



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

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

Dydd Iau, 15 Tachwedd 2012
Thursday, 15 November 2012

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Cynnig o dan Reol Sefydlog Rhif 17.42(vi) i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod
Motion under Standing Order No. 17.42(vi) to Resolve to Exclude the Public from the
Meeting

Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir
trawsgrifad o'r cyfieithu ar y pryd.

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 Antoniw

Mark Drakeford

Rebecca Evans

William Graham

Elin Jones

Lynne Neagle

Lindsay Whittle

Kirsty Williams

Llafur

Labour

Llafur (Cadeirydd y Pwyllgor)

Labour (Committee Chair)

Llafur

Labour

Ceidwadwyr Cymreig

Welsh Conservatives

Plaid Cymru

The Party of Wales

Llafur

Labour

Plaid Cymru

The Party of Wales

Democratiaid Rhyddfrydol Cymru

Welsh Liberal Democrats

Eraill yn bresennol
Others in attendance

Mair Davies

Marc Donovan

Cadeirydd, Bwrdd Fferylliaeth Cymru

Chair, Welsh Pharmacy Board

Aelod o Fwrdd Fferylliaeth Gymunedol

Cymru a Phennaeth Gallu Proffesiynol,

Alliance Boots

Community Pharmacy Wales Board Member

and Head of Professional Capability, Alliance

Boots

Paul Gimson

Cyfarwyddwr Cymru, y Gymdeithas

Fferyllol Frenhinol

Director for Wales, Royal Pharmaceutical

Society

Russell Goodway

Prif Weithredwr Fferylliaeth Gymunedol

Cymru

Chief Executive, Community Pharmacy

Wales

Jason Harding

Rheolwr Polisi, Diabetes UK Cymru

Policy Manager, Diabetes UK Cymru

Dr Ian Millington

Cymdeithas Feddygol Prydain

British Medical Association

Dr Aled Roberts

Cymdeithas Diabetolegwyr Clinigol Prydain

Association of British Clinical Diabetologists

Dr Mark Temple

Cymdeithas Feddygol Prydain

British Medical Association

Dai Williams

Cyfarwyddwr, Diabetes UK Cymru

Director, Diabetes UK Cymru

Dr Meurig Williams

Cynghorydd Rhanbarthol Cymru, Coleg

Brenhinol y Ffisigwyr

Regional Adviser for Wales, Royal College
of Physicians

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

Llinos Dafydd

Clerc

Clerc

Catherine Hunt

Dirprwy Glerc

Deputy Clerk

Phillipa Watkins

Y Gwasanaeth Ymchwil

sResearch Service

Dechreuodd y cyfarfod am 9.31 a.m.

The meeting began at 9.31 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Mark Drakeford:** Bore da a chroeso ichi i gyd i'r Pwyllgor Iechyd a Gofal Cymdeithasol. Rydym wedi cael ymddiheuriadau gan Darren Millar a Vaughan Gething, ac nid oes dirprwyon.

Mark Drakeford: Good morning and welcome to you all to the Health and Social Care Committee. We have received apologies from Darren Millar and Vaughan Gething, and there are no substitutions.

9.32 a.m.

Ymchwiliad i'r Gwaith o Weithredu'r Fframwaith Gwasanaeth Cenedlaethol ar gyfer Diabetes yng Nghymru a'i Gyfeiriad yn y Dyfodol—Tystiolaeth Lafar gan Diabetes UK Cymru
Inquiry into the Implementation of the National Service Framework for Diabetes in Wales and its Future Direction—Oral Evidence from Diabetes UK Cymru

[2] **Mark Drakeford:** Heddiw, rydym yn dechrau ar ein hymchwiliad i'r gwaith o weithredu'r fframwaith gwasanaeth cenedlaethol ar gyfer diabetes yng Nghymru a'i gyfeiriad yn y dyfodol. Diolch yn fawr iawn i'r tystion cyntaf o Diabetes UK Cymru. Croeso i Dai Williams, cyfarwyddwr Diabetes UK Cymru, ac i Jason Harding, rheolwr polisi Diabetes UK Cymru. Fel arfer, rydym yn gofyn i'r tystion am ryw sylwadau agoriadol byr, ac wedyn yn troi at aelodau'r pwyllgor i holi cwestiynau. Pwy sydd am wneud y datganiad?

Mark Drakeford: Today, we are beginning our inquiry into the implementation of the national service framework for diabetes in Wales and its future direction. Thank you very much to the first set of witnesses from Diabetes UK Cymru. Welcome to Dai Williams, director of Diabetes UK Cymru, and Jason Harding, policy manager of Diabetes UK Cymru. Usually, we ask witnesses to make some brief opening remarks, and then we move to questions from the members of the committee. Who would like to make the statement?

[3] **Mr Williams:** Good morning. Bore da. Thank you for coming and for inviting us to the meeting. I will make a brief introduction. I joined Diabetes UK Cymru about five years ago now. It was meant to be a fleeting visit, but I have stayed for five years, because I have been totally taken with the subject and amazed in many ways by how it is being dealt with in Wales. It is a worldwide problem, but I was just staggered by the cost of it to Wales. I have discovered that it costs the NHS in Wales roughly £0.5 billion a year, which is a tremendous amount of money, without accounting for the difficulty and misery that it causes thousands and thousands of people in Wales, one of whom is my son. He has type 1 diabetes, which is why I initially came to the organisation, and my wife has type 2 diabetes. I have been trying to make sense of it.

[4] I spent a lot of time working on health at the BBC in a previous career, and I am beginning to understand why we are facing this difficulty. Essentially, it is a problem with the NHS that lies at the base of it, in the sense that we have a system that is used to dealing with acute conditions. It is a medical model: somebody gets ill, you give them a tablet or medication and they get better—end of story. We have now moved into a world of chronic conditions, which is very different. If somebody gets ill these days, maybe in their 30s or 40s, that condition will be with them until the end of their life. Indeed, it will largely be responsible for the end of their life. The key with diabetes, therefore, is to see the patient as part of the solution and not as part of the problem. If patients are to have just three or four hours a year with their healthcare professional, they need to be coached by that healthcare professional and given the education to manage their condition effectively in the intervening periods. Unfortunately, that is not being given, and that lies at the heart of our problem. Indeed, of that £0.5 billion a year to the NHS, 87% is spent on treating complications caused as a result of diabetes. People still think about people having ‘just a touch’ of diabetes, but it is a dangerous condition and we are not making that clear to people. We are not making it clear that many of the solutions are in their hands.

[5] I was incredibly reassured when I came to Diabetes UK to learn that there was a national service framework in place. My background is in biochemistry and educational broadcasting. When I read the NSF, I thought that it was a great document and that it was really working. So, where was the problem? The problem came when I tried to work out who was responsible for overseeing the NSF. In England, there was a diabetes lead. In Scotland, there was a diabetes lead. In Wales, there was nobody.

[6] The Welsh Government seemed to have passed it on to the health boards to implement, and the health boards had passed it down to the clinical diabetes lead, who is an acute physician with a full-time job. Not only did that individual not realise that they were responsible for implementing the strategy, but they had next to no knowledge of key areas of implementation, of primary care, and even less knowledge of public health. Their responsibility for communication, management and leadership was outside their full-time job. If I needed a leg cut off, they would be great, but they were not so good at implementing a strategy. We do not even know, because we do not have the means of measuring the strategy, what kind of a mess has been made of it. There is nobody responsible for that £0.5 billion of expenditure at all. That is why I am interested to see where we go from here.

[7] **Mark Drakeford:** Thank you for that, and for your written paper. We will refer to it, no doubt, as we go along. Before we move to questions, I remind us all that this is equivalent to a one-day inquiry, carried out over the next three weeks. We are trying to do two things. One is to look back over the 10 years of the previous strategy, including the NSF. However, as the NSF comes to an end this year, we are also at the point of the Welsh Government working on its successor, and the new strategy covers however many years—and let us guess maybe five. So, part of what we are about today, as well as looking back, is looking forward to see whether there is anything that we can say in our committee report that might influence that future direction. We are keen to explore both things with you: what we have learned and where we might go from now.

[8] **Lynne Neagle:** I want to pick up on the issue of a clinical lead, which you placed a lot of emphasis on in your written evidence. Can you expand a bit more on how you think that would improve delivery in Wales? What concrete improvements would that lead to?

[9] **Mr Williams:** I want to be clear on this. After it was broadcast a couple of years ago, Dr Phil Evans was hastily named as the diabetes clinical lead. Phil is a great physician and does an awful lot for diabetes, but he has a full-time job. He chairs the national service advisory group on diabetes, but that is all. He has no time to give to being a clinical lead.

[10] The role of a clinical lead, essentially, is to make sure that the 12 standards of the NSF are being progressed in a logical manner and are being project-managed effectively across Wales. That is exactly what the clinical leads do in Scotland and England. It sounds obvious but we attend all the diabetes planning and delivery groups across Wales, and we attended the local diabetes services advisory groups before then. I went to Cwm Taf Local Health Board at one stage, when they had problems with people in care homes who had diabetes. There were large numbers of folk with end-stage diabetes and the health board did not know what to do. I was at Hywel Dda Local Health Board two days later and they were celebrating the fact that they had just had great successes in dealing with people in care homes. They had set up a cost-neutral network to manage the situation, with representatives of social services and primary care and with specialist nurses in the community. They had also developed a toolkit for care homes around Wales. I was quite taken aback. If they had that, why were they not sharing it with other health boards in Wales? There were various other examples of good practice like that, too. So, on the back of that, effectively, I see the clinical lead sharing that information and coming up with a strategy to make sure that it is developed, based on evidence of how it works and so on, and passed on to other health boards to show that good practice is being shared. At the moment, health boards seem to stand by themselves with no co-ordination. I would see the clinical lead facilitating that. I now hold away-days with the diabetes leads of each health board to do that: to share. We now have a mechanism for passing this stuff on and to help them with communication skills, which is where they are weak.

[11] The health boards have been feeding information back to the Welsh Government for some time. It is quite detailed information about their progress in individual health boards and processes et cetera, but they have received little or no feedback since 2009 from the Assembly. In some senses, the clinical lead would say, 'Hang on a second; this is where your strengths are, and this is where your weaknesses are. You drop your game here a little bit. Come up with a way of actually working more effectively with primary care, or with public health or whatever. Don't forget that you are not delivering education'. So, in the absence of that role, after 10 years of the national service framework, we find that we are still delivering structured education to only 2% of the people who need it. Indeed, when it comes to a technology appraisal, which is education for those people who have type 1 diabetes, there is basically a legal obligation to deliver it, yet we are still not doing it. Many people out there with type 1 diabetes are injecting themselves up to six times a day with insulin, which is an incredibly dangerous and important drug, with little or no guidance as to how to do it properly. That is just wrong.

[12] **Lynne Neagle:** In terms of what you said about there being this clinical lead figure in England and Scotland, have you been able to look at whether there have been any specific tangible benefits in those countries through having this clinical lead?

[13] **Mr Williams:** Absolutely. Someone like Dr Rowan Hillson is the example in England; she is a very well-known physician. She has the respect of the entire diabetes community, and the gravitas to advise and basically steer the way that diabetes care goes. Unfortunately, in England, at the moment, they are still reconfiguring their health services, which is a different set of problems than the ones that we are faced with. However, that guidance is there.

[14] In the case of Scotland, it is a similar role. They are helped greatly in Scotland because, 10 years ago, they came up with an integrated chronic care system called SCI-DC—the Scottish care information diabetes collaboration. In Wales, the primary and secondary care IT systems do not communicate with each other, and the IT systems in different health boards do not communicate with each other; so, there is no means of measuring things. In Scotland, the SCI-DC, quite simply, is a piece of software that enables all of those IT systems

to communicate. So, if I see my consultant, for example, and I am told that I have a foot problem, and then I go to see my GP or a podiatrist a month or so later, all of my data are in front of me. If I am at home and want to monitor my own condition, as a follow-on from my education, I can check on where I am with it. So, there is a lead up with this kind of system. Ninety-eight per cent of people in Scotland are on SCI-DC, so they know how their NSF, or whatever, is being implemented. They can see strong and weak points from the data that they have, and they can act accordingly. So, a lead in that sense, along with the appropriate tools and the information needed to fulfil their role, can do all of that.

[15] I am very pleased to know that, after several years of explaining to the Government how important this is, we will be having it in Wales. It is being given to us free from Scotland. It is a very simple and effective tool. There is to be an extension of the NSF, because the new diabetes delivery plan is not a replacement for the NSF; we have failed to deliver the NSF and, therefore, it is an extension of that to extend the delivery period to 2016. With things like SCI-DC, and what we learn from today's committee meeting, the timing is very good because we must get this new plan picked up and implemented so that the NSF is delivered properly. That is why this is so important today, so that we can learn from our mistakes and not repeat them.

[16] **Mr Harding:** Perhaps I could just add one thing to that. If you look at England and Scotland, and particularly at the clinical lead there, you will see that one of the key roles that they seem to provide is a co-ordination function. Scotland has looked at the key standards that they are trying to deliver in their action plan, and that role co-ordinates a range of sub-groups and task and finish groups to look at each of those specific areas and manages that process. In Wales, we have 12 standards within the national service framework and we have one person who does a full-time clinical role anyway, trying to manage that very complex implementation plan. In Scotland, with this diabetes lead and a co-ordination function, groups of people come together to look specifically at each of the standards and consider how to take that forward in Scotland. In England, the diabetes lead, Dr Rowan Hillson, also works very closely with an organisation called NHS Diabetes to look to see how to manage and co-ordinate functions. So, in England, it is not just the diabetes clinical lead; there is an organisation in place to try to share best practice, to look at the National Institute for Health and Clinical Excellence guidance that is provided, and to ensure that the new clinical commissioning groups are rolling that out properly. We have a real vacuum in Wales.

