



Cynulliad Cenedlaethol Cymru **The National Assembly for Wales**

Y Pwyllgor Iechyd a Gofal Cymdeithasol **The Health and Social Care Committee**

Dydd Mercher, 21 Tachwedd 2012
Wednesday, 21 November 2012

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Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir
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The proceedings are reported in the language in which they were spoken in the committee. In
addition, a transcription of the simultaneous interpretation is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Mick Antoni	Llafur Labour
Mark Drakeford	Llafur (Cadeirydd y Pwyllgor) Labour (Committee Chair)
Rebecca Evans	Llafur Labour
Vaughan Gething	Llafur Labour
William Graham	Ceidwadwyr Cymreig Welsh Conservatives
Elin Jones	Plaid Cymru The Party of Wales
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives
Lynne Neagle	Llafur Labour
Lindsay Whittle	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Dr Sharon Hopkins	Cyfarwyddwr Iechyd Cyhoeddus, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Director of Public Health, Cardiff and Vale University Local Health Board
Dr David Minton	Arweinydd Rhwydweithiau Gofal Cymdogaeth, Bwrdd Iechyd Lleol Aneurin Bevan Neighbourhood Care Networks Lead, Aneurin Bevan Local Health Board
Dr Leo Pinto	Meddyg Ymgynghorol a Chyfarwyddwr Clinigol, Bwrdd Iechyd Lleol Aneurin Bevan Consultant Physician and Clinical Director, Aneurin Bevan Local Health Board
Dr Hugo van Woerden	Cyfarwyddwr Iechyd ac Is-adran Gwella Gofal Iechyd, Iechyd Cyhoeddus Cymru Director of Health and Healthcare Improvement Division, Public Health Wales

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Llinos Dafydd	Clerc Clerk
Catherine Hunt	Dirprwy Glerc Deputy Clerk
Philippa Watkins	Y Gwasanaeth Ymchwil Research Service

Dechreuodd y cyfarfod am 10.35 a.m.
The meeting began at 10.35 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon Introduction, Apologies and Substitutions

[1] **Mark Drakeford:** Bore da a chroeso i chi i gyd i'r sesiwn gyhoeddus. **Mark Drakeford:** Good morning and welcome to you all to the public session.

10.35 a.m.

Ymchwiliad i'r Gwaith o Weithredu'r Fframwaith Gwasanaeth Cenedlaethol ar gyfer Diabetes yng Nghymru a'i Ddatblygiad yn y Dyfodol: Tystiolaeth Lafar—Byrddau Iechyd

Inquiry into the Implementation of the National Service Framework for Diabetes in Wales and its Future Direction: Oral Evidence—Health Boards

[2] **Mark Drakeford:** Dyma'r ail sesiwn yn ein hymchwiliad i'r gwaith o weithredu'r fframwaith gwasanaeth cenedlaethol ar gyfer diabetes yng Nghymru a'i ddatblygiad yn y dyfodol. Rydym yn croesawu tystion o'r byrddau iechyd y bore yma. Croeso i Dr Sharon Hopkins, cyfarwyddwr iechyd cyhoeddus, Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro; Dr Leo Pinto, meddyg ymgynghorol a chyfarwyddwr clinigol, Bwrdd Iechyd Lleol Aneurin Bevan; a Dr David Minton, arweinydd rhwydweithiau gofal cymdogaeth, Bwrdd Iechyd Lleol Aneurin Bevan. Diolch yn fawr i chi i gyd am ddod yma heddiw.

Mark Drakeford: This is our second session in our inquiry into the implementation of the national service framework for diabetes in Wales and its future direction. We welcome witnesses from the health boards this morning. I welcome Dr Sharon Hopkins, director of public health, Cardiff and Vale University Local Health Board; Dr Leo Pinto, consultant physician and clinical director, Aneurin Bevan Local Health Board; and Dr David Minton, neighbourhood care networks lead, Aneurin Bevan Local Health Board. Thank you all for attending today.

[3] Yn gyntaf, hoffwn ofyn ichi ddweud brawddeg neu ddwy am y gwaith rydych yn ei wneud, fel y gall aelodau'r pwyllgor fod yn glir ynghylch eich rôl yn y maes. Ar ôl ichi wneud eich cyflwyniadau, bydd cyfle ichi wneud unrhyw sylwadau agoriadol byr, cyn inni droi at aelodau'r pwyllgor i ofyn cwestiynau.

First, I will ask you to say a sentence or two on the work that you are doing, so that committee members are clear about your roles in this area. Following your introductions, there will be an opportunity for you to make any brief opening remarks, before we turn to committee members to ask questions.

[4] So, it would be helpful for us if you could say a sentence or two about the particular roles that each of you play in relation to diabetes services. Then, if there are any brief opening remarks, we will take those before moving on to the questions. Dr Pinto, do you want to start with the introductions?

[5] **Dr Pinto:** I am Leo Pinto and I am a consultant physician at Nevill Hall Hospital, Abergavenny. I am also the clinical director for diabetes with the Aneurin Bevan Local Health Board; I have held the post of clinical director since May this year. I represent the secondary care, or hospital, diabetes specialist teams.

[6] **Dr Minton:** I am Dave Minton and I am a general practitioner in Caerphilly. I am also one of the neighbourhood care network leads in Aneurin Bevan LHB, and I cover south Torfaen. I am the chair of the diabetes planning and delivery group for Aneurin Bevan LHB and, prior to that, I was the diabetes champion for Caerphilly Local Health Board for about five years before we merged. So, I have been doing the DPDG role for a couple of years now.

- [7] **Mark Drakeford:** So, your role is primarily primary and community focused.
- [8] **Dr Minton:** Yes, it is both primary and community care. We also set up a diabetes interest group to get a primary care view on everything. I sit on the directorate as well.
- [9] **Dr Hopkins:** I am Sharon Hopkins and I am the director of public health in Cardiff and Vale University Local Health Board and, at the moment, I am also the interim director of primary community and mental health. I am the lead executive in Cardiff and Vale for diabetes, so I am involved in the DPDG and with our primary care colleagues, our secondary care colleagues and the wider community.
- [10] **Mark Drakeford:** Thank you; that is helpful. Your microphones will come on automatically when you speak, so there is no need for you to press any buttons. Are there any opening remarks that you want to offer us?
- [11] **Dr Hopkins:** We would like to raise four issues with the committee. First, we want to bring your attention to the breadth of LHB responsibilities. As you know, as LHBs, we have the responsibility for our resident populations and our purpose is very much twofold: it is about keeping people well and caring for people. The services that we work with are spread right across community, primary and hospital settings, and, as you will hear later on, we are very much working towards having integrated services to try to improve things for our communities and our patients. That is particularly important for diabetes, given the issues around keeping people well, or treating risk factors, as well as caring for people. So, we must have those things working together as a single, integrated joint action plan, working with patients and with our staff. It is really important that we get the balance between the prevention agenda and the treatment agenda right and that those are very joined up, so that they are not seen as separate issues.
- [12] Secondly, if we are to halt the increase in diabetes, which is part of the conversation that we are having here at the moment, we really have to do more to treat risk factors and deal with some of the prevention issues. As you know, nearly all of the risk factors, particularly for type 2 diabetes, are increasing in our communities. Collectively, we are increasingly concerned about obesity. If I may, I wish to remind the committee that, if we go back some time and look at the issue of tobacco, when we first realised that tobacco was a key risk factor with respect to lung disease, it took us only 30 years to take positive action on that risk factor. We feel that we cannot afford to wait that long with diabetes. So, there is a sense of urgency about some of the joining-up work that we have to do here.
- [13] The third issue that we want to raise with you is the linkage of the actions that we are taking, whether on risk factors or treating diabetics. The actions need to be clearly linked to outcomes so that, when we are treating risk factors or caring for someone with diabetes, everything we do is clearly aimed either at reducing the risk factors or maximising treatment in order to minimise complications, and all of that through working with our communities and patients. This applies to whatever treatment we are working with and whichever clinician is working with us. This is about trying to get to the fact that it is not good enough for us just to measure things. We have to link, very clearly, that measurement to an outcome.
- [14] In addition to clarity on the outcomes, we have to get our information systems absolutely linked up to outcomes, so that we can describe what we are trying to achieve so that it is transparent for us as clinicians and healthcare professionals and for communities and patients. Our actions need to be much better linked to our performance systems.
- [15] Fourthly, we want to draw your attention to the issue of being more explicit about the choices that we make and the outcomes that we see as most important. Again, this becomes

