to Diabetes Structured Education programmes at the point of diagnosis. The Health Board aims to ensure that all individuals have access to this education within 9 months of diagnosis.

- Develop and implement a rolling programme of Type 2 Diabetes Structured Education to ensure equity and accessibility for patients.

- Raising awareness of Type 1 diabetes in primary care to ensure early diagnosis.

- Newly diagnosed individuals Type 1 diabetes (together with their parents or guardians and schools) receive education in relation to the management of their diabetes. Currently there is no structured education programme available however we are working collaboratively on an All Wales basis to identify and implement an evidenced based programme.

- Not all individuals can or want to access a structured education programme, therefore we are working in partnership to identify and develop innovative ways to providing education that supports individuals with their self-management and life style choices.

- The National Exercise Referral Scheme has been in place for a number of years and we aim to improve the referral and uptake of these sessions. Physical activity is proven to be of benefit to individuals with diabetes in supporting them to make good life style choices and address the issues of obesity.

- Implement the actions from the National Primary Care Diabetes Audit

- We aim to improve the confidence levels of primary care practitioners through integrated working with Specialist Services to support primary care in early diagnosis, management of diabetes and awareness raising of the risks and symptoms associated with diabetes.

- We are developing a Primary Care Dash Board with key indicators to support the implementation and monitoring of general practice data to support the transformation of diabetes primary care management as outlined in 'Our Healthy Future'.

WHAT ARE WE DOING IN PRIMARY CARE? (Continued)

- We have developed and are implementing a Diabetes Medicine Management Programme to optimise the use of medication in the management of diabetes to implement NICE Guidelines and improve the patient outcomes and quality of life. Improve adherence to medication compliance to deliver optimisation of medicine therapies, in all service areas.

- Enhance collaboratively working to utilise the skills and expertise of the Third Sector to provide high quality reliable advice on how to reduce risks of diabetes and what care to expect.

- In collaboration with our independent contractors, general practices and pharmacy develop and implement mechanisms to improve the accessibility of education and advice services in the community to widen the access to appropriate to support to patients in primary care.

- We are working to develop an Integrated Diabetes Service with the aim of increasing the skills within primary care to identify complications in diabetes early and provide telephone and email advice from Specialist Services at the point of need to support the management of the patient in the most appropriate setting in a safe and timely manner.

- We will be implementing personalised care plans to all patients on the Diabetes Register.

- We aim to ensure that all patients receive the key indicator measurements annually as set out in the National Diabetes Audit.

- Developing a business case for the provision of Diabetes Specialist Nurses within Primary Care to improve the skills of primary care practitioners and optimise the use of medicine therapies within appropriate settings to support self-management and improve clinical outcomes for patients.

- We are currently carrying out a review of patients on diabetes registers across primary care to identify those who have poorly controlled blood glucose levels. This will result in a review of medication and lifestyle/advice to optimise medicine management to improve management of diabetes and quality of life for the patients.

WHAT ARE WE DOING IN PRIMARY CARE? (Continued)

- A review of the current pre-conception information programme for all women of childbearing age on diabetes registers will be carried out to ensure that counselling and information is provided in all elements of the patient pathway.

- Deliver follow-up clinics in primary care settings to ensure patients are seen at appropriate intervals according to their clinical needs and as close to home as possible

Delivering Appropriate Access to Specialist Support Services

Aneurin Bevan University Health Board's Vision:

- **Children & young people will receive all of their diabetic care in specialist services**
- **Improve successful and patient experience of pregnancy outcomes in women with diabetes**
- **Equity of service and provision to hard to reach BME groups to improve their health care outcomes due to diabetes**
- **Increased proportion of people who have well managed diabetes as defined by NICE/All Wales targets for glycaemic control, blood pressure and lipids**
- **Reduce or delay the onset of complications associated with diabetes such as eye, foot, kidney and vascular complications and improve the management of these conditions**

Aims

- Appropriate provision of specialist Pump Services for Children and Young People (CYP) and Adults
- Deliver the actions around the National Paediatric Diabetes Audit and National In-Patient Diabetes Audit
- Deliver high quality transitional arrangements for CYP into Adult services
- Reduce the number of diabetes related eye, foot, kidney and vascular complications and nephropathy

WHAT ARE WE DOING IN SPECIALIST SERVICES?

- Continue to evaluate and implement a specialist pump service for CYP and adults.

