

Health and Social Care Committee

Meeting Venue:
Committee Room 1 – Senedd

Meeting date:
15 November 2012

Meeting time:
09:30

Cynulliad
Cenedlaethol
Cymru

National
Assembly for
Wales



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Agenda

1. Introductions, apologies and substitutions

2. Inquiry into the implementation of the NSF for diabetes in Wales and its future direction – Oral evidence (09.30 – 12.10)

09.30 – 10.20: Diabetes UK Cymru (Pages 1 – 7)
HSC(4)–30–12 paper 1 – Evidence from Diabetes UK Cymru
Dai Williams, Director, Diabetes UK Cymru
Jason Harding, Policy Manager, Diabetes UK Cymru

10.20 – 11.10: Royal College of Physicians, Association of British Clinical Diabetologists, and British Medical Association (Pages 8 – 14)
HSC(4)–30–12 paper 2 – Evidence from the Royal College of Physicians and the Association of British Clinical Diabetologists
Dr Meurig Williams, Royal College of Physicians Regional Adviser for Wales
Dr Aled Roberts, Association of British Clinical Diabetologists
HSC(4)–30–12 paper 3 – Evidence from the British Medical Association
Dr Ian Millington
Dr Mark Temple

11.10 – 11.20 Break

11.20 – 12.10: Royal Pharmaceutical Society and Community Pharmacy Wales
(Pages 15 – 30)

HSC(4)-30-12 paper 4 – Evidence from the Royal Pharmaceutical Society

Mair Davies, Chair, Welsh Pharmacy Board

Paul Gimson, Director for Wales, Royal Pharmaceutical Society

HSC(4)-30-12 paper 5 – Evidence from Alliance Boots

Russell Goodway, Chief Executive, Community Pharmacy Wales

Marc Donovan, Community Pharmacy Wales Board Member and Head of Professional Capability, Alliance Boots

3. Papers to note (12.10 – 12.15) (Pages 31 – 40)

Minutes of the meetings held on 17 & 25 October, and 7 November

3a. Forward Work Programme – November to December 2012 (Pages 41 – 43)

HSC(4)-30-12 paper 6

3b. Correspondence from Mick Antoniw AM on the Recovery of Medical Costs for Asbestos Diseases (Wales) Bill (Page 44)

HSC(4)-30-12 paper 7

3c. Correspondence from the Leader of the House on the Smoke Free Premises (Amendment) (Wales) Regulations (Page 45)

HSC(4)-30-12 paper 8

4. Motion under Standing Order 17.42(vi) to exclude the public from this meeting for item 5 and for the meeting on 21 November for item 1 (12.15)

12.15 – 13.15 Break

Private session

5. Inquiry into Residential Care for Older People – Consideration of draft report (13.15 – 14.30)

Health and Social Care Committee

HSC(4)-30-12(p1) – 15 November 2012

Inquiry into the implementation of the National Service Framework for diabetes in Wales and its future direction – Evidence from Diabetes UK Cymru

Diabetes UK

Diabetes UK is the leading charity that cares for, connects with and campaigns on behalf of every person affected by or at risk of diabetes. There are currently 3.7 million people in the UK with diabetes, including an estimated 850,000 people who have Type 2 diabetes but do not know it.

The charity helps people manage their diabetes effectively by providing information, advice and support and works with healthcare professionals to improve the quality of care across the UK's health services. It funds pioneering research into care, cure and prevention for all types of diabetes and works to stem the rising tide of Type 2 diabetes - through risk assessment, early diagnosis, and by communicating how healthy lifestyle choices can help many people avoid or delay its onset.

The charity has 300,000 supporters nationwide, 5,000 volunteers and 332 voluntary groups to raise funds and awareness, and to provide support and campaign for change

It has a professional membership of more than 6,000 healthcare professionals and provides a range of professional forums for exchanging ideas and sharing information.

Diabetes UK sits on the National Specialist Advisory Group for Diabetes (formerly the All Wales Diabetes Forum), the body that provides clinical advice to the Minister for Health on diabetes issues and is the lead organisation and funder of the Cross Party Group on Diabetes in the Welsh Assembly

Representatives from the charity attend all Diabetes Planning and Delivery Group meetings across the seven health boards in Wales. With no central co-ordination of diabetes services in the Welsh Government or NHS Wales, we are the only body that has a presence in all of these meetings and we deliver bi-annual co-ordination meetings with senior representatives from all health boards DPDGs to explore sharing of best practice

Diabetes UK would be happy to provide oral evidence if requested by the committee.

What is diabetes

There are two main types of diabetes: Type 1 and Type 2. Type 1 diabetes is most commonly diagnosed in childhood or in young adults but can occur at any age. Without insulin the condition is usually fatal and those with diabetes must therefore self-inject insulin. Insulin must be carefully balanced to prevent the blood glucose being too high which raises the risk of life-threatening and disabling complications and to prevent the blood glucose being too low which may cause life-threatening hypoglycaemia. Those with Type 1 diabetes must learn these balancing skills themselves.

Type 2 diabetes can progress slowly and with no obvious symptoms. Herein lies one of its grave dangers: at the time of diagnosis, around half of people with Type 2 diabetes have unwittingly sustained tissue damage. In cases where blood glucose control is not being achieved through diet, weight control and exercise, treatment with oral medication will commence. Ultimately, people with poor control of their Type 2 diabetes will progress to insulin treatment. 20% of people manage on diet and exercise alone. 80% take medication: 50% take hypoglycaemic agents and 30% take insulin.

Diabetes in Wales

There are 160,000 people with diabetes in Wales. Approximately, 16,000 (10%) have Type 1 diabetes and 144,000 (90%) have Type 2. This equates to 5.0% of the population. 1,373 children and young people have diabetes (97% have Type 1 and 3% Type 2).

An estimated 350,000 people have pre-diabetes (higher than normal blood glucose levels). This group has a fifteen times higher likelihood of developing Type 2 diabetes than the general population.

QOF data has shown a significant and consistent increase in prevalence each year. There have been approximately 7,000 new diabetes cases annually in Wales equating to a 5% annual increase. Increases in Type 2 diabetes are due to an ageing population and rapidly rising numbers of overweight and obese people. The Welsh Health Survey 2009 showed 57% of the Welsh population are overweight or obese. In some respects, this upward trend is a global phenomenon. The World Health Organisation predicts a doubling of Type 2 diabetes between 1995 and 2025.

Poorly managed diabetes is associated with serious complications that contribute a substantial financial cost to diabetes care as well as a significant impact on the quality of life for the individual. Cardiovascular disease is the leading cause of death in people with type 2 diabetes. Around 80% will die, many prematurely, as a result of heart attack or stroke.

5% of the population have diabetes but account for 15-20% of hospital inpatients with a greater length of stay in hospital and more complex admissions. People with diabetes have a 2x higher risk of experiencing a stroke. 1 in 3 people with diabetes will develop kidney disease; diabetes is the most common reason for starting dialysis. Diabetes is the leading cause of blindness in people of working age. People with diabetes are 15x more likely to have an amputation

Diabetes costs NHS Wales £500m each year. This equates to 10% of the total NHS Wales budget. At the current rate of increase in prevalence, it will cost £1bn by 2025. The vast majority of the cost is due to diabetes complications, which account for 80% of the total. Diabetes medication costs approximately 7% of the total. Evidence suggests that the costs of medication are rising. There was an 89% increase in prescribing costs in England for Type 2 diabetes between 1997 and 2007. Newer therapies now approved by NICE will increase the cost of diabetes medication significantly.

1. The National Service Framework on Diabetes (2003 – 2013)

1.1 The National Service Framework on Diabetes was established (2003). Developed by the Welsh Government in collaboration with senior clinicians and patient representatives; it is an impressive and thorough strategy with strong operational elements to improve and standardise diabetes services and care throughout Wales. It has remained the core document for diabetes planning and service delivery since its development.

1.1 The National Service Framework on Diabetes: Consensus Guidelines (2008) was a timely restatement of the original 2003 document. The Consensus Guidelines acknowledged the changing nature and treatment of diabetes in Wales, re-iterated the 12 standards of the original 2003 document and provided clarification on how Wales could work towards the NSF's full realisation by 2013. The Consensus Guidelines were distributed widely across Wales

1.2 The National Service Framework for Diabetes: Delivery Strategy (2009) was produced by the Welsh Government's Lead Co-ordinator for Cardiovascular Disease. It identified the degree to which diabetes services across Wales had achieved the NSF standards and provided recommendations to enable full compliance. The strategy's findings were not acted on, nor was the strategy distributed.

1.3 It has not been possible to ascertain how far the NSF has been delivered in Wales after 2009. Little data exists and where partial information is available, it has not been assessed.

1.4 The new Diabetes Delivery Plan (draft) produced by the Welsh Government will shortly be available for wider consultation. The strategy looks to extend the key elements of the National Service Framework from 2013 to 2016. The Committee's inquiry is timely as it has not been possible to establish what areas of the existing NSF have been delivered and why that is the case.

2. National Service Framework on Diabetes: Responsibility and accountability at a national level

2.1 Until late 2009, the Lead Coordinator for Cardiovascular Disease in the Welsh Government was responsible for diabetes services at a national level. The role was responsible for the assessment of NSF progress, the provision of advice on areas that required attention and coordination of that work across health boards. The role was discontinued at the end of 2009 and no replacement has been made.

2.2 Just prior to the termination of the role of Lead Coordinator for Cardiovascular Disease, an implementation document was produced, *National Service Framework for Diabetes: Delivery Strategy (2009)*. It noted achievements and areas of concern across all health boards in Wales. A new reporting format was attached to the delivery strategy as the Lead Coordinator noted that it was difficult to assess health board information and some reporting areas were incomplete. The delivery strategy was never distributed to health boards and it is not possible to confirm what happened to it. In meetings with senior health board representatives conducted by Diabetes UK Cymru during 2010, the report was unknown, and information on the areas of concern that required rectification had not been communicated to them. At the time, Diabetes UK Cymru concluded that because the Lead Coordinator role had not been replaced, the report was forgotten and no-one had assumed responsibility for taking the work forward. A hard copy of the report has been forwarded to the Chair of the Health & Social Care committee.