particularly critical for the area that we are talking about today, because we all know that we are working in a very resource-constrained environment. Whether our resources are people, time or money, you all know that, if we spend our resource in one area, in a resource-constrained environment, that will mean less in another area. We are very clear that our intention is always to provide the best possible outcome for the people we care for. However, in trying to make the decisions about where we take our actions, we need to be really clear about how those are contributing to a good outcome or the outcomes that we have collectively agreed we need to arrive at.

[16] **Elin Jones:** Good morning. It is probably timely that the health boards are in front of this committee discussing diabetes this morning, given the broadcast of the *Week In Week Out* programme last night. In case you did not see it, it was a programme on the report of the Public Services Ombudsman for Wales following the death of a patient in Bronglais General Hospital. I assume that you know of that incident and the ombudsman's report, because the Minister for Health and Social Services has written to all health boards to ask them to look at the ombudsman's recommendations on the monitoring of glucose levels in secondary care. Last night's programme also referred to some good practice in health boards—I think that the campaign is called ThinkGlucose, and work going on in Cwm Taf Local Health Board was shown. I want to ask the health boards, with regard to the secondary care setting in particular, how the recommendations of that report are now being implemented in Wales.

[17] **Dr Pinto:** The *Week In Week Out* programme highlighted the dangers that people with diabetes face when they go into hospital. Yes, this death was completely preventable and, as with the large majority of such cases, should have been prevented.

10.45 a.m.

[18] One important aspect of caring for people with diabetes in hospital is paying attention to certain basic things, such as taking note of their treatment, for example. It is people on insulin treatment who are at particular risk because, when they are acutely ill and go into hospital, many things change. For example, their food intake will change; they may not feel like eating. Some of the elderly may need help with eating. So, monitoring food intake is a very important aspect, which was also highlighted in the ombudsman's report, to make sure that people receive timely nutrition. The bedtime snack was another factor highlighted. Many people with diabetes are at risk of hypoglycaemia, which is very low blood glucose levels, particularly during the night when they are asleep and go without food for a long period of time. That is why the bedtime snack is an important preventive aspect of care, which, sadly, did not happen in that case.

[19] We have certainly taken note of the ombudsman's recommendations. In fact, all of these concerns were highlighted in the national diabetes in-patient audit report, published earlier this year. We have been taking part in the audit for the past three years—it is an annual audit. The audit highlighted that one in five people in hospital have diabetes. People with diabetes are over-represented in hospitals, compared with the community, where one in 20 people have diabetes. In hospital, there is a much higher proportion because people with diabetes are more likely to need hospital admission. Most often, it is due to an acute medical illness, or it may be due to the need for elective surgery. So, in other words, there are lots of people with diabetes in hospital.

[20] Just under half of these patients are on insulin treatment, and they are the ones who need particular attention. There are issues with appropriate nutrition and food intake and taking note of people's preferences for their meals. For example, in our health board, we have set up a diabetes in-patient care team. It is a dedicated team to look after people with diabetes in hospital and advise on their diabetes care. This was modelled on the ThinkGlucose campaign, which was highlighted in last night's programme. ThinkGlucose is a national

campaign. We have not been able to adopt the ThinkGlucose campaign in our health board because of the financial constraints, but we have adopted the good aspects of the ThinkGlucose campaign. For example, we have introduced HypoBoxes on wards—boxes that contain the necessary material to treat hypoglycaemia. They were introduced in the health board over a year ago, and they are on every ward. The staff have been provided with the necessary training to identify people with low blood glucose. As you may remember from the programme, the gentleman, in hospital, suffered a severe hypoglycaemic episode in the night, which led to further complications. So, it is a matter of recognising hypoglycaemia and trying to prevent it, because patients often need to have their medication altered when they come into hospital and are not able to eat, for example. The blood glucose needs to be monitored, as does food intake. So, the staff have been provided with training on all wards, and HypoBoxes are in place. That is one safeguard against these kinds of occurrences.

[21] The second change that we introduced was a dedicated, specific chart for insulin prescription, because medication error was another factor that was highlighted in the report. It was also highlighted in last year's audit. One in three patients with diabetes in hospital had some kind of medication error, often relating to insulin or other tablet treatment for diabetes. The chart system is a simple intervention, whereby you print units instead of writing the units. Often, units were abbreviated to 'u', which looked like a zero. You can imagine that that often led to people receiving a much higher—ten times higher—dose of insulin. Insulin is one of those high-risk medications; it is one of the top 10 worldwide high-risk medications. The person who prescribes has to describe the number of units, which are printed, so that has removed that potential for error, which was highlighted in the National Patient Safety Agency alert some years ago.

[22] The third change that we introduced was the colour-coded blood glucose monitoring chart because the nurses were testing the blood glucose and recoding it diligently but without realising that the particular blood glucose was low or sometimes dangerously low and that it needed immediate action. Along with the education of ward staff, the colour-coded chart makes it clear that when blood glucose drops below a certain dangerous level, it goes to the red zone, so it highlights the need for immediate action; HypoBoxes are on every ward and staff are trained to use them to correctly treat hypoglycaemia. In other words, on Aneurin Bevan LHB hospital wards, the good aspects of care recommended in the ThinkGlucose campaign have been adopted. Although it is a modified version, it serves that purpose of improving safety on the wards for people with diabetes.

[23] **Elin Jones:** Thank you for that comprehensive response. I have two follow-up questions: you obviously speak on behalf of Aneurin Bevan health board, but do you have any information for us on all health boards responding in a similar vein to the ombudsman's recommendations? Secondly, you said that the ThinkGlucose programme or way of working could not be implemented in full in the Aneurin Bevan health board because of financial constraints. If you did not have such constraints, would you want to see the ThinkGlucose way of working being implemented in its entirety throughout Aneurin Bevan health board hospitals?

[24] **Dr Pinto:** I cannot give a comprehensive answer on what is happening in other health boards. However, from talking to colleagues in other health boards, there is clearly an appreciation of the urgency or need to improve the care of in-patient diabetes. I believe that the report takes note of the amount of action that has arisen from it, in that it varies from place to place. Talking to the chair of Diabetes UK Cymru recently, he said that four or five health boards have expressed an interest in getting the ThinkGlucose toolkit.

