Pecyn dogfennau cyhoeddus

Y Pwyllgor Iechyd a Gofal Cymdeithasol

Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Lleoliad:
Ystafell Bwyllgora 1 - Y Senedd

Dyddiad:
Dydd Mercher, 21 Tachwedd 2012

Amser:
09:15

I gael rhagor o wybodaeth, cysylltwch â:

Polisi: Llinos Dafydd
Clerc y Pwyllgor
029 2089 8403
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Agenda

Sesiwn breifat
Yn ei gyfarfod ar 15 Tachwedd, penderfynodd y Pwyllgor i gwrdd yn breifat ar gyfer eitem 1 o dan Reol Sefydlog 17.42(vi).

1. Ymchwiliad i Ofal Preswyl ar gyfer Pobl Hŷn - Trafod yr adroddiad drafft (09.15 - 10.30)

Sesiwn gyhoeddus

2. Cyflwyniad, ymddiheuriadau a dirprwyon

3. Ymchwiliad i'r gwaith o weithredu'r fframwaith gwasanaeth cenedlaethol ar gyfer diabetes yng Nghymru a'i ddatblygiad yn y dyfodol - Tystiolaeth lafar (10.30 - 12.10)

Byrddau iechyd (10.30 - 11.30) (Tudalennau 1 - 72)
HSC(4)-31-12 papur 1 : Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg
HSC(4)-31-12 papur 2 : Bwrdd Iechyd Hywel Dda
HSC(4)-31-12 papur 3 : Bwrdd Iechyd Aneurin Bevan
HSC(4)-31-12 papur 4 : Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
HSC(4)-31-12 papur 5 : Bwrdd Iechyd Prifysgol Betsi Cadwaladr
HSC(4)-31-12 papur 6 : Bwrdd Iechyd Cwm Taf

Dr Sharon Hopkins, Cyfarwyddwr Iechyd Gyhoeddus, Bwrdd Iechyd Prifysgol

Caerdydd a’r Fro
Dr Leo Pinto, Meddyg Ymgynghorol a Cyfarwyddwr Clinigol, Bwrdd Iechyd Aneurin Bevan
Dr David Minton, Arweinydd Rhwydweithiau Gofal Cymdogaeth, Bwrdd Iechyd Aneurin Bevan
Bronwen John, Pennaeth Partneriaethau a Rhwydwaith, Bwrdd Iechyd Aneurin Bevan

Iechyd Cyhoeddus Cymru a 1000 o Fywydau a Mwy (11.30 - 12.10) (Tudalennau 73 - 80)
HSC(4)-31-12 papur 7
Dr Hugo van Woerden, Cyfarwyddwr yr Is-adran Iechyd a Gwella Gofal Iechyd, Iechyd Cyhoeddus Cymru

4. Papurau i'w nodi

4a. Llythyr gan y Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol - Trefniadau am ofal iechyd parhaus y Gwasanaeth Iechyd Gwladol (Tudalennau 81 - 82)
HSC(4)-31-12 papur 8

4b. Llythyr gan y Gweinidog Iechyd a Gwasanaethau Cymdeithasol ar y Bil Trawsblannu Dynol (Cymru) (Tudalen 83)
HSC(4)-31-12 papur 9

Health and Social Care Committee

HSC(4)-31-12 paper 1

Inquiry into the implementation of the National Service Framework for diabetes in Wales and its future direction - Abertawe Bro Morgannwg University Health Board

ABMU Health Board is currently working towards meeting the standards set out in the Diabetes NSF and welcomes the opportunity to contribute to the inquiry into its implementation across Wales.

ABMU Health Board has a Diabetes Planning and Delivery Group established and meets on a quarterly basis, as requested by the Health Minister. The group is a multi-disciplinary forum with representation from Diabetes Consultants and Specialist Nurses, service planning leads, primary care clinicians and managers, Diabetes UK and Patient representatives.

In 2011 the DPDG prepared and submitted a Diabetes Delivery Plan to Welsh Government, which cross-referenced required actions within the NSF and those from the All Wales High Impact Changes strategy. Considerable work was carried out to align this plan to the previous LDSAG Action plans that were in place in Swansea, Neath Port Talbot and Bridgend before the re-organisation of Health services in Wales.