- Implement the actions from the National Paediatric Diabetes Audit and National In-Patient Diabetes Audit.

- Support the pilot of the Patient Experience of Diabetes Services (PEDS) in adult services.

- Implement Patient Reported Experience Measures (PREM) in children & young people's services.

- Evaluate current transitional arrangements for CYP into adult services and measure against best practice to identify any gaps or needs.

- We are implementing the "Feet First" Pathway across all our hospital sites. This will support the early identification of complications associated with vascular and feet to ensure appropriate multi-disciplinary management and interventions are carried out in a timely and safe manner.

- We aim to develop and implement a Diabetes Patient Pathway across primary care and secondary care which will include all aspects of a patient's journey with diabetes.

- A review of the current pre-conception information programme for all women of childbearing age on diabetes registers will be carried out to ensure that counselling and information is provided in all elements of the patient pathway.

- Carry out a review of non-diabetic clinician education programme to identify gaps and develop a standard approach to ensure consistent implementation across all hospital sites.

- Work with primary care and secondary care to identify innovative ways to engage with and support BME groups in the identification and management of diabetes.

- Increase the availability of urgent specialist clinic slots.

- Carry out a detailed review and assessment of the provision of Diabetes Specialist Nurses to identify needs to ensure a fully skilled and equitable workforce deliver high quality services across Aneurin Bevan University Health Board to meet the needs of patients.

Improve the Patients Experience and Care whilst an In-patient having an acute episode

Aneurin Bevan University Health Board's Vision:

- **Improve the patients journey and experience of diabetes by reducing the number of emergency admissions to hospital; readmissions to hospital; and average length of stay**
- **High quality equitable delivery of diabetic services across Aneurin Bevan University Health Board**

Aims:

- To have educated non-diabetic clinicians in identifying people with diabetes and supporting the management of their diabetes whilst in hospital
- To have high quality in-patient services that demonstrate best practice in the management of people with diabetes

WHAT ARE WE DOING TO IMPROVE THE PATIENT'S EXPERIENCE AND CARE WHILE AN IN-PATIENT IS HAVING AN ACUTE EPISODE?

- We aim to extend the good practice identified in Nevill Hall Hospital's Diabetes In-Patient Team (multi-disciplinary) model across the Royal Gwent Hospital and Ysybty Ystrad Fawr to reduce the length of stay when patients are admitted to hospital with acute episodes other than the primary cause being their diabetes.
- Fully implement the actions from the National In-Patient Diabetes Audit.
- Provide education, advice and professional support to increase skills and knowledge within primary care to manage diabetes to reduce number of admissions, readmissions and length of stay.
- Provide a rolling programme of education to healthcare professionals on the identification and management of people with diabetes when experiencing an acute episode which is not associated with their diabetes.

"Together for Health " Diabetes Transformation Group – Driver Diagram

Key Theme	Priority Area	Key Actions	Lead Person
Optimise Patient Management in Primary Care	Reduce incidence of Type 2 Diabetes	Implement all levels of the Wales Obesity Pathway	John Holland
		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	
	Provide Diabetes Education to newly diagnosed patients and information for awareness raising of the risks of diabetes	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	
		Deliver diabetes structured education to all children & young people with diabetes	
		Provide accessible educational and support services via local pharmacies, such as vascular risk assessments, 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 Structured Diabetes Education Programme	
	Every patient with Diabetes will receive Annual Reviews against standard health checks	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	
	Address actions around National Diabetes Primary Care Audit	Provide pre-conception counselling for all women of childbearing age on diabetes registers	
	Optimise the use and management of Medication	Ensure that GPs, practice nurses and school nurses are aware of type 1 diabetes in schools and develop management systems to support individual pupils to play a full part at school	
	Provide specialist support to Neighbourhood Care Networks	Plan and deliver a recognised Structured Diabetes Education service that meets the necessary recommendations for quality and audit, which is in line with NICE guidance	
	Every diabetic patient to have a personalised care plan	Ensure culturally appropriate information is available to patients, families and carers in the appropriate language	
		All people with diabetes to have a personalised care in place	
	Implement Diabetes Integrated Service Model	All diabetic patients to receive all key indicator measurements annually as referred to in the National Diabetes Audit	
		Work with the third sector to ensure effective signposting to sources of information and support	
		Develop and implement Community Pharmacy & Medicine Management Programme	
		Develop and implement Diabetes Integrated Service Model	