[25] That brings us to the question of financial constraints. The cost of acquiring the ThinkGlucose package is around £18,000 a year. When we presented our case to the executives, the health board's financial position was quite difficult and our remit was to

improve quality of care within the existing resources, so that is what we have been trying to do. However, on whether the ThinkGlucose package would help to improve the care further, the answer is ‘yes, it certainly would’. The improvements made would be spread across the health board and maintain that level of standard. So, adopting a ThinkGlucose programme across all health boards in Wales would be a positive step in the right direction.

[26] **Mark Drakeford:** Could you confirm for us once more what the cost would have been of implementing the ThinkGlucose toolkit in full?

[27] **Dr Pinto:** I understand that for one hospital site, it was £18,000.

[28] **Mark Drakeford:** Per site?

[29] **Dr Pinto:** Yes.

[30] **Dr Hopkins:** I would like to provide a supplementary answer on what is happening across Wales. The insulin charts and the HypoBoxes that Dr Pinto mentioned have been developed for use across Wales along with the colour-coding measurement. The training packages for the staff look different across each site, so it is difficult to comment without asking every hospital site what it is doing about training. However, there has been a collective NHS Wales response to the report’s findings and to the follow-up to the audit that Dr Pinto talked about.

[31] **Mark Drakeford:** Lynne, I think that you wanted to follow this up, and then I will go to Darren.

[32] **Lynne Neagle:** To follow up on this issue, that does not seem like a lot of money to me. I know that every pound is precious in the NHS, but do you have any comment on the decision that was clearly taken that that was too much money to spend on this particular campaign? Can you also please clarify which aspects—you said that you have done some of it, but could not afford to do all of it—have been left out by that financial decision?

[33] **Dr Pinto:** We have been talking to the divisional director and executives about the need to improve the care that people who have diabetes have in hospital and the role of the ThinkGlucose campaign in that. There is a commitment and an acceptance or agreement that the care needs to be improved, but, at the moment, the focus is very much on managing the budget and reducing the deficit, if I may say so. So, we will continue pressing for that. What has been left out from that is the people who are coming in for elective surgery, for example. We would like to get involved there, because a lot of the patients who are coming in for elective surgery are not known to the specialist teams and a lot of them have problems with diabetes control. We would like to get involved in their care well before they come in for surgery, for example, when they are being assessed before surgery in the pre-admission stage. For example, when teams were set up to improve the care of people coming in for elective surgery in Plymouth, it was shown that they could improve the care of those people and reduce the length of their stay. In other words, they were delivering cost savings from that investment. So, we would like to do that in the coming months and years.

[34] **Mark Drakeford:** I am a bit conscious of the time; we are already nearly halfway through our session and we have several questions left. So, we turn to Mick, very quickly.

[35] **Mick Antoniw:** This is all meant to be part of a national strategy. Are you confident that there is an operational national strategy and is there any evidence of the fact that there is a national strategy that is working to create consistency and effectiveness across the LHBs?

[36] **Dr Hopkins:** The national service framework definitely lays out for us what the

expectations are against the achievement of standards. How we go about developing the action against those standards is not uniform across Wales. There are pros and cons to that. Where there is good practice and where we have evidence that something works, we need to share that and roll it out. Quite a lot of that sharing of practice has happened through working either with 1000 Lives or through the National Leadership and Innovation Agency for Healthcare. You could also argue that, for some of our communities, it is right that we will have different ways of doing things. For example, in Cardiff, I might want a slightly different response for my ethnic minority populations because their experience of diabetes is different to that of some of my other populations. So, some variation will be absolutely right. The key here is, where we have things that work and we have evidence of that, that we learn from each other quickly and get them rolled out. We do some of that, but I would say that we are not good enough at that and do not have a systematic way of ensuring that good practice and what works are systematically rolled out across all our services.

[37] **Darren Millar:** I want to touch on the financial issue again. We know that there are unprecedented challenges for the NHS in the current financial year and for the next few financial years. Some of the written evidence that we have received from health boards has suggested that that is a barrier to delivering the standards required by the NSF and has drawn attention to the fact that some of the other national service frameworks, such as for cardiac care, have received additional funding for implementation. What sort of order of additional funding do you think would be required to meet the NSF for diabetes in all Welsh health boards?

11.00 a.m.

[38] **Dr Hopkins:** That is a difficult question, is it not? We would have to go at things in sections and I guess we would initially be talking of the order of several hundreds of thousands of pounds within each of the health boards. I am thinking quite quickly here about structured education, more diabetic care in the community, integration across the system, education programmes, and education meaning professional training as well as education programmes with our population. What we were trying to raise with you in the fourth point in our opening remarks was that we recognise how difficult our resource environment is, and there are choices that we can make about where we put our money. We were having a conversation as a group the other day about some thorny issues surrounding NICE implementation, for example. We have a NICE technology appraisal on insulin pumps, and if we were to follow that to the letter of the NICE guidance, we would have to put several hundreds of thousands of pounds into insulin pumps across Wales, but the professional view is that, in terms of patient or population outcomes, that money would not give us the sort of value-added that we would get if we put it elsewhere.

[39] So, there is an issue here about how we make our choices and where we choose to spend the resource that we have. We could go on adding and adding funding, and we know that the more we get, the more we will find something to do with it, but there is more of an issue for us at the moment about whether we are clear with you, with our population, with us as providers, and with us as professionals, about what it is that we really want to get here. Are we brave enough to make some decisions such as, 'Okay, we are going to put the resource into this area, which will mean perhaps a little less resource going on over there'? This was a debate that we were having about structured education versus insulin pumps—if we want to stay in the realm of diabetes. Of course, as soon as you open that debate more broadly—I might be thinking about diabetes insulin pumps versus access to GPs on Saturday mornings—we find that there are all sorts of things that we are looking at all the time where we think, individually, they are important, but I am not sure we are as good as we might be at thinking, 'What is the real outcome that we want here? Can we make those agreements between us? This is what will really give us the biggest benefit'. So, 'yes please' to more money, if you have some more to give us, but I think we are also up for some really quite difficult work

around, ‘If these are the outcomes I’m looking for, these are the things I need to be doing in order to make sure that I am getting those best outcomes for our patient population and our communities’.

[40] **Darren Millar:** May I just build on this a little more? I was a member of the health committee in the previous Assembly, as well as being a member in this one, and one of the things that crops up in almost every report is that there is a national service framework that expects certain things to be done, and they are not being done, for a whole range of reasons. However, there is clear evidence in the papers that some local health boards are much closer to meeting those standards than others, even within existing resources. So, if some health boards are able to achieve those standards, why are others not? Is the central co-ordination of this sufficient? Are you getting sufficient advice, support and direction, if you like, from the Welsh Government to ensure that the NSF is actually being delivered?

[41] **Dr Hopkins:** I will start, but I know that my clinical colleagues have some views on this as well. In terms of why different areas manage to do things differently, it will come down to a set of different factors. It will come down to funds available locally—and we know that the spend per head of population is quite different across Wales, so some boards have more available per head of population than others. We also know that various of the different health boards have different pressures within their communities, and their communities may well have decided to make resource decisions in different ways. That is the background against which we working. That comes down very much to this issue about where we put our choices, and what we have made explicit about what is important within local communities.

[42] The leadership issue is also quite important, and we would collectively say that it is always helpful when there is very visible leadership or what we talked about in our opening remarks, namely clarity around the outcomes, so that it is—I will use a word that we have used a little bit when we have been discussing this—‘hardwired’ into the performance system.

