Health and Social Care Committee

Meeting Venue:
Committee Room 1 - Senedd

Meeting date:
Wednesday, 8 October 2014

Meeting time:
09.30

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

For further information please contact:
Llinos Madeley
Committee Clerk
029 2089 8403
HSCCommittee@wales.gov.uk

Agenda

1 Introductions, apologies and substitutions (09.30)

2 Papers to note (09.30) (Pages 1 - 6)

3 Factual briefing on the Public Health White Paper (09.30 - 10.30)

(Pages 7 - 15)
Dr. Ruth Hussey, Chief Medical Officer
Chris Tudor-Smith, Senior Responsible Officer
Tracey Breheny, Deputy Director of Substance Misuse Policy, Government and Corporate Business
Sue Bowker, Head of Tobacco Policy Branch

4 Motion under Standing Orders 17.42(vi) and (ix) to resolve to exclude the public from the remainder of the meeting and for item 1 of the meeting on 16 October 2014 (10.30)

5 Post-legislative scrutiny of the Mental Health (Wales) Measure 2010: Consideration of written evidence (10.30 - 11.15) (Pages 16 - 45)

6 Consideration of progress reports from the Minister for Health and Social Services (11.15 - 11.30) (Pages 46 - 49)

6.1 Progress report on: prevention of venous thrombo-embolism in hospitalised patients in Wales (Pages 50 - 62)

6.2 Progress report on: stillbirths in Wales (Pages 63 - 71)

6.3 Progress report on: implementation of the National Service Framework for diabetes in Wales (Pages 72 - 85)

Health and Social Care Committee

Meeting Venue:	**Committee Room 1 – Senedd**
Meeting date:	**Wednesday, 24 September 2014**
Meeting time:	**09.20 – 12.12**

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/Meeting/Archive/f22ab8ea-b4b2-4d67-a257-225a1338e7b8?autostart=True

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Concise Minutes:

Assembly Members:	**David Rees AM (Chair)** **Alun Davies AM** **John Griffiths AM** **Janet Finch-Saunders AM** **Elin Jones AM** **Darren Millar AM** **Lynne Neagle AM** **Gwyn R Price AM** **Lindsay Whittle AM** **Kirsty Williams AM**
Witnesses:	**Mark Drakeford AM, The Minister for Health and Social Services** **Professor Roger Walker, Chief Pharmaceutical Officer for Wales** **Andrew Evans, Welsh Government** **Detective Chief Inspector Roger Fortey, Gwent Police** **Inspector Catherine Hawke, Gwent Police** **Sergeant Jennie Tinsley, Gwent Police** **Sergeant Catherine Davey, Gwent Police**

Committee Staff:	**Llinos Madeley (Clerk)** **Helen Finlayson (Second Clerk)** **Sian Giddins (Deputy Clerk)** **Rhys Morgan (Deputy Clerk)** **Amy Clifton (Researcher)**

Transcript
View the meeting transcript.

1 Introductions, apologies and substitutions

1.1 There were no apologies.

2 Follow-up inquiry on the contribution of community pharmacy to health services

2.1 The Minister responded to questions from Members.

2.2 The Minister agreed to confirm in writing the date by which the joint review by the Chief Medical Officer and Public Health Wales of the national smoking cessation service review will be completed.

3 Motion under Standing Orders 17.42(vi) and (ix) to resolve to exclude the public from the remainder of the meeting

3.1 The motion was agreed.

4 The Committee's forward work programme

4.1 The Members discussed the forward work programme and agreed to return to this item at a later date.

5 Inquiry into new psychoactive substances (“legal highs”): Briefing from Gwent Police

5.1 The officers provided a briefing on new psychoactive substances to Members.

Health and Social Care Committee

Meeting Venue:	**Committee Room 3 - Senedd**
Meeting date:	**Thursday, 18 September 2014**
Meeting time:	**09.21 - 15.15**

This meeting can be viewed on Senedd TV at:
http://www.senedd.tv/Meeting/Archive/009d9907-5109-4b28-9700-1a0613aa396e?autostart=True

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Concise Minutes:
MeetingTitle

Assembly Members:	**David Rees AM (Chair)** **Mohammad Asghar (Oscar) AM** **Alun Davies AM** **Paul Davies AM** **John Griffiths AM** **Elin Jones AM** **Lynne Neagle AM** **Gwyn R Price AM** **Andrew RT Davies AM** **Kirsty Williams AM**
Witnesses:	**Dr Anna Kuczynska, Cardiff and Vale University Health Board** **Charlotte Moar, Cardiff and Vale University Health Board** **Dr Mark Vaughan, Royal College of General Practitioners Wales** **Dr Nazia Hussain, Royal College of General Practitioners** **Dr Peter Horvath-Howard, British Medical Association Cymru Wales** **Dr Charles Allanby, British Medical Association Cymru Wales** **Andrew Bell, Social Services Improvement Agency** **Sue Evans, Association of Directors of Social Services (ADSS)**

	Cymru Mark Drakeford AM, The Minister for Health and Social Services Andrew Goodall, Health and Social Services Albert Heaney, Welsh Government Dr Ruth Hussey, Welsh Government Martin Sollis, Welsh Government
Committee Staff:	Llinos Madeley (Clerk) Helen Finlayson (Second Clerk) Sian Giddins (Deputy Clerk) Joanest Varney-Jackson (Legal Advisor) Amy Clifton (Researcher) Philippa Watkins (Researcher)

Transcript
View the meeting transcript.

1 Inquiry into progress made to date on implementing the Welsh Government's Cancer Delivery Plan: consideration of draft report

1.1 The Committee considered and agreed the draft report, subject to minor changes, for its inquiry into progress made to date on implementing the Welsh Government's Cancer Delivery Plan and agreed the approach to launch the report.

2 Introductions, apologies and substitutions

2.1 Apologies were received from Rebecca Evans, Leighton Andrews, Darren Millar, Janet Finch-Saunders and Lindsay Whittle. Alun Davies, John Griffiths, Mohammad Asghar, Andrew RT Davies (morning only) and Paul Davies AM (afternoon only) were substituting respectively.

3 Papers to note

3.1 The Committee noted:

- the minutes of the 16 July meeting; and
- the correspondence received from the Minister regarding: Healthcare Inspectorate Wales; the Health Professional Education Investment Review; the Welsh Government's Cancer Delivery Plan; and the National Clinical Lead for Stroke Services.

4 Inquiry into access to medical technologies in Wales: evidence session 17

4.1 Apologies were received from Anthony Tracey.

4.2 The witnesses responded to questions from Members.

5 Inquiry into access to medical technologies in Wales: evidence session 18

5.1 The witnesses responded to questions from Members.

6 Inquiry into access to medical technologies in Wales: evidence session 19

6.1 Apologies were received from David Williams.

6.2 The witnesses responded to questions from Members.

6.3 Sue Evans agreed to supply the Committee with additional information in relation to the strengths and weaknesses of the '3 million lives' campaign in England, referenced in the ADSS's written submission to the Committee.

7 Motion under Standing Orders 17.42(vi) and (ix) to resolve to exclude the public from items 8, 10, and 11

7.1 The motion was agreed.

8 Inquiry into access to medical technologies in Wales: consideration of evidence received

8.1 The Committee considered the evidence received on the inquiry.

8.2 The Committee agreed to seek additional information from the BMA and RCGP on how much revenue funding is required, for example to cover training costs, in addition to the capital spend when introducing new technologies.

9 Scrutiny of the Minister for Health and Social Services and the Deputy Minister for Health: general and financial scrutiny

9.1 Apologies were received from the Deputy Minister for Health.

9.2 The Minister responded to questions from Members.

9.3 The Minister agreed to supply more information about the Welsh Ambulance Service Trust's recruitment plan for the additional 100 paramedics funded recently by the Welsh Government.