Key Theme	Priority Area	Key Actions	Lead Person
Appropriate Access to Specialist Support Services	Provisions of specialist pump services	Provide insulin pump service in line NICE guidance	Leo Pinto and Rebekah Price & Davida Hawkes
	Address actions around National Paediatric Diabetes Audit	Implement all key diabetes care processes referred to in the National Paediatric Diabetes Audit	Rebekah Price & Davida Hawkes
	Clearly adopted transition arrangements in place for children & young adults	Develop a transitional care plan to ensure appropriate and seamless transfer of care from paediatric to adult diabetes services	Lance Reed and Leo Pinto
	Reduce the number of diabetes related eye, foot, kidney and vascular complications and nephropathy	Participation in all aspects of the National Diabetes Audit (including the Pregnancy Care, Foot care and Patient Experience parts of the expanded audit programme) and take appropriate action to ensure continuous quality improvement	Leo Pinto
		Ensure that all healthcare professionals involved in diabetes care are educated in the management of diabetic nephropathy and recognition of non diabetic renal disease	Lance Reed
		In-patients with a diabetes related foot problem, or found to have one following initial assessment, should be referred to a multi-disciplinary diabetic foot care team within 24 hours of admission	
		Implement "putting feet first" pathway and quality standards set for prevention and management of diabetic foot disease	

Key Theme	Priority Area	Key Actions	Lead Person
Improve Management of in-patients with diabetes with acute episodes	Non Diabetic clinicians appropriately trained in identifying diabetic patients	Fully implement National Diabetes Audit in-patient guidelines	Leo Pinto
	Reduce number of emergency admissions to hospitals; readmissions and average length of stay	In-patients with newly diagnosed diabetes should be assessed by a multi-disciplinary team within 48-72 hours of admission and their diabetes care should be overseen by the team	
	Address actions around National Diabetes In-Patient Audit	Establish and continue a rolling healthcare professional education programme e.g. Think Glucose	
	Equity of service provision across ABHB		

Patient Experience

APPENDIX 2

(October 2013) - Together for Health - Diabetes Delivery Plan - Diabetes Transformation Group Progress Reporting Plan