[43] To take some of the work that we will do collectively around waiting times, it might not all be perfect, but we have made some huge strides. Part of that is because it is very much hardwired into our performance systems; it is seen as important, and we have agreed it collectively as something that is important. I would say that that is where the central leadership and clinical guidance is always going to be helpful, because it helps us in trying to make explicit decisions about choices. That, ultimately, is what it comes down to. As you said, we have umpteen national service frameworks. If we are talking about any one of them at any point in time, they are of equal importance, but they cannot be because we have to make choices about them.

[44] **Dr Minton:** To answer the question in a slightly different way, from the diabetes planning and delivery groups’ point of view, each of the DPDGs—I am sorry for abbreviating, but it will take forever if I say ‘diabetes planning and delivery group’ every time—has a very different membership. I noted from reading the submission of Diabetes UK that it feels that it is very secondary care-led. In Aneurin Bevan LHB, we are not—I am a primary care clinician and I chair the group, and we have a diverse membership, most of which come to it each time. I suspect that that group is set up differently in other health boards. I understand from clinicians on the committee that it is much more secondary care focused in Cardiff.

[45] We feel within Aneurin Bevan LHB, therefore, that we are picking out the issues that affect our residents at every level, and that we are getting opinions across from podiatrists, dieticians, pharmacy representatives, patient representatives, et cetera. We are getting all of those views and we are very much trying to look at this from a bottom-up point of view to see where we can influence their health to the best.

[46] What we did not have until very recently was a direct chain of command within the LHB, so we often feel that we are sitting there and I am making a decision and, if I happen to come across a member of the health board management, then I can ask, 'Can I do this?', he will say 'yes', and that will be the final answer. That has changed of late; we have better support coming in now with the restructure again—this is a big thing in Aneurin Bevan LHB, because we have gone from five LHBs to one, and another management restructure is going on at the moment, so it has been very difficult to get clear chains of command. That is starting to adjust itself. So, I would hope that we will be able to take the types of decisions that we were making and put those through to board level.

[47] The second aspect with regard to where we have not necessarily support, but co-ordination, is that there is currently no national meeting of chairs or members of DPDGs. Diabetes UK has tried to set this up on a couple of occasions, and it has been fairly successful when it has done so. However, to use the same phrase again, that is not 'hardwired' into the system. That will be the aspect that will allow us to start to share best practice and for us to say, for example, 'We have a problem with getting our dieticians to see enough of our patients, and we do not have consistent advice—what do you do in Betsi Cadwaladr LHB?' Once that comes together more, we would become more effective. I think that we are being quite effective as we are, but that is the next step.

[48] **Mark Drakeford:** I have a lot of Members wanting to ask questions, so I appeal to everyone for relatively focused questions, and I am afraid that we will probably have to have only one person answering. Vaughan is first, then Lindsay and then William.

[49] **Vaughan Gething:** Going back to a few things that have been mentioned and also thinking about our terms of reference, particularly the point about prevention, I was interested in the opening remarks of Sharon about risk factors and the need to take action based on outcomes, which was also mentioned in some of the answers that you gave. However, what I am really interested in is your view on what success would look like, given the state of our population. Are we talking about just stabilising and evening off the level of obesity and the number or the proportion of people who have diabetes or are you talking about reducing it? What then would you see as the outcomes that we should aim for in terms of prevention? You have talked in general terms about that, but I am rather more interested in whether you have a view on what specifics we should expect and what we should ask our health service—in secondary care, and in primary care in particular—to achieve.

[50] **Dr Hopkins:** I will be as brief as I can. I would expect the obesity epidemic to be flattening and then declining. Flattening will be difficult enough, but I think that that is what we need to aim for first, and then aim for declining. For diabetes in particular, I see that being followed through by a decrease in the prevalence, which is going upwards, so we need to see it flattening and then coming down. The treatment actions that we need to take then need to result in fewer complications, including admissions into hospitals for hypoglycaemia and hyperglycaemia. My colleagues could add to that, but you do not want us to move over.

[51] I think that prevalence and complications would be the two biggest things that I would go for initially. In aligning, in the first year, we would want to see what our GP colleagues are doing: if that is measuring blood pressure or doing foot checks or vascular checks, that is fine, but what I want to know is 'So what?' That gets into the information systems—are we collecting the right information and are we asking the right questions, so that we know that what we are doing in primary care is resulting in better treatment and, therefore, fewer complications?

[52] **Vaughan Gething:** You mentioned the need to take action. Apart from saying that you want to have information coming back to you, is there anything else that you identify as future action that we should take and over what period of time? If we are talking generally

about wanting things to flatten out and then level off, over what period of time would this be and what do we do or should we do to get there? I am not a public health expert, but I am on this committee and I need to have a view on it.

[53] **Dr Hopkins:** It will be a whole range of things. Again, I am sorry about this, David; you will have to keep me right on general practice issues. On general practice, it will have to be very much clearer that the checks that we ask our primary care clinicians to do are linked absolutely to maximising treatment. We are not confident that that is the case at the moment, are we, David? That is the very first thing.

[54] Secondly, we would want to ensure that our care is integrated across the system so that our primary and secondary care clinicians are working together and patients get access to expert care when they require it. When we measure things, we must aim to ensure that the treatment that is then put in place is as effective as it possibly can be.

[55] Coming back to the prevention side—these guys are secondary care experts on what needs to be done on the treatment front—we have to do some serious work with the food industry and what that looks like is a much longer conversation. We must ensure that, in our schools, the curricula around healthy schools in terms of eating and physical activity is absolutely there. We have to ensure that what we do in terms of setting good habits in the early years, whether through Families First or Communities First, is absolutely there and measured. Then we have to ensure that we have our raft of opportunities to ensure people get enough exercise. So, we have to ensure that exercise on referral, SlimLife and all of these activities that we run, some of which are in jeopardy—I heard only two days ago that the MEND programme has just gone into receivership—are put on sustainable footings. At the moment, they are not and we do not have the capacity within some of those services. For example, with regard to people who have obesity or weight problems, we do not have the capacity to enable all of them to be referred to lifestyle programmes. If we had longer, I would talk about the raft of 10 or 12 issues that we need to do much more about.

[56] **Vaughan Gething:** I would like to hear about those or perhaps come back to those. I appreciate that there are timing issues.

[57] **Mark Drakeford:** Okay. We will come back to that at the end. Lindsay, you are next.

11.15 a.m.

[58] **Lindsay Whittle:** I was really interested in insulin pump therapy; I have witnessed it at first hand and I think it is excellent. I appreciate that it is only for certain types of sufferers of a certain type of diabetes, but, in Scotland, I think that £1.5 million is ring-fenced for this and, in Northern Ireland, £2.5 million is ring-fenced. Do you see any benefit in us asking Ministers to ring-fence some money for this? If it is extra money, then I am sure that you will say ‘yes’. I am answering your question really, but should we ask Ministers to ring-fence money for insulin pump therapy? I notice that, in its evidence, Abertawe Bro Morgannwg LHB says it is fine and Hywel Dda LHB seems to be okay, but there is not much other evidence. It is not the full answer, but what would be your professional opinions on that?

[59] **Dr Pinto:** I will attempt to answer this. Insulin pump therapy is a big help for people who need it. The National Institute of Health and Clinical Excellence has issued guidance on insulin pump therapy. The NICE document says that if you follow the NICE advice to the letter, 12% of people with type 1 diabetes will need insulin pump therapy. Insulin pump therapy is also one of the most expensive therapies. However, some patients find it difficult to control their condition, their overall blood glucose level is very high, and when they try to increase insulin and control it better, they end up having severe, unpredictable hypoglycaemia

and are unable to carry on with their daily life or work, or drive to work or drive their children to school. So, for those people, insulin pump therapy would offer great benefits in terms of improved quality of life and getting back to normalcy and being able to carry on with normal life.