Following submission of the above delivery plan, the DPDG held a multi-disciplinary workshop in 2011 in order to identify the priorities for taking forward. As a result, the following initial priorities were agreed:

- **Patient Structured Education**
- **Insulin Pump Therapy**
- **Diabetic Foot**

In order to address these priorities, the following actions were carried out:

Patient Education - A Local Enhanced Service has been implemented across GP Practices in ABMU, where GPs are funded to put in place more regular reviews of Diabetes patients and guide them through a dedicated information booklet produced specifically for this initiative. A comprehensive review of the structured education programmes in place across ABMU has taken place, including analysis of current issues with delivery, financial implications and potential opportunities for re-design.

Insulin Pump Therapy (IPT) - a review of IPT has been carried out across ABMU and recommendations made to the DPDG in 2012. As a result a business case is currently being finalised regarding the resourcing of a specialist initiation team.

Diabetic Foot - The Podiatry team established a multidisciplinary joint foot clinic to enable patients to undergo medical and diabetic reviews at the same time as having their foot problems addressed, therefore reducing the risks of diabetic amputations.

By the end of 2011, eight clinics had been held, with 58 appointments, saving 17 patient amputations.

It is recognised that as with most new initiatives, the services identified above need financial investment and considering the financial pressures on health boards, it is very difficult to prioritise the significant funds needed. Nevertheless, the DPDG has begun to explore the opportunity of supplementing any business cases with potential cost savings from other parts of the Diabetes service, where efficiencies can be identified without compromising services to patients.

In addition to the above priorities, the DPDG has also reported other achievements that contribute to the overall implementation of the NSF, including a comprehensive in-patient exercise, where Hypo Boxes were delivered to each ward in ABMU and staff given training on dealing with Diabetic complications. Transition clinics have been established for Children about to enter adulthood in order to support their needs. Also, a unified secondary care IT system , Cellma, has been introduced in Swansea (although the service throughout ABMU- and elsewhere in Wales- continues to struggle in the absence of a national diabetes IT system linking all care providers).

Whilst the above progress contributes to the achievement of some of the main actions within the NSF, ABMU recognises that significant steps are required in order to achieve the NSF by 2013, requiring substantial resource investment at a time when the NHS financial envelope is tightened .

Hywel Dda Health Board Hospitals Diabetes Service Report

August 2012

Introduction

The diabetes service within Hywel Dda Health Board is primarily delivered in primary care which is in turn served by 4 specialist units based in the District General Hospitals (Bronglais, Glangwili, Prince Philip and Withybush). There is an approximate population of patients with diabetes of 20,000 (10,000 in Carmarthenshire, 5,000 in Pembrokeshire and 5000 in Ceredigion). Inequalities exist across the Health Board in terms of service provision and access to resource and since the formation of the Health Board we have been working at redressing these inequalities. Within the Health Board there are exemplar Primary Care units that provide state-of-the-art diabetes care near to patient homes and we have recently developed extra locations for delivery of secondary care clinics within the community setting.

Current Secondary Care staffing levels (for patients over 16 years of age)

Carmarthenshire

Consultants in Diabetes and Endocrinology: 3
Diabetes Nurse Specialists: 5 (WTE)
Community Diabetes Nurse: 3 (WTE)
Podiatrists: 0.4 (WTE) Specialist Diabetic Podiatry
Dietitians: 0.5WTE band 6 dedicated diabetes post with limited sessional input from other dietitian

Ceredigion

Consultants in Diabetes and Endocrinology: 1
Diabetes Nurse Specialists: 1.6 (WTE)
Community Diabetes Nurse: 0.8 (WTE)
Podiatrists: 0.2 (WTE) Specialist Diabetic Podiatry
Dietitian: 1WTE band 7 dedicated diabetes post, also functions as HB wide clinical lead for diabetes in dietetics

Pembrokeshire

Consultants in Diabetes and Endocrinology: 1
Diabetes Nurse Specialists: 1.2 (WTE)
Community Diabetes Nurse: 0.8 (WTE) funded by Pharmaceutical company funds – terminates in December 2012
Podiatrists: 0.5 (WTE) Specialist Diabetic Podiatry
Dietitian: 0.48 WTE band 6 dedicated diabetes post

Recent developments in the local diabetes services

Key points

- A secondary care clinic has recently been established on Cardigan Hospital. Community clinics are already held in Aberaeron, Amman Valley, Machynlleth and Tywyn.

- A certificate level module in Diabetes developed between Swansea University and the Health Board is now accredited as suitable training for the GP Local Enhanced Service in Diabetes in Hywel Dda Health Board. Seven courses involving over 100 participants (from all areas of the Health Board) have been held so far, including one held in Carmarthen and one in Aberystwyth. The next course is also scheduled to be undertaken in Carmarthen.