10 Supplementary Legislative Consent Memorandum - Criminal Justice and Courts Bill: consideration of draft report

10.1 The Committee considered and agreed the draft report for its consideration of the Supplementary Legislative Consent Memorandum – Criminal Justice and Courts Bill.

11 Inquiry into new psychoactive substances ("legal highs"): consideration of itinerary for engagement activity

11.1 The Committee agreed the itinerary for engagement activity for the inquiry into new psychoactive substances ("legal highs").

Agenda Item 3

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Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref SF/MD/2804/14

David Rees AM
Chair
Health and Social Care Committee

22 September 2014

Dear David

I am writing to provide you with an update on progress since the Welsh Government's response to Health and Social Services Committee's inquiry into Venous Thromboembolism Prevention in Hospitalised Patients in Wales.

Please find attached table and annexes setting out updates on each of the Report's recommendations.

Best wishes

Mark Drakeford AM.

Mark Drakeford AC/AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Bae Caerdydd • Cardiff Bay
Caerdydd • Cardiff
CF99 1NA

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

Venous Thromboembolism Prevention in Hospitalised Patients in Wales
Welsh Government update against Recommendations

Recommendations	Welsh Government Response	Progress
Recommendation 1: The Welsh Government recognises the importance of reducing the incidence of hospital acquired thrombosis (HAT) in Wales by actively considering whether compliance with the relevant NICE guidance should be included as a tier 1 priority for health boards, against which they will be performance managed. This should be considered alongside revised action through the 1000 Lives campaign. The Committee requests that the Welsh Government reports back to us the outcome of the consideration it gives to including compliance with the NICE guidance as a tier 1 priority and explains the reasons for the conclusion it reaches. This consideration should be given as part of the next review of tier 1 priorities. (p34)	**Accept in principle** • The Welsh Government is committed to reducing the incidence of hospital acquired thrombosis in Wales. • *Together for Health* sets out the Government's vision for better service quality and safety to improve health outcomes. This is described further in our Quality Delivery Plan (QDP) for the NHS: *Achieving Excellence,* where the expectation is on developing a new approach to monitoring NHS performance more focused on measuring clinically appropriate outcomes. • Alongside this, the QDP also acknowledges the need to develop a key set of metrics, described as 'quality triggers'. This will be a focused set of measures as part of routine monitoring of care quality and act as an early warning system to identify services that might give cause for concern. • Metrics to monitor action to prevent hospital acquired thrombosis will be included within the quality triggers. This will facilitate early local action where performance gives cause for concern, whilst providing a mechanism to maintain national oversight and the ability to escalate and intervene in areas of poor progress. This new approach will therefore ensure that any one of our identified core	**Outcome**: **In progress** Significant progress has been made against this recommendation. These actions have already been completed:- 1. The formation of a Steering Group consisting of 'experts' with representation from each Health Board (HB). This is chaired by Dr Simon Noble, a world recognised expert in this field and also includes Prof Beverly Hunt from the Royal College of Physicians. The first meeting was held in May 2013. 2. The Department of Health definition of a hospital-acquired thrombosis has been agreed and adopted. This is "any venous thrombo-embolism arising during a hospital admission and up to 90 days post discharge". 3. A hospital acquired thrombosis (HAT) measure is included (developmental) in this year's Tier 1 measure and each organisation is currently finalising its data collection method. On 2 September a letter and reporting template was issued to HBs for robust and consistent reporting on this measure to Welsh Government. (Annexes 1, 2 and 3).

Recommendations	Welsh Government Response	Progress
Pack Page 52	quality indicators 'triggers' action when performance gives cause for concern, generating a 'tier 1' type approach and focus. • Our focus must be on supporting continuous quality improvement for our health services. NHS Wales has made progress in tackling the complexity associated with preventing hospital acquired thrombosis, but it is fully accepted there is still much to do. • The 1000 Lives Plus programme will continue to actively support all NHS organisations in tackling this important area, to ensure the spread and embedding of best practice to reduce the risk of this serious condition.	This has been achieved through empowering NHS Wales clinicians to develop a measure that is directly linked to improving patient outcomes and also 'makes sense' to clinical staff. The measure collects information on: a. Number of suspected Hospital Acquired Thromboses per calendar month of which b. Number of Root Cause Analysis reviews completed to identify numbers of possible avoidable HATS c. A summary of learning and actions, from the Root Cause Analysis process These quality triggers will facilitate early local action and provide a mechanism to maintain national oversight and the ability to escalate and intervene in areas of poor progress. The focus however will be on supporting continuous quality improvement.
Recommendation 2: A standard procedure be implemented to reduce hospital acquired thrombosis (HAT) in Wales, mandating clinicians to	**Accept in principle** • The tools and resources developed through the 1000 Lives Plus collaborative provide NHS organisations in Wales with a clear and systematic	**Outcome: In progress** All clinicians are already required to follow best practice and recommend the best treatment

Recommendations	Welsh Government Response	Progress
risk assess and to consider prescribing appropriate thromboprophylaxis – mechanical or chemical – for all hospitalised patients. (p35)	process for assessing and determining treatment options for those identified at risk of thrombosis. • This, together with a number of measures to help teams test and track the reliability in implementing these interventions, is set out in the 'How to Guide' developed by the 1000 Lives team in partnership with others, notably Lifeblood, the thrombosis charity. The adoption of this approach enables organisations to demonstrate they are providing evidence-based care in line with the NICE guidance for reducing the risk of venous thromboembolism. • The 'Transforming Maternity Services' 1000 Lives Plus collaborative has made significant progress over the past year in developing specific advice and resources tailored to suit the needs of pregnant women. The programme has strong multidisciplinary support and has recently published an updated 'How to Guide' to assist clinicians in Wales in adopting a systematic, all Wales approach. This is being implemented in all maternity units in Wales. • All clinicians are already required to follow best practice and recommend the best treatment options for, and in discussion with, their patients on an individual basis. • As set out in recommendation 1, 1000 Lives Plus will have a renewed focus on supporting health boards and trusts to ensure widespread and	options for, and in discussion with, their patients on an individual basis. The standard procedure already exists in the form of NICE guidance and the 1000 Lives 'How to Guide'. However NICE have recently announced that they will be revising their guidelines in response to new evidence that suggests patients are being 'over treated' with prophylaxis. We await this response to make appropriate changes in Wales. Root Cause Analysis (RCA), following collection, reporting and analysis of suspected HAT incidents, will identify shortcomings in assessment and treatment. This evidence will be used to engage and educate the frontline staff. This will encourage the change of practice needed to further reduce HAT. There is already evidence of improvement reported. Just three examples are: • *An increased focus on re-assessment at ABMU (entered at this year's NHS Wales Awards) which has resulted in an increase in the assessment and re-assessment rate and a decrease in the HAT incidence rate.* • *A pilot development to the All Wales Prescription chart within the Medical Directorate at Cwm Taf. This has resulted in appropriate assessment and treatment for VTE prophylaxis increasing to 98% in the pilot area.*