[60] Selective use of insulin pumps is important. An audit was conducted by the Welsh Endocrine Diabetes Society last year, which looked at the pump usage across the health boards in Wales. The proportion of people who were getting pump therapy was quite small. In fact, a Wales-wide average was 3.3%. In Aneurin Bevan Local Health Board, it was slightly lower at 2.5%. So, yes, there are probably more people out there who would benefit.

[61] In terms of resource allocation, speaking from the Aneurin Bevan LHB point of view, of those people who are deemed to benefit from insulin pumps and who are referred for assessment by the specialist team, none have been turned down because of resource constraints. However, there is probably a greater proportion of people out there who would benefit, and ring-fencing has been shown to work in Scotland and Northern Ireland. Therefore, I would support ring-fencing, if it would be possible to ring-fence a certain amount. What that amount would be has to be worked out by experts in this area. I would support that.

[62] **William Graham:** I have a question for Dr Minton, and thank you for your evidence. The concluding paragraph of your evidence states that the health board would welcome a revised national service framework or successor document to help drive forward change. Would you like to illuminate the committee a little more about that? Do you mean an enhanced one or something completely different?

[63] **Dr Minton:** We have had view of the new delivery strategy document as well, which does take some of the aspects of the NSF and changes the way of looking at it. There are several aspects of the NSF that are perhaps not appropriate for us to look at now. I will try to keep the answer quite short. I thought that the difference in the delivery plan was that it was a more sensible document for us to be able to follow up. We used to send reports on a quarterly or six-monthly basis to the Welsh Assembly Government regarding how we were implementing the NSF and very rarely had any response, which was disheartening—I think that is the easiest way to put it. Having something that is more structured and easier for us to get our heads around is sensible, and most of the changes that have gone into the new delivery document we agreed at the diabetes planning and delivery group. We have not met as a full DPDG to discuss it, but a splinter group, if you will, met to talk about it.

[64] With regard to the biggest things I would want to change in this, I do not think that we should be focusing on the number of patients that receive structured education for example. We should be focusing on the number of patients that are offered structured education. If you go back to the insulin pump question, it is not a question of the number of patients who use insulin pumps, but the number of patients who are offered it as a therapeutic option. We can get bogged down in an outcome thing of saying, ‘We have 160,000 diabetics and we should have 160,000 going through structured education, but we only have 72,000.’ If they have all been offered it and declined, then that is perfectly reasonable. Personally speaking, as an insulin-dependent diabetic who has gone through the process of considering a pump, it was not for me. It would not have worked for me and I did not feel that it was appropriate, and I certainly would not want my secondary care colleagues to be hit over the head with a stick because I said ‘no’. It is a matter of looking at how we, as a service, offer the provision of care and then ensuring that we do it properly, as opposed to looking, as a fairly blunt instrument, at the numbers of people who go through the education.

[65] I would also like to echo the point about public health and looking at things like the SlimLife programme and exercise on prescription. If we fit similar things into the document,

it will show that we are providing appropriate educational care as well. That is how I would like to change the way in which we report on it to show that we offer those services and give our patients the choice.

[66] **Lynne Neagle:** I want to ask about primary care. Dr Hopkins referred to getting more out of the nine tests that GPs are meant to offer. However, we heard last week that a significant proportion of patients are not getting the nine tests that they are meant to get under the national service framework. When I asked about that last week, I was told that GPs do not have the time to do it. What is your view on this issue? In Gwent, are people complying with the offer of the nine tests? How universal is that in the rest of Wales? What do you think about the view that GPs do not have the time to do that?

[67] **Dr Minton:** At the risk of annoying all of my GP colleagues, I would not necessarily agree that we have not got the time to do it. I slightly disagree with the argument that the nine tests are not being done. If we look at the nine things that need to be done, they are all being at least offered. The two tests that are probably not being done routinely and regularly are urine microalbumin testing—sending a urine sample off to look for small amounts of protein as a first marker of potential kidney disease—and retinal screening. I think that the other seven are being routinely offered.

[68] I understand that the data saying that the nine tests are not being offered routinely comes from the national diabetes audit that picks information out of GP surgeries, straight out of our computer systems via a tool called Audit+, which queries the data that we put into our computer systems, takes them out, gets the numbers and magically sends them into the ether to give the audit. That is not being well signed up to. I cannot remember the exact percentages, but I think that less than 20% of practices in Gwent, and it may have been less than 10%, have signed up to the national diabetes audit. This is something that, within practice, we need to do nothing with. We simply sign a piece of paper to allow the data to be taken. Personally, I would want to see it being made compulsory that we just pull the data out. That can be done. It can be done at the same time as data gets pulled out for our contracts for the quality and outcomes framework points. That could certainly be done. However, if you look at the measuring of blood pressure, cholesterol and HbA1c kidney function, they are all being done in virtually every practice—certainly in Gwent. The last time that I did an assessment of practices for their QOF, which I used to do in my previous job, was three years ago, but I did not go to any practice that did not achieve full points for screening and performing the tests within the diabetes area. To get the full points, you have to have done more than 90%, so I would question the assertion that a significant number of them are not being done.

[69] One test that perhaps is not being done is retinal screening. They are all being referred. The retinal screening service is outstanding and does an extremely good job, but I do not know whether it is being slightly overrun by too many patients. The 12-month drop is going to 15 or 18 months. There have been suggestions from the Diabetic Retinopathy Screening Service for Wales that it wants to do screening every two years, instead of every year, and I do not know a clinician who would agree with that. That may be one area where the tests are not happening.

[70] The other is getting the urine samples to send to the laboratory. That, unfortunately, is down to—and I am not blaming patients for this—the patient coming for an appointment, getting a urine container and then remembering to bring the urine sample back, which is something that we all forget to do. Therefore, without having looked at it completely, those are the two areas that I suspect are the issue. I can say with as much confidence as I can that the stuff that we routinely test in practice is being done. Whether we are hitting the targets is a different question.

[71] **Mark Drakeford:** Do you have a question on this, Darren?

[72] **Darren Millar:** Yes, a very brief one. At the moment, the screening tends to be related to those people with high risk factors. When the over-50s annual screening programme is introduced in Wales, to what extent do you think that diabetes ought to be routinely screened for?

[73] **Dr Minton:** The Diabetes UK screening, which happened in National Diabetes Week—which was actually a fortnight last year, which I thought was rather clever—involved going into pharmacies and testing anyone who looked as though or felt they were at risk. There was a great deal of concern among the GP fraternity that that would create an enormous amount of additional work. Certainly, the local medical committees were worried that patients would make huge numbers of appointments for fasting blood tests with nurses and that there would be a huge capacity issue. That did not happen. I have not seen the exact figures; I have only had informal discussions with practices about how many people came in, but I believe that the pick-up rate was less than 2%. A national screening programme of everyone, even those who appear to have one or more risk factors, does not seem to pick many people up.