- In Carmarthenshire the Community Diabetes Nurse Specialists and the Dietitian, deliver the XPERT structured education course for people with type 2 diabetes. Our follow up data demonstrates that this programme is successful at improving metabolic control in these patients. Similar courses are now being delivered in Ceredigion and the first one in Pembrokeshire has just completed. These will be facilitated by employing part time community diabetes nurses in these counties. In Ceredigion, the Diabetes Nurse Specialists and Dietitian deliver 5 courses per year. Resources for these courses are currently limited with an absence of dedicated administration support and the patient education packs are funded by charitable funds.

- Diabetic outpatient activity is becoming more sub-specialised, with (for example) significant numbers of diabetic pregnancies and a rapid increase in the use of insulin pumps.

- The National Diabetes Inpatient Audit showed that over 1 in 6 inpatients in Hywel Dda Hospital have a diagnosis of diabetes, confirming the fact that people with diabetes require considerably more hospitalisation than the rest of the population. It was also noted that diabetic foot inspections on the ward were very poor; we are trying to put in place a new foot inspection check to be carried out for every patient referred onto the wards. This will be carried out by nursing staff, with red flags for diabetic foot problems to be referred to the multidisciplinary foot team on all secondary care sites within 24-48 hours (in keeping with new NICE guidelines).

- Open Access diabetic Podiatry clinics are run, one session per week on 3 of the 4 secondary care sites for rapid access for diabetic foot emergencies linking primary care diabetic foot problems into a secondary care multidisciplinary team clinic, with access to diabetologist, vascular input, orthopod links and access to plaster technicians and surgical appliances. On the 4th site (Withybush Hospital) there are twice weekly specialist Podiatry hospital based Diabetes foot clinics.

- Iechyd Hywel: Workplace cardiovascular health checks for those over the age of 40 began in September 2009. The pilot project was undertaken in Carmarthenshire and over 800 checks were performed in the first two years on employees of Tata Steelworks and Hywel Dda Heath Board. The pilot project was a finalist in the 2010 Wales NHS Awards. This pilot was also awarded the Hywel Dda Best of Health Award: Excellence in Improving Health and Wellbeing. In the next month the program will begin offering checks to staff in Pembrokeshire.

- The number of clinical contacts made by members of the Carmarthenshire diabetes team in various settings last year was 15,674. Access to this information across the Health Board is compromised by the lack of an electronic patient record outside of Carmarthenshire. This facility was established within the Carmarthenshire hospitals before reconfiguration in to the current tri-county Health Board.

- Audit of the Carmarthenshire electronic records for the 1,496 patients followed up in the Trust's outpatient clinics show a high level of completeness of the clinical record. Mean duration of diabetes was 22.3 years for Type 1 patients and 14.6 years for Type 2 patients. Not surprisingly, diabetic complications are common in this secondary care cohort, with 35% recorded as having microvascular disease and 25% with macrovascular disease. Despite the advanced nature of the diabetes, cardiovascular risk factor mean values in these patients were: HbA1c 8.5%, blood pressure 134/71 and cholesterol 4.1, respectively. Once more this information for Ceredigion and Pembrokeshire is not readily available due to the lack of an electronic database.

New clinical developments

Insulin pump therapy is now administered to increasing numbers of patients with type 1 diabetes. There are now over 100 adults and 50 children on insulin pumps in Carmarthenshire. An audit of insulin pump usage and effectiveness has been performed this year that has demonstrated excellent results. Ceredigion currently have 16 adult patients and 5 children receiving insulin via pump therapy. In Pembrokeshire there are currently 19 patients on pump therapy. There is no specific funding for the pumps, funding is via the general diabetes budget.

The service for **Diabetes in Pregnancy** for Carmarthenshire has further developed with the establishment of a weekly multidisciplinary clinic at GGH which includes obstetric and diabetes consultants, midwives, diabetes nurse specialist and dietitian. During 2011 a total of 93 patients attended this clinic (255 visits), consisting of 17 with type 1, 7 with type 2 and 61 with gestational diabetes. This information is less readily available in Pembrokeshire and Ceredigion due to the lack of electronic patient records. However, in Pembrokeshire there is a weekly diabetes in pregnancy multidisciplinary clinic.

Continuous blood glucose monitoring equipment is now available to investigate those patients with erratic glycaemia, particularly those with difficult hypoglycaemia problems. In all hospital sites there is a Hospital wide blood glucose testing capability linked in with pathology systems.