Theme	Outcomes	Key Themes	Objectives	Lead Division	Responsible Lead	Timescales	Current Position (RAG Rating) for this
Children & Young People	(1) Children & young people lead healthier and more active lives as a result of improved glycaemia control (2) A reduction in the proportion of children & young people with DKA at diagnosis (3) A reduction in the proportion of children & young people admitted for diabetes related complications (DKA and Hypoglycaemia)		All children & young people with newly diagnosed diabetes are seen within 24 hours by a paediatric specialist with their on going care delivered by a multidisciplinary team	Family & Therapies	Rebekah Price	Jan-14	
			All children & young people with suspected diabetes have immediate same-day referral to a specialist paediatric diabetes team	Family & Therapies & Primary Care	Davida Hawkes	Feb-14	
			Implement all key diabetes care processes referred to in the National Paediatric Diabetes Audit	Family & Therapies	Davida Hawkes	Oct-14	
			Deliver diabetes structured education to all children & young people with diabetes	Family & Therapies & Primary Care	Rebekah Price	Dec-14	
			Have appropriate out-of-hours phone advice services to support children & young people, their parents or guardians and clinical staff	Family & Therapies	Davida Hawkes	Achieved	
			Provide insulin pump service in line NICE guidance	Family & Therapies & Primary Care	Sian Millar	Mar-15	
			Ensure that GPs, practice nurses and school nurses are aware of type 1 diabetes in schools and develop management systems to support individual pupils to play a full part at school	Family & Therapies, Primary Care	Rebekah Price	Mar-14	
			Develop a transitional care plan to ensure appropriate and seamless transfer of care from paediatric to adult diabetes services	Family & Therapies, Unscheduled Care	Davida Hawkes	Achieved	
			Through the Wales Paediatric Diabetes Interest Group (Brecon Group) establish a Quality Assurance Programme for paediatric diabetes services	Family & Therapies	Nicola Kelly	2016	
Preventing Diabetes	(1) Reduced incidence of Type 2 diabetes (2) Reduced inequality gap for incidence of diabetes across all age groups		Implement all levels of the Wales Obesity Pathway	Local Pulbic Health Team	Jane Layzell	Apr-14	
			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'	All Divisions	Jane Layzell	Apr-14	
			Promote better public awareness of the risk factors for, and dangers of, developing diabetes and the importance of early presentation to primary care	All Divisions	John Holland	Ongoing	
			Utilise the third sector to provide high quality reliable advice on how to reduce the risks of diabetes and what care to expect	All Divisions	John Holland	Ongoing	
Detecting Diabetes Quickly	Increased proportion of individuals who understand the affect of a new diagnosis of diabetes and start effective self-management of the disease		Provide accessible educational and support services via local pharmacies, such as vascular risk assessments, lifestyle advice, and annual contracted "community pharmacy delivered" public health campaigns	All Divisions	John Holland	Ongoing	
			At diagnosis, provide all individuals with evidence based education for their type of diabetes, and sign post them to Structured Diabetes Education Programme	Primary Carer & Networks	John Holland	Mar-14	
			Achieve QOF targets for the number of patients referred to Structured Diabetes Education within 9 months of diagnosis	Primary Care & Networks	John Holland	Mar-14	
			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	Primary Care & Networks	John Holland	Mar-15	
			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	All Divisions	John Holland	Ongoing to March 15	
Delivering Fast, Effective Care	(1) Reduction in number of emergency admissions to hospital; readmissions to hospitals; and average length of stay (2) Reduction in number of diabetes related eye, foot, kidney and vascular complications (3) Improved successful pregnancy outcomes in women with diabetes (4) Reduction in inequity gap for health care outcomes due to diabetes, with special emphasis on BME group (5) Increase the proportion of people who have well managed diabetes as defined by NICE/All Wales targets for glycaemia control, blood pressure and lipids		Participation in all aspects of the National Diabetes Audit (including the Pregnancy Care, Foot care and Patient Experience parts of the expanded audit programme) and take appropriate action to ensure continuous quality improvement	All Divisions	John Holland	Rolling Programme	
			Fully implement National Diabetes Audit in-patient guidelines	Unscheduled Care	Leo Pinto	Mar-14	
			Provide pre-conception counselling for all women of childbearing age on diabetes registers	Primary Care & Unscheduled Care	John Holland	Jun-14	
			Ensure that all healthcare professionals involved in diabetes care are educated in the management of diabetic nephropathy and recognition of non diabetic renal disease	Unscheduled Care	Leo Pinto	Sep-14	
			In-patients with a diabetes related foot problem, or found to have one following initial assessment, should be referred to a multi-disciplinary diabetic foot care team within 24 hours of admission	Podiatry Directorate	Lance Reed	Mar-15	
			Implement "putting feet first" pathway and quality standards set for prevention and management of diabetic foot disease	Podiatry Directorate		Mar-15	
			Review and refresh Diabetic Retinopathy Screening Service Wales service to ensure that it achieves the best outcomes for all patients	DRSS Wales	WG	Ongoing	
			In-patients with newly diagnosed diabetes should be assessed by a multi-disciplinary team within 48-72 hours of admission and their diabetes care should be overseen by the team	Unscheduled Care	Leo Pinto	Oct-14	
			Establish and continue a rolling healthcare professional education programme	Unscheduled Care	Leo Pinto	Apr-14	
			Ensure provision of an insulin pump service in line with NICE guidance	Unscheduled Care	Leo Pinto	Achieved	
			Ensure culturally appropriate information is available to patients, families and carers in the appropriate language	All Divisions	John Holland	Ongoing	
Supporting Living with Diabetes	(1) Increase the proportion of people with type 1 and type 2 diabetes who achieve effective self-management of the disease (2) Increase in the number of patients having well controlled blood sugar levels (3) Reduction in number of glycaemia emergencies as a result of diabetes		Plan and deliver a recognised Structured Diabetes Education service that meets the necessary recommendations for quality and audit, which is in line with NICE guidance	All Divisions	John Holland	Ongoing	
			All people with diabetes to have a personalised care in place	Unscheduled Care & Primary Care	Leo Pinto & John Holland	Mar-15	
			All diabetic patients to receive all key indicator measurements annually as referred to in the National Diabetes Audit	primary Care & Networks	John Holland	Mar-14	
			Develop and implement Community Pharmacy & Medicine Management of diabetes within the community	Primary Care & Networks & Medicine Management	John Holland & Mike Curson	Ongoing	
Improving Information	Public able to make effective choices about their care based on regularly updated information on the effectiveness of diabetes services	WG	Work with NWIS to implement national diabetes patient management system across Local Health Boards	All Divisions	All Leads	Ongoing	
		ABHB Board	Health Boards to publish regular and easy to understand information about the effectiveness of their diabetes services	All Divisions	All Leads	Ongoing	
		ABHB Board	Work with the third sector to ensure effective signposting to sources of information and support	All Divisions	All Leads	Ongoing	
Targeting Research	Increased and improved research activity resulting in improved healthcare outcomes for people with diabetes	All Aims	Work with Diabetes Research Network to secure research and development funding for diabetes	All Divisions	All Leads	Ongoing	
		All Aims	Encourage more people with diabetes to participate in research activity	All Divisions	All Leads	Ongoing	