2.3 *The All Wales Diabetes Forum*, now the *National Specialist Advisory Group on Diabetes (NSAG)* was established in 2008. It was formed to provide clinical advice to the Minister for Health on diabetes issues. In an advisory capacity, it worked constructively alongside the Lead Coordinator for Cardiovascular Disease. Diabetes UK Cymru is a member of the NSAG. The NSAG meets for two hours every three months. It has communicated its concern to the Welsh Government that the Lead Coordinator for Cardiovascular Disease has not been replaced. It has also communicated that it is not possible for the body to replace the vacant Lead Coordinator role. Requests made to the Welsh Government for support to enable the NSAG to cover the most pressing shortfalls that have emerged since the Lead Coordinator was not replaced, have been declined.

2.4 Since the end of 2010, Diabetes UK Cymru has attempted to clarify where responsibility for diabetes services resides at a national level. When the Lead Coordinator position ceased to exist, health boards were instructed to submit their quarterly reports to the Health and Social Services department and in early 2011, to NHS Wales. Neither body has provided a response to the health boards' reports.

3. National Service Framework on Diabetes: Health Board accountability and compliance

3.1 With the re-organisation of health boards in Wales (a reduction from twenty two to nine) in 2009, *Local Diabetes Service Advisory Groups* were changed into *Diabetes Planning and Delivery Groups (DPDGs)*. The groups are tasked with developing a local delivery plan for the National Service Framework on Diabetes.

3.2 Each DPDG is led by a chair, usually but not always a senior clinician. The membership of each DPDG varies between health boards but is usually composed of diabetes clinicians, specialists in related disciplines and front line staff such as diabetes specialist nurses. Patient representatives from the local community also attend. Some DPDGs are attended by 15+ health board professionals while others have meetings with only five attendees. Rarely do meetings occur where all disciplines are represented. Secondary care professionals predominate many meetings making aspects of diabetes

services that relate to primary care or public health difficult to consider. If some disciplines are not represented, it is not possible to obtain an update of work in that area or ascertain how well services are meeting NSF requirements.

3.3 DPDGs meetings occur for two hours every quarter. A rigorous assessment of the health board's work in meeting the NSF is not possible in meetings of this duration. It is never attempted. Discussions tend to focus on a small number of contemporary issues or updates on discussions from previous meetings. While Diabetes UK acknowledges that work is also conducted outside of these meetings, it is difficult to ascertain when a thorough assessment of the health board's delivery plan against the NSF occurs.

3.4 DPDGs appear to be quite isolated bodies. Quarterly reports to NHS Wales or the Welsh Government have not received responses. If the quarterly reports that are also sent to the health board's Management Board do receive a response, these responses are not mentioned in DPDG meetings. DPDG attendees have discussed frustrations with not being able to action work agreed in meetings or to change practice to meet NSF obligations because decisions need to be taken higher up in health boards. There is a reluctance to raise issues that have financial repercussions acknowledging the budget cuts that are occurring across all health boards until 2015. Patient representatives report raising the same issues over and over again with little progress made. Many report disillusionment and are starting to disengage.

3.5 The Health & Social Services Department have stated in meetings with Diabetes UK Cymru that delivery of NSF is the responsibility of the health boards. Putting local decision making in clinical hands has obvious advantages but assuming that consultants with full time clinical roles can also develop, manage and deliver complex diabetes strategies without any support systems is in the charity's view erroneous. DPDGs appear to operate in isolation, there is minimal co-ordination between health boards, issues with financial repercussions are parked, and there appears little or no assessment of NSF progress at a health board or national level through this framework

4. National Service Framework on Diabetes: Reporting

4.1 Until the end of 2009, quarterly reports from health boards on NSF compliance were submitted to the Lead Co-ordinator for Cardiovascular Disease in the Health & Social Service Department. These reports were collated and feedback provided. After the Lead Coordinator's departure, health boards continued to submit quarterly reports to the Health & Social Services Department but received no feedback.

4.2 In early 2011, health boards received updated instructions from the Medical Director for NHS Wales. Health Boards were to use a new self assessment tool that was utilised by many PCTs in England to better enable them to implement NICE Quality Standards for Diabetes in Adults and the National Service Framework on Diabetes. The utilisation of this new questionnaire produced by a company called Innove was negotiated by the All Wales Diabetes Forum (now the National Specialist Advisory Group on Diabetes). Health Boards were requested to complete this new questionnaire and send information to the Health and Social Service Department.

4.3 In England, PCTs complete the questionnaire and send it to Innove which assesses the raw questionnaire data and produces an annual national report and specific reports for each PCT explaining how they rank against neighbouring PCTs. The PCT reports also provide recommendations on areas that the PCT needs to focus on to improve their diabetes services and to ensure they meet the guidelines and standards of NICE and the NSF on Diabetes.

4.4 Health Boards in Wales started to utilise the new reporting framework in mid 2011. The self assessment tool was completed and raw data sent to the Health and Social Services Department. As well as utilisation of the self assessment tool, Innove offered one year of free assessment of this raw

data to enable NHS Wales and health boards to receive analysis of this raw data and to establish a benchmark of their performance. The offer was declined. The NSAG on Diabetes requested assistance from the Health and Social Services Department to enable assessment of the raw data. The request was declined.

4.5 Information submitted through the old reporting framework and through the new self assessment tool submitted on a quarterly basis has received no response from the Health and Social Services Department. Health boards have received no feedback for nearly three years. It seems clear that while data capture systems exist, there are no arrangements in place to assess the data.

4.6 In Spring 2012, Diabetes UK Cymru collated all of the self assessment data and produced an individual report for each health board. A collated report was given to the Minister for Health. Individual reports were given to the Chair of each DPDG at a best practice away day organised by the charity. It was the second meeting of its kind but the first time health board staff tasked with delivering the NSF had come together to discuss best practice and mutual challenges with some information to inform discussions. The reports demonstrated that all health boards were struggling with significant aspects of the NSF, and that a number of areas required a national approach if they were to be dealt with effectively. The reports have been submitted to the Chair of the Health and Social Care Committee for Inquiry consideration.

As is perhaps clear, Diabetes UK Cymru is concerned at the process and systems currently utilised to manage diabetes services in Wales. Our submission has been informed by our attendance of Diabetes Planning and Delivery Group meetings in all health boards since their establishment in 2010, meetings with the Minister for Health and officials from the Health & Social Services Department, and our attendance of the All Wales Diabetes Forum/NSAG on Diabetes and the lead role we play in the Cross Party Group for Diabetes.

Lack of information has not made it possible to provide the Committee with a more detailed assessment of how diabetes services in Wales meet the twelve standards of the National Service Framework for Diabetes established in 2003. We do not believe any contributor to the Committee's considerations can provide this information with confidence. With the launch of a new Delivery Strategy to replace the National Service Framework in 2013, this is an unfortunate position.

While a granular assessment of each of the standards is not possible, Diabetes UK Cymru feels that the Committee's work would benefit from a consideration of the broad themes and recommendations listed below.

Together for Health: A Diabetes Delivery Plan consultation document was received by Diabetes UK Cymru on the 19th September 2012. The draft document represents the Welsh Government's replacement of the National Service Framework and its plans for diabetes services from 2013 – 2016.

It is hoped that recommendations that are made when the Health & Social Care Committee concludes its Inquiry can be included in the final version of the new Delivery Plan. This would naturally avoid a repetition of the mistakes made over the previous decade implementing the NSF on Diabetes.

Diabetes UK Cymru believes the following issues merit consideration by the Committee.

- The Ministerial Forward to 'Together for Health: A Diabetes Delivery Plan' states, '*I expect by 2013, services will meet the Standards set out in the Diabetes National Service Framework published in 2003 and by 2016, we will deliver the new commitments to the public that are outlined in this Delivery Plan for NHS Wales*'. The presumption is erroneous. Significant elements of the NSF have not been delivered. The reasons why the NSF has not been implemented and how this shortfall should be rectified need to be acknowledged, an understanding of why this has occurred established, and remedial action articulated in the new Diabetes Delivery Plan

- As previously stated, the National Service Framework on Diabetes is a commendable strategy. It appears clear that its primary failing has been its lack of implementation and more specifically, a failure of effective oversight. Systems of assessment and clear processes to rectify areas of concern have not been present since 2009. Large amounts of raw information and data have been produced by health boards but no assessment of that information occurred. There appears no clear system or processes in place to assess that information in the health boards or at a national level. There appears no clear system or processes to respond to health boards on their reports and where diabetes services are unacceptable. It has not been possible to identify lines of responsibility or accountability at a health board or national level.
- The draft Diabetes Delivery Strategy suggests the formation of an All Wales Implementation Group to oversee the new plan. Diabetes UK Cymru believes the success of the new strategy rests on how this group is composed, how it functions, how frequently it meets, how well it is supported by research and administrative functions in the Welsh Government, and the authority it retains to hold health boards to account. It is estimated that diabetes and its complications costs NHS Wales £500m annually. What type of oversight body does the Committee feel is required to effectively manage this level of expenditure?
- To rectify the shortcomings in implementation of the NSF and provide the leadership required to ensure effective delivery of the new Delivery Strategy, Diabetes UK Cymru feels that a full time Diabetes Lead is required to manage and be accountable for the operational delivery of the new Delivery Plan. This role would provide direct reports to the All Wales Implementation Group (AWIG). The AWIG should be composed of senior clinicians and Health & Social Services representatives to ensure a close working relationship between Government and the NHS. It should meet bi-annually to assess reports from the Diabetes Lead operational role. Clear lines of reporting and accountability should be established between the Diabetes Lead and the Diabetes Planning and Delivery Groups in each health board. The Diabetes Lead should be operational in focus. The role should have access to appropriate levels of administrative and research support in the Welsh Government to enable it to assess information from the health boards to make informed judgements on progress and compliance to the new Delivery Plan's objectives in a timely and appropriate manner. The resource required to provide this level of leadership and accountability would cost less than 0.01% of NHS Wales annual diabetes expenditure
- The ability to ascertain the effectiveness and quality of diabetes services has been hampered by the lack of an effective secondary care information and IT system. The new Diabetes Delivery Strategy commits NHS Wales to the establishment of a new integrated national diabetes patient management system. It is a bold move and the charity commends the Welsh Government. It will enable NHS Wales to gather high quality information on future diabetes care and services and fills an important gap that has become apparent when trying to assess NSF compliance over recent years.
- The Welsh Assembly Government has an agreement in place with NICE meaning that the Institute's Technology Appraisals, Clinical Guidelines and Interventional Procedure Guidance all apply in Wales. NICE appraisals, guidelines and guidance are common threads through many standards in the National Service Framework on Diabetes. A number of existing commitments were included in the National Service Framework in 2003 and have yet to be delivered. Examples such as the provision of Structured Diabetes Education for people with Type 1 diabetes and the provision of insulin pumps have fallen short of expectations and what is legally required. While it is commendable that a recommitment to these services is evident in the new Diabetes Delivery Plan, a financial commitment to their provision is also required or their implementation will continue to fail. £1.5m ring fenced funding for insulin pumps in Scotland and £2.5m in Northern Ireland demonstrate how other countries in the UK have approached the issue.