[74] Screening people with a high BMI figure, people in south-east Asian populations, those who have already had strokes, who are already hypertensive, and those who have already had heart attacks or who have angina is extremely worthwhile and certainly picks people up. That is already being done. Anyone who is being treated as secondary prevention because they already have a cardiovascular condition is already being screened at least once a year in the practices anyway. Therefore, I suspect that we would not pick up that many people from a national screening programme of people over 50. I do not know whether my colleagues would agree—

[75] **Darren Millar:** Is there discussion with the diabetes planning and delivery groups about the opportunity with the over-50s annual checks kicking in at some point before the next Assembly elections and how that might be a tool to identify—

[76] **Dr Minton:** We at our DPDG have not had that discussion, but it is something we should do, and we will certainly put it on the agenda for next time. Interestingly, checks for those aged over 75, which were being done up until—forgive me if I am wrong—seven or eight years ago, had very low rates of picking up diseases, including diabetes. They did not pick much up and were not considered to be worth while.

[77] **Darren Millar:** Whether they are worth while or not, they are going to be introduced—

[78] **Dr Minton:** I appreciate that.

[79] **Rebecca Evans:** It has been suggested to us that there should be separate national service frameworks for people with type 1 and type 2 diabetes. We have heard that people with type 1 diabetes perhaps lose out to people with type 2 diabetes, perhaps because it is a much more recognised condition. What is your view on that and what are the health boards' approaches to the two types of diabetes?

[80] **Dr Pinto:** Perhaps I can try to answer that. Yes, there is a point here because, although diabetes is considered as a single entity, it is a minority of patients—that is, 10% or less—who have type 1 diabetes who have the more severe form of diabetes and they often lose out because, for example, they need more intensive specialist care earlier on. Type 1 diabetes often occurs in childhood or at a young age, so these people live for a long period with diabetes and are therefore susceptible to developing the complications of diabetes. Due to the fact that they do not produce any insulin, they are at risk of developing ketoacidosis,

going into a diabetic coma and requiring emergency hospitalisation. Therefore, a balance has to be struck. There are many similarities in the problems facing people with type 1 and type 2 diabetes. For example, the nine health checks that people with type 2 diabetes need would benefit people with type 1 diabetes. Therefore, I do not think having separate NSFs for type 1 and type 2 diabetes would make a difference. However, it is for all healthcare providers to bear in mind that type 1 diabetes is a slightly different category, that people with it require more intensive follow-up and that they are the ones who need to be referred to specialist teams early on. It is about raising awareness, but I do not think that separate NSFs are necessarily the answer.

11.30 a.m.

[81] **Mick Antoniwi:** You made a reference earlier to the way in which the smoking campaign was dealt with and how long that took. Is there a danger that we are being too complacent about the nature of our public health campaigning with regard to the link between obesity and lifestyle and making people aware of the specific health risks? Would you welcome a much more aggressive and specific public health campaign?

[82] **Dr Hopkins:** As a director of public health that is absolutely music to my ears. I could not say anything else. However, in all seriousness, the risk factor issues for type 2 are critical and this of course does not just link into diabetes. Unless we get a real handle on some of these risk factor issues, we are always going to be chasing our tails. We know that the demands on secondary care services will be getting ever greater, as the demographics in Wales demonstrate. That is because some of the lifestyle factors are so difficult to deal with. It goes to people's choices and how they feel about what responsibility they take. It goes to options and choices and it is such a difficult issue to deal with. Unless we have a Wales-wide approach, very much bought into by our communities, it will be a difficult issue. I would say, 'Yes, please, absolutely' for much more focus, much more publicity and much more concentration. It is easy to do the stuff that is immediately in front of you—and that is right and proper—and it is easy to ignore the stuff that will take quite a while to result in harm, is it not?

[83] **Dr Pinto:** The health benefits of preventing obesity go far beyond preventing diabetes; there are other ramifications.

[84] **Elin Jones:** I want to ask a question about duplication in the system, especially between primary and secondary care of diabetes. We had reference to that by the physicians that we saw in our session last week. They said that there could be some duplication of care between specialists in secondary and primary settings. Do you think there is an issue there? Should there be greater clarity about the setting that individuals with different diabetes, type 1 or type 2, are seen in, whether it is secondary out-patient care or primary care?

[85] **Dr Minton:** I certainly think that there is an element of some duplication going on. The most common situation I find in my practice—as a specialist GP, not many of my patients go to a secondary care clinic—is that somebody comes to see me because I have a recall for them but they also go to the hospital at a similar time, and then they have all the blood tests done twice in two months, which frustrates the laboratory because it has to refuse to do one of them, and that probably drives them potty. That happens occasionally. The issue with that tends to be around the recall system that we use in primary care. We are so heavily computerised that we tend to call people in at exactly the same time each year and, often, the recall system in secondary care does not quite work out to the exact 12 months. It is similar to what I said with the DRSSW, you tend to have a bit of drift. Occasionally, patients have an annual review and then their second six-month review within three months of each other, which seems a little crazy.

[86] We have tried to take on the patients' annual reviews, which is when the nine checks get done. That tends to be done more in primary care now than in secondary care. We try to keep secondary care colleagues for more specialised requirements and try to take on the burden of doing the annual reviews. We have done that fairly successfully in Aneurin Bevan health board area. The recall we rely on for getting their nine checks done tends to be done in primary care. We are trying to look at that duplication and we have things in place. We are also looking at a more sensible and integrated care model. There are patients who do not necessarily require highly specialised input and do not need to be seen by the hospital clinic. However, if I have a problem, I can contact Leo and say, 'What do I do with this chap? I want to do this or this', and he could suggest, 'I think you should do the latter'.

[87] **Elin Jones:** To address some of that duplication of effort, would sharing patient information and better IT systems be part of the solution to that?

[88] **Dr Minton:** Yes, very much so. In Aneurin Bevan, we have the clinical work station, so I can quickly pick up any results and see letters that have been written, if needed. The rate-limiting step with that is that information does not automatically come into my clinical system inbox, because the clinical systems are not compatible. The tests that I conduct do not automatically go into the patients' secondary care records—there is not a continuing healthcare record. I am sure that we could talk for hours on this topic, so I will stop there. However, it would be useful to be able to see when the tests have been done, so that we can tie things up.

[89] **Mark Drakeford:** Thank you all for an interesting and useful session. The key challenge for us as a committee in this short inquiry will be to make some recommendations to the Welsh Government as to the key actions that it should be taking in the plan that is currently being developed for the next five years. As Dr Hopkins reminded us a few times, it is all about choices. There is no point in us saying to the Government that it has to do everything. I invite you, beyond this session, to give us any further advice that you can on what you think are the key things that we should identify for the Welsh Government on what it must do over the five-year period of the plan in order to improve diabetes care in Wales. That is what we will be trying to think of when we review all the evidence. If you have further thoughts on that, it would be helpful. Thank you for the time that you have given up to spend with us today.

11.37 a.m.

**Ymchwiliad i'r Gwaith o Weithredu'r Fframwaith Gwasanaeth Cenedlaethol
ar gyfer Diabetes yng Nghymru a'i Ddatblygiad yn y Dyfodol: Tystiolaeth
Lafar— Iechyd Cyhoeddus Cymru a 1000 o Fywydau a Mwy
Inquiry into the Implementation of the National Service Framework for
Diabetes in Wales and its Future Direction: Oral Evidence— Public Health
Wales and 1000 Lives Plus**

[90] **Mark Drakeford:** Bore da. Rydym am fwrw ymlaen yn syth â sesiwn olaf y bore yma ar ein hymchwil i'r gwaith o weithredu fframwaith gwasanaeth cenedlaethol ar gyfer diabetes yng Nghymru a'i ddatblygiad yn y dyfodol. Croeso i Dr Hugo van Woerden—bydd yn rhaid i chi fy helpu gydag ynganiad eich cyfenw. Dr van Woerden yw cyfarwyddwr is-adran iechyd a gwella gofal iechyd yn Iechyd Cyhoeddus Cymru. Rwyf

Mark Drakeford: Good morning. We will continue straight to the final session this morning as part of our inquiry into the implementation of the national service framework for diabetes in Wales and its future direction. Welcome to Dr Hugo van Woerden—you will have to help me with the pronunciation of your surname. Dr van Woerden is the director of the health and healthcare improvement division for Public

am ofyn i chi am unrhyw sylwadau agoriadol Health Wales. I will ask you for some brief
byr sydd gennych, ac yna byddaf yn troi at opening remarks, and then I will turn to
aelodau'r pwyllgor i ofyn eu cwestiynau. committee members to ask their questions.