APPENDIX 3

Together for Health - Diabetes Delivery Plan 2013-2016

1 Children & Young People

Outcomes: (1) Children & young people lead healthier and more active lives as a result of improved glycaemia control (2) A reduction in the proportion of children & young people with DKA at diagnosis (3) A reduction in the proportion of children & young people admitted for diabetes related complications (DKA and Hypoglycaemia)

	Objectives	Link to Driver Diagramme Key Themes	Lead Division/s	Responsible Lead	Actions	Timescales	Baseline
1.1	All children & young people with newly diagnosed diabetes are seen within 24 hours by a paediatric specialist with their on going care delivered by a multidisciplinary team	Appropriate Access to Specialist Support Services	Family & Therapies	Nicola Kelly & Dr Rebekah Price	Clarification required on the term of 'Paediatric Specialist'.	Jan-14	If this term means Paediatrician then this is in place and is supported with 'on call' cover
1.2	All children & young people with suspected diabetes have immediate same-day referral to a specialist paediatric diabetes team	Appropriate Access to Specialist Support Services	Family & Therapies & Primary Care & Networks	Barbara Cannito & Dr Davida Hawkes & John Holland	Links will be made to primary care division to ensure that all GPs are aware of the need to refer immediately to Diabetes Specialist Team	Feb-14	Same day referral in place. If' out of hours' via children's assessment area via on call paediatrician 24/7
1.3	Implement all key diabetes care processes referred to in the National Paediatric Diabetes Audit	Appropriate Access to Specialist Support Services	Family & Therapies	Nicola Kelly & Dr Davida Hawkes	A Business Case is currently being developed for the Point of Care testing at clinic appointments to increase the level of compliance	Oct-14	50% compliance with Hba1c at clinic appointments
1.4	Deliver diabetes structured education to all children & young people with diabetes	Optimise Patient Management in Primary Care	Family & Therapies and Primary Care	Barbara Cannito & Dr Rebekah Price	The All Wales Brecon Group looking at options for delivering Structured Education	Dec-14	Anticipated resource implications to introduce Structured Education
1.5	Have appropriate out-of-hours phone advice services to support children & young people, their parents or guardians and clinical staff	Appropriate Access to Specialist Support Services	Family & Therapies	Nicola Kelly & Dr Davida Hawkes	The specialist team are currently looking to extend from office hours to provide a service from 0.9hrs to 21.00 hrs. Plan is being developed for ongoing role out of education sessions to professionals	Achieved however further work planned	available. However, 'out of hours' service is available via on call general paediatric team/registrar on call/CAU standardised guidelines are also available to on-call doctors 24/7.
1.6	Provide insulin pump service in line NICE guidance	Appropriate Access to Specialist Support Services	Family & Therapies	Sian Millar & Dr Rebekah Price	Ongoing Review	Mar-15	Insulin Pump Services is currently being expanded in line with NICE Guidance
1.7	Ensure that GPs, practice nurses and school nurses are aware of type 1 diabetes in schools and develop management systems to support individual pupils to play a full part at school	Optimise Patient Management in Primary Care	Family & Therapies and Primary Care	Barbara Cannito & Dr Rebekah Price & John Holland	Awareness raising in primary care with GP and Practice Nurses links through Neighbourhood Networks	Mar-14	Specialist Diabetes Team continue to deliver a well documented programme to educate staff, including signing off training to check glucose levels and administration of insulin (insulin usually administered by parents/school staff).
1.8	Develop a transitional care plan to ensure appropriate and seamless transfer of care from paediatric to adult diabetes services	Appropriate Access to Specialist Support Services	Family & Therapies	Nicola Kelly & Dr Davida Hawkes		Achieved	Nurses and Dieticians actively inform and prepare clients around their 16th Birthday regarding their transition into adult services. 5 joint paediatric and adult medical clinics are held each year for transition.
1.9	Through the Wales Paediatric Diabetes Interest Group (Brecon Group) establish a Quality Assurance Programme for paediatric diabetes services	Appropriate Access to Specialist Support Services	Family & Therapies	Nicola Kelly & Dr Rebekah Price	ABUHB continue to support this scheme through the Brecon Group	2016	Once scheme developed a review of cost implications for peer review clinics will be developed.