- Every person with diabetes is supposed to receive a planned programme of nationally recommended checks each year. Derived from both the National Service Framework and NICE guidance, there are nine key care processes. They are: Blood glucose level measurement, Blood pressure measurement, Cholesterol level management, Retinal screening, Foot and leg check, Kidney function testing (urine) and (blood), weight check and smoking status. The checks exist to identify and effectively respond to problems before they become serious. It is estimated that 80% of diabetes costs are associated with the treatment of complications. In 2010 – 2011, 37.7% of people with Type 2 diabetes did not receive all of their checks and 61.4% of people with Type 1 diabetes did not receive all of their checks.
- The National Service Framework (Standard 2) and the new Diabetes Delivery Plan rightly acknowledge the importance identification and early diagnosis of diabetes. There are an estimated 66,000 people with undiagnosed diabetes in Wales and 350,000 people with higher than normal blood glucose levels. This group has a 15x higher likelihood of developing Type 2 diabetes than the general population. By the time they are diagnosed, 50% of people show signs of complications. The only national public awareness/risk assessment campaigns in Wales over the last two years have been paid for by the third sector. There are no plans for a national campaign in 2013.
- The importance of a complete and thorough reassessment of the management and oversight of the delivery of the National Service Framework and the new Diabetes Delivery Plan can be evidenced with the following unfortunate incident that received national coverage a few months ago. Mr David Joseph (a gentleman with Type 2 diabetes) was admitted to a hospital in Wales in 2008. Following a number of errors, Mr Joseph died a few months later. A key complaint by the family was that nursing staff demonstrated unacceptable levels of awareness and skills in caring for diabetes patients. An investigation by the Public Services Ombudsman for Wales upheld the family's complaint, and made a wide range of recommendations to rectify the failings identified. One key recommendation was that the health board '*carry out an in-depth review of the skills and knowledge of nursing staff regarding diabetes care and take appropriate action thereafter*'. Quarterly reports produced by health boards on the National Service Framework required confirmation of appropriate training of ward staff on diabetes care. As explained above, these reports have been produced by health boards but no person or body in NHS Wales or the Welsh Government have read or assessed the reports. In the last quarterly reports produced and seen by Diabetes UK Cymru, all health boards in Wales reported failing to train their ward staff on diabetes care. It is not possible to say how long this deficiency has been in place or how it can be rectified.

<http://www.ombudsman-wales.org.uk/en/investigations/public-interest-reports-listed-by-subject/case-201100456.aspx>

ends

Agenda Item 2b

Health and Social Care Committee

HSC(4)-30-12(p2) – 15 November 2012

Inquiry into the implementation of the National Service Framework for diabetes in Wales and its future direction – Evidence from the Royal College of Physicians and the Association of British Clinical Diabetologists (ABCD)



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From The Registrar
Patrick Cadigan MD FRCP
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By email HSCCommittee@wales.gov.uk

20 September 2012

Dear Sir or Madam

Re: Inquiry into the implementation of the National Service Framework (NSF) for diabetes in Wales and its future direction

The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 26,000 Fellows and Members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

The RCP is grateful for the opportunity to respond to the above call for evidence. In so doing, we have liaised with the Association of British Clinical Diabetologists (ABCD) and would like to make the following joint submission.

We strongly believe that the inquiry should result in action. Data on the implementation of the NSF is available to the Welsh Government but deficiencies in implementation persist.

Diabetes teams in the hospital and community are able to implement most of the care outlined in the NSF. However, they are under considerable pressure from their provision of acute general medicine cover to unscheduled care.

The Welsh Government places great emphasis on empowering patients to manage their own conditions, and make decisions about their care. However, to this end, the lack of availability of structured education in diabetes in many areas of Wales is very unhelpful. Screening for diabetes also appears to be difficult to provide currently.

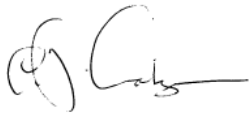
The deficiencies in implementation of the NSF share similar themes across the Welsh UHBs. For instance, most UHBs are not able to offer a psychology service specifically for people with diabetes.

More patients in Wales are likely to benefit from Insulin pump therapy and structures to address this should be supported, particularly at a time when funding in all areas of the NHS is being squeezed.

The quality of diabetes inpatient services in Welsh hospitals is variable, and should be addressed.

Diabetes teams should be empowered to deliver the NSF. The integration of primary and secondary care in Welsh UHBs should facilitate an integrated approach to Diabetes care for individuals with diabetes

Yours faithfully

A handwritten signature in black ink, appearing to read 'P. Cadigan', written in a cursive style.

Dr Patrick Cadigan
Registrar

Health and Social Care Committee

HSC(4)-30-12(p3) – 15 November 2012

Inquiry into the implementation of the National Service Framework for diabetes in Wales and its future direction – Evidence from BMA Cymru Wales

Fifth Floor, 2 Caspian Point, Caspian Way, Cardiff Bay, Cardiff, CF10 4DQ



September 2012

**National Assembly for Wales
Health and Social Care Committee**

**Inquiry into the implementation of the National Service Framework for
diabetes in Wales and its future direction**

INTRODUCTION

BMA Cymru Wales is pleased to provide a response to the Health and Social Care Committees inquiry into the implementation of the National Service Framework for diabetes in Wales and its future direction.

The British Medical Association represents doctors from all branches of medicine all over the UK. It has a total membership of just over 150,000 including more than 3,000 members overseas and over 19,000 medical student members.

The BMA is the largest voluntary professional association of doctors in the UK, who speak for doctors at home and abroad. It is also an independent trade union. BMA Cymru Wales represents some 7,000 members in Wales from every branch of the medical profession.

RESPONSE TO THE INQUIRY

Although BMA Cymru Wales is not submitting a substantive response to this inquiry, we have consulted our members across Wales on the implementation of the National Service Framework and we do wish to bring a number of their comments to your attention.

Please do not hesitate to contact BMA Cymru Wales should you require any further information.

General comments

There are around 160,000 people with diabetes in Wales. This equates to 5.0% of the population. QOF data has shown a significant and consistent increase in prevalence each year. It's estimated that 66,000 more people have the condition but have not yet been diagnosed. Much of this is due to the rising number of people who are overweight and obese. The annual Welsh Health Survey says the problem affects 57% of adults, with 22% being obese. In children, 35% are considered overweight or obese (19% obese).

Welsh Secretary: Dr Richard JP Lewis, CStJ MB ChB MRCGP Dip IMC RCS (Ed)
Chief Executive/Secretary: Tony Bourne

British Medical Association
bma.org.uk/wales

Diabetes costs NHS Wales £500m each year, and accounts for 15-20% of all hospital inpatients often with complex needs and requiring longer stays in hospital.

The prevalence of diabetes is remorselessly increasing and Wales figures are higher than UK average yet the resources to deal with this are travelling in the opposite direction as they come out of a budget that is shrinking in real terms.

We have been widely supportive of the 2003 National Service Framework (NSF). It is viewed by many as the key document for the planning and delivery of diabetes care in Wales.

Implementation of the NSF currently appears to be variable – even within LHBs –, for example, nearly all Type 2 diabetics in the North West are managed by GPs, with the hospital service looking after the bulk in the North East. As such, we would welcome a national analysis of the implementation of the NSF.

The status of the 2009 National Service Framework for Diabetes: Delivery Strategy, which provided an overview of compliance with the NSF, is unclear and we believe not used by Health Boards or Welsh Government.

We would support the revision and extension of the NSF/Delivery Strategy after an assessment of the implementation of the NSF both nationally and locally at the Health Board level - since performance against the standards appear to be largely unknown.

We believe that Health boards should be more accountable on their delivery of diabetes care and in meeting the requirements of the NSF, this should include regular reporting to the Welsh Government and detailed assessment and publication of their returns. It appears that data collection mechanisms do exist but that no analysis is undertaken by Government, therefore the Health Boards themselves do not know how they are performing comparatively. It is also testament to the failure of Welsh Government on this matter that the third sector has had to perform its own one-off data collection and analysis of Health Board performance.

Metabolic syndrome is a combination of medical disorders that, when presenting together, increase the risk of developing cardiovascular disease and diabetes. The term encompasses the whole spectrum and can be identified before diabetes has developed. In fact, if the Committee is looking at prevention as part of this inquiry then the focus should really be on Metabolic Syndrome and associated conditions, including:

- High blood pressure
- High blood sugar levels
- High levels of triglycerides, a type of fat, in your blood
- Low levels of HDL, the good cholesterol, in your blood
- Too much fat around your waist

Specific Comments

The aims of the NSF are well placed, and much has been established – such as GP registers and a recall system. But it is worth asking the question, were all the aims in the original document realistic and achievable? And are they still in 2012 since the nature and treatment of diabetes have changed since 2003.