9.45 a.m.

[17] **Mark Drakeford:** A number of Members are indicating that they wish to ask questions. Who wants to ask a question as a follow-up on this topic? I know that Elin wants to ask a question, so we will round up on this topic first.

[18] **Elin Jones:** I want you to explain to me the role of clinical lead and your expectation of it. I am struggling slightly with whether that needs to be a clinician or whether what you are describing—I think you used the words 'project management'—is a national co-ordination of the expectation to deliver on the next framework, or the extension of the framework, and that that is the missing part of the jigsaw, and so it need not necessarily be a clinician. You could be taking a clinician out of doing clinical work. The clinical lead has to be somebody with the right gravitas, authority and accountability to deliver, but it could be a Welsh Government official, for that matter, if it is identified clearly and given the right backing.

[19] **Mr Williams:** You have hit a key problem with this, because, as we have said, one important thing that we need to do is to move from a medical model to a more socially based model. This is an effective partnership with the patient at that level. As I said, 87% of the cost is due to complications. The clinical lead for Wales is one issue. The same problem is

experienced in every health board. You have a clinical lead in every health board trying to co-ordinate across secondary care, which is where they are based and what they understand, across primary care, which is complicated within itself, and into the world of public health. A lot of the ways of dealing with this and involving the patient are to do with communication skills. Just because someone is a consultant physician, it does not necessarily mean that they have people skills in that sense or the communication skills that are needed to empower people so that they can understand their condition and manage it effectively themselves, let alone the bigger problem with primary health.

[20] It is quite extraordinary when you think about it. We find ourselves now with a major epidemic in Wales. If you cast your mind back a few years, when we had the threat of a flu epidemic, it was all hands on deck, we had leaflets delivered to our houses, and we were all made aware of minute changes in the genetics of the virus and Tamiflu and so on. The flu epidemic did not happen, luckily. However, we are in the middle of a diabetes epidemic. The figures are massive: 9% of the population are affected, if you include the undiagnosed. You have 350,000 people waiting in the wings with pre-diabetes, out of a population of 3 million. These are staggering numbers. Yet, we are not aware of it. Why are we not aware of it?

[21] An old friend of mine, Ray Gravell, died of diabetes. When he was told that he had it, he said, 'No problem; I have a touch of diabetes, and the good news is that it is not the dangerous type'. Mari, his wife, says, if only they had known it was dangerous. They did not know. We are in the middle of this epidemic. You are right: the clinical issue is a problem, and understanding of diabetes and the context is essential, but the consultant-level expertise is not really necessary—although I think it is important because doctors tend to be fairly cliquy in some ways, so you need that respect to get them on board. However, there are broader issues: you need the communication, management, medical knowledge and leadership to carry that kind of thing off.

[22] **Mr Harding:** My personal view is that a project manager and a co-ordinator are required above and beyond a clinician. There is already a national specialist advisory group that gives advice to the Minister on diabetes issues, which meets once every three months. That gathers together a range of clinicians. There are two examples that bring it to life. The first example is, if you look at the commercial sector, can you contemplate an organisation with revenue of £500 million a year that had no chief executive officer or senior management team? It is a difficult scenario to consider.

[23] The second thing is that Diabetes UK has been working with a family. I understand that one of the daughters, Amelia Bertram, provided evidence to the committee based on her father, who died in a hospital in the Hywel Dda Local Health Board area due to various mistakes that occurred. That family has spoken to the Minister, Healthcare Inspectorate Wales, the ombudsman, various Assembly Members—some of them are present in this room—Members of Parliament and various health board chief executives, with a view to trying to ensure that the errors that were correctly acknowledged by the ombudsman are rectified. The family is still meeting with all those people and attempting to push this work forward, because they have little confidence that it will be done and that these changes will occur. They have no person in Wales to approach to seek reassurance and who could co-ordinate and take that work forward.

[24] **Mark Drakeford:** We will now move on to a couple of other topics, because time will soon be upon us. I call William next, then Kirsty.

[25] **William Graham:** My question arises out of your previous answer on patient education. We note the structured education plan, but could you tell us about the effectiveness of current guidance and the way in which those outcomes are measured?

[26] **Mr Williams:** Could you be quite clear about what you are after, please?

[27] **William Graham:** I am asking about patient education. We note the structured education plan, but I am asking for your opinion as to the effectiveness of the guidance and, in the guidance given, what outcomes can be measured.

[28] **Mr Williams:** There is a lot of evidence on structured education and how effective it is. To be clear, structured diabetes education, as you rightly say, is education that has been trialled and tested, and is monitored. There is effectively a curriculum, so you are getting the same information. The package is delivered effectively. It does work. We have managed, over 10 years, to achieve about 2% of freedom of information requests—that was last year. Structured education for type 1 patients is mandatory; health boards are legally obliged to do it, however, some are simply not doing it, which I find extraordinary. This came in in 2003 and we are still not there; it seems to have been kicked into the long grass somewhere down the line.

[29] When my son was diagnosed, for example, he ended up going home with an awful lot of insulin pens and needles and things of that kind, with no clear idea as to what he was doing. You may roughly know what you are doing, but there is a very tight balance to be had—every parent who I have spoken to has said the same thing—and your margin of error is very slim. There is a balance to be had between the energy spent walking, thinking, sleeping, and so on, and the food that you are eating—the carbohydrate intake—and the extra amount of insulin you are taking.

[30] Every parent who I know will recall the first time they witnessed their child going through a hypoglycaemic attack. It can be that the child simply feels woozy or it could be that they have a fit. It is very worrying and it is not just that, but the effect on the child. You are supposed to keep your blood sugar levels at a precise level, but if you have gone through a hypoglycaemic attack, or if they happen regularly because your management is not right, then the outcome is that you tend to use less insulin. You therefore tend to ride your sugars high to avoid the hypoglycaemic attack and that is dangerous in the long term.

[31] My son received his diabetes education at St Thomas' Hospital when he was a student, and he said to me, 'Dad, for the first time, I feel that I'm in control of my diabetes, not my diabetes being in control of me'. That was a big difference because, a few weeks before I had sent him there, I had a phone call from him saying, 'Dad, I don't know where I am, or what's happening to me', and that was because he was having a hypo in the flat, 200 miles away. The education does work, so it is terribly important that people get what they are entitled to, because with type 1 diabetes, it is a life and death situation.

[32] With type 2 diabetes, it is very straightforward. Work is being done by the Diabetes Prevention Program in the States. Through its DEPLOY study—Diabetes Education and Prevention with a Lifestyle Intervention Offered at the YMCA—it provided an educational programme, delivered in a non-clinical setting, and the outcome was quite remarkable. Type 2 is caused primarily by genetic and lifestyle factors. There was a mean reduction in body weight of about 6% out there. You cannot cure diabetes, but if you reverse the symptoms, you can improve the outcomes considerably. It is about coming up with a proper package of structured education, not necessarily delivered by diabetes specialist nurses, but delivered earlier up the stream. As soon as someone is diagnosed, they should be given a full explanation of their condition. I frequently get people calling me and, last week, I received a phone call from a healthcare professional who had been diagnosed, who had seen her GP and been given a package of Metformin and told to come back in two months. She asked me, 'Can you tell me what exactly is wrong with me and what I should do?' That is no way to start a relationship with something like diabetes. You need to be fully informed.

[33] **Mr Harding:** Just to add quickly to that, various structured education programmes are available in Wales, in a similar way to England, and are being looked at by NICE. Clinicians came together to assess those particular programmes with a view to money saved over a person's lifetime if you provide that programme, the reduction in complications that occur, and basic indicators for a person with diabetes, such as their health, and their HbA1c level. They were able to demonstrate reductions. So, NICE advised it because it improves self-management for diabetes and it saves money. There is one statistic that provides a nice bit of context for this: approximately 5% of people in Wales have diabetes, but 15% to 19% of people in hospital have diabetes. So, that is three times larger. One of the key reasons for that is that people go into hospital when their diabetes is not managed properly and they experience complications. Structured diabetes education is put in place, hopefully as early as possible when somebody is diagnosed, to enable them to manage that more effectively. Very briefly, in 2008, Diabetes UK did a survey of approximately 8,000 of its members, and 60% of those people said that they did not understand the medication that they were taking, and 80% did not follow the self-management regime effectively. If you extrapolate that statistic forward, these are the people who will be in Welsh hospitals in five to 10 years' time.

[34] **Rebecca Evans:** Referring to complications of diabetes, there is a greater understanding, certainly over the last 10 years, of the link between diabetes and mental ill health. I was wondering how you would like to see that reflected in the future work of the Welsh Government. Is it well understood?

[35] **Mr Williams:** You could turn that around the other way, because I think that there is certainly a greater tendency for people with mental health problems to have diabetes. By and large, that is caused as a side-effect, a heterogenic effect, of the medication that they are taking. You will often find that somebody who has a mental health problem will be seeing a mental health team to deal with that problem, and indeed they will be focused on that problem, but they will not notice that, in dealing with that problem, the individual has developed diabetes. They may be much better mentally, so to speak, but they are then suffering from the consequence of diabetes, which, broadly speaking, goes untreated because that is not the job of the mental health physician. So, you get that kind of issue.

[36] The other side of it is that, if someone has diabetes, the chances of them suffering serious depression or something of that kind are massive. I was chatting to one of my charity directors in London, someone at a very senior level, who has had type 1 diabetes for a long time now, and I said, 'You know, I have got multiple sclerosis', and she said, 'How do you feel?', and I said, 'How do you feel about your diabetes, because you work in the field?', and she said, 'I don't think about it, because, if I thought about it, I couldn't cope with it'. It is a lot to carry. You are managing your whole life; as I said with my son, you are managing your life within a few levels of sugar, basically, and you are injecting six times a day. It does cause depression greatly, with type 2 diabetes. Once you find that you have a long-term condition, one that you do not understand, which potentially has very serious consequences, you are depressed. There is a very strong link there.

[37] One of the guidelines says that psychological support should be available for people who have diabetes, but unfortunately it simply is not there. Type 1 tends to affect teenagers, mainly. There is a massive drop out in teenagers. There is a thing called diabulimia around at the moment, which is where young women want to fit in, their diabetes makes them different, they want to fit in with body image, and the insulin gives them a means of doing that. It is not careless use of insulin; it is actually very skilled use of insulin. Instead of keeping yourself at the right levels of glucose, you are riding it high, and that is diabulimia. The results of that are that a young lady in west Wales is in danger of losing her foot at the age of 24. I have been with clinicians who have told teenagers aged 18 and 19 that they have dangerous liver damage. We are continually meeting people in their late 20s who are suffering from the realisation that they have been managing it wrongly, because they have not had the

psychological support earlier on, and they are facing the consequences in their 20s as opposed to their 30s and 40s. Of course, those people will be with the NHS with increasing difficulties, and increasingly expensive difficulties, that are affecting them for the rest of their lives.

10.00 a.m.

[38] **Kirsty Williams:** I must say, gentlemen, that you are remarkably sanguine this morning, given the content of your paper. The Minister is on record as saying that she expects the standards to be met by 2013, and we are about six weeks away from 2013. Given the debacle regarding reporting, information about which you have supplied in your evidence, is there any way that the Minister would have any clue as to whether the standards have been met, or not, given the catalogue of errors with regard to reporting information to the centre?

[39] **Mr Wililams:** I can safely say that we are not going to meet the NSF by 2013, and we would not know if we had. The structured education is a very easy one; we know that we are currently at 2%, which is a long way away from 100%.

[40] **Kirsty Williams:** Could you back up some of the statements that you have made? It seems that we have local health boards, on the one hand, that are struggling hugely, sending data or information to the centre that are routinely ignored, or certainly do not seem to provide a basis for any feedback to them about how they can improve their work. I am astonished that you have said that, at some stages, you, as a charitable organisation, have had to take the data and analyse them because there has been a refusal or a failure to do that by Welsh Government officials. How did we end up in that situation?

[41] **Mr Williams:** I do not know. It has taken me a long time to study it, to try to work out what the issues are and then understand it. In the particular case that you talked about, in Scotland, as we have said, they have Scottish Care Information Diabetes Collaboration, so the stuff is there. In England, they use an objective measure by a company called Innove. It is a list of about 150 questions about processes and so on. Those questions are put to the health boards, which answer 'yes' or 'no'—so, they either have or have not done something. At that stage, in England, the questionnaire is sent off to the company, which applies software to it and compares it with the quality and outcomes framework and the national diabetes audit figures, and a package is given to each primary care trust that explains exactly how well they are doing, how they compare with their neighbours and offers recommendations regarding what they should concentrate on next. They give a steer regarding ways to manage the condition. In Wales, we got the questionnaire, which was customised by Dr Phil Evans and Dr Meurig Williams. All of the health boards went off, worked on it and sent it in, but we had not bought the software. That was the first blow. The second blow was that we contacted Innove and said that this was a problem for us, and it said that it would give us a year's free trial—it would analyse the data for a year and give us the feedback so that we would at least have a baseline. That was turned down by the medical director.