Recommendations	Welsh Government Response	Progress
	sustainable implementation of this approach.	• *A VTE protocol used by the Trauma & Orthopaedic team in Ysbyty Glan Clwyd that has facilitated a reduction in their HAT incidence.*
Recommendation 3: Health boards should develop a standardised method to demonstrate a hospital acquire thrombosis rate for each hospital in Wales and at a national, all-Wales level. We recommend that health boards learn from the work already undertaken by Betsi Cadwaladr University Health Board and others so that a standard methodology can be rapidly developed and implemented across Wales. (p35)	**Accept** • As the Committee's inquiry has found, making a diagnosis of hospital acquired thrombosis can be difficult and may follow a hospital stay. • The NHS in Wales has demonstrated a strong commitment to develop a standard methodology to enable both a local and a national rate for hospital acquired thrombosis to be measured, despite the complexity involved. Progress has continued in this area. The 1000 Lives Plus programme will coordinate this activity and support the accelerated development and implementation of an agreed all-Wales measure.	**Outcome: Complete** The Steering Group has agreed the principles of the methodology to be used. This has been mandated in the instructions given to all organisations by Welsh Government. Work is being planned to update the All Wales Radiology Management System (RADiS) to automate some data collection therefore simplifying the whole process for the HBs. The Royal College of Radiologists (Wales) has also agreed on terminology that should also help simplify data collection.
Recommendation 4: A root-cause analysis should be undertaken for each case of venous thromboembolism (VTE) at Welsh hospitals, or for patients presenting VTE within 3 months of being discharged from a Welsh hospital, to establish whether they were acquired as a result of hospital treatment. (p35)	**Accept in principle** • It is essential we have mechanisms in place to review and learn from any events which may result in avoidable harm to patients. • Root-cause analysis is an approach already widely used in NHS Wales. However the approach can be very time consuming, so it is essential we develop tools which can easily to be used in practice to drive learning, but without adding too great a burden if the process becomes too time consuming for clinicians – diverting them from direct patient care.	**Outcome: In progress** This has been stipulated as part of the Tier 1 measure reporting and the HBs and Trusts are currently developing plans to put this process into place. The Steering Group has agreed and advised that Root Cause Analysis (RCA) should be a two stage process. All organisations should put in place a process to filter those incidents identified as 'potentially hospital acquired' from the total number of those identified as fitting

Recommendations	Welsh Government Response	Progress
	• Velindre NHS Trust has already developed such a tool which has been shared across Wales through the 1000 Lives Plus collaborative. The 1000 Lives Plus team will facilitate the development of agreed tools for use across different health settings. This is expected to be adopted across Wales for all patients diagnosed with a hospital acquired thrombosis during their hospital stay, or within three months of their discharge.	within the agreed definition. This filter would take the format of two questions: 1. Was a documented risk assessment performed? 2. Did the patient receive appropriate thromboprophylaxis? If the answer to either question 1 or 2 is "no" then the HAT could potentially have been avoided and the standardised Health Board Root Cause Analysis (RCA) process should then follow.
Recommendation 5: The Welsh Government and health boards work together to raise awareness amongst patients and clinicians of the risks of developing hospital acquired thrombosis (HAT). We recommend that this should take the form of a public education campaign to improve understanding of the risks of HAT and the severity of the problem. (p35)	**Accept** • Both NICE guidance and the 1000 Lives Plus 'How to Guide' for reducing hospital acquired thrombosis, describe the need for involving patients. This includes both the need to raise awareness of the symptoms and the risks, as well as providing information on ways to reduce their risk or to act on any concerns or symptoms. In addition, the actions set out in recommendation 2 should lead to an increased awareness amongst clinicians. • However, it is clear much more does need to be done to raise awareness of the risks. Clinicians and organisations need the tools to do this effectively. We have a number of successes to build on and learn from. This includes the previous	**Outcome: Complete** The 1000 Lives Improvement Service, working in collaboration with 'Lifeblood – The Thrombosis Charity' has developed the 'Ask about Clots' campaign that was launched by the Minister for Health and Social Services on April 4th 2014. The campaign draws on two patient stories – one from a survivor of HAT and one from a mother who lost her daughter to HAT. The publicity campaign targets the general public and clinicians. A pack that includes infographics (Annexes 4 and 5), a video and links to a website has been developed and distributed to all health boards. There has been

Recommendations	Welsh Government Response	Progress
	‘Clean Your Hands’ Campaign, which has been effective at both raising awareness amongst hospital staff, patients and the wider community about the importance of hand washing in helping to combat infections. • More recently, the 1000 Lives Plus S.T.O.P communication campaign, launched earlier this year to reduce the risk of infection by focusing on the better use and management of catheters and cannulas, is already showing great results across Wales in reducing unnecessary use of these devices. We also need to be mindful of the existing work of organisations such as Lifeblood and the important role they have already played in raising awareness, and build on this. • The communications arm of the 1000 Lives Plus team will coordinate this work, in partnership with all key stakeholders. They will review the evidence and look at best practice in this area to put forward proposals for an awareness raising approach across NHS Wales during 2013/14.	a parallel campaign on Twitter and many hospitals are now playing the video in public areas. The campaign was also promoted at the 1000 Lives national learning event in June. To link with World Thrombosis Day (October 13th) 1000 Lives are currently planning an event in Wales to run in parallel to the international event in London. ‘Ask about clots’ is being promoted at the international event and being offered internationally as a ready-made campaign for engaging the public with the view of reducing the risk (the theme of this year’s campaign).

Yr Adran Iechyd a Gwasanaethau Cymdeithasol
Cyfarwyddwr Cyffredinol a Prif Weithredwr, GIG Cymru

Department for Health and Social Services
Director General and Chief Executive, NHS Wales

Llywodraeth Cymru
Welsh Government

To: Chief Executives, Medical Directors & Nurse Directors
Health Boards

Our Ref: AG/LL/DCL

2 September 2014

Dear Colleague

An Update on Hospital Acquired Thrombosis (HAT)

Developing a fatal condition in a hospital setting is entirely counterintuitive, yet evidence to the HSCC inquiry in 2012 suggests it occurs at a significant rate in the case of Venous Thrombo Embolism (VTE).

The number of people who develop such clots is substantial, and the number of deaths that may have been prevented by improved awareness and treatment was a matter of real concern to the committee. Information received at the inquiry convinced us that there are practical steps available by which this can be achieved and that these actions are within our reach. I know we all believe that more could and should be done to raise the importance of preventing VTEs, and making both professionals and patients more aware of the severity of the problem.

The report, produced following the inquiry, made clear that we must minimise the number of people suffering avoidable hospital-acquired clots and made a number of recommendations, all of which were accepted by Welsh Government and the expectation is that all healthcare organisations would be working towards full implementation of these.

Local mechanisms for the national reporting of HAT incidence must be put in place, together with systems for gaining assurance that healthcare organisations are actively investigating each incidence. The aim being to ensure learning from them, so improvements can be made leading to the reduction in the number of avoidable incidents of HAT.

Therefore all organisations should put in place a process to filter those incidents identified as ‘potentially hospital acquired’ from the total number of those identified as fitting within the agreed definition.

This filter would take the format of two questions:

1. Was a documented risk assessment performed?
2. Did the patient receive appropriate thromboprophylaxis?

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If the answer to either question 1 or 2 is “no” then the HAT could potentially have been avoided and the standardised Health Board Root Cause Analysis (RCA) process should then follow.

All Health Boards and Velindre NHS Trust through their membership on the national steering group have agreed that they have a mechanism in place to collect data on the number of patients who may have had a Hospital Acquired Thrombosis and so the measure to be reported was agreed as:

1. Monthly reporting on the number of suspected Hospital Acquired Thromboses each calendar month
2. Quarterly reporting of the number of potentially avoidable incidents assessed through Root Cause Analysis carried out
3. This quarterly reporting will be supported by a summary of learning and actions

Can I emphasise that reporting of this measure is not to allow comparison of ‘performance’ across Health Boards and NHS Trusts – the specialty mix and details of collection make this invalid. It is a measure for improvement to allow HBs to take ownership of this issue, help them study and improve clinical practice and further reduce the incidence of HAT in Wales. It also allows the government and public to be reassured that this improvement action is receiving high priority.

This is an agreed Tier 1 target that now needs to be implemented. Based on information gathered from the HAT Steering Group, we would expect draft reports to be submitted by end of each month (10 working days) where possible starting end of September for your August data. If you already collect this data you may wish to send your April, May June and July figures at the same time.

Your quarterly report will only be required once you have completed a quarter of data and undertaken the RCA process. We will use this year to work through issues and this will allow us to have a formalised process in place for 2015/16. Proformas for the data collection are enclosed with this letter.