The all Wales retinopathy screening also works well, though it is stretched and some members have stated that the annual review is slipping to every 15 months. Access to podiatry also needs to be improved.

GPs screening of the population is considered by some not to be very effective in isolation. Many GPs are undertaking this screening as an enhanced service, but lifestyle factors have the biggest part to play in prevention and reduction of incidence.

GPs are responsible for about 75-80% of diabetes care and treatment. QOF has facilitated the establishment of registers and the software needed to manage this - all patients should now be able to access an annual review at least, often more regular. Across Wales GP practices participate in the National Diabetic Audit via Audit+, this feeds in to the UK wide review of diabetes management.

In this way, it is important that primary care is involved in the local Diabetes Planning and Delivery Groups (DPDG) within Health Boards. It should be ensured that the DPDGs monitor rigorously the Health Boards progress in meeting the NSF. It is not clear whether this role is fulfilled at present; in fact it is questionable what the DPDGs do achieve. This should be looked at and their roles strengthened.

There needs to be a thorough review of how secondary care services are delivered and if this expertise would be better based in the community so support services can be accessed more easily.

Unlike activity based payments as seen in secondary care and despite the increased prevalence of diabetes, in primary care the nature of QOF (because QOF is a comparative payment not absolute) means that the increased numbers of patients with diabetes does not attract any additional funding for the GP team to deliver care. The movement of care into the community therefore results in GP practices having to pick up the cost from elsewhere as the extra work brings no resource once payment thresholds in the Diabetes DES have been exceeded.

Measures to tackle or reduce the number of people who are overweight or obese would greatly help to reduce the incidence of diabetes. The issue of the funding of surgery for those who are morbidly obese also needs to be looked at as many people, who have been clinically considered as suitable, with Type 2 diabetics can respond very well with this surgery.

An extensive public health campaign is needed to promote exercise, healthy eating and weight control. This could include an element of compulsion such as the introduction of robust legislation. The proposed Public Health (Wales) Bill could potentially have a huge role to play here. These two things will work to reduce the incidence of type 2 diabetes.

On the back of the Olympics perhaps Wales could take the lead in re-establishing physical education and sport as an important aspect of the curriculum in Wales from Infants through to University.

Only by an aggressive programme of health promotion, possibly backed by strong legislation, will we get there.

Other matters highlighted by members include:

RETINAL SCREENING

I agree that establishing the programme has helped to improve the baseline screening - but the service has been unable to meet the annual screen that was planned and is required under QOF - the programme needs to be modified in line with evidence supporting the most cost effective screening interval.

INCIDENCE /PREVALENCE

I agree that the health service in Wales needs to reduce the number of patients who have not been identified with DM but this will need to recognise that resources are required to support the increasing pressure on primary and community based services as a result of increase numbers of the population diagnosed with DM.

Increasing diagnoses will also have cost implications which need to be resourced.

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LOCAL DIABETES SERVICE ADVISORY GROUPS

Involvement by GPs is patchy and limited.

Local Medical Committees and General Practice Committee Wales (GPCW) have a professional interest in ensuring services for patients are delivered in an effective and safe manner and can support Health Boards and others to ensure resources are utilised to deliver care – feedback from colleagues suggest that this does not appear to be recognised and few LMCs/GPs appear to be actively invited to groups.

Health Boards should facilitate and support involvement of both GPs and practice nurse representatives on these groups and provides support for practices to release staff inc practice nurses.

AUDIT AND PERFORMANCE MANAGEMENT

This area appears to fall short. Data collection should also utilise information gathered for routine clinical care and management.

In General Practice we need to ensure that any new codes required for monitoring or audit also add to the delivery of care and not just be useful as a management/performance requirement.

ENSURING PROFESSIONAL STANDARDS

GPCW agrees that ongoing Training/CPD and ensuring that staff are up to date and informed is of fundamental importance to service provision and development. CPD organisers must ensure that CPD activity is organised and available locally, is relevant and that support to release staff is provided.

REDUCING THE BURDEN OF DM

Reducing the incidence of DM (and other chronic disease) will require a partnership approach between Government, Health Boards, Local Authorities, education providers at various levels, private industry and with individual communities to encourage healthy food choices and active lifestyles. The BMA has undertaken extensive work in this area – for example on childhood obesity, nutritional labelling and active travel and we eagerly await the publication of the Public Health (Wales) Bill.

ETHNICITY

We recognise that there is a need to pay significant attention to the ethnic minority population of Wales. GP Practices in areas consisting of a high proportion of ethnic minority residents will need additional support from Health Boards in meeting their needs as this is not adequately covered by QOF.

OLDER PEOPLES CARE

Diabetic care and services should not discriminate against patients on any basis, including that of age. It is important to recognise that there are certain factors which clinicians do need to consider when providing care / treatment for older people – for example, very tight diabetic control may result in adverse outcomes due to the increased risk of hypoglycaemia and falls. That said diagnosis, support, access to treatment or care etc should be no different.

OFFENDER HEALTH

It would appear evident that DM and other chronic conditions are more common amongst the prison population due to the lifestyle factors that increase the risk of DM and other chronic conditions – it would greatly inform the debate if Welsh Government were able to provide figures for the incidence /prevalence of diabetes and total numbers in the prison population.

Although “close liaison with diabetic specialist teams “ should be established - it does need to be recognised that GPs providing GMS care within a secure setting can and do provide the appropriate

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level of care with suitably trained general nursing staff and do not need specialist nursing staff/teams to visit/run services within a secure service.

Primary healthcare teams within the “secure setting” need to ensure inmates receive the same level of care within a prison setting as any individual would expect from the NHS.

WORKFORCE ISSUES

As GPs and practice nurses deliver the vast majority of diabetic care, the primary care team are key and should be supported by diabetic nurses and diabetologists – this needs to be recognised and prioritised by those tasked with developing workforce plans.

As more care is provided closer to patients’ homes and in the community, we need to ensure that resources follow this move. Including looking at the number of GPs and Practice / Community Nurses.

FUNDING

It is encouraging that it is recognised that the majority of care is delivered by GPs and their team. Some of this care goes beyond what resourced by OOF. There must be adequate resources provided for the primary care team in delivering diabetes care.

PERFORMANCE MANAGEMENT

Need to be wary of duplications here and what the impact is of performance management procedures in the time clinicians have to deliver direct care to patients.

STRUCTURED EDUCATION PROGRAMMES FOR PATIENTS

I am supportive of this, but the extent of provision across Wales is unclear and appears to be inconsistent at best.

RECORD KEEPING/SHARED CARE/PATIENT HELD RECORDS

Again we need be careful of duplications here, but this is an area which could be looked at and possible better ways of working identified.

EVIDENCE OF APPROPRIATE TRAINING /CPD

Agree this is required. For clinicians this will be evidenced through the clinical appraisal process and, when it commences, Revalidation.

GP/PRIMARY CARE LEADERSHIP

The Kings Fund recognises that the lead professionals ought to be based in primary care – I think that each HB/locality could identify and support GP champions to lead the services



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2 November 2012

Annwyl Mark

Health and Social Care Committee inquiry into the implementation of the national service framework for diabetes in Wales and its future direction in Wales

On behalf of the Welsh Pharmacy Board of the Royal Pharmaceutical Society and our members in Wales, I am pleased to submit comments to contribute to the above inquiry.

The RPS is the professional body for pharmacists in Wales and across Great Britain. We are the only body that represents all sectors of pharmacy.

The RPS promotes and protects the health and well-being of the public through the professional leadership and development of the pharmacy profession. This includes the advancement of science, practice, education and knowledge in pharmacy. In addition, it promotes the profession's policies and views to a range of external stakeholders in a number of different forums.

1. General comments

We welcome the review of the Diabetes NSF and the focus by the Committee on diabetes care in Wales. As the professional leadership body for pharmacy, we recognise the importance of developing services which adequately provide individuals diagnosed with diabetes with the professional advice and information needed to help them effectively manage their diabetes. We also acknowledge the importance of providing professional advice to individuals who may be at risk of diabetes and the importance of helping them to

understand more about the importance of diet, exercise and other lifestyle issues that could help reduce the risk of diabetes.

We have long advocated and continue to advocate that pharmacists, working in all settings, have a critical role to play in the prevention and management of diabetes. Using their extensive expertise in medicines, pharmacists can work with other healthcare professionals at different stages in the patient pathway to improve prevention, diagnosis, treatment and care. Some pharmacists are now independent prescribers and many have specialised in diabetes care offering patients additional opportunities to access a health care professional to support their ongoing diabetic care needs. Examples of areas where pharmacy can contribute to diabetes care are attached at Appendix A.

We have welcomed the increased focus on the management of diabetes in Wales stimulated by the Diabetes NSF and the Diabetes Consensus Guidelines¹ issued by the Welsh Assembly Government in 2008. We have generally been supportive of the principles and actions contained in these frameworks and in particular their intent to incorporate the role of pharmacists in service developments across the diabetes care pathway. We must however echo the points we previously made to the Committee and reiterate our concern that opportunities have been missed in harnessing the skills of pharmacists in the development of models of care across Wales.