New guidelines for the management of hypoglycaemia, ketoacidosis, diabetes in pregnancy as well as diabetic painful peripheral neuropathy have been developed and are currently being implemented. A bespoke insulin prescribing chart has also being introduced throughout the HDHB hospitals. A further development that is currently in progress is a staff education package that will improve levels of knowledge and competence in our non-specialist staff. This will inevitably improve the care of our in-patients with diabetes.

Health Board Diabetes Nurse Specialists are currently developing **Insulin Passports** for patients with diabetes.

Carmarthenshire Diabetes Patient Record

We now have detailed clinical information on 8,133 people with diabetes. The annual number of patient contact entries by the diabetes multidisciplinary team in 2011 was 15,674. This enables excellent communication between members of the diabetes team and also with patients, their carers and primary care staff. As the electronic record is used by the whole multidisciplinary diabetes team, we often look at each other's entries and this provides a powerful safeguard against errors that could cause harm. Since the EPR system enables us to aggregate

large amounts of data, we can get an accurate assessment of many clinical and laboratory data which reflect upon the quality of the service (see below).
The link to the Telepath system allows automatic transfer of patients' pre-clinic test results to the EPR, although the new units for recording HbA1c (IFCC having replaced DCCT) have required manual entry into the record so far. As mentioned above this system is not available in Ceredigion or Pembrokeshire and current levels of resource do not allow for this to be purchased. The acquisition of an all-Wales electronic diabetes record and database system (as available in Scotland) would negate the need to resource such a system specifically for our localities.

Patient participation

Patients continue to be represented at all stages in the design and delivery of diabetes services. The Carmarthenshire Diabetes Patient Reference Group meets regularly before each Diabetes Network meeting to discuss a range of issues relevant to the local diabetes services. Five members of this group also attend the Network meetings where these issues are further discussed. Efforts are underway to re-establish Diabetes Reference Groups in both Ceredigion and Pembrokeshire; indeed the first meeting of the Ceredigion Patient Reference Group has been arranged for 08/10/2012.

Structured patient education

The Community Diabetes Nurse Specialists and Dietitian, continue to deliver the XPERT structured education course for people with type 2 diabetes funded from charitable sources until NHS funding is forthcoming. In Carmarthenshire XPERT has been running since 2006. In the last financial year 4 programmes were run with one annual update day and an INSULIN XPERT programme completed. Ceredigion has run 5 programmes with 49 people attending. As noted above the Pembrokeshire team has recently recommenced these courses also. On all sites structured education courses for Type 1 diabetes patients (DAFYDD courses) are delivered by the inpatient diabetes teams.

Education of healthcare professionals

The following are examples of educational courses designed and/or delivered by our multidisciplinary diabetes team:

- Annual Diabetes Update Day for certificate trained diabetes staff: the last one was held in June 2012 and was attended by over 100 diabetes care professionals from Carmarthenshire and the rest of West Wales.
- In Ceredigion GP Update half days (spring and autumn) have run successfully for 3 years with excellent feedback for primary and secondary care teams from Ceredigion, south Gwynedd and north Powys.
- Diabetic Foot Training Day for GP's and Practice Nurses enable them to examine diabetic feet competently. Diabetic Foot Assessment training is also running along side a Tissue viability wound healing course for District, practice and ward nursing staff (6 sessions per year across the three counties of Hywel Dda).
- Diabetes Training Days are also organised by the Community Diabetes Nurse Specialists for Care Home and Social Services staff.
- The hospital/community based diabetes team also delivers Merit I and Merit II courses to local GP's and Practice Nurses to enable them to care for patients who require insulin.
- We are now into our fifth year for delivering the Swansea Certificate level module in Diabetes.
- Currently we are working on the development of a staff education and awareness programme to improve the hospital care of patients with diabetes.
- Annual training for all health care workers in county council run care homes in Carmarthenshire with the development of a Diabetes Toolkit
- Diabetes Nurses in Ceredigion have delivered Diabetes Update Days for Registered Nurses and so far this year 77 nurses have attended. They have also arranged an Insulin Master-class which is due to be held on October 3rd and the study day is almost fully subscribed with both Primary and Secondary staff. It is hoped that a condensed version of the Update day can be delivered to F1 and F2 doctors in the Post-Graduate Centre on a rolling basis.

- Supplementing Diabetes specific health care professional training, Motivational Interviewing training has been available within Pembrokeshire for the last 4 years and all the Pembrokeshire hospital diabetes team is trained to a high level. Currently this training is being rolled out across all health board secondary care sites.