2 Preventing Diabetes

Outcomes: (1) Reduced incidence of Type 2 diabetes (2) Reduced inequality gap for incidence of diabetes across all age groups

	Objectives	Link to Driver Diagramme Key Themes	Lead Division/s	Responsible Person	Actions	Timescales	Baseline
2.1	Implement all levels of the Wales Obesity Pathway	Optimise Patient Management in Primary Care	ABHUB Local Public Health Team	Jane Layzell	All Divisions to work collaboratively with Public Health Wales on implementation of Pathway	Apr-14	Weight Management programme is being piloted in Torfaen
2.2	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'	Optimise Patient Management in Primary Care	All	Jane Layzell	Review implementation of Exercise Referral on prescription and identify gaps	Apr-14	Weight Management programme is being piloted in Torfaen
2.3	Promote better public awareness of the risk factors for, and dangers of, developing diabetes and the importance of early presentation to primary care	Optimise Patient Management in Primary Care	All	John Holland	Primary Care & Networks to work collaboratively through All Wales Diabetes Group, Local Partners and Third Sector to support design and delivery of awareness campaigns	Ongoing	

2.4	Utilise the third sector to provide high quality reliable advice on how to reduce the risks of diabetes and what care to expect	Optimise Patient Management in Primary Care	All	John Holland	Continue to work collaboratively with Diabetes UK	Ongoing	
3	**Detecting Diabetes Quickly**						
Outcomes: Increased proportion of individuals who understand the affect of a new diagnosis of diabetes and start effective self-management of the disease							
Objectives		**Link to Driver Diagramme Key Themes**	**Lead Division/s**	**Responsible Person**	**Actions**	**Timescales**	**Baseline**
3.1	Provide accessible educational and support services via local pharmacies, such as vascular risk assessments, lifestyle advice, and annual contracted "community pharmacy delivered" public health campaigns	Optimise Patient Management in Primary Care	All	John Holland & Mike Curson	Primary Care & Networks to work with Medicine Management and contracted pharmacies to identify education and support services through improving links via Neighbourhood Networks	Ongoing	Community Pharmacy Wales are currently lobbying for service development for a vascular risk programme
3.2	At diagnosis, provide all individuals with evidence based education for their type of diabetes, and sign post them to Structured Diabetes Education Programme	Optimise Patient Management in Primary Care	Primary Care & Networks, Dietetics	John Holland & Clare Norris	Implement "First Step" X-Pert to all newly diagnosed patients with a view to them attending the full structured 6 week programme. Implement single co-ordinated approach to education across ABUHB to deliver equity and increase access	Mar-14	Diabetes Structured Education currently being provided. However uptake is poor, access and equity is inconsistent
3.3	Achieve QOF targets for the number of patients referred to Structured Diabetes Education within 9 months of diagnosis	Optimise Patient Management in Primary Care	Primary Care & Structured Educators	John Holland	Ensure structured advertising of Structured Education Programme is delivered wide and monitor referral rates and measure against QOF	Apr-14	
3.4	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	Optimise Patient Management in Primary Care	Primary Care & Structured Educators	John Holland	work collaborative with partners i.e. local authorities, leisure services, pharmacy, primary care to develop training programmes to meet the diversity of the population within ABUHB area. Work with Wisdom Bank increase accessibility and peer support to trusted sites for information and advice to support	Mar-15	
3.5	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	Optimise Patient Management in Primary Care	All	John Holland & Leo Pinto	Up-skill general practice staff in the management of diabetes and to recognise early indicators through the integrated service model. Develop mechanisms for training and educational leaflets for staff to support early detection. Programme of regular diabetes update sessions for primary care professionals will be developed and implemented	Ongoing to March 2015	
4	**Delivering Fast, Effective Care**						
Outcomes: (1) Reduction in number of emergency admissions to hospital; readmissions to hospitals; and average length of stay (2) Reduction in number of diabetes related eye, foot, kidney and vascular complications (3) Improved successful pregnancy outcomes in women with diabetes (4) Reduction in inequity gap for health care outcomes due to diabetes, with special emphasis on BME group (5) Increase the proportion of people who have well managed diabetes as defined by NICE/All Wales targets for glycaemia control, blood pressure and lipids							
Objectives		**Link to Driver Diagramme Key**	**Lead Division/s**	**Responsible Person**	**Actions**	**Timescales**	**Baseline**
4.1	Participation in all aspects of the National Diabetes Audit (including the Pregnancy Care, Foot care and Patient Experience parts of the expanded audit programme) and take appropriate action to ensure continuous quality improvement	Appropriate Access to Specialist Support Services	All	John Holland, Leo Pinto, Lance Reed, Rebekah Price	Continue to participate in national audits and develop and implement action plans following recommendations of audit reports	Rolling Programme	
4.2	Fully implement National Diabetes Audit in-patient guidelines	Improve Management of in-patients with diabetes with acute episodes	Unscheduled Care	Leo Pinto	Continue to participate in national audits and develop and implement action plans following recommendations of audit reports	Mar-14	
4.3	Provide pre-conception counselling for all women of childbearing age on diabetes registers	Optimise Patient Management in Primary Care	Primary Care, Unscheduled Care & Family & Therapies	John Holland & Sian Millar	Links to be made with Family & Therapies, Primary Care & Networks to identify appropriate mechanisms to ensure that all child bearing age women receive information and advice on pre-conception and the risks	Jun-14	This is currently being delivered, however a review will take place to identify gaps. A service runs with joint antenatal clinics and DSNs provide advice to female patients of childbearing age.
4.4	Ensure that all healthcare professionals involved in diabetes care are educated in the management of diabetic nephropathy and recognition of non diabetic renal disease	Appropriate Access to Specialist Support Services	Unscheduled Care	Leo Pinto	Review of current educational programme to be undertaken to identify specific educational needs	Sep-14	The Directorate has access to specialist renal services locally