2. Missed opportunities for diabetes care in Wales

Our submission to the Committee's inquiry into the contribution of community pharmacy to health services in Wales² outlined a number of areas where we believe opportunities have been missed to harness the skills and benefits of pharmacy into models of primary care. We believe that the same issues are equally relevant when considering developments in diabetes care in Wales and would like to emphasise a number of key points with regard to diabetes care:

2.1 Integrating community pharmacy services into primary care models of diabetes care

The Diabetes NSF and the Consensus Guidelines are underpinned by the concept of

¹ Welsh Government (2008) [*Designed for the Management of Adults in Diabetes Mellitus across Wales: Consensus Guidelines*](#), October 2008 (Accessed 25th October 2012)

² Royal Pharmaceutical Society (2011) [*RPS Contribution to Health and Social Care Committee's inquiry into the contribution of community pharmacy to health services in Wales*](#), September 2011

integrated care provided by multidisciplinary health care teams. Community pharmacy services are referred to explicitly in a number of the NSF Standards and the potential to incorporate pharmacy services into diabetes care existed right from the outset when the NSF was issued in 2003. We believe however that after nearly a decade opportunities have been missed in the implementation of the NSF to formally integrate the role of community pharmacy into national and standardised primary care models for diabetes care. This is disappointing given that the mechanisms for integration were readily available from 2005 onwards following the introduction of the Community Pharmacy Contractual Framework (CPCF).

We believe opportunities could have been taken to use the provisions of the CPCF to develop national enhanced services for diabetes care to help deliver the NSF in the areas of health promotion, medicines management and self care support. We continue to advocate that services of this nature can be developed in a way which complements the care provided by GPs, ensuring patients can access the appropriate healthcare professional at the right time. We are particularly supportive therefore of the Committee's recommendations following the inquiry into community pharmacy in 2011 regarding the development of a national specification for community pharmacy enhanced services including a national Chronic Conditions Services.

2.2 A coordinated approach to health promotion

In terms of health promotion and raising awareness of diabetes we were fully supportive of the community pharmacy diabetes risk health promotion campaign in 2011. The review of this campaign³ clearly demonstrated the potential of community pharmacy in reaching a high number of people through campaign activity. While we welcome the development of annual public health campaigns delivered through community pharmacy as part of contractual obligations we believe more could be done on a regular basis to ensure pharmacists can help raise awareness of diabetes and signpost people who may be at risk to their GP as part of a formalised and coordinated process.

There is a significant volume of research which suggests that pharmacy interventions can have long term positive effects for people already diagnosed with diabetes in terms of

³ Public Health Wales (2011) [Community pharmacy diabetes risk health promotion campaign](#), August 2011 (Accessed 24th October 2012)

adopting healthy lifestyles as well as self managing their condition more effectively. We believe that the opportunity for providing health promotion advice and structured patient education through pharmacy should be incorporated into NHS service developments, ensuring pharmacy plays a significant and recognised role in disease prevention and the identification of people at risk of diabetes.

3. Issues for future service developments

We continue to advocate that pharmacists should be the universally accessible frontline clinical provider of all aspects of pharmaceutical care, responsible for all aspects of medicines use and management. Anecdotally, conversations with our members suggest that the role of pharmacists does not receive much attention in the development of local plans to deliver national frameworks, including the Diabetes NSF. The lack of new integrated models of care would tend to support this anecdotal evidence.

After nearly a decade, the principles of the Diabetes NSF remain relevant and important to the care of people with diabetes in Wales today. As far as the role of pharmacy is concerned in diabetes care we would ask that the following issues are given careful consideration in the development of future integrated services in Wales:

3.1 Access to the Individual Health Record

In order to achieve meaningful and effective integration in primary care and across patient pathways as outlined in 'Together for Health', we believe it is essential that pharmacists are able to have secure access and input to a patient's electronic health record. A truly integrated system could be used to help reduce prescribing errors, reduce levels of wasted medicines, reduce costs and ensure continuity of shared care. It could also facilitate dialogue between pharmacists and other health professionals, including GP's - the most effective method of improving patient healthcare. In terms of diabetes care, ensuring access by pharmacists to the Individual Health Record (IHR) will help them to provide the right advice on lifestyle and medication, tailored to the specific health needs of each individual diagnosed with diabetes.

We raised the issue of access to the IHR previously to the Committee during the inquiry into the contribution of community pharmacy to health services and welcomed the recommendation of the committee to ensure "*access to summary patient records when*

*patients are registered with a community pharmacy*⁴. We maintain that access to the IHR is essential for modern pharmacy services in Wales, providing pharmacists with the tools to support professional judgement in their role in unscheduled patient care. We were disappointed therefore that the recent NHS Wales Informatics Service (NWIS) consultation strategy for enabling integrated information services in 2012⁵ did not include community pharmacy within its vision for the integration of services. We have responded to the NWIS consultation calling for community pharmacy systems and access to the Individual Health Record (IHR) to be included in their final strategy.

3.2 Ongoing pharmaceutical care and support

Ongoing pharmaceutical care is a key ingredient in effective diabetes care. To ensure patients can get the best from their medicines following a diagnosis of diabetes and the development of treatment plan, patients should expect to receive medication checks and support from their community pharmacist. Medicine Use Reviews (MURs), undertaken on an annual basis, provide an ideal framework to allow community pharmacists to help patients understand more about their medicines, identify problems they may have in taking their medicines and identify patients who may be at risk of making poor use of their medicines through poor adherence. Similarly Discharge Medication Reviews (DMRs) play an essential role in ensuring a safe and effective transition from hospital to home. It is important that these services are appropriately resourced and that community pharmacy is supported on a regular basis to provide the advice and support that patients need to optimise medicines use, reduce waste, improve health outcomes and deliver better value for the NHS for investment made in medicines.

3.3 Improved dispensing and prescribing arrangements

There should be better use of the NHS repeat dispensing service to increase efficiency, streamline practice workloads and improve patients' access to their medicines. Independent pharmacist prescribers have undertaken extra training and may prescribe autonomously for any condition within their clinical competence. These skills can particularly benefit patients with long-term conditions and complex medication regimes. The RPS and RCGP are

⁴ National Assembly for Wales Commission (2012) [Inquiry into the contribution of community pharmacy to health services in Wales – Key conclusions and recommendations](#) – page 1, May 2012 (accessed 24th October)

⁵ NHS Wales Informatics Service (2012) [Enabling Integrated Care: The health and social care strategy for enabling integrated information services in 2012 – Draft for consultation](#), September 2012 (Accessed 24 October 2012)

developing processes to facilitate GPs and pharmacists working more closely together, to utilise these skills where they can best improve patient care.

4. A standard model of pharmaceutical care for diabetes care

If these issues in 3.1 – 3.3.above are appropriately addressed we believe Wales could benefit from a standardised model of diabetes care where:

- Pharmaceutical care planning is integral to the diabetes care pathway
- Pharmacists are responsible for the pharmaceutical care of patients with diabetes and an integral part of the multidisciplinary diabetes team
- Electronic communication allows the transfer of prescriptions and clinical data between care settings, the pharmacists, and other members of the multi disciplinary team
- Pharmacists have appropriate access to the Individual Health Record
- Health promotion for diabetes patients is a key domain of community pharmacy
- Repeat prescriptions for diabetes patients is the responsibility of community pharmacy
- The specialist skills of pharmacist independent prescribers are utilised to support the long term care of people with diabetes
- Community pharmacy acts as a gateway for referral to other services when health promotion and illness prevention interventions fail.

Appendix B illustrates how this vision of integrated care might translate into practice for diabetes care.

5. Key recommendations

We believe that the key to the integration of pharmacy into diabetes care essentially rests with the effective implementation of multidisciplinary models of chronic conditions management in Wales. The tools for improvement have already been developed including the Diabetes NSF, the Consensus Guidelines, the Model and Framework for Chronic Conditions Management, and the CPCF. These tools now need to be used innovatively to develop multi-disciplinary care that is truly integrated.

Specifically we recommend the following action is taken to help improve diabetes care in Wales:

Recommendation 1: Urgent action should be taken to ensure pharmacists in all healthcare settings can appropriately access the Individual Health Record as part of an integrated IM&T strategy for Wales

Recommendation 2: A national specification for community pharmacy enhanced services should be developed as part of a Welsh Chronic Conditions Service that incorporates:

- Risk assessment
- Health promotion activity and lifestyle advice
- Self Care advice
- Medicines Management advice and adherence support
- Independent prescribing
- Medication review
- Signposting and referral to other services
- Integration with the diabetes care pathway

Recommendation 3: Local Health Boards should take steps to improve pharmaceutical care and medicines safety by harnessing the skills of pharmacists in the development of integrated, multidisciplinary diabetes pathways of care.

Recommendation 4: Enhanced service developments that incorporate the skills of pharmacist prescribers should be explored and developed to meet the needs of patients with chronic conditions including diabetes.

I trust this response is helpful and look forward to elaborating on these issues in due course.

Yr eiddoch yn diffuant



Paul Gimson
RPS Director for Wales

cc. Health and Social Care Committee Clerk

Areas where pharmacy interventions can improve diabetes care

Community pharmacists and their teams play a central role in the daily life of people with diabetes. Examples of areas of the patient pathway in which pharmacists are making successful interventions include:

Disease prevention

Pharmacists can help to identify people at risk of developing diabetes, offer lifestyle advice and appropriate interventions. Some medicines predispose people to a risk of diabetes and this risk may be identified as part of the repeat dispensing process. As part of their public health role, pharmacists can give healthy eating advice or smoking cessation support.

Diagnosis

Early diagnosis of diabetes can significantly reduce the risk of developing complications. Pharmacists can identify symptoms which require onward referral for medical intervention from requests for over the counter medicines and when advising for minor ailments. Community pharmacy staff are familiar with the symptoms of diabetes and are well-placed to identify patients with the condition when they present a prescription or request an over the counter (OTC) medicine.

Disease management

Following a diagnosis of diabetes, pharmacists can contribute to the patient's knowledge of their condition, boost understanding of their medicines and increase their ability to self-care. They can also improve patients' adherence to medicines, which can be extremely poor in people with long-term conditions. It is estimated that up to 50 per cent of patients do not take their medications correctly and up to two-thirds of people with type 2 diabetes do not take their oral hypoglycaemics as prescribed.

Medicines Use Reviews (MURs) provide an opportunity for a patient to meet with a pharmacist and discuss the medicines they have been prescribed. The pharmacist will help patients to understand how their medicines should be used, why they have to take them, and to identify any problems.