[42] **Mr Harding:** Within the evidence that we have provided, we have shown that there was a system in place until 2009. There was a specific role in the Welsh Government of a cardiovascular and diabetes lead. That role fulfilled a range of functions, but one of its key functions was to act as the recipient of information from the different health boards, which were reporting on a quarterly basis on their national service framework, to reflect on that information and to assess where work was being done constructively and positively and to acknowledge that, but also to identify where work was not being delivered to the standards and the expectations and then to communicate back to the health boards with action to rectify that and to provide an oversight function.

[43] The charity was never clear as to what happened to that role. I imagine that, within the Welsh Government, there are always changes in departmental processes and systems, but

it appears that that role was not replaced and no actions were taken to make allowances for the responsibilities that role was delivering. There is a body that comes together to provide advice, which meets on an infrequent basis—as people have full-time jobs in other areas—and over the next three years, there was a reliance on that body to pick up that function, which was clearly practicably not possible. There were various attempts to see how to resolve that issue and to acknowledge that there was a problem, but that was not dealt with. Over the past few months, we have had the new diabetes delivery plan, so there may very well be a slightly different process in place. As to how robust that will be, we are unsure. You can only see how robust a system is when it is in action.

[44] **Mr Williams:** The more damaging effect as a consequence of that, which was upsetting, was that we went from the local diabetes service advisory groups, where there were no managers present. It dawned on me, after attending these for a few months, that we were rereading the minutes that we had made for the previous meeting and that we were going to do it again. When I asked who was seeing these minutes within the hospital board, there were general shrugs—they were ‘sent up’. The bottom line is that no-one saw them, so it was a self-sustaining meeting. That change happened because of the cardiovascular co-ordinator, after we discussed this. The head of the NHS at the time introduced a change to diabetes planning and delivery groups to replace the LDSAGs. There was to be a manager on that, which was great. We were then to report to Government; that was one of the outcomes.

[45] So, as you can see, we went from a poorly attended LDSAG to a quite well-attended DPDG. There was enthusiasm, because the group was being watched, so it had to get things moving. As soon as there was no feedback from the results sent to the Assembly, the eye was taken off the ball. The attendance dropped off, the momentum and enthusiasm faded away and you ended up with a ragbag. In some meetings we have attended, more patient representatives have been present than healthcare professionals. That is not the way forward. Diabetes has complications—it is a multidisciplinary condition. You need to get the kidney people, the paediatrics folk, the public health people and the GPs to come along to have their say as to how we are implementing this. It needs to be co-ordinated. If you have five or six patients and one or two members of staff, that is not going to happen. That has been the effect. There was a loss of momentum. This is why we cannot afford to let that happen again. The outcome of this committee is crucial, and the Government needs to keep its eye on the ball, basically, and really manage this, going forward.

[46] **Mark Drakeford:** What do we say as a committee, then? We have heard the problem. You have told us that the Welsh Government is likely to adopt the Scottish information system, and that that is a good thing. If we were to recommend to the Welsh Government in our report that the difficulty of information coming in and not being acted upon should not re-occur, what should that recommendation be? What is going to make the difference?

[47] **Mr Harding:** If you were to look at a document that is about to be released in early December, which is jointly produced by NHS Diabetes in England and Diabetes UK, it specifically looks at the situation in England at the moment, and how to manage that very fluid landscape, how to map progress and have good management structures within the new clinical commissioning groups across the old English primary care trusts. The document recommends two very specific things. At a very local level, it talks about how to manage, compose and direct work by local diabetes networks. They are the equivalent of diabetes planning and delivery groups in Wales.

[48] As a basic minimum, to make those groups function effectively, it recommends having a clinical lead, but also, importantly, a network manager—a person who is there to make the group function, to ensure that people come to the group, that the right people are represented on the group, that people are aware of the information that needs to be read before

a meeting, that the meetings are co-ordinated well, that action points are taken forward after a meeting and that someone checks if those actions points are done. So, at a basic level, how do you negotiate, deliver and implement work at that level? That guidance has considered that.

[49] One level up from that, thinking about governmental areas, how important is resource for having something that functions well? It is easy to write strategies, produce papers and have implementation plans, but for oversight and accountability you need a person or a group of people to accept responsibility for the delivery of that plan.

[50] **Mr Williams:** There is a second very important point. I absolutely agree with what Jason is saying. At a broader level, the question is: where is public health and where is primary care? As I said, we are in the middle of a diabetes epidemic. People need to know that. We did it for flu, and it did not happen. People need to understand where we are in Wales. We have a major problem and people need to understand what it is. The key thing is that the NSF is built around standard 3. Basically, standard 3 in the NSF says that diabetes care should be patient centred. You need to empower the patient and they need to understand their condition. They know it is dangerous, but it need not be. They need to be given the tools to manage their condition. It is crucial that we make patients part of the solution, not part of the problem, because however we manage it, unless we work from that point of view, as I said, they are with the healthcare professionals for three or four hours a year, but the rest of the year they are in free fall. We need to ensure that they have a parachute so that they have some way of getting safely to the ground.

[51] **Mark Drakeford:** We are into the last 10 minutes. Lindsay, Mick, and possibly Elin, might also want to come back, so we will try to make sure that we cover all these questions.

[52] **Lindsay Whittle:** Thank you, Chair; I will try to be brief in that case. I have two questions. One of the first events I attended when I was elected in May 2011 was a diabetes awareness event in the Assembly. I met a young man from Oakdale—I am sorry I cannot remember his name—who had an insulin pump attached to him. I notice in your evidence that you say that we are not following the NICE guidelines. In Scotland, £1.5 million is ring-fenced for this and £2.5 million in Northern Ireland; in Wales, I guess, it is nothing. That should clearly be ring-fenced. I appreciate that you say in your evidence that it is not suitable for all people with type 1 diabetes, but I am sure it would have a tremendous impact on people's lives.

[53] **Mr Williams:** We see this when we go to places like Germany and America. Just to correct you slightly, it is not a NICE guideline; a NICE guideline is advice freely given and taken, so to speak. This is a NICE technology appraisal, which is mandatory, which means that there is a legal obligation to fulfil it and we are not doing it. As we have said, Scotland and Northern Ireland are taking it seriously and are delivering on it.

[54] Pumps are not right for everyone, as we have said. The context is very easy and the bottom line is: your pancreas is continually fine-tuning your insulin needs to whatever you are doing and you do not even think about it. You are asking someone with diabetes without a pump to make a rough guess as to where they are six times a day. If you have a pump, it is delivering insulin every few minutes and you can change it and fine-tune it depending on the kind of meal you had. If that carbohydrate is delivered quickly, then it delivers a burst of insulin quickly. If you had a curry for example, it will fine-tune that insulin delivery over six or seven hours. It takes that long and goes right the way through, but you have a fighting chance. If you are controlling it, the outcomes are better. It is not right for everyone, but the bottom line is that you are legally entitled to a pump if it is clinically appropriate. That is not happening in Wales, and I get many parents and many adults who are very upset about this. Somebody said to me, 'I've had diabetes since I was six; I am now in my early fifties and it is the first time I feel in control'. That should not be happening; we have a legal responsibility

that we are not delivering on.

[55] **Lindsay Whittle:** That is clearly a recommendation, Chair. Secondly, your evidence said that around 66,000 people in Wales are walking around with potential diabetes. How can we all, including the voluntary sector and health authorities, help identify and warn people?

[56] **Mr Williams:** There are two things. One is that you need to explain to people that diabetes is dangerous, as I have said. They need to be aware of diabetes. There have been no public health campaigns and nothing from Public Health Wales on this. I refer you back to the flu epidemic to look at the activity there. Secondly, one needs to do a basic risk assessment. This is not complicated. The risk factors include diabetes being genetically in the family, and lifestyle. There is some very good evidence for basic risk assessment, but we have not been doing it in Wales.

[57] Diabetes UK held a pilot scheme a few years ago. We did it for a fortnight with the help of the BBC and we managed to sign up every chemist shop in Wales. They all did risk assessments. Within 10 days, we risk-assessed 20,000 people. That has happened once with the BBC, once officially with pharmacies in Wales, and again with pharmacies in Wales when the Stroke Association came on board with us. That is not going to happen next year. The pharmacies have put in a submission of their own here. They have a terrifically big role: you are walking down the road and you see a poster and it is easy to go into a pharmacy there and then have a risk-assessment done. The wonderful thing about that is that it is a window of opportunity.

10.15 a.m.

[58] If you explain to someone that they are in danger and that they should do something about it, you also explain the cause of danger. You cannot do anything about genetics obviously, but you can change lifestyle and that is the window of opportunity here. I would highly recommend providing an ongoing risk assessment in pharmacies. It costs virtually nothing—we funded the last ones. That would make a huge difference. All pharmacists are trained and have been doing it for the last few years. That would be part of their routine. We should open the door to greater involvement with pharmacies so that they can provide lifestyle advice in the context of a broader public understanding of the dangers of diabetes and how to mitigate those dangers. That would be a way to move forward.

[59] That is a way to move forward not only on diabetes, because there is always a negative spin on the condition: it is the major cause of kidney failure, blindness, amputations, stroke and heart attacks. So, this offers a window of opportunity. Being told that you are at risk of diabetes is not necessarily a negative matter because you get an opportunity to correct it before you are faced with the consequences of ignoring it. This will not only be effective against diabetes, but will have a huge impact on other long-term conditions. So, it is an early warning system. If we respond to that appropriately and quite cheaply by using pharmacies, and with the appropriate public support, we can move forward; it is basic communications. One might ask where public health is on this, because that is what I understand its role to be.

[60] **Mick Antoniw:** You have mentioned the area that I wanted to ask about, namely community pharmacies. Since the standards framework, the whole thinking about the role of community pharmacies has developed quite considerably. All sorts of issues arise in terms of the link between GPs, hospitals, exchange of information and records and so on. However, in terms of moving forward, would you place a much greater emphasis on community pharmacies as a delivery point for that whole educational programme rather than on GPs or hospitals or other mechanisms? Where do you see that fitting in because there is always the danger of confusion and of people duplicating work and so on?

[61] **Mr Williams:** There is no danger of duplication at the moment. We are free from that. We all have a role to play. The first point to make, as you said, is on the general awareness of diabetes. At the moment, most structured education is delivered through secondary care, but that is a case of closing the stable door after the horse has bolted. Diabetes specialist nurses are hard-pushed and are specialists, but they are giving basic dietary advice to people who have had diabetes for 10 years. That is way too late, and why are they doing that? There should be awareness of the condition from the start and that is a public health remit.

[62] We are bad at delivering information on risk. You do not say, 'If you do not do something about this, you will lose a leg or a kidney or whatever'; that is a negative way of doing so and tends to send you into a spiral of fatalism when you end up doing nothing. Communicating risk is about choice at the end of the day. If you say to people, 'If you do not do something, there could be dire consequences, but if you do something and lose a stone or so, this is how we will help you: here is a book to help you through it and you could feel five years younger.' That is a choice—either you have a dodgy illness or you feel five years younger. That message should be communicated by public health. People should go to their pharmacy to get a risk assessment and basic dietary information. The nutritional information currently given is in the form of proteins, carbohydrates and fats. The levels of health literacy in Wales are low. People do not eat carbohydrates, fats and proteins; they eat fish, chips and bread. We need to help people to understand this information through food labelling and supermarkets. There are all sorts of ways in which we can help with that.

[63] We need to provide structured education through primary care a long way upstream so that when people are diagnosed and have that window of opportunity to change, we can supply them with the means to change. We are not doing that at the moment. So, there is a role for public health, supermarkets, pharmacies and primary care to alleviate the pressures on secondary care. Specialist nurses should not be doing this work. In-patients with diabetes are currently at 19%. Those are people who might have fallen off a bike, ladder or whatever. They are in hospital for other conditions besides their diabetes and the fact that they have diabetes means that it will be worse by the time they get out of hospital and that they will be in there for three or four days longer. That is expensive. At 19%, reducing those three or four days per patient is a lot of money saved. So, the education needs to be right across the board and not just for the public.

[64] As we have said, the figure for insulin errors in Prince Charles Hospital was 60% in some places. That is a lot of errors. There needs to be a general awareness of diabetes. Health professionals not dealing with diabetes is not our problem; it is everybody's problem because wherever you are in hospital and wherever you are nursing, you will come across somebody with diabetes. You need a rudimentary knowledge that these patients need special attention. There needs to be a general increase in the education process across the health service and across Wales, tiered to the specifics of the individuals who are receiving the care.

[65] **Mick Antoniw:** If you were to sum up, what would you want community pharmacies, for example, to focus on with regard to their functions? If you were making a recommendation now about their role—you have talked across the board and I understand that—what would you say is the most important contribution that they could make?

[66] **Mr Williams:** At the moment, I would say risk assessment.

[67] **Mr Harding:** There is a realism that is required here. Up until 2015, health budgets are going to be reduced in Wales, right across the country. There are 350,000 people in Wales who have higher than average blood glucose levels, which is termed as pre-diabetes. Those people would benefit from some basic medical advice on diet and exercise, because they are 15 times more likely to develop diabetes and they are also likely to develop other chronic

conditions, which they are just waiting to develop. If you do not utilise pharmacies and just rely on primary and secondary care, with reducing resources and massive population groups with new waves of people coming through who potentially have these conditions, the system is not going to be able to cope. It is more a question of whether there are any other options to not include them.

[68] **Elin Jones:** Do you think that there is resistance within the NHS to having a major on-going campaign on diabetes awareness and checking for symptoms of diabetes, because if the 66,000 were to be diagnosed tomorrow, they would all want the nine tests? There is also the £350,000 that it would cost GP surgeries to monitor that population as well. Do you think—though not as a conscious decision by a Minister or a civil servant—that the system is wary of attracting too many patients into its service if it promotes the issue too much?