4.5	In-patients with a diabetes related foot problem, or found to have one following initial assessment, should be referred to a multi-disciplinary diabetic foot care team within 24 hours of admission	Appropriate Access to Specialist Support Services	Podiatry Directorate	Lance Reed	Implement Putting Feet First pathway across all sites	Mar-15	Pathway in place in NHH
4.6	Implement "putting feet first" pathway and quality standards set for prevention and management of diabetic foot disease	Appropriate Access to Specialist Support Services	Podiatry Directorate	Lance Reed	Implement Putting Feet First pathway across all sites	Mar-15	Pathway in place in NHH
4.7	Review and refresh Diabetic Retinopathy Screening Service Wales service to ensure that it achieves the best outcomes for all patients	Appropriate Access to Specialist Support Services	DRSS Wales	Welsh Government	Review being carried out by Welsh Government	Ongoing	
4.8	In-patients with newly diagnosed diabetes should be assessed by a multi-disciplinary team within 48-72 hours of admission and their diabetes care should be overseen by the team	Improve Management of in-patients with diabetes with	Diabetes Directorate	Leo Pinto	Review current provision in NHH and roll out across RGH and YYF	Oct-14	This is currently being provided in NHH
4.9	Establish and continue a rolling healthcare professional education programme	Improve Management of in-patients with diabetes with acute episodes	Diabetes Directorate	Leo Pinto	Review current professional rolling programme and identify development needs to inform and delivery outcomes of national in-patient audit	Apr-14	Professional Programme in place
4.1	Ensure provision of an insulin pump service in line with NICE guidance	Appropriate Access to Specialist Support Services	Diabetes Directorate	Leo Pinto	Ongoing Review	Achieved	Pump Service being delivered
4.11	Ensure culturally appropriate information is available to patients, families and carers in the appropriate language	Optimise Patient Management in Primary Care	All	All Leads	Work collaboratively across all Divisions to review all current information to identify gaps in provision	Ongoing	Translation service is available
4.12	Develop and implement integrated diabetes services to increase the management of diabetes within the Community	Optimise Patient Management in Primary Care	Primary Care & Unscheduled Care	John Holland & Leo Pinto	Work collaboratively with primary and unscheduled care to develop and implement Diabetes Integrated Services Model across all Neighbourhood Care Networks	Mar-14	Model agreed, first stage of implementation i.e. telephone and email will be available from January 2014
4.13	Develop and implement Community Pharmacy & Medicine Management Programme to ensure effective management of diabetes	Optimise Patient Management in Primary Care	Primary Care & Networks, Medicine Management	John Holland & Mike Curson	Work collaboratively with Pharmacy & Medicine Management Division to implement programme	ongoing	Plan developed and being implemented
5	**Support Living with Diabetes**						
Outcomes:(1) Increase the proportion of people with type 1 and type 2 diabetes who achieve effective self-management of the disease (2) Increase in the number of patients having well controlled blood sugar levels (3) Reduction in number of glycaemia emergencies as a result of diabetes							
Objectives		**Link to Driver Diagramme Key Themes**	**Lead Division/s**	**Responsible Person**	**Actions**	**Timescales**	**Baseline**
5.1	Plan and deliver a recognised Structured Diabetes Education service that meets the necessary recommendations for quality and audit, which is in line with NICE guidance	Optimise Patient Management in Primary Care	Primary Care & Networks	John Holland	Implement "First Step" X-Pert to all newly diagnosed patients with a view to them attending the full structured 6 week programme. Implement single co-ordinated approach to education across ABUHB to deliver equity and increase access. Review and implement education for Type 1 Adults	Ongoing	X-Pert currently being delivered
5.2	All people with diabetes to have a personalised care in place	Optimise Patient Management in Primary Care	Unscheduled Care & Primary Care & Networks	John Holland and Leo Pinto	Agreed Care Plan to be developed and implemented	Mar-15	
5.3	All diabetic patients to receive all key indicator measurements annually as referred to in the National Diabetes Audit	Optimise Patient Management in Primary Care	Primary Care & Networks	John Holland	Ongoing review of practice uptake and implementation to measure and monitor compliance.	Ongoing	Currently being implement but inconsistencies identified
6	**Improving Information**						
Outcomes: Public able to make effective choices about their care based on regularly updated information on the effectiveness of diabetes services							
Objectives		**Link to Driver Diagramme Key**	**Lead Division/s**	**Responsible Person**	**Actions**	**Timescales**	**Baseline**
6.1	Work with NWIS to implement national diabetes patient management system across Local Health Boards	Welsh Government	Transformation Group	All Leads	Proactively work with All Wales Group and NWIS in development of system	ongoing	Meetings commenced
6.2	Health Boards to publish regular and easy to understand information about the effectiveness of their diabetes services	ABHB Board	Transformation Group	All Leads	Development of mechanisms for information sharing being developed through All Wales Diabetes Planning & Delivery Group	Ongoing	Reporting schedules set up