A vision of integrated community pharmacy services in Wales

The following scenario outlines a vision where community pharmacy services can work much more effectively, delivering a greater range of services and enhancing patient care in the community. To achieve this level of service however the CPCF will need to be utilised more effectively in local and national planning.

Mrs Jones is a regular visitor of her local community pharmacy, for her families self care needs. She mentions to the healthcare assistant (who as part of the national scheme has been trained as a health advisor) how tired she feels as she is not getting a good night's sleep due to the number of times she needs to get up in the night to go to the toilet. She is referred to the pharmacist for a consultation.

The pharmacist recommends that Mrs Jones has her blood pressure and blood glucose checked through the pharmacy "early detection" screening service. The tests show above normal levels of blood glucose and a raised blood pressure. An appointment is made for Mrs Jones to re-attend the pharmacy for a fasting blood glucose test and to recheck her blood pressure, at which it was found that both her blood glucose and blood pressure were still above national guideline recommendations and the local referral guidelines agreed with the patient's practice. The pharmacist discusses the results with Mrs Jones and sends them to her GP. An appointment is booked electronically for Mrs Jones to have an assessment at her GP's Surgery. After a diabetic assessment in the surgery the GP confirms the diagnosis of early type 2 Diabetes and she is registered as such.

As a person with a chronic condition she is regularly assessed including an annual review by the practise nurse with foot checks, referral for retinopathy, lifestyle and dietary advice and a full clinical medication review by the practice pharmacist.

As Mrs Jones' blood pressure is not controlled, the pharmacist changes Mrs Jones' medication and arranges for on going monitoring of her blood pressure and HbA1c through her local pharmacy .The community pharmacist enters all relevant information electronically onto Mrs Jones' medical record and periodically rings Mrs Jones to see if she has any problems with her medication.

Once Mrs Jones condition has been stabilised she uses the 'Repeat Prescription Scheme' to obtain her medication.

Once a year Mrs Jones's community pharmacist undertakes her Medicines Use Review (MUR) to check compliance issues and the information is fed directly into Mrs Jones' medical record electronically. The pharmacy also provides Mrs Jones with healthy lifestyle advice that is supportive to the management of her condition.

Overall community pharmacy contributes effectively to the care of Mrs Jones, allowing for opportunistic interventions and referrals to others service, monitoring of her medication needs as her condition changes, and support to allow Mrs Jones understand more about the medicines she is taking. This level of service maximises health outcomes for Mrs Jones and stabilizes her chronic conditions. It also prevents emergency admissions to hospital and reduces pressures on the acute sector of the NHS, ensuring the most complex and urgent cases are not delayed.

Inquiry into the implementation of the National Service Framework for diabetes in Wales and its future direction – Evidence from Alliance Boots



A submission from Alliance Boots

Executive summary

- Community pharmacies play a vital part in the treatment of people with diabetes. They are regular users of pharmacies, in some cases for their whole lives.
- Alliance Boots believes that more emphasis needs to be put on implementing Standards 1 and 2 of the NSF – reducing the risks of developing diabetes; and early identification of people who do not know they have the disease.
- All-Wales arrangements should be put in place to allow pharmacies to support patients with diabetes in four key areas: prevention, early identification, support at diagnosis, and long-term support.
- Pharmacies, with their convenient locations, accessibility and wide reach across the community could deliver services targeted towards at-risk populations, particularly those which are not regularly using GP surgeries.
- Greater support to help patients with medicines, particularly in the crucial first 90 days following diagnosis and the prescription of new medicines, would help increase adherence with long-term treatments
- These pharmacy services should form part of the new Chronic Conditions Service recommended by the Committee in its report on “the contribution of community pharmacy to health care services in Wales”.

Crynodeb gweithredol

- Mae gan fferyllfeydd cymunedol ran hollbwysig wrth drin pobl gyda diabetes. Maent yn defnyddio fferyllfeydd yn gyson, mewn rhai achosion ar hyd eu hoes.
- Mae Alliance Boots yn credu fod angen rhoi mwy o bwyslais ar weithredu Safonau 1 a 2 y Fframwaith Gwasanaeth Cenedlaethol – gostwng y risg o ddatblygu diabetes, a dynodi'n gynnar y bobl na wyddant fod diabetes arnynt.
- Dylid rhoi trefniadau ar waith ar draws Cymru i ganiatáu i fferyllfeydd gefnogi cleifion gyda diabetes mewn pedwar maes allweddol: atal, dynodi cynnar, cefnogaeth adeg diagnosis, a chefnogaeth hirdymor.
- Gallai fferyllfeydd, gyda'u lleoliadau cyfleus, hygyrchedd a chyrraedd eang ar draws y gymuned gyflenwi gwasanaethau sydd wedi'u targedu tuag at boblogaethau mewn risg, yn arbennig rai nad ydynt yn defnyddio meddygfeydd yn rheolaidd.
- Byddai mwy o gefnogaeth i helpu cleifion gyda meddyginiaeth, yn arbennig yn y 90 diwrnod hollbwysig yn dilyn diagnosis a phresgripsiwn am feddyginiaeth newydd, yn helpu i gynyddu cydymffurfiaeth gyda thriniaethau hirdymor.
- Dylai'r gwasanaethau fferylliaeth ffurfio rhan o'r Gwasanaeth Cyflyrau Cronig a argymhellwyd gan y Pwyllgor yn ei adroddiad ar "Cyfraniad Fferylliaeth Gymunedol i Wasanaethau Gofal Iechyd yng Nghymru".

About Alliance Boots

At Alliance Boots, our mission is to be the world's best pharmacy-led health and beauty group. The group's businesses in the UK employ over 70,000 people. These businesses include:

- Boots UK pharmacy chain (2,472 stores)
- Boots Opticians (655 practices)
- Alliance Healthcare (Distribution) Ltd, our full-line wholesaler (12 service centres)
- Central Homecare, our clinical homecare specialist division

There are 101 Boots stores in Wales, of which 99 have registered pharmacies. In Wales, our business employs around 2,000 people, including:

- 180 pharmacists
- 280 healthcare assistants
- 30 trainee pharmacists (one-year posts)

Boots pharmacies are well distributed across Wales and are located in places where people live, shop, work and travel, with many open well beyond normal office hours and at weekends. Our chain encompasses those which serve small, local and rural communities, including some of the most deprived locations in the country, through to high streets and those which are part of the largest retail and destination shopping centres.

Alliance Healthcare (Distribution) Ltd is the only UK wholesaler delivering medicines to all pharmacies, dispensing doctors and hospitals. Our Fforestfach service centre in Swansea makes deliveries to pharmacies across Wales. Around 200 people are employed at Fforestfach.

Alliance Healthcare also offers innovative added-value services to its independent pharmacy customers across Wales, such as flu vaccination training, an online service for private prescriptions (Web-prescriptions), support materials for medicines use reviews and for other NHS-commissioned services. Alliance Healthcare also supports Alphega, a pan-European virtual pharmacy network. Alphega has 19 participating independent pharmacies in Wales.

1. The role for community pharmacy in Wales in relation to diabetes

- 1.1. Community pharmacy has expanded its role in recent years and now provides a wide range of clinical and public health services (NHS and non-NHS) within easy reach of the people who need them most.
- 1.2. Pharmacists are able to help people maintain and improve their health; providing health messages, advice and services in areas such as physical activity, diet and weight management, stopping smoking, minor ailments and sexual health. Many of these are of particular relevance to people with diabetes.
- 1.3. Community pharmacies already play a vital part in the treatment of people with diabetes. Alongside healthy diet, medicines are the mainstay of treatment for people with both Type 1 (insulin-dependent) and Type 2 (non-insulin-dependent) diabetes. These people are regular users of pharmacies, in some cases for their whole lives.
- 1.4. Although they receive a good service from pharmacies through getting regular and convenient supplies of the medicines they need, we believe that more could be done to support patients with taking their medication. This is discussed later.
- 1.5. We also believe that pharmacies should play a much greater role in helping to identify people who do not know that they have diabetes. Many of the early symptoms of diabetes – thirst, tiredness, frequent urination – can seem minor. People may seek relief from symptoms through self-medication or other products bought from pharmacies rather than consult a GP. This gives many opportunities for pharmacies to help with early identification and referral for diagnosis or treatment.
- 1.6. Pharmacies in Wales have already successfully taken part in public health campaigns designed to raise awareness of the symptoms of diabetes and to screen customers who might be at risk. We discuss later how we think these schemes could be expanded and extended nationally.

2. The progress being made on implementing the NSF for diabetes and its adequacy and effectiveness in preventing and treating diabetes in Wales

- 2.1. We believe that the care for people with diabetes has improved over the past decade. In part, this can be attributed to the national service framework (NSF), alongside the targeting of diabetes within the Quality and Outcomes Framework (QOF) of the General Medical Services contract for GPs.
- 2.2. During 2011, over 6.4 million prescriptions items were dispensed in Wales for medicines under the British National Formulary heading of “endocrine diseases” (predominantly diabetes) at a cost of nearly £69m¹.
- 2.3. Since 2003, the total number of medicines dispensed has risen by 42% to 72.2 million, but the average cost of each item has actually fallen by 23% to £8.14 per item. This is in large part due to the purchasing efficiencies driven by community pharmacies.
- 2.4. Another key area has been the improvement in treatments, such as new longer-acting insulin products and more sophisticated systems for administering them, and new medicines. Diagnostic equipment, used by patients for the self-measurement of blood glucose levels, has also improved markedly, becoming more accurate and more portable.

¹ Prescriptions dispensed in the community in Wales, 2001 to 2011. Statistics for Wales, March 2012.

Recently we have seen these tests being linked to new technologies, including smartphones, to give patients greater control over how they live with diabetes.