The Minister recently launched the ‘Ask about Clots campaign’, developed by 1000 Lives Improvement, that encourages patients to ask healthcare professionals about their risk of developing a deep vein thrombosis (DVT). Empowered patients, taking an active role in reducing thrombosis, will remind healthcare professionals to be more aware of the risks and ensure that all patients are assessed and treated appropriately.

1000 Lives Improvement are working with all Health Boards and trusts and third sector organisations to raise awareness of the issue with the public and have resources that you can use to make a real difference to patient care.

Further information can be found at www.askaboutclots.co.uk

Yours sincerely

Dr Andrew Goodall
Director General and Chief Executive, NHS Wales

Ruth Hussey
Chief Medical Officer

Enc

Hospital Acquired Thrombosis

Reporting Schedule	**Monthly**
Health Board	
Date of Report	

Completed By	
Contact Number	
E-mail Address	

Reporting Template: The total number of suspected hospital acquired thromboses each calendar month.

Sumbission Date: 10 working days after month end or 14th of the following month.

Number of suspected hospital acquired thromboses each calendar month

April 2014	May 2014	June 2014	July 2014	Aug 2014	Sept 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Total
												0

Quarter 1 Total	0	Quarter 2 Total	0	Quarter 3 Total	0	Quarter 4 Total	0

Return form to: Lisa.Phillips@wales.gsi.gov.uk

Hospital Acquired Thrombosis

Reporting Schedule	**Quarter**
Health Board	
Date of Report	

Completed By	
Contact Number	
E-mail Address	

Reporting Template:
> The number of Root Cause Analysis (RCA) completed (based on the quarter's number of suspected HAT).
> The actual number of preventable HATs (detemined from the Root Cause Analysis).
> The number of cases not felt to be HAT
> Summary of learning and actions.

Sumbission Dates:
Quarter 1 2014/15: 14 October 2014 (Data for April to June 2014)
Quarter 2 2014/15: 14 January 2014 (Data for July to September 2014)
Quarter 3 2014/15: 14 April 2015 (Data for October to December 2014)
Quarter 4 2014/15: 14 July 2015 (Data for January to March 2015)

	Q1	Q2	Q3	Q4	Total
Number of suspected hospital acquired thromboses each quarter	**0**	**0**	**0**	**0**	**0**
Number of Root Cause Analysis (RCA) completed					**0**
Actual number of preventable HATs					**0**
Number felt not to be HAT					**0**

Summary of lesson learnt to improve delivery	Corrective actions agreed

Return form to: Lisa.phillips@wales.gsi.gov.uk

GIG CYMRU NHS WALES

Ask about CLOTS

A CLOT IS A BLOCKAGE IN A BLOOD VESSEL.

It can travel to other places in the body.

There are different names for **CLOTS...**

DEEP VEIN THROMBOSIS

A PULMONARY EMBOLISM

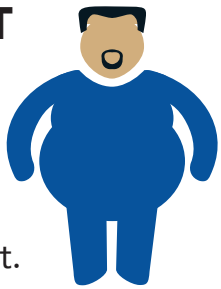
ANYONE CAN GET A CLOT!

1,250 PEOPLE IN **WALES** ARE AT **RISK** OF DEATH **ANNUALLY** FROM BLOOD CLOTS

66% of clots happen in **HOSPITAL** or in the **90 DAYS** following admission.

Some ongoing medical conditions increase the risk of developing a clot.

OVERWEIGHT people have a **200%** higher chance than other people of developing a clot.



A little or very overweight people.

PREGNANT WOMEN have a higher risk of developing a clot.

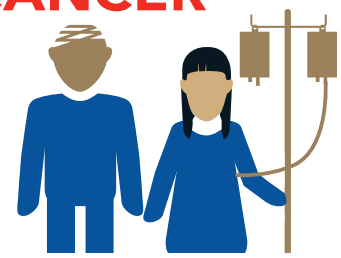
25% people who have **SERIOUS SURGERY** can get clots.

1% of people **aged 80+** develop **CLOTS**

OLDER PEOPLE

People who have **CANCER**

ILLNESS and **POOR HEALTH** increases the risk of a clot



You have a **HIGHER CHANCE** of getting a clot in **HOSPITAL**

Than on an **AEROPLANE!**

Clots can be **AVOIDED!** Ask to be assessed for **YOUR RISK**

EVERYONE SHOULD ASK ABOUT CLOTS

Ask your **DOCTOR, NURSE** or **HEALTH PROFESSIONAL** about **CLOTS.**

www.askaboutclots.co.uk #askaboutclots

1000 LIVES i O FYWYDAU

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: SF/MD/2849/14

David Rees AM
Chair
Health & Social Care Committee

22 September 2014

Dear David

Stillbirths in Wales – Progress Report

In response to your letter of 9 July, I enclose a progress report on implementation of the nine recommendations following the one-day inquiry into stillbirths in Wales in February 2013.

While there is still further work to be done to fully implement the recommendations, I am pleased to report the considerable progress made to date and the engagement of clinical professional staff across NHS Wales.

Best wishes

Mark Drakeford

Mark Drakeford AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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Llinell Ymholiadau Cymraeg 0845 010 4400
Correspondence.Mark.Drakeford @wales.gsi.gov.uk

HSCC One Day Enquiry into stillbirths in Wales.
Welsh Government update against recommendations

Recommendations	Welsh Government Response	Progress
Recommendation 1: Public awareness of stillbirth and its risk factors is essential to reducing stillbirth rates in Wales. We recommend that the Welsh Government take an active lead – via the recently established National Stillbirth Working Group – in developing key public health messages as a matter of priority. This will raise the awareness of expectant parents and those planning to start a family of the risks of stillbirth and allow them to make more informed choices about their health and pregnancy.	**Accept:** This will form part of the work of the National Stillbirth Working Group Working with SANDS, the National Stillbirth Working Group will develop public health messages that will be given to women and their partners through written material and discussion at antenatal consultations. The aim is to roll this out across Wales from autumn 2013.	**Outcome**: As similar work was being proposed by Sands (the stillbirth and neonatal death charity), and the Department of Health (DH), there was agreement that the Welsh Government would collaborate in this work. The Public Health Messages Task and Finish Group was formed in early 2013 with midwifery representation from Wales. A complete list of risks associated with stillbirth was developed and the messages subsequently tested with focus groups of first time parents and midwives from across the UK. This produced useful feedback specifically that women were keen to hear about the risks but only about things they were able to do something about. A writing group is now in the process of creating a narrative for these messages. This group includes representation from the Royal Colleges, Public Health England and the Perinatal Institute. The draft narrative of public health information for women has now been tested with the Royal College of Obstetricians and Gynaecologists (RCOG) women's panel. This resulted in further useful feedback and a further reworking of the narrative.