[91] If there are any brief opening remarks that you are able to offer us, that would be helpful, and then we will get into the questions and discussion.

[92] **Dr van Woerden:** Thank you for the invitation to come here today. I will reflect briefly on some of the other consultation documents, which I felt were helpful. The national specialised advisory group wrote to you, and it highlighted a few things about information technology and structured diabetes education, which are recommendations that are worth supporting. The British Diabetic Association also wrote and made a number of recommendations at the end of its document, quite a lot of which are to do with structured education. Again, I would be supportive of those. One point in particular that it raised was the possibility of a small central administration and co-ordination team to deal with issues such as structured diabetes education, which may be worth considering.

[93] The Welsh Government is introducing a policy institute for Wales, and there may be the possibility of commissioning some policy analysis around a number of areas that might be of interest. I am not sure whether it is possible for them to be taken forward on a Wales-only basis, but I think that it is worth considering, particularly around the whole agenda of whether there are any legislative approaches to encourage lower salt, sugar and animal fat in processed foods. There is also a legislative, structural approach to encouraging walking, cycling, physical activity in schools and, thirdly, the advertising of particularly unhealthy foods. So, I think that there are a number of what I call societal structural things that policy analysis might help with.

[94] In terms of health boards, I think that it might be worth considering recommendations to chief executives of health boards—that they prioritise structured diabetes education, because it is highly cost-effective. Also, chief executives would be in a position to ask that, within the context of the 1000 Lives campaign, diabetes was prioritised for the 2013-14 planning cycle. I think that that might be worth thinking about. Within the context of that 1000 Lives approach, which is very much the approach of local groups thinking, 'How do we improve plan, do, study and act cycles?', things like avoidable amputations could be a priority, as could in-patient diabetic monitoring and, as has been touched upon by others already, the comprehensive annual diabetic checks in primary care, and driving up levels with that.

[95] The only other one that I would raise is that it might be possible to try to influence or recommend that the NHS Wales Informatics Service puts some priority on developing a national integrated patient management system for diabetes, which is the technological side, if you like, of linking up data. In that context, it may be worth looking at the Scottish Care Information—Diabetes Collaboration, which has taken this forward in a Scottish context. I think that that has parallels.

[96] **Mark Drakeford:** Thank you for some very interesting practical things, which we need. I think that we are coming towards the point when we will be focusing on what we think are the key steps that need to be taken next. So, that is very helpful in that way.

[97] **William Graham:** We heard in evidence last week that diabetes is now reaching epidemic proportions. Perhaps you could comment on that. Clearly, there is an impact of an increasing prevalence of diabetes, in any case. Where should resources really be focused?

[98] **Dr van Woerden:** There is evidence that the prevalence of diabetes is rising, and that seems to be related primarily to rising average body weight, if you like, towards an obesity

epidemic, which is probably the main driver behind that. Personally, I would argue that, in the focusing of resources, you would need to have a drive forward on everything and, in local contexts, pick priorities and move them forward. That is a way of saying that, at a Government level, it is best to maintain a strategic focus and create some energy and drive that allows some flexibility at the local level. If people choose to drive A first, and then B and then C, they will do it better, and someone else will pick B first, and then A and then C. The capacity to allow local teams to say, ‘We will pick this to focus on first’, creates buy-in, which has quite a powerful effect.

[99] **William Graham:** So, you are suggesting that for our suggested recommendations to the Government. Is that the approach that you suggest, in terms of leadership?

[100] **Dr van Woerden:** Yes. It very much ties in with the 1000 Lives Plus approach, which tried to gather information at a national level to paint the broad picture, but then, at local level, ask local teams to look at their own local information, pick a local priority, focus intently on improving that in a cycle whereby they constantly review what they are doing, until they reach a high level, and then move on to the next local priority. That creates a very strong buy-in, and often makes the greatest difference, in reality.

11.45 a.m.

[101] **Mark Drakeford:** Is energy and drive a conspicuous feature of the Welsh Government’s performance in relation to diabetes?

[102] **Dr van Woerden:** A number of the consultation responses included views on vacant posts and the potential impact of that. However, I have not been directly involved in that.

[103] **Mick Antoniw:** I am quite interested in what you said today and what you said in your paper. You talk about the fundamental importance of lifestyle choices and that what seems to be happening is that society is doing less exercise and becoming more obese and that there is this deluge heading our way that will result in increasing ill health, particularly diabetes, and if only we could change people’s habits. You also made a number of suggestions for possible legislation in relation to sport and exercise in schools, food content, advertising and so on. In terms of the work that you have done on public health and your knowledge of what happens in public health in the rest of the UK and, possibly, further afield, is there any evidence anywhere to demonstrate that any of these campaigns to improve lifestyle are working?

[104] **Dr van Woerden:** Simply focusing on providing people with information on lifestyle seems to have a relatively small impact. I guess that that is why, in my opening remarks, I focused on what I call structural issues, given that the way that society is structured has a profound effect—it is sometimes called an obeseogenic environment, or even a diabetogenic environment. That is an environment where kids play indoors more—on the Xbox, for example—rather than going out to ride a bike, where there is less physical education offered in schools and where older people find it difficult to walk on unsafe pavements. In Holland, for example, there is an enormous number of cycle routes, which creates an environment in which cycling is easy to choose as an option—creating the capacity for that option to be chosen. Similarly, there are pressures from advertising. Evidence suggests that the advertising of foods that have low nutritional value, particularly those aimed at children, has an effect on the consumption of those foods. So, there is a question about the extent to which we want a society that promotes or accepts that practice.

[105] I guess that what I am trying to say is that you have to make a change in society slowly. If the smoking ban had been introduced 20 years ago, it would not have worked, because society could not have coped with it. So, it is a balance between society as a whole

recognising that there is a problem and wanting to do something about it and being happy to have imposed upon it a degree of restriction—whether that is in relation to advertising or other things—that allows people to encourage each other to move in a healthier direction. There is a fine balance between empowering people, respecting people’s autonomy and creating structures that encourage positive and healthy choices.

[106] **Mick Antoniw:** My main concern is what works. When the advertising started in relation to smoking, it was very much along the lines of, ‘It can damage your health’, and we eventually ended up with, ‘This will kill you’, accompanied by pictures of diseased lungs and a whole series of other things. So, the advertising became very in your face. I am concerned that what you are saying are all things that we all seem to know and are all in our face. Are there any examples of the types of work or campaigns that are having an effect in changing these lifestyle choices, or are we basically saying, ‘This is what we’d like to do, but there’s very little that we can do about it’?