[69] **Mr Williams:** At the moment, there is certainly a problem with structured education because we do not have the facilities to deliver it. The bottom line is: the sooner you catch diabetes, the greater the awareness of dealing with it, because you are catching it upstream. If that means that more people have to have standard tests, which include testing blood pressure, lipids and so on, then they need those. That is much better than presenting with diabetes, receiving a diagnosis and being told that there are complications because it has been unrecognised. It is a much cheaper intervention. The earlier that people are identified and can be equipped with the skills to cope with their condition, the less problematic the complications will be. It is common sense.

[70] **Mark Drakeford:** Thank you. I am sorry that we have run out of time so quickly; I am sure that there is much more that people would have liked to ask you about this morning. We have heard some interesting answers, combined with the information in your written submission, about the key actions that you think need to be in the next plan to make sure that the national service framework gets delivered. In reflecting on this morning's session, if you think that there are key recommendations that we, as a committee, should make to the Government about things that it must include in the next plan and make sure they happen, that would be very helpful for us when we think about things that we want to identify as key priorities. Diolch yn fawr.

10.24 a.m.

**Ymchwiliad i'r Gwaith o Weithredu'r Fframwaith Gwasanaeth Cenedlaethol
ar gyfer Diabetes yng Nghymru a'i Gyfeiriad yn y Dyfodol—Tystiolaeth
Lafar gan Goleg Brenhinol y Ffisigwyr, Cymdeithas Diabetolegwyr Clinigol
Prydain, a Chymdeithas Feddygol Prydain
Inquiry into the Implementation of the National Service Framework for
Diabetes in Wales and its Future Direction—Oral Evidence from the Royal
College of Physicians, Association of British Clinical Diabetologists, and
British Medical Association**

[71] **Mark Drakeford:** Bore da, a chroeso ichi i gyd. Diolch yn fawr am ddod i'n helpu y bore yma yn ein hymchwiliad i'r gwaith o weithredu'r fframwaith gwasanaeth cenedlaethol ar gyfer diabetes ac i'n helpu i feddwl am yr hyn y gallwn ei wneud yn y dyfodol. Croeso i Dr Meurig Williams, cynghorydd rhanbarthol Cymru yng Ngholeg Brenhinol y Ffisigwyr, Dr Aled Roberts o Gymdeithas Diabetolegwyr Clinigol Prydain,

Mark Drakeford: Good morning, and welcome to you all. Thank you for coming to help us this morning with our inquiry into the implementation of the national service framework for diabetes and to help us to think about what we can do in future. I welcome Dr Meurig Williams, regional adviser for Wales at the Royal College of Physicians, Dr Aled Roberts from the Association of British Clinical

a Dr Ian Millington a Dr Mark Temple o Gymdeithas Feddygol Prydain Cymru. Fel arfer, gofynnaf i chi am unrhyw sylwadau agoriadol byr. Ar ôl hynny, byddaf yn troi at aelodau'r pwyllgor, a fydd yn gofyn cwestiynau. Pwy sydd am ddechrau?

Diabetologists, and Dr Ian Millington and Dr Mark Temple from the British Medical Association Wales. As usual, I ask the witnesses for any brief opening comments. After that, I will turn to committee members to ask their questions. Who would like to begin?

[72] Is anyone going to begin by offering us some brief opening remarks?

[73] **Dr Williams:** Diolch am y cyfle i ddweud rhai geiriau agoriadol.

Dr Williams: Thank you for the opportunity to make a few opening remarks.

[74] I have two or three brief points. First, in setting the standards of the Wales diabetes national service framework almost 10 years ago now, one of the main beneficial effects has been to reduce the variation in the quality of care throughout Wales. I remember speaking to a focus group of patients just before the NSF was introduced in my patch in west Wales—I am also a practising consultant diabetologist and have been treating diabetes for 35 years—and one of its main concerns was the variation in the quality of care. Whereas one surgery offered very good diabetes care, the other surgery down the road hardly offered any diabetes care at all. The NSF has helped enormously to reduce the variation in quality.

[75] My second point is that we have found it frustratingly difficult to measure progress with regard to attaining these NSF standards. That is a theme that I may come back to later. Our information systems are not up to it. There is no joined-up information system. My third and final point in my opening remarks is that the NSF is dated. It is 10 years old, and diabetes has moved on tremendously. The treatments for diabetes have changed in a major way in the last 10 years. About half the drugs we now use in diabetes were not developed 10 years ago. There has also been a huge increase in the number of people with diabetes. Our local numbers show that the number of people with detected diabetes in Carmarthenshire in the last 12 years has gone from just over 5,000 to 10,500. That is an illustration of the huge challenge we have had with regard to deploying resources to try to provide good-quality care.

10.30 a.m.

[76] **Dr Millington:** I would like to develop some of those themes. I agree that the number of cases is increasing. There is some ethnic variation, which can be important for some of the larger cities. The complexity of the cases has increased and the complexity of the medication has very much increased in secondary and primary care. Unfortunately, the resources have not matched the increase in numbers and there are some areas where, as GPs, we have great difficulty in obtaining services for all of our diabetic patients.

[77] Dietetics and podiatry are specialties where there is quite a shortage; no more than half of our patients can access those services in the community, which is a serious indication of how the numbers have increased. With 80% being dealt with in general practice, there is an issue about diabetic specialist nurses, which are almost exclusively outreached from hospitals. We could do with that resource being available for the more complex cases in primary care as well.

[78] With the NSF, the important thing is that there are significant differences between type 1 and type 2 diabetes and that does not necessarily come across in the NSF as it stands. There is a case for making it clear that they are almost like two disease processes, or even for having two NSFs. To pick up on the information issue, that is one area where general practice does step forward and information bases are very good. I was involved in the development of the choice of codings for the diabetic NSF, which at least gives us some data to go on.

[79] Basically, diabetes is not a medical problem in its early stages; it is really about the population and obesity and about getting in early—starting in childhood. The Welsh Medical Committee has presented the Minister with a good report on obesity, which concentrates on prevention and deals with some of the more severe obese cases as well.

[80] Finally, if we are going to address diabetes and prevent it, it is not a medical problem at that early stage; it is a population problem. I am sure that Dr Mark Temple, as a public health physician, might want to add to that.

[81] **Mark Drakeford:** Dr Temple, would you like to do that now, or pick up on it during questions?

[82] **Dr Temple:** Shall I pick up on that in questions? I am sure that the committee will ask about it.

[83] **Mark Drakeford:** I am sure that they will. We have 50 minutes only and four people to question. So, not everyone will be able to ask every question. I am sure that you understand that I am keen to get as many questions in as possible; I will go to Elin, then to Lynne, then Kirsty and then anybody else who wishes to come in.

[84] **Elin Jones:** Dr Williams, dywedaso ch nad oes efallai system integredig o wybodaeth yn gweithio'n lleol neu'n genedlaethol ar hyn o bryd. Rydym wedi clywed tystiolaeth eisoes gan Diabetes UK, a gododd bryderon sylweddol iawn ynglŷn â'r diffyg rheolaeth genedlaethol o'r fframwaith gwasanaeth cenedlaethol. Mae gwaith da yn digwydd yn rhai ardaloedd yng Nghymru o fewn gwahanol fyrddau iechyd, ond nid oes gyriant cenedlaethol o'r fframwaith a dim atebolrwydd cenedlaethol i Lywodraeth Cymru. A oes gennych sylwadau ynglŷn â hynny?

Elin Jones: Dr Williams, you mentioned that perhaps there is not an integrated information system working locally or nationally at the moment. We have already heard evidence from Diabetes UK, which raised significant concerns about the lack of national management of the national service framework. There is good work being done in some areas of Wales in different health boards, but there is not a national drive of the framework and it has no national accountability to Welsh Government. Do you have any comments on that?

[85] **Dr Williams:** The integration of diabetes services is an all-important step that, largely, we still need to take. We seem to be living in silos still. There is some excellent practice in primary care and some very good practice in secondary care and, unfortunately, communication between the two is often lamentably lacking.

[86] With a chronic disease such as diabetes, which is an excellent model for other chronic diseases, such as cardiac disease, kidney disease and stroke, et cetera, patients will inevitably, during the course of their disease, which goes on for many years, as we know, be moving from one part of the health sector to another, between primary and secondary care. We need communication and information systems that track that movement. Ultimately, many of these people end up housebound or in care homes and then they become totally inaccessible. So, we have to shore up community services to get at these people.

[87] There are patches of good diabetes care, and I would point to what we are trying to achieve in Carmarthenshire with the appointment of diabetes specialist nurses in the community. They have been working there for the last six years or so, and they have been able to provide good diabetes care to these hard-to-reach groups, which, hitherto, had no diabetes care at all. We also need other members of the hospital-based diabetes team, and Ian has spoken about the lack of podiatrists and dieticians, who also form part of the core diabetes

team in the hospitals, as do consultants. We all need to do much more work in the community to support primary care, in the management of complex diabetes in particular. Much of diabetes management is fairly straightforward, but when people start to get complications and comorbidities, then it can become very complicated. We need to look after many of those people in the hospital setting, but others can be looked after outside the hospital setting, provided you have very good community services that also support primary care.

[88] We need electronic information systems and I am sure that Diabetes UK Cymru has mentioned those to you this morning. We need those not only to be able to track on an individual patient basis—to have all the comprehensive information about individual patients and to avoid duplication of care, which is occurring in the two sectors—but also to be able to aggregate that information to measure whether we are achieving the targets that we set for ourselves. I am sure that you have heard of the Scottish system, which I have been to observe on two occasions. Indeed, only two weeks ago, I was up in Edinburgh being shown exactly how it works. We are planning to adopt such a system throughout secondary care in Wales. The terrific advantage of this system is that it picks up information from the GP systems—the EMIS and the Vision systems—and creates a two-way traffic system. So, the information is put into the system in a hospital setting and, no doubt, in the community setting in time, for example by community pharmacies—their drug lists are important, given that they probably hold the most accurate or very good data on medications—which means that we can have joined-up information.

[89] **Mark Drakeford:** Does anybody want to add anything to that? Ian?

[90] **Dr Millington:** I just want to say that the information systems in general practice are very good. There are developments that will enable the sharing of that information, but most of the patients are looked after in primary care, with very little reference to secondary care. Most of the referrals for patients with diabetes to secondary care are often because of complications, not because of the diabetes, and it is a multifactorial and a multidisease process if it deteriorates, so one needs to have an overview of that. That is when you need a general physician, and the best general physicians at the moment are general practitioners.

[91] **Elin Jones:** I want to ask about the diabetes planning and delivery groups; I assume that all health boards have these groups. We heard reference this morning to their being a vehicle to allow that integration of discussion and decision at a local level or a health board level, but that they need to work as a managed network rather than just as a meeting every three months, with people going away and doing nothing and then turning up to the next meeting in three months' time. So, it should be a managed network. We had that message quite clearly this morning. Do you have views on that?

[92] **Dr Millington:** With diabetes groups, the problem is that parts of diabetes are very exciting for doctors, while parts of it are really about regular monitoring and management. Sometimes, the regular monitoring and management takes second place to the exciting developments, but the numbers requiring day-to-day monitoring and management are huge, while the numbers involved in the more exciting stuff are much more limited. So, we have to be careful that we balance one against the other; otherwise, we end up with a *Tomorrow's World* scenario where everybody thinks that that is the only way forward. However, there is a case for the groups. They are not quite as developed as they might be, and they have grown up with the exciting developments rather than the day-to-day management that is required for most patients.

[93] **Dr Temple:** I am going to speak slightly outside my official position. I am a type 1 diabetic, so I will speak as a patient rather than as a medic on this occasion. The biggest difficulty, echoing what Ian said, is that what you really need as a diabetic patient is a good general physician, especially if you have type 1 diabetes, as I do. I have had diabetes for 40

years. I have seen numerous consultants and hospital teams, and I have moved around the country. You want somebody who looks after you and your diabetes, not your diabetes with you as a secondary consideration, and that needs to be a general physician. When you have a problem, you want a specialist to dip in and deal with it, but your day-to-day care is run by you and your advisers, not by the hospital or the GP, because they are not with you 24 hours a day. This is a 24-hour-a-day, 365-days-a-year condition, and you need to be sure that you can get the support that you need where you are and when you need it. That means good primary care, and that means not merely good GPs, but GPs who have access to good specialist nurses, good podiatry and good eye support. That is what it is about. Anything else, I am afraid, is just icing on an interesting cake. Whether you want to eat it or not is a separate question.

[94] **Dr Roberts:** I have a comment about DPDGs, but I first want to clarify that I am a diabetologist in Cardiff, but I am here to represent British clinical diabetologists. Public health, general practitioners, secondary care practitioners, dieticians and pharmacists are quite well represented on our DPDG in Cardiff, so we have quite a powerful forum, but one wonders at times who is listening, to echo the previous remarks. We discuss what is happening on a local basis, but we are not really involved in the strategic efforts of our health board, it seems to me.

[95] **Dr Williams:** I would echo that, as far as our DPDG in Hywel Dda LHB is concerned. Again, we represent all the vested interests in diabetes, including a powerful patient group, but the missing link is that the management of the health board itself is not fully engaged.

[96] **Mark Drakeford:** Thank you. That was exactly Elin's point.