- 2.5. However, we believe that the areas that have not progressed so well since the NSF was launched relate to Standards 1 and 2 – reducing the risks of developing Type 2 diabetes and identifying people who do not know they have the disease.
- 2.6. In order to reach the ambitions of “Together for Health” for improving health as well as treating illness, the Welsh Government will need to put a much greater focus on prevention and early identification of major chronic diseases. Community pharmacies could play a key role in this.
- 2.7. The debate around creating a “compact with the people of Wales”, currently out for consultation about initial views, could be one way of increasing this focus. Many of the risk factors for diabetes are inherent from an unhealthy lifestyle – poor diet, lack of exercise, smoking and excessive drinking. Unless the public is also involved with improving its own health, the NHS will be doomed to an unsustainable future of “picking up the pieces”.

3. Potential future actions

- 3.1. We believe that all-Wales arrangements should be put in place that allow pharmacies to support the implementation of Standards 1, 2 and 4 (patients will receive high quality care throughout their lifetime) within the diabetes NSF. These would focus on four stages: prevention, early identification, support at diagnosis, and long-term support.
- 3.2. **Supporting healthy lifestyles** Pharmacies take part in health promotion campaigns organised by Public Health Wales and LHBs. Three of these are now national, which helps in getting bigger public health messages across. We believe that this work needs to be developed in a structured and comprehensive way, similar to the work being done in Scotland through the Public Health Service elements of the pharmacy contract. Pharmacy staff, predominately recruited from their own neighbourhoods, make passionate and trusted advocates for services to aid healthy living, including weight management, smoking cessation and alcohol interventions. Boots pharmacies participated in the national diabetes risk awareness campaign in 2011 and the “One in 10” national campaign on combined stroke and diabetes risk in September 2012. We are pleased that more campaigns are being organised on an all-Wales basis, as this assists with the logistics of distributing materials to our pharmacies and getting feedback from them.
- 3.3. **Early identification** Pharmacies should be able to undertake risk assessments and basic tests on customers who might be at risk from diabetes (or other long-term conditions). People would be identified on the basis of self-referral following NHS Wales awareness campaigns or in-pharmacy promotion of the service. Pharmacy staff would also consider customers for assessment on the basis of other interventions, such as consultations for non-prescription medicines or minor ailments. These services would target at-risk populations using the convenience, accessibility and reach of pharmacies, especially for those who are not regular visitors to GPs. Referrals would be made to GPs or appropriate support services, as required. These services do not have to be confined to diabetes alone. The recent “One in 10” public health campaign focused on the estimated one in 10 of the Welsh population at risk from either diabetes or strokes.
- 3.4. **Support at diagnosis** Once a patient has had a clinical diagnosis of diabetes (or another chronic condition) there is then a period in which more intensive support is needed to help them come to terms with the diagnosis and its consequences. This would include support for patients who have been prescribed a long-term medication for the first time. Pharmacies should be able to help these patients during the first 90 days through providing support for self-care, signposting local support organisations, providing

information, advice and, if necessary, aids or devices to support medicines management and enhance compliance, alongside lifestyle change support.

- 3.5. **Long-term support** Once patients have been established on treatment for diabetes, as above [Para 3.4], then there is a continuing need to for support to ensure that they get the best from their medication. This is particularly important when the effects of the disease, or related complications such as high blood pressure, may not be immediately obvious. Pharmacies are already able to undertake annual medicines use reviews (MURs) and to reconcile medicines after discharge from hospital (DMRs) but pharmacies should also be able to support patients on a continuous basis, as necessary, with advice, aids or devices, and/or reminders (such as charts or text messages). Increased adherence should help maintain health and prevent or delay the development of complications, reducing hospital admissions.

4. Recommendations

- 4.1. Alliance Boots would like to make the following recommendations to the Health and Social Care Committee as part of its inquiry into the implementation of the NSF for diabetes and its future direction:
- Greater emphasis should be placed on implementing Standards 1 and 2 of the NSF (prevention and early identification). Community pharmacies should be involved in delivering this through structured all-Wales services and campaigns
 - More support should be given to patients who have been newly diagnosed with diabetes (and other chronic conditions). A service should be put in place to allow pharmacies to support patients through the crucial first 90 days after being prescribed a new medicine
 - Services should be developed to support patients on long-term medicines in order to improve adherence and delay complications
 - These pharmacy services should form part of the Chronic Conditions Service recommended by the Committee in its report on “the contribution of community pharmacy to health care service in Wales” [May 2012, Recommendation 4, p56]

Response submitted by:

Sian Wilton
Head of Wales
Boots UK
Regional Pharmacy Office
36 Queen Street
Cardiff CF10 2RG

21 September 2012

Health and Social Care Committee

Meeting Venue: **Committee Room 1 – Senedd**

Meeting date: **Wednesday, 17 October 2012**

Meeting time: **10:30 – 12:25**

This meeting can be viewed on Senedd TV at:

http://www.senedd.tv/archiveplayer.jsf?v=en_200000_17_10_2012&t=0&l=en

Cynulliad
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Wales



Concise Minutes:

Assembly Members:

Mark Drakeford (Chair)
Mick Antoniw
Rebecca Evans
Vaughan Gething
William Graham
Elin Jones
Darren Millar
Lindsay Whittle
Kirsty Williams

Witnesses:

Lesley Griffiths, Minister for Health and Social Services
Gwenda Thomas, Deputy Minister for Children and Social Services
Alan Brace, Welsh Government
Steve Milsom, Welsh Government
David Sissling, Welsh Government

Committee Staff:

Llinos Dafydd (Clerk)
Catherine Hunt (Deputy Clerk)

1. Introductions, apologies and substitutions

1.1 Apologies were received from Lynne Neagle. There were no substitutions.

2. Welsh Government Draft Budget 2013–2014 – Ministerial scrutiny

2.1 The Minister for Health and Social Services and the Deputy Minister for Children and Social Services responded to questions from members of the Committee.

3. Papers to note

3.1 The Committee noted the letter from Minister for Finance and Leader of the House.

4. Motion under Standing Order 17.42(vi) to exclude the public from the meeting for item 4

4.1 The Committee agreed the Motion.

5. Welsh Government Draft Budget 2013–2014 – Consideration of evidence

5.1 The Committee discussed the evidence it had received and the key issues to be included in its letter to the Finance Committee.

TRANSCRIPT

View the [meeting transcript](#).

Health and Social Care Committee

Meeting Venue: **Committee Room 1 – Senedd**

Meeting date: **Thursday, 25 October 2012**

Meeting time: **09:30 – 13:59**

This meeting can be viewed on Senedd TV at:

http://www.senedd.tv/archiveplayer.jsf?v=en_200000_25_10_2012&t=0&l=en

http://www.senedd.tv/archiveplayer.jsf?v=en_200002_25_10_2012&t=0&l=en

Cynulliad
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National
Assembly for
Wales



Concise Minutes:

Assembly Members:

Mark Drakeford (Chair)
Mick Antoniw
Rebecca Evans
Vaughan Gething
William Graham
Elin Jones
Lynne Neagle
Lindsay Whittle

Witnesses:

Grant Duncan, Welsh Government
Dr Chris Jones, Welsh Government
Sarah Wakeling, Welsh Government
Sarah Rochira, Older People’s Commissioner for Wales

Committee Staff:

Sarah Beasley (Clerk)
Llinos Dafydd (Clerk)
Catherine Hunt (Deputy Clerk)
Sarah Sargent (Deputy Clerk)
Stephen Boyce (Researcher)

1. Introductions, apologies and substitutions

1.1 Apologies were received from Darren Millar and Kirsty Williams for the whole meeting and from Elin Jones and Lynne Neagle for the afternoon session.

2. Scrutiny of the Older People’s Commissioner for Wales’ Annual Report

2.1 The Older People's Commissioner for Wales responded to questions from members of the Committee.

3. Papers to note

3.1 The Committee noted the minutes of the meetings held on 3 and 11 October.

4. Motion under Standing Order 17.42(vi) to exclude the public from the meeting for item 5

4.1 The Committee agreed the Motion.

5. Inquiry into Residential Care for Older People – Consideration of draft report

5.1 The Committee considered the draft report and agreed to schedule a session to consider it again on 7 November.

6. Draft Human Transplantation (Wales) Bill – Factual briefing from Welsh Government officials

6.1 The officials responded to questions from members of the Committee on the draft Human Transplantation (Wales) Bill.

TRANSCRIPT

View the [meeting transcript](#).

Health and Social Care Committee

Meeting Venue: **Committee Room 1 – Senedd**

Meeting date: **Wednesday, 7 November 2012**

Meeting time: **09:30 – 11:55**

This meeting can be viewed on Senedd TV at:

http://www.senedd.tv/archiveplayer.jsf?v=en_200000_07_11_2012&t=0&l=en

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Concise Minutes:

Assembly Members:

Mark Drakeford (Chair)
Mick Antoniw
Rebecca Evans
Vaughan Gething
William Graham
Elin Jones
Darren Millar
Lynne Neagle
Lindsay Whittle
Kirsty Williams

Witnesses:

Lesley Griffiths, Minister for Health and Social Services
Christopher Brereton, Welsh Government
Christopher Humphreys, Welsh Government

Committee Staff:

Fay Buckle (Clerk)
Claire Griffiths (Deputy Clerk)
Lisa Salkeld (Legal Advisor)

1. Introductions, apologies and substitutions

1.1 There were no apologies or substitutions.

2. Food Hygiene Rating (Wales) Bill: Stage 2 – Consideration of Amendments

2.1 In accordance with Standing Order 26.21, the Committee will dispose of amendments to the Bill in the following order:

Sections 1 – 26

Schedule

2.2 The Committee considered and disposed of the following amendments:

Section 1:

No amendments were tabled to this section, therefore it was deemed agreed to.

Section 2:

Amendments 1, 2 and 3 (Lesley Griffiths) were agreed to, in accordance with Standing Order 17.34 (i).

Section 3 and 4:

No amendments were tabled to this section, therefore it was deemed agreed to.

Section 5:

Amendment 28 (Darren Millar)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Mick Antoniw Mark Drakeford Rebecca Evans Vaughan Gething Lynne Neagle	
5	5	0
As the vote was tied, the Chair used his casting vote in the negative (in accordance with SO 6.20 (ii)), Amendment 5 was not agreed to.		