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		In summer 2014 an agency has been briefed to generate some creative ideas for producing a leaflet of key risks associated with stillbirth that women can actually do something about (stopping smoking, watching out for signs of infection, being aware of fetal movement etc). This work will be presented on 23 September 2014 to the Public Health Messaging Task and Finish Group for final comments and drafting prior to publication.
Recommendation 2: We recommend that the Welsh Government work with professional bodies and health boards in Wales to ensure that all expectant parents receive adequate information from clinicians and midwives about stillbirth and its associated risks. Discussion of stillbirth should form a routine part of the conversation held between health professionals and expectant parents during the course of a pregnancy.	**Accept:** This will form part of the work of the National Stillbirth Working Group. The public health messages that will be given to women and their partners through written material and discussed at antenatal consultations will include standardising the information/advice on and management of reduced fetal movements. The aim is to roll this out across Wales from autumn 2013.	**Outcome:** Sands has been leading the national work to explore and agree messages that women and the wider public should know about stillbirth. (See recommendation 1). Sands also provided the content on fetal movements for the newly published all Wales pregnancy book, “Bump, Baby and Beyond” (April 2014). The publication is given to all women at the beginning of their pregnancy and contains information to support parents from the early stages of pregnancy through to toddler years.
Recommendation 3: We recommend that the Welsh Government work with professional and regulatory bodies, and relevant academic institutions, to ensure that stillbirth, its associated risk factors and interventions, and bereavement training are more prominently featured in Welsh	**Accept in principle:** Welsh Government will raise these issues with those responsible for midwife and medical education.	**Outcome:** <u>Midwives</u> The curriculum standards for pre-registration midwifery education are set by the Nursing and Midwifery Council (NMC). Standard 17 details the competencies required for midwives to register with the Council and this includes providing care for women who have suffered

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midwifery and obstetric training curricula. The Welsh Government should work with health boards to monitor and regularly review the training needs and competence of health professionals in relation to stillbirth.		pregnancy loss, stillbirth or neonatal death. The issue of the prominence of stillbirths in current Welsh midwifery programmes was discussed with the all Wales Midwifery Education Group in early 2014. The curriculum content was reviewed and Welsh Government has received assurances that the content meets the NMC standard, is relevant, evidence based, up to date and appropriate. <u>Obstetricians</u> Until now there has been no requirement to develop expertise/experience of counselling in relation to the risk of stillbirth. However, the UK RCOG Curriculum Committee has addressed this and counselling will now be included in the curriculum from August 2014.
Recommendation 4: We recommend that the Welsh Government scope the viability of establishing a maternity network to drive the standardisation of care across Wales. We believe that at least a virtual clinical network should be established within the next 12 months.	**Accept:** As part of the work of implementing the Strategic Vision for Maternity Services Welsh Government is in the process of scoping the viability of establishing a maternity network. The scoping will be completed by July 2013 and will include the financial implications of setting up and maintaining such a network. Based on the conclusions of the scoping exercise consideration will then be given on whether to set up a maternity network. This will include the possibility of setting up a virtual network.	**Outcome:** Scoping the viability of establishing a maternity network was completed in July 2013 and included the financial implications of setting up and maintaining such a network. A Maternity Network has now been set up and managed by Public Health Wales, 1000 Lives service improvement programme. A senior Improvement Manager for maternity services has been appointed. Her role as the network manager is full time and is a permanent substantive role. An advert for a clinical lead for the network will

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		soon be advertised and this person should be in place by autumn 2014. The expectation is that this role will be filled by a consultant obstetrician. Once in place, the steering group of the network will be established. The aim is to undertake this by autumn 2014. The stillbirth work will be the first work-stream to be prioritised by the network.
Recommendation 5: We recommend that the Welsh Government undertake a review of the number of women in Wales who deliver more than thirteen days after their due date. The outcome of those pregnancies and the factors that led to the decision not to induce within the recommended guideline time should be considered in every case. Further consideration ought to be given to whether women with other high risk factors such as advanced maternal age, smoking or weight should be induced closer to their due date.	**Accept** This will form part of the work of the National Stillbirth Working Group and will be competed by March 2014.	**Outcome:** This work is proving to be challenging as it will involve time consuming manual data collection. Attempts have been made by two health boards to explore how information could be extracted through existing data collection systems but this has proved to be unachievable. This issue will take priority once the Maternity Network meets in autumn.
Recommendation 6: We recommend that the Welsh Government investigate and report on evidence presented to the Committee that having to seek specialist foetal medicine consultations outside Wales now exceeds the cost of providing the	**Accept in Principle:** Health boards are responsible for the planning and commissioning of services through consideration of a range of factors in determining the best possible place for treatment. David Sissling will write to the Chief Executives of the	**Outcome:** Welsh Health Specialised Services Committee has been leading review of this provision. They are currently working with Cardiff &Vale University Health Board (C&V UHB) to confirm their proposals to provide more timely access

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service within Wales. The Welsh Government should also explore the proposal that specialist foetal medicine services should be commissioned at the tertiary rather than secondary level**.**	Health Boards to bring this recommendation to their attention. The expectation will be that they scope the options for the provision of specialist fetal medicine for the population of Wales. A progress report will be expected from each Health Board at the end of the first quarter of the financial year 2013/14	to fetal services (including fetal cardiac and specialist paediatric input). A draft service specification has been developed and has been shared with each of the leads, as well as Dr Orhan Uzun, fetal cardiologist, for comment and amendment by end of September 2014. WHSSC is also working with C&V UHB regarding access to Chorionic Villus Sampling, which is part of the combined screening test for Down's screening that health boards are implementing. Officials have asked C&V UHB to accept referrals from other health boards and have also suggested they re-train interested consultants in Abertawe Bro Morgannwg University Health Board and Aneurin Bevan University Health Board as a sustainable solution. A meeting with the leads from each of the health boards is planned for the end of October 2014 to agree arrangements.
Recommendation 7: We recommend that a national minimum standard for reviewing perinatal deaths should be developed and rolled out across Wales. We also recommend that a wider, more imaginative approach to Welsh Government funding for medical research and investigation is adopted, and that the Welsh Government seek detailed costings for a national perinatal	**Accept:** The development of a national minimum standard for reviewing perinatal deaths is being carried out as part of the work of the National Stillbirth Working Group. Discussions on developing a national perinatal audit for Wales from the All Wales Perinatal Survey are being taken forward though collaborative work with the Healthcare Quality Improvement Partnership (HQIP) and MBRRACE -UK (Mothers and Babies - Reducing Risk through Audits and Confidential	**Outcome:** Wales is working in collaboration with DH and Sands in a UK Perinatal Mortality Review. The review group has reached consensus on what should be included in any review: *'all perinatal losses, [from 22 weeks gestation until 28 days after birth], excluding terminations of pregnancy and those with a birth weight of less than 500 g'.*

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audit for Wales from the All Wales Perinatal Survey. We believe that the initial investment in this audit could yield significant benefits in the future detection and prevention of stillbirth**.**	Enquiries across the UK) The financial implications of all options will form part of the discussion on a way forward.	The recommendation is that there will be one UK online tool for collection of data and the DH is in the process of carrying out a cost/benefit analysis of standardising perinatal review which should be completed in autumn 2014. Once this has been completed the UK group will consider how to take this forward. Officials conducting the All Wales Perinatal Survey (AWPS) have been kept informed of this work.
Recommendation 8: We recommend that the Welsh Government publish a detailed plan of how it proposes to tackle the problem caused by the low rate of post-mortem for stillborn babies. The plan should include: • details of how training will be delivered to health professionals in order that they are better equipped to raise this very difficult issue with grieving parents, • details of what improved information will be developed for parents so that they are able to make more informed decisions; • an assessment of the actions needed to improve the	**Accept:** Through both work carried out by SANDS and on feedback from parents in Wales, the National Stillbirth Group are improving services. An excellent example where sharing good practice is leading to the possibility of immediate improvements is in organising speedy access to services. The group agreed the need to standardise the process for baby transfer to Cardiff for PM and improving the pathological examination of the placenta (to pick up placental pathology more reliably), by utilising the specialist perinatal pathologists at Cardiff. The ability to arrange a post-mortem on a specific date and to transport a baby to Cardiff and back on the same day helps parents to know where their baby is at all times	In order to address this recommendation a Perinatal Pathology Sub-Group was set up to recommend actions to increase the uptake of post-mortems. <u>Training for Health Professionals</u> An all Wales standardised training package has been developed, focussing on practical issues such as gaining consent and the legal requirements. Cardiff and Vale University Health Board has agreed to undertake a ‘train the trainer’ event regarding consent for post mortem and plan to undertake a training event with all health boards in mid September 2014. <u>Improved information</u> Working with Sands, the all Wales Information for parents/consent package has been