[97] **Mick Antoniw:** To come back, you seem to be saying that a lot of good work is going on and that a lot of new lessons are being learned as advances are made, but when it comes to having a national standards framework, the framework is not operating as such and there are no benefits from that. I was particularly interested in the point that you were making, Dr Temple. We have had and will have further evidence on the role of community pharmacists, whether in education or in risk assessment and so on. Where do you think they fit into this? What particular role would or could they have, subject to the technology, the information exchange and so on? We hear different viewpoints expressed by different sections of the profession on this.

10.45 a.m.

[98] **Dr Millington:** We work closely with community pharmacists. There is a good case for community pharmacists doing the monitoring of the day-to-day part of diabetes. That is certainly a role. To go back to the point that I made about diabetes, it is really a condition, and it often overlaps with many other conditions. Most of my patients who have diabetes have other conditions, and when you get into the complexity of management, you probably need the overall skills of a general physician, who, in the main, is a general practitioner, to take a view, because it is not a simple process when you are dealing with multiple diseases, and multiple drug regimes, and a little bit of knowledge. I held my hand up for more than 40 years of that. That helps when you are taking forward complex cases. There is a real role, certainly for early detection, but we have to be very careful. We know that there are many cases out there that have not been discovered, and if you go for early detection and you pile those cases on top of the presently overloaded system, the resources just will not cope.

[99] **Mark Drakeford:** We heard a bit about that earlier.

[100] **Dr Temple:** In my experience, I am a type 1 diabetic, so I am in the minority group

that is always getting overlooked and lumped with the majority group. For us, our diabetic needs are very simple: give us the insulin, give us the monitoring kit, and we will do the rest. For the rest of our illnesses, we go to our GPs and we try to stay out of hospital, apart from the diabetic service, because if we have to go into hospital, the one thing you can guarantee is that our diabetes will not be looked after properly, because they will take our insulin away. That is standard—or it used to be. It is not quite anymore.

[101] As far as type 2 diabetes is concerned, I would echo what Ian says. We are actually dealing with a very complex thing, and, yes, of course the community pharmacist has a role, but then so does everybody else. So do all of you in this room, because you have the power to stop the environment that people are living in, which is generating diabetes. That is your power and, to date, I am afraid, politicians have not used that power to prevent the diabetes epidemic. You can do it. It is up to you, but you have not done it. So, actually, it is everybody's problem, rather than being someone's problem. So far, nobody has been prepared, apart from the health professionals, to try to do anything about it. It is really a community problem, type 2 diabetes; hence, it is everybody's business. All of you have a role in helping diabetics to look after their lives. We are talking about 5% of the population.

[102] **Mark Drakeford:** We are going to try to push ahead with a few other questions, because everybody is keen to ask one.

[103] **Lynne Neagle:** I have two questions, one on care and the other on prevention. We have had evidence that a significant proportion of people are not getting the nine annual health checks that they are meant to have, and which of course are covered by the national service framework. I wondered whether you could say a little about why that is, and whether there is anything that we could be recommending that would address that.

[104] Secondly, on the issue of prevention, the BMA paper talks about the importance of public health and says that we need a public health campaign, and that

[105] 'This could include an element of compulsion, such as the introduction of robust legislation'.

[106] I wondered whether you could say a little more about what you think that should cover.

[107] **Dr Millington:** Shall I take the first question, and perhaps Mark will take the second? Delivering on care is incredibly difficult in general practice at the moment. The work has increased exponentially, but the resources have not matched it. Most GPs do what they can. They do not go to work to be a bad GP, but they do not always have the resources. The management of diabetes is a team approach. It is certainly not just down to the general practitioner. If you go into any general practice treatment room, you will see that they are overloaded at the moment. General practice is struggling, and that may have something to do with it. The numbers are increasing. When I qualified, we were told that 2% of the population were diabetic, of which 1% was known. We are now above 5%, and, in parts of the country with high ethnicity, it is above 10%. The resources have not matched that, and that is why they may not be getting it. It is not for a lack of effort. The one thing that we have not said is that patients are not always aware of the importance of some of the care that is required. Often, it is seen as what others do to them, not what they do for themselves. We really have to raise that profile as well, and that can be incredibly difficult with a fatalistic population in an incredibly poor area of Wales, such as in some of the areas where I have worked. That can be very difficult.

[108] **Mark Drakeford:** Mark, what is this legislative compulsion?

[109] **Dr Temple:** There are a number of things. For a start, the whole environment is highly obesogenic. If you go down through the city centre, you will see lots of fast food outlets. I will sound like a moralising preacher now, so please forgive me, but it is a part of my job to point out what is wrong in society. We encourage people to snack, and to snack on high-calorie, high-fat foods. Fat has been labelled as bad, so we are replacing fat with complex carbohydrates that are relatively simple, and, to enhance the flavour and ensure the preservation of foods, we increase the sugar content. All that leads to obesity.

[110] I remember, when I was a GP, seeing a 14-year-old and I was devastated to discover that he had maturity-onset diabetes. It is unbelievable to see that in a young man of Welsh origin—and this was not an ethnic person by any stretch of the imagination—who was not at that point a properly established teenager, and yet, as far as his body is concerned, he was a mature individual. That was because he was eating too much energy-rich food and not taking any exercise. It is no good our blaming him. He lives in a society where children are put in front of televisions. Why are they put in front of televisions? Because televisions are on 24 hours a day, so that the television companies can make money. Why are snack foods available? So that snack food companies can make money. We really have to face the fact that, either we can serve what used to be called God, or we can serve what used to be called mammon. At the moment, we are serving money making. I am sorry if that sounds moralising and preachy, but the consequence is that people's health suffers. People will put on weight, they will grow fat, and then they will develop diabetes. That, I am sorry, is the way it is. We need to face some fairly robust questions about whether the liberty of the individual to become fat and have a good time should be matched by not spending money on preventing them from getting fat and looking after the consequences of that. That is what we are facing at the moment. We have allowed people to become fat, and we have not put steps in place to treat the consequences of that.

[111] **Lynne Neagle:** Obviously, not all the levers are devolved to the Welsh Government, but is there anything specific that you would like to see the Welsh Government doing to tackle this problem that it is not doing at the moment?

[112] **Dr Temple:** I would love to see the technical advice notes to planning authorities looking at the concentration of food outlets, licensed premises, et cetera, because they encourage people to snack their way down the high street, as it were. There are fast food outlets in every town and everybody thinks that going there is a normal thing, and supermarkets also produce massively processed foods. We have to encourage people to go back to get their food from the land, to prepare it and to eat it. A good, balanced diet, which I am sure my colleagues in the dietetics department will encourage, is good for everybody, and it helps to prevent diabetes, too. It is fairly fundamental that we encourage the production of food to give to people in their homes, and not food that comes via a factory.

[113] **Dr Roberts:** This comes back to the basics of the NSF, and we should be empowering and educating patients who have diabetes and people who do not to make good choices. The way in which the NSF asks us to do this is to provide structured education. I can speak for my area by saying that we barely scratch the surface with type 2 diabetes education, and we do not provide type 1 diabetes structured education. This is something that clinicians within our organisation across Wales have been campaigning for in health boards, and it is still something that we fail to provide. That is the message that needs to come strongly from this committee.

[114] **Mick Antoniwi:** Are school dinners within satisfactory parameters? You may not know the answer.

[115] **Dr Temple:** I do not know the details of what is in school dinners, but I believe that Jamie Oliver did something about trying to improve the quality of food. When my children

first went to school, school dinners were cooked in the school. When they left school, it was all cafeteria-type food, with food brought in from central units, because it was more cost-effective. It put 'nutrition' on my daughter's plate at lower cost. Once again, we find that it was not the quality that was thought about, but the price. I am afraid that one thing that I thought was that investing in good food for your children was a good investment for the nation. It was what Winston Churchill said when he introduced school milk.

[116] **Dr Williams:** On this general theme of prevention and early detection of diabetes, patches of good activity are going on as far as public health in Wales is concerned; for instance, there are community activity programmes, healthy schools schemes and health and wellbeing strategies. However, we need much more of this type of activity. That requires a population-wide approach, but, with regard to the individual approach—Aled emphasised the importance of individuals knowing what the score is—we are lamentably lacking in the early identification of diabetes.

[117] We have a very strong evidence base to say that, when you do these health checks on people, not only do you identify all those thousands of people whose diabetes is present but not known to them yet, but you also identify—and Jason from Diabetes UK Cymru mentioned this point—an even larger number of people who are very likely to develop diabetes over the next 10 years or so. We are not addressing standards 1 and 2 of the NSF. We have evidence that, if those people who are most at risk of having diabetes, with what we call pre-diabetes, are able to change their lifestyle—we have various approaches to doing this—they will reduce their risk of progressing to diabetes by 58%. That is a phenomenally effective way of preventing the consequence of this obesity epidemic that we have in western countries in general.

[118] So, I would make a plea that we really need to put some resources into doing systematic health checks on people. I am not alluding to the online cardiovascular check for the over 50s—that will widen health inequalities, because it will be the computer-literate people in society who will go for that. I am talking about systematic health checks, asking people to come in for a simple health check that will not only tell them about their diabetes risk, but also their risk of developing heart disease, stroke and kidney disease. There are NSFs for all those three conditions with shortcomings in prevention and early identification.

11.00 a.m.

[119] **Kirsty Williams:** We heard evidence this morning—you alluded to this earlier, Dr Williams—that there have been significant developments in treatment technologies for diabetics, and we heard from Diabetes UK this morning about the inability of clinicians to give people the very latest and best treatment. Do you have any views on that?

[120] Dr Temple, several times this morning, Diabetes UK said, 'Where is public health?'. Can you talk about some of the challenges that Public Health Wales faces and the impact that those have on the ability of public health doctors to respond to diabetes? It seemed that no-one disagreed with the contents of the NSF. Everyone knows what needs to be done, yet we find it nigh on impossible to get there. The Minister says that the standards will be met by 2013, which is very close now. Diabetes UK said that that is not going to happen and, from what you are all saying this morning, it seems that you all acknowledge that that is not going to happen. What is the single most important thing that we could recommend to the Minister for Health and Social Services to allow you to do what you need to do as people who do not just talk about diabetes but who actually deal with diabetes?

[121] **Dr Millington:** The simple answer is time. We need time with patients. A great deal of the education does not require a doctor. It may not even require a nurse. However, when you get to the patient, you need time to manage their condition. That is a very difficult thing

to generate in the current climate in general practice. If we had more time, and if we had more resources, we could do more. Time is about the team, not just the general practitioner—that is nurse time and everything else. We are providing the dietary advice because there is no-one else to give it. The podiatry is not being done, so we are having to deal with the complications. So, time is the answer and, with the increase in the number of people with the condition, it is getting harder and harder to find that time.

[122] **Mark Drakeford:** Dr Temple, where is public health?

[123] **Dr Temple:** We are drowning. Of all the branches of healthcare, we are the only one that has had a 25% cut since 2000. You are asking us to do more. We would love to do more, but please give us the tools—and that means people. We need the funding. We are facing the same cuts as everyone else, but we had already had a cut before these current cuts. I am sorry, but that is the case. In 2000, there were 56 of us; there are now 30. Ask us to do a bit more and we will struggle. We will do our best, but we cannot be asked to fit 10 quarts into a half-pint pot. We have been shrinking. The problem is that public health has been cast as wooliness and so on. Actually, we do some pretty hard and nasty things some of the time. I would echo what Ian said; one of the problems has been that everyone has been in a rush to get everything done today. Some things take a bit of time.

[124] Going back to my role with patients, the one thing that infuriates me is that, when you finally manage to get to see someone, you get two minutes. You barely have a chance to explain the complications and complexity that you are facing and you want help to be steered through that morass when you are told that time is up and someone else is waiting. Actually, it is the case that someone needs to give patients and healthcare staff the time. That means that we need more people. I am sorry, but that is the way it is.

[125] **Kirsty Williams:** Would you be good enough to supply the committee with a note on the fall-off in the number of public health doctors in Wales? A great deal of what we hear about in committee is to do with public health. It would be very helpful to have some data on how public health has been going over the past decade.

[126] **Dr Temple:** I will do my best to provide that as quickly as possible.

[127] **Mark Drakeford:** That will be very helpful.

[128] **Kirsty Williams:** I want to ask about the technologies and the latest treatments. Do you have access to those?

[129] **Dr Williams:** Access is still a little patchy. Mark mentioned the insulin pump. That is a fantastic advance in the management of type 1 diabetes, but it is more expensive than giving insulin in the way that we have in the past. However, because it provides better control of the diabetes, the investment is worthwhile. It will be very cost-effective in the long run in reducing the number of advanced diabetic complications. I would remind the committee that more than 50% of the cost of diabetes care lies in the treatment of diabetic complications. Kidney dialysis costs well over £30,000 per year. With lower limb amputation, I am familiar with prices that are now 10 years out of date, which would be £35,000 for each lower limb amputation. It is phenomenally expensive. There is a huge variation in the rates of lower limb amputation in England. There is a fivefold variation between areas in England. We do not know what the variation is in Wales, because we do not have the information systems that will enable us to track that down. I will come back to the information systems, because that is a new technology, I guess. We need some investment there in order to be able to do these measurements and this benchmarking of different services and providers, and identify those places that are not performing up to standard so that we can remedy the situation to provide good care for the whole of the population, and not just in patches.