6.3	Work with the third sector to ensure effective signposting to sources of information and support	ABHB Board	Transformation Group	All Leads	Continue to proactive support and involve Third Sector in service transformation	Ongoing	Already in place
7	**Targeting Research**						
Outcomes: Increased and improved research activity resulting in improved healthcare outcomes for people with diabetes							
Objectives		**Link to Driver Diagramme Key**	**Lead Division/s**	**Responsible Person**	**Actions**	**Timescales**	**Baseline**
7.1	Work with Diabetes Research Network to secure research and development funding for diabetes	All Key Themes	All	All Leads	Ongoing review of current research projects	ongoing	Baseline being established
7.2	Encourage more people with diabetes to participate in research activity	All Key Themes	All	All Leads	Engage Patient Reference Groups in Research	Ongoing	Baseline being established

Appendix 4

Reporting Indicators on Diabetes Delivery Plan

Outcome Indicators:

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 incidences of complications of diabetes by geography and deprivation

NHS Assurance Measures:

% of children and young people achieving improved glycaemia 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 glycaemia control (HbA1c <59mmol(7.5%))
% of children with diabetes achieving normal growth	
% of children, young people and adults receiving Structured Diabetes Education within 12 months of diagnosis	
Diabetic compared to non-diabetic: number of emergency admissions to hospital; readmissions to hospital; and average length of stay	
% of people with diabetes related limb amputation	
% of people with diabetes with sight threatening retinopathy or blindness	
% of people with diabetes with new foot ulcer	
% of people with diabetes reaching end stage renal disease or requiring renal replacement therapy	
% of successful pregnancy outcomes in women with diabetes	
% of people with a diagnosis of diabetes who are satisfied with their personal care plan	
% of people with diabetes having well controlled blood sugar levels	
% of people experiencing a glycaemia emergency as a result of their diabetes	
% of people with diabetes who receive all key indicator measurements for diabetes	