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provision of perinatal pathology.		updated. The revised 'Guide to Post-Mortem Examination of a Fetus, Baby or Child' is currently in the process of being approved by the National Pathology Quality and Regulatory Compliance Group. <u>Improved service provision</u> Because of current vacancies, pending retirements and a desire to increase the number of post-mortems a business case to WHSSC for additional funding of consultant perinatal pathology sessions is being prepared by Cardiff and Vale University Health Board. It is estimated that an additional 2.46 sessions per week by a consultant perinatal pathologist may be required.
Recommendation 9: In the absence of the large charities and interested industry that fund the bulk of research for other health conditions, we recommend that the Welsh Government, through the National Institute for Social Care and Health Research's Clinical Research Centre, commission a comprehensive piece of work on the underlying causes of stillbirth. This work should be undertaken in cooperation with health professionals and academics with expertise in this field, and should draw on international knowledge of stillbirth. This work should be completed by the	**Accept:** With the support of the National Institute for Social Care and Health Research (NISCHR), and in parallel with the work of the National Stillbirth Group, maternity units in Wales will be collaborating with the Scottish Research Study. This work involves a trial to test a package of care that may help reduce the risk of stillbirth when a woman reports reduced fetal movements. There will be no financial implications for Welsh Government. The aim of the Scottish research study is to test the hypothesis that a protocol for detection and management of reduced fetal movements reduces rates of stillbirth. The study will test an intervention combining raising patient awareness of fetal	**Outcome:** With the support of the National Institute for Social Care and Health Research (NISCHR), and in parallel with the work of the National Stillbirth Group, maternity units in Wales are collaborating with the AFFIRM Scottish Research Study. This work involves a trial to test a package of care that may help reduce the risk of stillbirth when a woman reports reduced fetal movements. The aim of the Scottish research study is to test the hypothesis that a protocol for detection and management of reduced fetal movements reduces rates of stillbirth. The study will test an

Recommendations	Welsh Government Response	Progress
end of this Assembly.	movement counting, with a management plan for health professionals for women who present with reduced fetal movement. In parallel with the 1000 Lives work, a group of obstetricians and midwives are now developing Welsh involvement with the support of the NISCHR	intervention combining raising patient awareness of fetal movement counting, with a management plan for health professionals for women who present with reduced fetal movement.

Inquiry into National Service Framework for diabetes in Wales and its future direction – progress update from the Welsh Government (September 2014)

Following the publication of the *Inquiry into National Service Framework for diabetes in Wales and its future direction* (June 2013), I and my officials considered the report's recommendations as part of the consultation on the development of the Welsh Government's Diabetes Delivery Plan, which was launched in September 2013. A number of the recommendations from the report were included in the Diabetes Delivery Plan which is only in the first year of implementation; it will take time to deliver all of the actions set out in the plan. I have committed to provide annual reports on progress with the first report due by the end of the year. The Committee's request for an update at this point in the implementation has meant that only some initial high level progress can be reported in some aspects of the Delivery Plan.

Diabetes Delivery Plan

The Diabetes Delivery Plan was launched in September 2013, and the majority of the recommendations from the Inquiry were included within the Plan. In October 2013, the NHS Wales Diabetes Implementation Group was established to give strategic leadership on the implementation of the Delivery Plan across Wales.

Following a stakeholder group exercise, the Implementation Group set its priorities for its first year. Their priorities are focussed on four specific areas: improving care for children with diabetes; preventing diabetes in our population; making our services as effective as possible; and helping people manage their care. Under these work streams, a number of specific areas of activity were identified that should be taken forward, either in the first year, or through the whole period of the Plan. Some of the specific areas include: the development of a paediatric diabetes network and implementation of paediatric diabetes unit peer assessment programme (both of which are under way); delivery of a diabetes patient management system; developing a whole patient pathway for foot care; and developing proposals for effective delivery of diabetes structured education. The Diabetes Implementation Group is also working with the Heart Disease Implementation Group on risk identification across both disease areas. The Implementation Groups priorities will be finalised at their meeting at the end of September 2014. In finalising their first year recommendations in September, it will allow health boards to give them due consideration as part of their annual planning cycle and enable them to include them in next year's work programme.

All health boards have produced local diabetes delivery plans, which have taken into account the all Wales strategic priorities as set out by the Diabetes Implementation Group. They have also included the key outcomes from their local plans within their integrated three plans, to ensure that they are part of the overall strategic direction for their health board.

A generic monitoring process has now been established for all of the Welsh Government's delivery plans. For diabetes, this requires health boards to submit data on progress against their plan by the end of October 2013. This data, alongside the other data sources such as the Diabetes National Clinical Audit, will form the basis of an annual report on progress against the Diabetes Delivery Plan, which will be published by the end of this year. In addition, health boards will publish their individual progress reports on their websites, and all Diabetes National Clinical Audit reports will publish data at local health board level. Through this process, the Welsh public will be able to assess the performance of diabetes services in Wales, both at a national and local level.

Welsh Government's update against the recommendations set out in the HSC Committee's report on their *Inquiry into National Service Framework for diabetes in Wales and its future direction* – September 2014

Report Recommendations	Welsh Government response – August 2013	Welsh Government update – September 2014
Recommendation 1 We recommend that the Welsh Government should ensure implementation of the National Service Framework through strengthened oversight and monitoring arrangements, as a priority in the forthcoming delivery plan. We believe this should include a national leadership post to coordinate health boards' progress in delivering the NSF, and to facilitate the sharing of experiences and good practice between health boards.	**Response: Accept** The Welsh Government remains committed to the implementation of the 12 standards set out in the National Service Framework for Diabetes in Wales (NSF) and the Diabetes Delivery Plan will include as a priority the development of effective oversight and monitoring arrangements. My officials will work with the Local Health Boards (LHBs), the Diabetes Delivery Plan Implementation Group and the Diabetes National Specialist Advisory Group (NSAG) to develop robust and effective monitoring arrangements both for the implementation of the plan the continued establishment of the NSF standards. A national diabetes clinical lead role will be developed to support both the delivery of the plan and to support Local Health Boards in the continued implementation of the NSF standards. The national lead will need to work closely with the Implementation Group to facilitate the sharing of experiences and best practice between LHBs.	A standardised monitoring arrangement has been developed by the Welsh Government for all the Delivery Plans, including the Diabetes Delivery Plan. Local health boards are required to provide an update on progress in delivering their local plans, and additional data from the various strands of the Diabetes National Clinical Audit data are utilised as part of the monitoring process. Audit data are now available across all audits at local health board level. Data collection for the first year monitoring of the Plan will be concluded by the end of October 2014, with an all Wales annual report being published by the end of the year. A national diabetes clinical lead role has been developed, and Dr Julia Platts has been appointed. Details of her appointment were sent to the Chair of the Health and Social Care Committee in July 2014.
Recommendation 2	**Response: Accept**	Following the launch of the Diabetes