[130] **Dr Roberts:** Just to add to that quickly, on the theme of time, as hospital clinicians we spread ourselves between in-patient care for people with diabetes and others. I agree with the point made that hospitals are a dangerous place for people with diabetes. In our hospitals, 10% of the diabetic population are having a hypo every day. We are not very good at managing it. Some 18% of the hospital population are people with diabetes. It is a big problem. We are in the communities supporting GP practices, and we are in the clinics supporting the technological advances that Meurig has just mentioned. We have plans to develop all of these areas. As diabetologists, just like other people managing chronic diseases, we are a powerful resource for decision-making and managing acute streams. That is seen as core business in hospitals; therefore, there is a conflict between the care that we want to provide for people with diabetes—a horizontal approach that we all have plans for—and providing care for what is seen as core business by the health boards.

[131] **Mark Drakeford:** So, you get pulled away from the horizontal work to deal with the flow through of patients that are coming just through—

[132] **Dr Roberts:** I think that we can relate to that, as physicians.

[133] **William Graham:** I wish to ask you a bit about bariatric surgery. I appreciate that, obviously, it is a consequence of what you have already described. It is a possible interim solution, hopefully avoiding further complexity. Is that something that we could emphasise?

[134] **Dr Roberts:** It is an option. Obviously, we are limited in Wales in terms of how many procedures can be undertaken. There are data continually emerging about the management of diabetes with bariatric surgery, and it is hotly debated. Clearly, we do not cure diabetes with bariatric surgery. It is a treatment, like any other treatment for diabetes. Diabetes will eventually return if lifestyle options are not the correct lifestyle options. It is definitely a powerful tool. The most recent evidence suggests that it is cost-effective, compared with two years of therapy. So, there are a lot of data emerging. It is just not on our radar at present, because we are limited to the number of referrals that we can make. Specifically, I feel that we are being asked to refer the wrong sort of patients. The patients that we have been asked to refer have probably the highest anaesthetic risk during these procedures, and we are probably targeting the wrong group. Again, I guess that that is up for debate.

[135] **Kirsty Williams:** Is that because they have to have such a high BMI before they will be considered? I have constituents who cannot get surgery and are eating themselves to that higher BMI so that they can get the surgery.

[136] **Dr Millington:** That is covered very well in the Welsh Medical Committee report to the Minister, where bariatric surgery was one of the key areas. One was about prevention and the other was about bariatric surgery because it was felt that these were the two areas that were perhaps not as well addressed as they could have been, and we are hoping that the Minister will comment on that report.

[137] **Mark Drakeford:** Is that a publicly available document, or was it specifically for the Minister?

[138] **Dr Millington:** I am not absolutely sure about that at the moment; I suspect it is not in the public domain at the moment because it has gone to the Minister. The Welsh Medical Committee is a committee of doctors who have looked at this and it was a very well-written paper by Dr Peter Stephens and one of the consultants who specialises in bariatric surgery. That, I think, would perhaps answer some of the questions you may wish to raise. It has been done by experts rather than by a jobbing general practitioner.

[139] **Lindsay Whittle:** I have seen insulin pump therapy in practice. The Scottish Government and the Northern Ireland Government ring-fence money, but the Welsh Government does not. I know it is not suitable for everyone with diabetes type 1, but it can help a lot of people. Should our recommendation to the Government be to ring-fence some money for this?

[140] **Dr Williams:** As far as I understand, health boards are given a block grant and, out of that, they are supposed to find money for various treatments, including expensive treatments. So, as far as I am concerned, it should come out of their budget. That happens in the health authority that I work in. There is quite a variation in the percentage of people with type 1 diabetes who are having pump treatment. NICE recommends that we should be treating about 10% or 12% of our type 1 population. We are treating those sorts of numbers in the Hywel Dda area, but it varies a lot. I think Cardiff and Vale LHB is similar, as far as I know, but there are other areas in Wales where the numbers are less. I do not know where the problem lies, whether it is a resource problem from the health authority, or a lack of expertise on the ground. It is a very labour-intensive thing as far as the secondary care diabetes team is concerned.

[141] **Dr Roberts:** I would agree with that. We are not up to those sorts of figures in Cardiff, but we do have an up-and-running pump service. It comes back to some other points that we have raised. We struggle to provide the resources to provide the type of pump service that we wish to, and this pump service is not just available for people with type 1 diabetes across the piece; we use pumps in women who wish to become pregnant and who want to improve their diabetes care, or who are pregnant and need to improve their diabetes care. These services have to interdigitate and, as I have explained, we struggle with our current resources in the climate in which we work, with the vastly reduced amount of time that specialist diabetes nursing colleagues, who are being pulled in any number of directions, have to be able to provide that sort of service in a way in which we would want.

[142] **Mark Drakeford:** If you are willing to give us just a couple more minutes, we will extend the session until 11.15 a.m. so that Rebecca can ask the final question.

[143] **Rebecca Evans:** Will you comment briefly on how satisfied you are with how diabetes prevention and management is treated in the training of GPs and in their continuous professional development? How easy is it for GPs to stay on top of all the developments in that field when they have a myriad of other conditions to deal with as well?

[144] **Dr Millington:** It is a long time since I trained in Cardiff, so I am not sure I would be able to comment on that. There is lots of information available; again, it is having the time to introduce that, but we are in a position where the doctor resource is very much about looking after a patient with complications and trying to prevent them. We need to go beyond the medical profession for the prevention bit because there are other people out there who will help us. Whereas I think that GPs are aware of it, you do get the conversation where the patient says, 'Oh gosh, don't talk to me about my diet again; I came in with a cold', and that is the difficulty. People know what they are supposed to do, but it is against this environment that does not encourage people to follow the line, so we are seen as difficult and boring.

11.15 a.m.

[145] We are seen as the people who give the advice that they do not want to hear. It has to start much younger than that. There is information out there for general practitioners, but, when you have to deal with the complex management of the patient, sometimes, you do not have a lot of time for the rest. I do not think that it is a lack of information. Going back to my answer to Kirsty, it is about time. I think that other people can do this as well as we can, and

probably better. It has to start in schools and with mothers and with maternity services, before they are born. We have to look at this. I do not think that the issue is with the general practitioners; it is with us, as a population, dealing with our colleagues, friends and patients.

[146] **Dr Roberts:** The opportunities that have arisen for us in Cardiff with a community approach are that we have consultant sessions put into the community and are using that as an educational resource more than anything, not just for patients, but for GPs and practice nurses. Practice nurses cannot be forgotten in all this because they deliver a lot of the diabetes care, including the annual health checks that we mentioned earlier. I agree that our dieticians and nurses should be able to provide this, but we have no extra resource to provide the community approach that we are all doing in different parts of Wales. No one size fits all and there is no extra resource to provide this. It would be nice if we could go out into the community with one of our diabetes nurses and a dietician and upskill everyone, and include the patient in that, and increase structured education on the back of it. That is what we managed to do with our community pilot scheme in Cardiff, which was part of the chronic conditions management programme from the Welsh Government. We do not have the resources outside that pilot scheme to do what we did within the pilot scheme. One of the most powerful things that came out of that pilot scheme, from a patient perspective was structured education and how much they got out of that extra structured education that was provided.

[147] **Mark Drakeford:** Diolch yn fawr iawn am ddod i'n helpu y bore yma. **Mark Drakeford:** Thank you very much for coming to help us this morning.

[148] I will repeat what I said to our previous set of witnesses. As a committee, we want to make recommendations in our report to the Welsh Government about its plan for the next five years. You have given us some useful information to help with that. If, when reflecting on the morning's session, you think that there are particularly important things—even in an era of very difficult resource constraint—that we should say to the Welsh Government, such as 'If you did these three things over the next five years, they would really make a difference' or if you have any thoughts, after today, that you are able to share with us, that would be especially helpful.

[149] Diolch yn fawr iawn i chi i gyd. Thank you very much to all of you. We will Cymerwn egwyl fach nawr. now take a short break.

*Gohiriwyd y cyfarfod rhwng 11.18 a.m. ac 11.28 a.m.
The meeting adjourned between 11.18 a.m. and 11.28 a.m.*

[150] **Mark Drakeford:** Croeso nôl i bawb. Rydym yn parhau gydag eitem 2 ar ein agenda, sef ymchwiliad i'r gwaith o weithredu'r fframwaith gwasanaeth cenedlaethol ar gyfer diabetes yng Nghymru a'i gyfeiriad yn y dyfodol. Diolch am fynychu'r cyfarfod y bore yma. **Mark Drakeford.** Welcome back to everyone. We are continuing with item 2 on our agenda, namely an inquiry into the implementation of the national service framework for diabetes in Wales and its future direction. Thank you for attending this morning.

[151] Hoffwn gyflwyno'r bobl sydd ar y panel. Mae'n siŵr ein bod wedi cwrdd â chi i gyd eisoes, ond bore da i Mair Davies, cadeirydd Bwrdd Fferylliaeth Cymru; Paul Gimson, cyfarwyddwr Cymru, y Gymdeithas Fferyllol Frenhinol; Russell Goodway, prif weithredwr Fferylliaeth Gymunedol Cymru; a Marc Donovan, aelod o fwrdd Fferylliaeth I would like to introduce the people on the panel. I am sure that we have met all of you before, but good morning to Mair Davies, chair of the Welsh Pharmacy Board; Paul Gimson, director for Wales of the Royal Pharmaceutical Society; Russell Goodway, chief executive of Community Pharmacy Wales; and Mark Donovan, a member of

Gymunedol Cymru a phennaeth gallu proffesiynol Alliance Boots. Community Pharmacy Wales's board and head of professional capability at Alliance Boots.

[152] Yn ôl yr arfer, gofynnaf a oes gennyh unrhyw sylwadau agoriadol byr ac ar ôl hynny, trown at aelodau'r pwyllgor i ofyn eu cwestiynau. As usual, I will ask you if you have any brief opening remarks, after which, we will turn to committee members for their questions.

[153] I am not sure who would like to start, but if you have any brief opening remarks, those would be helpful.

[154] Mair, a ydych chi am ddechrau? Mair, do you want to start?

[155] **Ms Davies:** Bore da. Diolchaf i'r pwyllgor am y cyfle i roi tystiolaeth ar weithrediad y fframwaith ar gyfer diabetes yng Nghymru. **Ms Davies:** Good morning. I thank the committee for the opportunity to give evidence on the implementation of the framework for diabetes in Wales.

[156] We thank the committee for the opportunity to contribute to this inquiry into the implementation of the diabetes NSF. One thing that has struck me while preparing for today was the lack of pharmacy representation not only on the original working and project group for this NSF, but on the local diabetes planning and delivery groups. That is despite the fact that medicines are the mainstream treatment for diabetes. That is not in our submission but it struck me when I was doing background research on this.

11.30 a.m.

[157] The Royal Pharmaceutical Society has made several recommendations in its written submission and I hope that the committee will give them serious consideration to enable pharmacists in all care settings to help improve diabetes prevention, identification and care in Wales.

[158] **Mark Drakeford:** Does anyone else wish to make some comments?

[159] **Mr Donovan:** Thank you for the opportunity to give evidence to the committee once again, building on your recent inquiry into the role of community pharmacy in having a positive impact on the healthcare needs of the people of Wales. We believe that progress has been made in the care of people with diabetes, but we also recognise the step change that is required in the service to address the projected increase in the diabetic population and its significant impact on NHS resources. In relation to the national service framework, we recommend that more emphasis be placed on implementing standards around prevention and early detection, given that 80% of the cost of diabetes is driven through avoidable complications. Community pharmacies are ideally placed to deliver coaching and to support patients and their carers in an empowering manner towards self-care.

[160] Additionally, we believe that more support should be given to patients who are newly diagnosed with diabetes, especially during the crucial first 90 days after being prescribed a new medicine. Services should be developed to support patients on long-term medicines to improve adherence and delay or avoid complications. These pharmacy services should form part of the chronic conditions service, which the committee recommended in its recent inquiry into community pharmacy: a service that builds on existing national services, develops collaborative working across primary care and develops the patient's ability to self-care by delivering or signposting to lifestyle change support. We strongly recommend that the committee should ensure that the contribution of community pharmacy to chronic conditions

management becomes an integral part of any revised national service framework so that community pharmacy services cease to sit outside the patient pathway and move to being integrated more fully into the diabetic care pathway.

[161] **Mark Drakeford:** I will go to William Graham first for questions.

[162] **William Graham:** Thank you for your paper. In evidence this morning, we heard that diabetes can now be described as an epidemic. Would you concur?

[163] **Mr Gimson:** Mark just alluded to that, in that the figures that show that it is increasing, particularly type 2 diabetes, which is linked to lifestyle—there is an obvious link and you can see why it might be increasing. We also have an ageing population. You can repeat the figures that you gave, Mark, but it is something like 3.8 million, is it not? Is that what you said?

[164] **Mr Donovan:** No, I did not mention any figures, but—

[165] **Mr Gimson:** There is a figure in the audit report, I think. However, it is well known that it is a condition that is growing and growing and that the number of diabetics is increasing, particularly those with type 2 diabetes, because of its link to lifestyle.

[166] **William Graham:** Risk assessment in pharmacies is paramount—clearly that needs to be done. How do you think you can report on the outcomes that you are seeing so that more information is available and better decisions can be made?

[167] **Mr Donovan:** Risk assessment is a crucial part of identifying patients who are diagnosed and those who are not diagnosed. There are an estimated 66,000 undiagnosed cases of diabetes in Wales. Nearly 300,000 people in Wales are living with or could be affected by these conditions. That needs to be addressed. Our risk assessment public health campaign—which we may be able to explore during this session—has identified numerous people that community pharmacies have been able to coach and support, to refer on and provide with lifestyle advice. That is a great demonstration of the role that we can play in public health in association with public health campaigns. It is a vital opportunity for the people of Wales to be detected early to avoid these complications, which are a huge burden on the NHS, and affect many thousands of people and the carers of those people.