As Amendment 28 was not agreed to, Amendment 29 (Darren Millar) fell.

Amendments 4 and 5 (Lesley Griffiths) were agreed to, in accordance with Standing Order 17.34 (i).

Amendment 6 (Lesley Griffiths)

For	Against	Abstain
Mick Antoniw Mark Drakeford Rebecca Evans Vaughan Gething Lynne Neagle Elin Jones Lindsay Whittle Kirsty Williams	William Graham Darren Millar	
8	2	0
Amendment 6 was agreed to.		

Amendments 7, 8 and 9 (Lesley Griffiths) were agreed to, in accordance with Standing Order 17.34 (i).

Section 6:

Amendment 33 (Kirsty Williams)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Mick Antoniw Mark Drakeford Rebecca Evans Vaughan Gething Lynne Neagle	
5	5	0
As the vote was tied, the Chair used his casting vote in the negative (in accordance with SO 6.20 (ii)), Amendment 33 was not agreed to.		

Amendment 34 (Kirsty Williams)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Mick Antoniw Mark Drakeford Rebecca Evans Vaughan Gething Lynne Neagle	
5	5	0
As the vote was tied, the Chair used his casting vote in the negative (in accordance with SO 6.20 (ii)), Amendment 34 was not agreed to.		

Amendment 10 (Lesley Griffiths)

For	Against	Abstain
Mick Antoniw Mark Drakeford Rebecca Evans Vaughan Gething Lynne Neagle	William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	
5	5	0
As the vote was tied, the Chair used his casting vote in the negative (in accordance with SO 6.20 (ii)), Amendment 10 was not agreed to.		

Amendment 35 (Kirsty Williams)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Mick Antoniw Mark Drakeford Rebecca Evans Vaughan Gething Lynne Neagle	
5	5	0
As the vote was tied, the Chair used his casting vote in the negative (in accordance with SO 6.20 (ii)), Amendment 35 was not agreed to.		

Amendment 11 (Lesley Griffiths) was agreed to, in accordance with Standing Order 17.34 (i).

Section 7:

Amendment 23 (Elin Jones)

For	Against	Abstain
William Graham Elin Jones Darren Millar Lindsay Whittle Kirsty Williams	Mick Antoniw Mark Drakeford Rebecca Evans Vaughan Gething Lynne Neagle	
5	5	0
As the vote was tied, the Chair used his casting vote in the negative (in accordance with SO 6.20 (ii)), Amendment 23 was not agreed to.		

Amendment 26 (Elin Jones) was withdrawn.

Amendment 30 (Darren Millar)

For	Against	Abstain
William Graham Darren Millar Kirsty Williams	Mick Antoniw Mark Drakeford Rebecca Evans Vaughan Gething Elin Jones Lynne Neagle Lindsay Whittle	
3	8	0
Amendment 30 was not agreed to.		

As Amendment 23 was not agreed to, Amendment 24 (Elin Jones fell).

As Amendment 30 was not agreed to, Amendment 31 (Darren Millar fell).

Section 8:

Amendment 12 (Lesley Griffiths) was agreed to, in accordance with Standing Order 17.34 (i).

Section 9:

As Amendment 23 was not agreed, Amendment 25 (Elin Jones) fell.

As Amendment 26 was withdrawn, Amendment 27 (Elin Jones) fell.

As Amendment 30 was not agreed, Amendment 32 (Darren Millar) fell.

Amendments 13 and 14 (Lesley Griffiths) were agreed to, in accordance with Standing Order 17.34 (i).

Section 10:

No amendments were tabled to this section, therefore it was deemed agreed to.

Section 11:

Amendments 15, 16 and 17 (Lesley Griffiths) were agreed to, in accordance with Standing Order 17.34 (i).

Sections 14 – 21:

No amendments were tabled to these sections, therefore they were deemed agreed to.

Section 22:

Amendment 18 (Lesley Griffiths) was agreed to, in accordance with Standing Order 17.34 (i).

New Section:

Amendment 19 (Lesley Griffiths) was agreed to, in accordance with Standing Order 17.34 (i).

Section 23:

No amendments were tabled to this sections, therefore it was deemed agreed to.

Section 24:

Amendments 20 and 21 (Lesley Griffiths) were agreed to, in accordance with Standing Order 17.34 (i).

Section 25:

Amendment 22 (Lesley Griffiths) was agreed to, in accordance with Standing Order 17.34 (i).

Section 26:

No amendments were tabled to this sections, therefore it was deemed agreed to.

Schedule

No amendments were tabled to the schedule, therefore it was deemed agreed to.

2.3 The Chair advised that all sections of the Bill had been agreed by the Committee and as all amendments had been disposed of, Stage 3 will commence from 8 November 2012.

2.4 Under standing order 26.27, Members agreed that the Welsh Government should prepare a revised Explanatory Memorandum.

3. Motion under Standing Order 17.42(vi) to exclude the public from the meeting for item 4

3.1 The Committee agreed the motion.

4. Inquiry into Residential Care for Older People – Consideration of draft report

4.1 The Committee considered the draft report and agreed to schedule a session to consider it again on 15 November.

TRANSCRIPT

View the [meeting transcript](#).

Health and Social Care Committee

HSC(4)-30-12 paper 6

Health and Social Care Committee Forward Work Programme: November – December 2012

To: Health and Social Care Committee

From: Committee Service

Meeting date: 15 November

Purpose

1. This paper invites Members to note the Health & Social Care Committee timetable attached at Annex A.

Background

2. Attached at Annex A is a copy of the Health & Social Care Committee's timetable until the Christmas 2012 recess.

3. It is published as an aid to Assembly Members and any members of the public who may wish to be aware of the Committee's forward work programme. A document of this kind will be published by the Committee at regular intervals.

4. The timetable is subject to change and may be amended at the Committee's discretion as and when relevant business arises.

Recommendation

5. The Committee is invited to note the work programme at Annex A.

ANNEX A

THURSDAY 15 NOVEMBER 2012

Morning and afternoon

Inquiry into National Service Framework for Diabetes

Oral evidence sessions

Inquiry into residential care for older people

Consideration of draft report (private)

WEDNESDAY 21 NOVEMBER 2012

Morning only

Inquiry into National Service Framework for Diabetes

Oral evidence sessions

Inquiry into residential care for older people

Consideration of draft report (private)

THURSDAY 29 NOVEMBER 2012

Morning only and afternoon

Inquiry into National Service Framework for Diabetes

Oral evidence sessions

Recovery of Medical Costs for Asbestos Diseases (Wales) Bill*

Stage 1 – Approach to scrutiny

Inquiry into residential care for older people

Consideration of draft report (private)

WEDNESDAY 5 DECEMBER 2012

Morning only

General scrutiny session

Minister for Health and Social Services

Recovery of Medical Costs for Asbestos Diseases (Wales) Bill*

Stage 1 – Member in Charge to open

Human Transplantation (Wales) Bill*

Stage 1 – Approach to scrutiny

Monday 10 December 2012 – Sunday 6 January 2013: Christmas recess

Please note that items marked with a star (*) are dependent on legislation being introduced by the respective Members in Charge and remitted to the Health and Social Care Committee for Stage 1 scrutiny by the Business Committee.

Mick Antoniw AM

GMB House
Morgan Street
Pontypridd
CF37 2DS

Email: mick.antoniw@wales.gov.uk

Tel: 01443 406400

Mark Drakeford AM
Chair, Health and Social Care Committee
National Assembly for Wales
Cardiff
CF99 1NA

5 November 2012

Dear Mark

Recovery of Medical Costs for Asbestos Diseases (Wales) Bill

I intend to introduce the Recovery of Medical Costs for Asbestos Diseases (Wales) Bill shortly, subject to the Presiding Officer's determination. A proposed timetable for its consideration by the Assembly is being submitted to the Business Committee for agreement on 13 November 2012.

To assist with the Health and Social Care Committee's forward work planning, you will wish to be aware that the proposed milestones for stages 1 and 2 are as set out below—

Introduction into the Assembly	26 November 2012
Deadline for stage 1 consideration	8 March 2013
Plenary debate on general principles and motion on financial resolution (if necessary) – end of stage 1	20 March 2013
Stage 2 begins	21 March 2013
Earliest possible date for stage 2 consideration	22 April 2013
Stage 2 ends – deadline for stage 2 in committee	10 May 2013

Please contact me if you have any concerns.

Yours sincerely



Mick Antoniw AM

Agenda Item 3c

Health and Social Care Committee
HSC(4)-30-12(p8) – 15 November 2012

Jane Hutt AC / AM
Y Gweinidog Cyllid ac Arweinydd y Ty
Minister for Finance and Leader of the House



Llywodraeth Cymru
Welsh Government

Eich cyf/Your ref
Ein cyf/Our ref

Chairs of Health & Social Services
Committee and Enterprise &
Business Committee
National Assembly for Wales
Cardiff
CF99 1NA

5 November 2012

Dear Mark and Nick,

Thank you for your letter of 17th October setting out the arrangements for your Committees to meet concurrently to consider evidence associated with the Smoke Free Premises (Amendment)(Wales) Regulations.

I very much appreciate that you have accommodated this scrutiny on top of your scheduled business for the next session. As for your point about timetabling, I'm sure you will agree that given the interest shown both within and outside the Senedd, it would be very helpful to complete the work as quickly as possible. Perhaps the Clerk to the sub committee could let my office know when you have established a timeframe for the report to be considered by the respective parent Committees.

Many thanks for your co-operation in taking this forward.

I am copying this to the Presiding Officer.

Jane Hutt AC / AM
Y Gweinidog Cyllid ac Arweinydd y Ty
Minister for Finance and Leader of the House

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

English Enquiry Line 0845 010 3300
Llinell Ymholiadau Cymraeg 0845 010 4400
Correspondence.Jane.Hutt@wales.gsi.gov.uk

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