We welcome the forthcoming delivery plan for diabetes, and recommend that the Welsh Government commits to taking appropriate action should health boards fail to deliver the services outlined in the plan.	The implementation of the Diabetes Delivery Plan falls to the NHS in Wales and at a local level to each individual LHB. In addition to monitoring progress, the Welsh Government and the Implementation Group will support LHBs through identifying opportunities for actions at an all Wales level and through facilitating the sharing of best practice through peer review. The Diabetes Delivery Plan will require each LHB to produce a local delivery plan to address progress against the plan, as well as continued implementation of the Diabetes NSF standards. LHBs will be held to account on their progress by the Welsh Government as well as by the local populations that they serve, and to facilitate this public accountability LHBs will be required to publish details of their progress on their websites. Appropriate action will be taken to challenge health boards which fail to deliver the services outlined in the Delivery Plan.	Delivery Plan in September 2013, all health boards produced their own local plans. These local delivery plans have taken into account the Diabetes Implementation Group's priorities in their development, and outcomes have been included in all of the health boards' three year integrated plans. The first monitoring cycle for local delivery plans is currently underway, with health boards required to submit data to the Welsh Government by the end of October 2014. Health boards will also publish their local data on their own web sites, and the Welsh Government will use the data to publish the first annual report on the Diabetes delivery Plan by the end of this year.
Recommendation 3 We recommend that the forthcoming delivery plan should include a requirement for all GP practices to participate in the National Diabetes Audit.	**Response: Accept in principle** Participation in the National Diabetes Audit (NDA) has been a crucial tool in developing improved diabetes services in Wales and continued, full participation will be a priority in the Diabetes Delivery Plan. Welsh GP participation in the Adult NDA has improved to over 80%, from about	The Diabetes Delivery Plan did put a clear expectation on health boards to fully participate in all strands of the Diabetes National Clinical Audit programme. Data has now been collected for the core diabetes audit, which includes GP data. The first report from the core audit, Care Processes and Treatment Targets, is due

	50%, in the latest audit round, and the Diabetes Delivery Plan will instruct LHBs to continue to build on this improvement. It is the clear expectation of the Welsh Government that GP practices in Wales should participate fully in the National Diabetes Audit.	to be published in October. Once published, the Welsh Government will assess the participation rate from GPs in Wales, and consider whether any action is required.
Recommendation 4 We recommend that the Welsh Government's delivery plan should require that all diabetes patients are offered all 9 key annual health checks, and that health boards' performance in meeting this requirement should be monitored through full participation in the National Diabetes Audit.	**Response: Accept** The Delivery Plan will have as a key priority that all patients are offered all 9 key annual health checks. These health checks are established indicators under the Quality and Outcomes Framework (QOF) as well as being monitored as part of the National Diabetes Audit (NDA). The NDA is currently working to ensure that the QOF and NDA measures are aligned, which would allow the monitoring of this to be conducted using either of these processes. As part of their work, the Implementation Group will consider the most appropriate way forward to ensuring compliance with the Delivery Plan, which will include the optimal approach towards monitoring progress. Full participation in the NDA will be a priority under the Diabetes Delivery Plan.	The Delivery Plan includes an action that all patients are offered all 9 key annual health checks. These checks should be part of routine care offered within primary care. Progress on the delivery of this action will be included in the annual report on the Diabetes Delivery Plan. The Diabetes National Clinical Audit also includes the uptake of this as part of their report on 'Care Processes and Treatment Targets', due to be published in October. Following discussions with the audit team, it was agreed that data from this audit report will also be published online at local health board level, so that local users are able to assess the performance of their health board.
Recommendation 5 We recommend that the forthcoming diabetes delivery plan should ensure that local Diabetes Planning and Delivery Groups' relationships with health boards	**Response: Accept** Each LHB has established a local DPDG as part of the implementation of the Diabetes NSF and these groups will be vital in assisting LHBs in the development	All local health boards, with the exception of Powys tHB, have a DPDG that have been involved in the development of their local delivery plans. Powys tHB, as part of their consideration on how to support the

are formalised. Health Boards should demonstrate how they take account of DPDG recommendations and fully engage with their work. Arrangements should be put in place to adopt a national approach for DPDGs, to include national terms of reference for their operation and a requirement to meet with each other to share best practice.	of their updated local delivery plans; which need to take account of the needs of their local population. The Diabetes Delivery Plan will require LHBs to formalise their relationships with their DPDGs, and to include their DPDGs terms of reference (ToR) as part of their updated local plans. The Implementation Group will take forward a peer review approach to share best practice and DPDGs will be included in this process; including consideration of the development of a common set of ToR principles that all LHBs might adopt for their DPDGs.	delivery of all the Welsh Government Delivery Plans, have concluded that they will move to a locality based approach as the best method to deliver at a local level, linked to their three GP areas. The Chair of the Implementation Group, with the agreement of all health board Chief Executives, has made a commitment to visit each health board DPDG, accompanied by the local Chief Executive. These visits will link the work of the Implementation Group with the local delivery groups, and also assess whether there are any issues with the function of DPDGs. Although, with Powys now moving to a different delivery model, a single generic ToR for DPDG would not now be applicable, the feedback from these visits will be considered by the Implementation Group and, if appropriate, recommendations on future DPDG structures issued to local health boards.
Recommendation 6 We recommend that the introduction of an integrated diabetes patient management system should be a priority for the Welsh Government. We note the commitment already made to introduce such a system, and recommend that a clear timetable for its introduction is included in the forthcoming diabetes delivery plan.	**Response: Accept** The development of an integrated diabetes patient management system will be important for long term improvements in health care outcomes for people with diabetes in Wales. The Diabetes Delivery Plan will have the development of such a system as a key strategic priority for the NHS in Wales. The development of a	Following discussions between the Welsh and Scottish Governments, it was agreed that Wales would be able to use the Scottish diabetes patient management system as a basis for developing our own version. The Scottish Government has allowed us to use their system for free. NHS Wales Informatics Service (NWIS) have worked with their Scottish

	patient management system will fall to the NHS Wales Informatics Service and my officials will work with this agency to finalise a timetable for its implementation.	counterparts, and diabetes clinicians in Wales, to scope the project and the requirements for a Welsh system. The requirements and indicative timescales for the project were developed this spring, and an Outline Business Case (OBC) is currently being developed to gain final approval for the project. Although, the system was gifted from the Scottish Government, there will be costs associated with its development, implementation and future running. These will be fully costed in the OBC so that the Welsh Government and health boards are able to effectively plan for its Implementation.
Recommendation 7 We recommend that future public health campaigns on diabetes should reflect the need to raise awareness of the risk factors associated with – and the early symptoms of - diabetes.	**Response: Accept** Prevention and early detection of diabetes are clear priorities for this Government and will be included in the Diabetes Delivery Plan. Any future public health campaigns will need to include raising awareness of the risk factors associated with diabetes, and early symptoms of the disease. Also, public health campaigns linked to lifestyle behaviours need to stress the risks associated with such behaviour, such as the links between obesity and diabetes.	To support the current public health messages, 'Add to Your Life' was launched in April 2014. It is a confidential and easy to use self-assessment, which can be undertaken on-line or, with support, over the telephone by NHS Direct Wales. It provides an opportunity for people who are 50 or over to get an overall picture of their health, and will support them to improve their health and well-being in small achievable steps, as well as improving access to the most effective prevention services. The system includes risk assessment for diabetes, and advice on prevention and the disease's link with lifestyle behaviours.

		We also have our Change Life Wales campaign, which promotes and encourages people to adopt healthier lifestyles including a balance diet and more physical activity.
Recommendation 8 We recommend that the Welsh Government and health boards work together to expand the role of pharmacies in conducting risk assessments, to help improve early identification of people with diabetes. Pharmacies should also play a direct role in future public health campaigns. We believe the Welsh Government should specifically consider the value of including the HbA1c test for existing patients as an enhanced service as part of the Community Pharmacy Contractual Framework.	**Response: Accept** The early detection of diabetes will be a key theme of the Diabetes Delivery Plan and risk assessments have an important role to play. The Welsh Government will introduce an over 50s health checks programme to provide an online resource for people to assess their health and wellbeing. It will help identify risks to their health and provide advice on actions to reduce those risks and improve their health. It will also sign-post people to the most appropriate local support for changing lifestyle behaviours, and where appropriate direct them to seek advice from their GP, or other health professional. In addition, with regards to diabetes specific risk assessment, the Implementation Group will be tasked to look at all Wales solutions to this issue. They will bring forward recommendations on the most appropriate and effective way to deliver diabetes risk assessment to the people who need it; where they need it. A key factor in any such solution will be	The early detection of diabetes is a key theme of the Diabetes Delivery Plan. Through the development of the Welsh Government 'Add to Your Life' service, confidential diabetes risk assessment are now available on line, or through NHS Wales Direct, to the over 50s. It is designed to support them to improve their health and well-being in small achievable steps, as well as improving access to the most effective prevention services. The role out of the service includes targeted community support in partnership with the Communities First programme, so that its effectiveness will be maximised in those communities that need it the most. Since Add to Your Life was rolled out nationally in April 2014, there have been more than 5,000 visits to the site, with nearly 3,000 completed assessments undertaken. As part of the Implementation Group's first year they set up a working group to look at risk assessment. This work will continue in the second year of the group with a focus on developing clear recommendations on the development of