[168] **Mark Drakeford:** One of our previous witnesses suggested to us that it might be helpful to have a separate NSF for people with type 1 and type 2 diabetes, rather than having them both under the same umbrella, because they are very different conditions and, in particular, they require a different sort of response. The argument was that that could be a helpful way of shaping things in the future. I imagine that community pharmacists tend to concentrate on lifestyle advice and so on for people with type 2 diabetes. Do you think that that would be a helpful distinction to make?

[169] **Mr Gimson:** With type 2 diabetes, there will be more focus in any plan on early prevention and diagnosis. I am not so sure about it post-diagnosis. There are obvious differences, but many similarities as well. To be honest, I could not comment on whether having a separate NSF would be better or worse. There are obvious differences in how they are managed, but there is also a huge amount of overlap. I do not know whether anyone has anything to add to that.

[170] **Ms Davies:** There is so much overlap. In days of old, you would not see type 2 diabetes being treated with insulin, but that is not the case nowadays. A lot of the advice and counselling that are now given are to do with treatment, certainly as far as community pharmacy is concerned. With regard to lifestyle, the development of type 2 and its prevention,

there could be a different strategy, but as to whether you need a different NSF, I would not like to comment on that.

[171] **Lindsay Whittle:** Prevention is better than cure. I am coming up to my bus pass year now—I am not happy about that—and everywhere I go, television, radio, newspapers, GPs and pharmacies all tell me to have a flu jab. I have never had flu in my life. However, nobody warns me that I could be one of the 66,000 people in Wales walking around with undiagnosed diabetes. As I said, prevention is better than cure. I know that you have played your part in Diabetes UK Cymru's campaign in the past about encouraging people to be tested in pharmacies. Do you think that more money should be spent and that greater emphasis should be put on that so that we could identify people at an early stage? I was not totally encouraged by the evidence that we heard from the GPs today that they could cope or even that they wanted to cope, to be blunt. I got the message, 'Please do not test 66,000 more people, because we could not cope'. Well, we will have to cope. We would have to cope if we had a flu epidemic and we have this diabetes epidemic with us now, do we not?

[172] **Mr Gimson:** The answer is 'yes'. The campaign was an example of where, with some co-ordination, support and structure, pharmacists were able to identify quite a lot of people at risk of diabetes and, more importantly, give everyone some structured advice. By having a more structured service in community pharmacy you could make more opportunity—we do, anyway—of the example that you have just provided. Every contact with a healthcare professional should be used to reinforce these lifestyle messages and to provide some of these screening services. A good example of that is that we had a campaign that ran for two weeks, but having the philosophy of that campaign as part of an enhanced service that ran throughout the year would seem to make much more sense.

[173] **Ms Davies:** An additional thing here is that yes, it is frightening to think that we could identify x thousand new type 2 diabetics, but if we do not identify them and complications arise, the cost of treating those complications is way in excess of treating them initially or even preventing type 2 diabetes. It is about deciding where we put the money. Prevention and community pharmacy can deliver that, because perceived healthy people are in there.

[174] **Mr Goodway:** In respect of that specific campaign, the follow-up discussions that we have had with the BMA and GPC are that they would really like pharmacy to go further. The issue for them was that we were not doing the tests, we were just doing a risk assessment, getting people, effectively, to fill in a form by ticking boxes and then you would assess whether that individual was a candidate for diabetes. Some people, like me, just walk through the door, and, being fair, fat and 50, we are candidates for diabetes and should go and get tested. What GPs are saying is that there are so many people who could be identified as candidates, if pharmacies could go that one stage further and do the test, it would reduce the number of potential candidates being referred to the GP. That may be a development that we could consider at some stage during the next campaign.

[175] **Lindsay Whittle:** That would be excellent. I see you in a whole new light now, Russell. [*Laughter.*]

[176] **Lynne Neagle:** It is my understanding that some pharmacies do offer diabetic testing. Is that right?

[177] **Mr Donovan:** Some pharmacies can test blood-sugar levels, which is one indicator and goes some way to having a better picture of the patient. A HbA1c test is the gold standard and a far better test, but not many pharmacies offer that currently. A fasting blood glucose or blood glucose test would give us an indication, but there are also other elements, such as waist measurement, BMI and blood pressure, which help to paint a more holistic picture of

what is happening to the patient in front of us and how we can manage and signpost them to the next level of diabetic care.

[178] **Mark Drakeford:** We heard evidence from Diabetes UK that the campaign will not be repeated next year. Is that a done deal, or is it just an anxiety that it has?

[179] **Mr Goodway:** My understanding is that there have been discussions—I am not sure whether those have concluded—with Public Health Wales, which nominates these national campaigns. I think it will be every other year that that campaign will be run through community pharmacies. However, did we not recently do, or are we about to do, a diabetes stroke campaign?

[180] **Mr Donovan:** We have just done that—it finished recently.

[181] **Mr Goodway:** I know that we have been working with the Stroke Association as well as Diabetes UK in trying to identify which national campaigns would be most significant in terms of information and data that the NHS wants to collect.

[182] **Mark Drakeford:** As a committee, we were impressed by the evidence that we had during our investigation of community pharmacy by that campaign, what it achieved and what lessons there were for making more successful campaigns in the future. It would be a shame if that was not being built on, but if it is going to happen every other year, then maybe that is not such a concern.

[183] **Lynne Neagle:** I want to ask about medicine use reviews and what you think the potential is for them to contribute to better diabetes management?

[184] **Mr Gimson:** Obviously, one of the things about type 2 and type 1 diabetes is that, as they go further down the road of the condition deteriorating, more and more medicine is needed. So, medicine use reviews are a really important aspect of what pharmacy can currently provide to help these patients. What we have seen from some of the research is that, when you give people with diabetes a much more structured approach to their care, including things like lifestyle, public health and advice about their medicines, their outcomes are better and, obviously, it is important for someone with diabetes to take their medicines properly, because that is what helps to prevent further complications. So, medicine use reviews and making things like the discharge medicine service work are really important. I think that I am right in saying that diabetes is not one of the targeted areas. At the moment, there are four areas that pharmacists are asked to target and diabetes is not one of them, although it falls within the remit of the other 50%. So, that might be something to think about: whether there needs to be more targeting and support around that, but medicine use reviews are a really important part of what pharmacists can do.

[185] **Mr Donovan:** To build on that, MURs give us a great opportunity to have a conversation with a patient—not just patients with diabetes—in looking at the medication specific to their disease. We have a conversation about their lifestyle and an opportunity to intervene and coach them about their smoking status or exercise levels. That is the value of the conversation. We were listening to the GPs give evidence and time is tighter everywhere in the NHS; we understand that. We know that the conversation in the pharmacy, through public health campaigns, is valuable. The MUR gives a real opportunity to sit down with a patient in a pharmacy to talk through their wider health needs, beyond their prescription, for example.

11.45 a.m.

[186] **Ms Davies:** I would just add that one of the other things that should happen during

this MUR is that you identify red flags, for example where a diabetic has developed complications and have not gone back to the specialist services. A fundamental and important part of this, given the cost of diabetes complications, is to prevent those complications from happening.

[187] **Mark Drakeford:** Kirsty and Mick both want to ask follow-up questions on this point.

[188] **Kirsty Williams:** We heard from GPs this morning that patients can sometimes be resistant. We all know that we should not smoke, what we should and should not eat and that we should exercise more, but behavioural change is difficult. The approaches used in the past do not seem to lead to significant behavioural change, so do you have any ideas about what kind of services pharmacies will be able to deliver that would perhaps make people more motivated to keep to their medication regime and look after the diabetes better and address some of these lifestyle issues? The messages have been the same for an awfully long time, but the figures suggest that they do not work because lifestyle factors mean that the number of people with type 2 diabetes is going up. Do you have any new approaches that would have better results in achieving behavioural change?

[189] **Mr Gimson:** Some of those questions are quite detailed public-health, psychology-type questions. I alluded to a study earlier where the patients of a pharmacy were split into two groups—one received normal care from the whole system and the other received a more structured package of care. The latter package of care was about focused and targeted education and reinforcement, so that every time the patients picked up their scripts or were in the pharmacy, there was a programme of educational messages available to them. The programme was structured to ensure that the patients were doing different things each time—they did not repeat what had already been done—and it was that structure that helped them. However, that structure is not there at the moment; it is very ad hoc.

[190] I think I heard Ian Millington or one of the other contributors say earlier that people are fed up of being told not to smoke. That is perhaps because everyone is telling them not to smoke and it is not done in a co-ordinated fashion across the piece. One of the things that we are looking for is that the care of diabetes, which includes the whole public health and prevention thing, is more co-ordinated, so that everyone can make the best use of the time that they have with the patient in order to intervene. If that approach is more integrated, then there can be more co-ordination in relation to who is saying what. However, I cannot comment on how behaviour can be changed by doing that.

[191] **Ms Davies:** I can follow on from that. This issue has been recognised within pharmacy and a lot of training is being done on motivational interviewing and behavioural change not just with pharmacists, but with all members of the pharmacy team—it is dependent on who sees the patient for the first time. So, the issue has been recognised and health literacy and motivational interviewing training is still being carried out for pharmacies in Wales. You cannot tell people to change—change has to come from within—but there needs to be a big shift in the way pharmacists and healthcare professionals were trained in the past.

[192] **Mick Antoniw:** I have two short questions to follow on from that. First, mention was made in the last evidence session about the adoption of the Scottish IT system, which enables the exchange of records, information et cetera. Does that involve you and, if not, should it, or should it not? Secondly, a fairly strong theme emerging from the British Medical Association is that one area on which community pharmacy should focus is risk assessment and early detection. What are your thoughts on that?

[193] **Mr Gimson:** With IT, one of the things that we have repeatedly called for is giving

pharmacists appropriate access to the individual healthcare record. So, that is my answer to that question, because by having that access, we would have more of an understanding of patients' conditions. At the minute, in some ways, you have to guess from what is on the prescription in front of you that a patient is diabetic. You have no access to any other records, so you do not know that they are diabetic until you have either talked to them or made a guess from what is on the prescription. So, that appropriate access to the integrated healthcare record is key for the management of any chronic condition.

[194] **Mr Goodway:** We would go as far as to say that if you want to exploit the potential of community pharmacy to the full, access to the patient record is a prerequisite and a critical next step.

[195] **Mark Drakeford:** Will the Scottish system, which we are told will be part of the next five-year plan, be of help to you or will it be of help only once this basic flow of information is sorted out?

[196] **Mr Gimson:** There was a recent consultation on integrated IT in healthcare in Wales, and it did not say much about pharmacy, which we were disappointed about, so we have responded to that consultation saying that. I would guess that the answer would be that we hope so, but, at the moment, we do not know.

[197] **Mark Drakeford:** Mick's second point was to do with whether the particular contribution of community pharmacy is at that risk-assessment, early-identification end of the spectrum.

[198] **Mr Donovan:** I would totally agree. Standards 1 and 2 of the national service framework are where we would perhaps encourage the emphasis to be put, or the review. We have to do that in a responsible manner and not throw lots of patients towards GPs and other healthcare providers, of course, but pharmacy needs to be an integral part of this care pathway. The care pathway does not start when they are in front of a GP, being diagnosed with diabetes or having a complication; it needs to start much earlier. Community pharmacy can play a real, crucial part in identifying and risk-assessing patients so that we make the most of their journey through the healthcare system.

[199] **Mr Goodway:** On that, the education of the population is also an important contribution that community pharmacy can make, because so many pharmacies receive so many visits each week, each year. If I have one concern, it is about the tendency in recent years to co-locate a pharmacy in a doctor's surgery. What you then end up with is that the people who visit that pharmacy are only those who have been to see the doctor first and, therefore, you close off that access to the general population. When a pharmacy is on the high street, people can get messages, either visually or when they walk through the door. In terms of education and managing lifestyles or of encouraging people to change lifestyles, that is an amazing contribution that community pharmacies can make, but if you hide them behind the door of GPs' surgeries, they will not have the access to the public in the same way.

[200] **Elin Jones:** On the sharing of information and the use of patient information by pharmacists, I want you to explain to me the benefit for diabetes patients from pharmacists having that access to information. So, if you have a type 2 diabetic walking into a pharmacy to pick up their prescription, what difference would the pharmacist having that information by seeing it on the screen at the back of the pharmacy make for that type 2 diabetic and what would the pharmacist do with that information that would be different?

[201] **Ms Davies:** If you are doing a medicines use review and you are talking about adherence with a patient, if you have their HbA1c for the last three months, namely their blood glucose level, that gives you an idea, if they tell you that they are taking the medication,

that it is not working if it is not within the parameters. You would have that sort of useful information. From a safety perspective, you need the proper diagnosis or what complications a patient has, depending on what else they would be asking for.

[202] **Elin Jones:** It would only trigger a benefit if there was a formal MUR happening in that relationship between the patient and the chemist, or would you see chemists walking out to the front, delivering the prescription and asking, 'How are you taking this medication? I have seen your record'? I am wondering what benefit there is to the patient. I am not against the principle, by the way; I say that just in case you were wondering.