[107] **Dr van Woerden:** The Scandinavian countries have, perhaps the most successfully, done this over a number of decades. Rather than having a focused campaign, they have approached it from many different angles. Shaping society in a particular direction can be done over a number of decades, but it is about each section of society doing its bit. So, there is a legislative framework in which it operates, and the public sector pushes towards that. Advertising has a role, but, as I said, I do not believe that it has a primary role, because I think that its impact is relatively small.

[108] **Darren Millar:** I wanted to touch on the evidence that you sent to us about the 1000 Lives Plus campaign, and the opportunity that the methodology in that campaign might present to tackle the diabetes crisis that might face us in the future. Can you tell us a bit more about the 1000 Lives Plus methodology and why, in your opinion, it is superior to the national service framework approach?

[109] **Dr van Woerden:** I think that they are complementary, rather than one being superior. The 1000 Lives Plus approach is a way of taking forward some of the theories that have been highlighted in the national service framework. The ideas behind 1000 Lives came from Don Berwick in the United States and have some evidence base to them. They also have a reasonable evidence base in industry with companies such as Toyota, and some of the Japanese work on quality circles, looking at continuous improvement methodology in that sort of context. So, I think that they are well supported. The NHS is making a commitment to train 25% of the workforce in these methodologies, so the timing is opportune, and diabetes could be taken forward as an important area in which this could be applied.

[110] The methods use a mixture of what I would call soft and hard approaches. The soft approach is about winning the heart, as I was saying, at a local team level, getting people to be passionate about this and to champion things at a local level. That will create a degree of urgency by saying, ‘Look, it is really important that we do something about this’ with the sense that we can do something about it, which fosters a culture in which we talk openly about problems in a way that is not too judgmental, and that focuses on solving the problem rather than criticising. That is the soft approach.

[111] The hard approach is picking specific things that can be measured and measuring them on an ongoing basis, charting them so that you can see the direction of the trend, and placing that in a prominent place in relation to the teams so that the teams see the charts every day, and there is a feedback loop to see the difference being made.

[112] **Darren Millar:** What indicators would you like to see more attention being paid to? If one of the issues in the NSF is to diagnose diabetes and bring it into the open, we will see an ever-increasing trend, which might be discouraging for people working with diabetics,

given the explosion in the growth of diabetes. So, what positive indicators of a downward trend would you like to see? You mentioned the number of amputations carried out, but what others would you like to see being measured?

[113] **Dr van Woerden:** The three areas or approaches that are proposed at a high level to be focused on are harm, variation and waste. So, first, where are we doing harm? For example, if somebody in a hospital forgets to check the blood glucose sufficiently frequently, or if somebody misses an insulin injection, that is all avoidable harm. On avoidable harm, particularly around foot care, as I said, at the end of the day, a potential reduction in amputations has been shown to be easily achievable. I come back to the fact that there are quite widely known areas on which it is appropriate to focus, and to allowing a local team in secondary or primary care or in a GP cluster to pick what it will work on first from a menu of the widely known areas that it is important to focus on. This approach would mean looking at its own data and saying where it particularly needs to improve. It creates this mixture of tightness and looseness. In other words, it is tight in the sense that they will improve and set high standards, but loose in the sense that there will be some freedom at an individual and local level to drive that and have ownership.

[114] **Darren Millar:** Is there not a risk if there is no consistency that it will be difficult to measure progress across the country as a whole? If you have local indicators that are different from one area to the next, it will be challenging to see an overall picture, will it not?

[115] **Dr van Woerden:** The national diabetes audit works across England and Wales and produces an annual report—in fact, a bunch of annual reports, some of which are focused on in-patient care, and some on GP processes. That approach is complementary, because it paints a broad picture and it also allows experts to say, ‘Here are some areas where measurement is appropriate’, rather than inventing your own. So, from that menu of the national diabetes audit, it would be quite easy at a local level to say—

[116] **Darren Millar:** Which areas you are going to concentrate on.

[117] **Dr van Woerden:** Yes, exactly.

[118] **Mark Drakeford:** Can I ask you a question about structured education? Last week, we took evidence from Diabetes UK, which pointed towards what it regarded as the lamentably low number of people in many parts of Wales receiving structured programmes of education, including for type 1 diabetes, for which these things are meant to be mandatory. This morning, we have heard a slightly contrary view from one of our previous witnesses, which was that counting the number of people who receive education programmes is not the sensible measure, rather we should be counting the number of people who are offered the opportunity to receive structured education—presumably, the argument being that quite a lot of people who are offered the opportunity choose not to take it up. I am interested in what you think about that difference of view, but also whether you are able to help us more generally. Is this an area of concern in chronic disease management, when we are looking more and more to self-care and people being able to take responsibility for managing their own conditions? That is, while you can offer people programmes and opportunities to develop their self-care techniques and so on, there may be large numbers of people who would rather not go down that route themselves?

[119] **Dr van Woerden:** The evidence of surveys of patients indicates that a high proportion of them have relatively limited knowledge of areas that could be helpful to them. So, there is a problem in relation to knowledge, clearly. The randomised controlled trials show that a number of packages of structured education are very cost-effective and, over a number of years, are probably cost-saving, which, in an environment in which NICE put a threshold of £20,000 per QALY, or quality adjusted life year, is very competitive. It is

profoundly important, and you would think that you would prioritise it.

[120] The GP angle is that there should be an opt-out for people who refuse structured education. It is similar with some of the other things. For example, some of the quality outcomes framework targets have the capacity for the GP to indicate by some code that an offer was made and declined. I think that it may have been suggested that there be such a code in this context, but there is a difference between that and an individual GP who may be concerned about the financial implication if they did not meet a target because some patients in their practice were refusing. At a macro level, I do think that this is a really important one, because, ultimately, you are right that patients need to be empowered to look after their own condition. We all go through a reaction when we get a diagnosis of disease. Initially, we may be in denial and think, 'I can't really believe I've got this', or we may be angry or guilty or a bit down about it, and then we come to the point where we accept it and want to do something about it, and I think that people go through that cycle at different points. The challenge then is for somebody who is at the point of saying that they want to do something about it to get ready access to structured education. As I said in my opening remarks, this is one of the major areas that I would say is a strategic priority.

12.00 p.m.

[121] **Mark Drakeford:** Thank you very much. Do Members have any further questions at this point? I see that you do not. We probably have managed to explore with you all the points that we needed to. Thank you for helping us with our inquiry.

[122] Diolch yn fawr iawn am fod yma y Thank you for coming here this morning.
bore yma.

[123] Thank you for helping us with our inquiry. That is the end of this part of our agenda.

Papurau i'w Nodi **Papers to Note**

[124] **Mark Drakeford:** Mae dau bapur i'w nodi heddiw. Y cyntaf yw papur 8, sef llythyr oddi wrth y Dirprwy Weinidog at Kirsty Williams yn wreiddiol, ond mae copïau ar gael erbyn hyn i bob aelod o'r pwyllgor. Papur 9 yw llythyr oddi wrth y Gweinidog ar y Bil Trawsblannu Dynol (Cymru), yr ydym wedi'i drafod eisoes. Diolch i chi i gyd. Byddwn yn cyfarfod nesaf ddydd Iau, 29 Tachwedd.

Mark Drakeford: There are two papers to note today. The first is paper 8, namely a letter from the Deputy Minister to Kirsty Williams originally, but copies are now available to all committee members. Paper 9 is a letter from the Minister on the Human Transplantation (Wales) Bill, which we have already discussed. Thank you, all. We will meet next on Thursday, 29 November.

Daeth y cyfarfod i ben am 12.01 p.m.
The meeting ended at 12.01 p.m.