	community pharmacies. Due to their close community links, pharmacies need to be considered in the development of any new public health campaigns. The Welsh Government will also task the Implementation Group to specifically consider the value of including HbA1c testing in pharmacies as part of their work on developing all Wales solutions to diabetes specific risk assessments.	appropriate risk assessment interventions, which use innovative models to target hard to reach groups. This work is also considering the appropriateness, and viability, of developing HbA1c testing as part of a suite of risk assessment interventions. Regarding diabetes risk assessments the last formal work on this was undertaken in September 2012. The national community pharmacy “1 in 10” public health campaign,which was facilitated by Public Health Wales and delivered in partnership with Diabetes UK and the Stroke Association, ran in all 713 pharmacies in Wales in September 2012. More than 14000 people completed the questionnaires and were provided with information and advice on diabetes and stroke risk factors. Analysis of completed questionnaires revealed that 14.5% were at high risk of developing diabetes i.e. a one in three risk of developing Type 2 diabetes in the next 10 years. The Diabetes Implementation Group is also working with the Heart Disease Implementation Group on risk assessment, as the risk factors for the two disease groups have much in common.
Recommendation 9 We recommend that the Welsh Government should urgently address the variances in the provision of structured	**Response: Accept** Patient empowerment is crucial to improving health care outcomes for people with diabetes and education is a	The provision of NICE compliant structured education is a key objective of the Diabetes Delivery Plan. The provision of improved access to

education for people with diabetes. The forthcoming delivery plan should require all health boards to provide NICE-compliant structured education programmes and ensure equality of access to appropriate, timely education for all patients across Wales.	vital part of developing patient empowerment. The provision of NICE compliant diabetes structured education programmes will be a priority under the Diabetes Delivery Plan. The Quality and Outcomes Framework for 2013/14 has established an indicator for referral to a structured education programme within 9 months of entry onto the diabetes register and LHBs will need to ensure that programmes are available for people who are referred to them. In addition to people with newly diagnosed diabetes having access to NICE-compliant structured education, the Implementation Group will consider other ways of delivering effective education to people with diabetes through the most appropriate and effective channels. Every opportunity needs to be taken to educate the person with diabetes if we are to improve health care outcomes for this sector of the population.	diabetes structured education has been a key work stream for the Implementation Group in its first year. They have assessed current capacity and delivery in all health boards, and will issue costed recommendations to all health boards following their meeting at the end of September 2014. This will allow health boards to act on the recommendations of the group within their annual planning cycle, and make any changes from the beginning of the next financial year. In addition to the Implementation Group's work on structured education, they are also considering other options to deliver diabetes education in situations where structured education is either not appropriate, or for groups that have been identified as resistant to this model of education.
Recommendation 10 We believe that insulin pump therapy and the necessary accompanying education should be available to all suitable candidates to improve their quality of life. We recommend that the Welsh Government's forthcoming delivery plan include a requirement to improve the availability of education and training on	**Response: Accept** The Diabetes Delivery Plan will set out to achieve significant progress in patient access to intensive insulin therapy as there is evidence that such treatment reduces microvascular complications in type 1 and type 2 diabetes. Any provision should be evidence based and take account of patient choice, but the plan will	The Diabetes Delivery Plan set out the expectation that health boards need to deliver insulin pump services in line with NICE guidelines. Insulin pump therapy is an area of work that the Implementation Group is considering as a priority for its second year.

the use of insulin pumps.	set as a priority the provision insulin pump service in line with NICE guidelines.	
Recommendation 11 We recommend that the ThinkGlucose programme should be introduced in all health boards across Wales.	**Response: Accept in principle** ThinkGlucose is a commercial product and the 1000 Lives Plus programme is currently considering options for the introduction of a similar, non-commercial, pan Wales programme. It will be the remit of the Implementation Group to consider all Wales solutions for improvements in diabetes health care, and one of its first tasks will be to consider the most appropriate programme to implement; whether that be ThinkGlucose or a Welsh developed programme under the auspices of 1000 Lives Plus. The effectiveness of ThinkGlucose has highlighted the benefits of introducing such a programme across all LHBs in Wales. Therefore, an appropriate programme should be introduced at the earliest opportunity.	The Diabetes Delivery Plan put an expectation on health boards to establish and continue a rolling healthcare professional education programme, e.g. ThinkGlucose. ThinkGlucose has now been established in two health boards, Cwm Taf and Hywel Dda. Depending on the progress of the other health boards in implementing a healthcare professional education programme, which will be assessed following submission of monitoring data in October, the Implementation Group will consider whether it would be more appropriate to develop all Wales options as one of its priorities for its second year of operation.
Recommendation 12 We recommend that the Welsh Government undertake an audit of the number of diabetes specialist nurses in post across Wales, and the proportion of their time spent on general duties. The Welsh Government should consider the merits of issuing guidance to health boards on recommended numbers of diabetes nurses per head of population.	**Response: Accept** Diabetes Specialist Nurses have a crucial role to play in delivering improved care to people with diabetes, both in the community and hospital, and an important facilitation role in the delivery of structured education. The availability of this resource will need to adequately reflect local needs in the development of LHBs' local diabetes delivery plans.	The Welsh Government requested data from all health boards for an audit of Diabetes Specialist Nurses (DSN). In addition to numbers of staff, the audit requested data on training and other support activity to fully reflect the role, and position, of the DSN within their local context. All health boards have submitted data,

	The Welsh Government will conduct an audit of diabetes specialist nurses in line with the recommendation and work with the Diabetes NSAG to consider the merits of issuing guidance to health boards.	and a draft report is being prepared that will assess the responses and issue recommendations. It is expected that the report will be published autumn 2014.
Recommendation 13 We recommend that the Welsh Government monitors the capacity of the Diabetic Retinopathy Screening Service to provide annual checks for diabetic patients as the growing prevalence of diabetes increases demand for the service.	**Response: Accept** Since its introduction, the Diabetic Retinopathy Screening Service has provided all-Wales screening to detect sight-threatening diabetic retinopathy at an early stage before visual loss occurs. The continued effectiveness of this service is key to improving treatment and care for people with diabetes. The capacity of the Diabetic Retinopathy Screening Service to provide annual checks will be part of the monitoring of the implementation of the Diabetes Delivery Plan. The Implementation Group will also consider how this resource can optimally deliver screening in the future whilst utilising the service's data to improve research; with a view to delivering additional health outcomes.	The Welsh Government has worked closely with the Diabetic Retinopathy Screening Service for Wales over the last year to ensure continued effectiveness and to consider how the delivery of the service may be optimised in the future. An annual report on the service's activity in financial year 2013/14 has been published, so that there is full transparency on their current activity and effectiveness. Data from this report will be included in the annual progress report for the Diabetes Delivery Plan, which will be published before the end of the year. On the 17th of September, the Welsh Government announced funding worth £561,000 to replace 34 Digital Retinal Cameras (DRC). Investment in the latest high-tech cameras which will enable the Diabetic Retinopathy Screening Service Wales to continue to detect damage to the retina caused by diabetes. This will allow all people over the age of 12 who have been diagnosed with diabetes and registered with a GP in Wales to be referred and screened every year.