[203] **Ms Davies:** The benefit to me as a practitioner would be safety. I would feel safe in knowing that I have the right diagnosis, know what we are treating, and know what they have been treated for in the past. If, for instance, they are being treated with a drug and they have a renal problem, I would think, 'Maybe this isn't quite the right drug' because of that renal problem. However, I would not know that otherwise. That is why that information would be useful—for patient safety.

[204] **Mr Gimson:** We have focused quite a lot on access to the record. What we are talking about in conjunction with that is that the delivery of care needs to be much more integrated, so we hope that if the appropriate access is granted, there would be a much more integrated model of care. An example at the other end of the spectrum would be when we identify patients who might be at risk of diabetes. The process of alerting them and referring to specialists is quite Machiavellian at the moment, and it may involve telling them to go to the doctor's or involve sending off a form through a campaign, but once all the systems start to join up you can feed into the system more formally. When and if we get access to the records, it would need to be done alongside making sure that the care pathways are much more joined-up. We are just one part of a multidisciplinary team now, but we cannot be part of that team until we have access to the same information as everyone else.

[205] **Ms Davies:** It is also about giving information back, so if anything happens within that setting, everybody else involved in the care of that patient knows about it. I would hope that we would also be able to put information into that system on any other things that they are taking, including, for instance, over-the-counter medicine.

[206] **Mr Donovan:** There is also a role in how we monitor the patients, meaning that we would have a view of whether they have had their annual eye test or whether we need to support them regarding blood pressure, or whether they have risk of stroke et cetera. We can have that more general, in-depth conversation. However, there is also another level. We know that some pharmacists in Wales can prescribe now, and diabetic patients tell us that they are back and fore to different healthcare providers all the time, maybe for small tweaks in their anti-hypertensive medication, for example. If the pharmacist is part of that treatment and understands the diagnosis and the targets that we need to get to with a patient's blood pressure, why cannot our pharmacists start to prescribe different or increased doses of medication to allow the diabetic patient to get to the target as part of the care plan? We cannot do that without access to the patient record, and if we need a radical service redesign to deliver great care to patients with diabetes and other chronic conditions, which I believe we can, we have to take these big, bold steps to allow pharmacists to be fully tooled up and to make those prescribing decisions and other decisions for their patients' healthcare.

[207] **Mark Drakeford:** Rebecca is next, but I just have one question first. In terms of patient education, we heard what you have said about those early things that pharmacists can do in terms of basic education, coaching and stuff like that. We have heard during the morning of a fairly lamentably low level of structured education for people who are identified as having type 1 diabetes, where there is a NICE technology appraisal that says this education ought to be provided, and of advice on education about type 2 diabetes. Is there a contribution

that you think pharmacists could make to making greater inroads into the numbers of people who receive the education, which people generally think they ought to have and would be beneficial? If so, where is that contribution best made?

[208] **Ms Davies:** We could probably send you a paper on exactly what Paul was referring to earlier—the situation where two groups of patients in two pharmacies were given structured counselling and where the results were very positive, with great patient satisfaction. So, there is plenty of evidence coming on board that suggests that there can be a programme there, but I would emphasise that pharmacists will need time to do this. You cannot just think that they can do this—they will need time. The one thing that is essential is time with patients. It can be done, they know what needs to be done, and there are education programmes out there ready for them to deliver, but they would need time to deliver them,

12.00 p.m.

[209] **Mr Gimson:** Every single healthcare professional who comes into contact with a diabetic throughout their care has a role in educating that patient about their condition, and that is not joined up at the moment. A pharmacist might be providing messages that either replicate or are different from what someone else along the chain has said. The pathway that co-ordinates those things is not there. The key is to have a structured education process for the patient, and that is what I think is lacking at the moment. Everyone should be a part of that, not just the pharmacists.

[210] **Ms Davies:** Pharmacy does need to be integrated into that care pathway, which it currently is not.

[211] **Mr Donovan:** It could be part of the chronic condition service that has been discussed previously. Developing patients' ability to self-care, as well as providing education for patients, raising awareness and empowering them, and bringing them from scared and uninformed to an informed view of their disease, is a role for pharmacies if we package it up into some sort of service like the chronic condition management service. The first year of care after diagnosis is absolutely crucial, and we would love to explore that with Government in developing a service, namely how we can hit the first year of care after the diagnosis of something like diabetes or other chronic conditions.

[212] **Rebecca Evans:** As you are so visible and accessible in the community, you might be able to bring particular benefit to some of the high-risk groups, particularly people living in deprived communities and ethnic minorities, which I know also have a higher risk than others of developing diabetes. Can we learn anything from your previous diabetes screening campaign about the higher-risk communities and the role that you can play in raising awareness of diabetes?

[213] **Mr Donovan:** You are absolutely right. We see hundreds of thousands of people coming through our pharmacies every week, and raising awareness and targeting messages at high-risk groups is crucial. I was looking at some evidence that Public Health Wales has produced recently about pharmacies targeting areas throughout Wales, with more specific direct messaging to those people who are further at risk, and that has worked particularly well. The national public health team will look to build on that, but it is a lesson to be learned. Are we brilliant at it? No, I do not think so, but we have learned that we can address those groups far better because we are seeing so many people.

[214] **Rebecca Evans:** Do you think that there is a need for the message to be packaged in different ways, depending on your audience? If so, is that something that you are already doing?

[215] **Mr Gimson:** That goes back to the point about having structured education and delivering a package of structured education that would be tailored to your specific audience. I must admit that I am not aware of too much having been done around that area. I know that some work has been done on tailoring the message to those ethnic minorities and trying to have a greater impact with them, but I do not have that information to hand, sorry. It is part and parcel of making sure that you have a structured education that is tailored to the audience, rather than an ad-hoc, un-joined-up approach. It all fits into that package.

[216] **Mark Drakeford:** Are there any further questions from anybody? I see that there are not. Thank you all very much indeed. I will repeat to you what I have said to everyone else, which is that, in some ways, the most important part of our report will be those things that we can say to the Welsh Government ought to be the key priorities for the plan that it is working on for the next five years of how to deliver the NSF better in Wales in the future. There have been things that you have said to us this morning that will help us to think about those recommendations. However, if, after the session, when you have had a chance to think about the questions, you think of any really key things that we should be saying to the Welsh Government if it wants to make a success of delivering diabetes services over the next five years, it would be very helpful for us to hear from you. Diolch yn fawr iawn. Thank you very much indeed.

12.05 p.m.

Papurau i'w Nodi Papers to Note

[217] **Mark Drakeford:** Mae mwy nag un papur i'w nodi. Mae cofnodion cyfarfodydd 17 a 25 Hydref i'w nodi, ac, ar yr agenda Gymraeg, ond nid ar yr agenda Saesneg, mae'n dweud bod cofnodion ein cyfarfod ar 7 Tachwedd ar gael hefyd. Felly, a yw pawb yn hapus gyda'r rheini? Gwelaf eich bod.

Mark Drakeford: There is more than one paper to note. We have the minutes of our meetings on 17 and 25 October to note, and the Welsh agenda, but not the English, states that the minutes from our meeting on 7 November are also available. So, is everyone happy with those? I see that you are.

[218] Mae'r flaenraglen waith, sef papur 6, ar gyfer mis Tachwedd a Rhagfyr ar gael er gwybodaeth ichi.

The forward work programme, namely paper 6, for November and December is available for your information.

[219] **Elin Jones:** Hoffwn godi pwynt am y flaenraglen. Rwy'n gwybod ein bod wedi gwneud gwaith a chael sesiwn gyda'r byrddau iechyd sydd ar hyn o bryd yn cyflwyno'u syniadau o ran ailgyflunio, sef BILI Betsi Cadwaladr a Hywel Dda, ond mae elfen arall yn y drafodaeth honno sydd o ddiddordeb i ni, sef gwaith y fforwm clinigol ac efallai hefyd y ddeoniaeth. Byddwn yn gobeithio ar ryw bwynt y gallem gael tystiolaeth gan y fforwm cenedlaethol, nid efallai o ran ei safbwynt ar yr hyn sy'n digwydd yn y byrddau unigol ond o ran yr hyn yr hoffent ei weld yn digwydd yn genedlaethol fel cynllun cenedlaethol i'r gwasanaeth iechyd. Nid wyf yn gwybod a fyddai hynny'n bosibl ar ryw bwynt ond credaf y byddai'n fuddiol inni glywed ei farn,

Elin Jones: I want to raise a point about the forward programme. I know that we have done some work and had a session with the health boards that are currently submitting their ideas for reconfiguration, namely Betsi Cadwaladr and Hywel Dda LHBs, but there is another element to that discussion that is of interest to us, namely the work of the clinical forum and perhaps also the deanery. I would hope that, at some point, we could get evidence from the clinical forum, not perhaps from the point of view of what is happening within individual boards, but on what it would like to see happening at a national level, as a national plan for the health service. I do not know whether that might be possible at some point, but I think that it would be beneficial for us to hear its views, because I

oherwydd credaf fod ganddo farn ddiddorol. think that it has some interesting views.

[220] **Lynne Neagle:** I am personally keen to hear from the deanery, whether in formal session or not. I am quite happy to do it in a briefing afternoon, but I think that it would be very useful indeed.

[221] **Mark Drakeford:** A couple of organisations have told me that they think that they have a national perspective on all this, in the sense that their members are part of these processes everywhere in Wales. So, it might be useful for us to hear from them to get that more national perspective, as the deanery and the forum are at that level.

[222] **Kirsty Williams:** I would be very happy to hear from the deanery. I am aware that the dean has some very interesting perspectives, having gone to see him, and it would be worthwhile those views being aired in a public forum. The national clinical forum is worthy of greater scrutiny, given what has happened. I am not saying that people should or should not intervene, but when the chair of one organisation redrafts another organisation's report off his own back without reference to anybody else, we need to understand why, given the nature of those reports. I would like to hear about the role of the clinical forum, how it carries out its function and what it sees itself doing. I would also be really glad to hear what the role of the civil servant observers are, because that is not clear either. You do not send people to a meeting to observe and then do nothing with what they have observed. It is just fanciful.

[223] **Mark Drakeford:** Unless it is diabetes information.

[224] **Kirsty Williams:** We heard just this morning that we do not have enough civil servants to keep an eye on things, and yet we have civil servants going to meetings to observe without any outcomes. I just want to find out what is going on.

[225] **Mark Drakeford:** I will have a discussion with Llinos to see whether we can find time—although I doubt that it will be before Christmas—to reflect on the processes that have been going on around Wales, to hear from those organisations that have a more overall, national role to play, or that have members who have been a part of these processes everywhere and may have some interesting reflections for us on the differences that they have observed—the strengths and the things that could be done better and so on. So, we will do that.

[226] Paper 7, to note, is correspondence from Mr Antoniwi on his Recovery of Medical Costs for Asbestos Diseases (Wales) Bill. Just for Members to know, should the Bill be introduced on 26 November, which I think is the hoped-for plan, and if it is then referred to the committee for Stage 1 consideration, as we anticipate the Business Committee will do, time has been allocated to allow us a very brief discussion on our general approach to scrutiny, and whether we have learned any lessons or want to make changes as a result of our experience of the Food Hygiene Rating (Wales) Bill process. We will do that on 29 November, and then time has been set aside for Mick as the Member in charge of the Bill to provide oral evidence to us on 5 December so that we can get our work on that Bill under way before the Christmas break.

[227] **Mick Antoniwi:** Just to clarify, I will obviously exempt myself from any matters relating to the scrutiny of the Bill. I will arrange a substitute or whatever in respect of the Stage 1 opening as well.

[228] **Mark Drakeford:** Yes. You cannot be a member of the committee for that time.

[229] You will see that the final paper to note is a letter from Jane Hutt, as the Minister with responsibility for Assembly business, on smoke-free premises. I think that I have said to you

before that I met with Nick Ramsay, and Nick and I will write later today, I think, to the whips of all four parties saying that we hope to have two sub-committees with 10 people all together, and it will be important for the whips to make sure that the people nominated by either committee are such that we end up with the right party representation on that final group. Do you see what I mean? We could end up with no Liberal Democrat on it if no Lib Dem were nominated from here or from the Enterprise and Business Committee. So, we need a little bit of choreography to make sure that we get the right result there, and party whips will have to keep an eye on that. We hope to have the work under way before Christmas, but the bulk of it will have to be done afterwards.

12.12 p.m.

**Cynnig o dan Reol Sefydlog Rhif 17.42(vi) i Benderfynu Gwahardd y Cyhoedd
o'r Cyfarfod**
**Motion under Standing Order No. 17.42(vi) to Resolve to Exclude the Public
from the Meeting**

[230] **Mark Drakeford:** Cynigiaf

Mark Drakeford: I move that

yn unol â Rheol Sefydlog Rhif 17.42(vi), fod y pwyllgor yn penderfynu cwrdd yn breifat ar gyfer eitem 5 yn y cyfarfod hwn ac eitem 1 yn y cyfarfod ar 21 Tachwedd.

in accordance with Standing Order No. 17.42(vi), the committee resolves to meet in private for item 5 in this meeting and for item 1 in the meeting on 21 November.

[231] A yw'r Aelodau i gyd yn fodlon â hynny? Gwelaf eich bod, felly byddwn yn cwrdd yn breifat ar ôl yr egwyl.

Are all Members content with that? I see that you are, so we will meet in private after the break.

*Derbyniwyd y cynnig.
Motion agreed.*

*Daeth rhan gyhoeddus y cyfarfod i ben am 12.12 p.m.
The public part of the meeting ended at 12.12 p.m.*