Diabetes Planning and Delivery Group (DPDG)

The Hywel Dda Diabetes Network was established in 2008. The Network is an inclusive group with representation from all the important local stakeholders in diabetes. These include the hospital based diabetes teams, Community Diabetes Nurses, GP's, health managers, patients and the voluntary sector. It provides the focus for strategic planning of local diabetes services. In addition individual group members, in their capacity as leaders of the various components of the local diabetes services, are also able to implement agreed developments in service delivery.

To develop the Diabetes Delivery Plan we have used the Diabetes E Health Needs Assessment Tool which has been employed to inform the implementation of the Diabetes NSF in the English PCT's for the last few years. This consists of a questionnaire in 16 sections which we have now adapted for use in Wales. The Delivery Plan document, derived from the questionnaire, lists the actions required to conform to the NSF, who is responsible, the timescale, the priority rating and the resource implications. Many of these actions do not require a significant resource and it is anticipated that these will be completed within a relatively short timescale. An up-to-date Diabetes E assessment is included with this document.

The DPDG has been particularly involved with developing the **Diabetes Enhanced Services Business Case** and the **HDHB Diabetes Care Pathway**

Research and Clinical Trial work

Our Unit presented a study titled "Risk identification in the workplace for cardiovascular disease and type 2 diabetes" at the annual national Diabetes UK Conference in March 2011. Our data was also presented in poster form at the annual British Dietetic Association Meeting. Both Prince Philip (PPH) and Glangwili Hospital (GGH) sites have participated in studies on prandial insulin commencement (LanScape). The GGH site has also contributed to a number of other clinical studies during the last year (TIDE Study, LANScape Study, trial on long acting DPP-IV, a study on new long acting insulin, Once weekly Exenatide study).
At GGH we are also conducting in-house research projects. Two studies have now started and a third is in the development phase.
We currently support 4 PhD studentships linked to Swansea and Aberystwyth Universities and have our first MD student starting in October 2012. 2 of the Carmarthenshire diabetes consultants hold NISCHR clinical fellow awards.

National Diabetes Inpatient Audit 2011

All Hywel Dda Health Board hospitals undertook the audit last year and will be doing so again this year (week beginning 17th September 2012).

Hywel Dda Health Board Diabetes Local Enhanced Service (LES)

To date only the first phase of the LES has been funded that compensates GP practices for looking after a greater percentage of their diabetes patients. In order to comply better with many of the NSF standards the subsequent phases (that includes aspects such as screening, education programmes and pre-diabetes) would need to be resourced.

Summary

Diabetes related activity with Hywel Dda Health Board is dynamic and highly functional. Indeed many aspects of our service are look upon with envy by our neighbouring Health Boards. Levels of resource relating in particular to electronic patient records/data systems, patient/staff education, dietetic and podiatry services impact on our ability to deliver all aspects of the NSF for diabetes.

<u>Health Board Diabetes self assessment tool</u> **Health Board Name:** Hywel Dda Health Board **Date:** September 2012

Section 1 - Leadership				NSF standard
1.1	Does the LHB have a Diabetes Planning and Delivery Group (DPDG)?		**Yes**	All
1.2	Does the LHB have a Diabetes Planning and Delivery Group (DPDG) lead?		**Yes**	All
1.3	What is the name of the LHB DPDG lead?		**Dr Meurig Williams/ Dr Sam Rice/ Claire Hurlin**	N/A
1.4	Does the DPDG have representation from:	CHC	**Yes**	All
		Consultant Diabetologist	**Yes**	
		Diabetes specialist nurse	**Yes**	
		Diabetes UK	**Yes**	
		Dietetics	**Yes**	
		LHB Executive (s)	**Yes**	
		Patient representative	**Yes**	
		Paediatrician	**Yes**	
		Pharmacy	**Yes**	
		Podiatry	**Yes**	
		Primary care	**Yes**	
		Psychology	**No**	
1.5	Does the LHB have a designated clinical lead for Diabetes service implementation?		**Yes**	All
1.6	Has the LHB developed a model of care for the Diabetes service that clearly defines what the population should expect and indicates which elements of the service deliver which activities, where, when and how?		**Yes – Diabetes Model of Care**	2-12

1.7	Has the LHB documented a longer term vision and goals for the Diabetes service?	**No however there is a Clinical Services Strategy which documents the vision for chronic diseases.**	2-12
1.8	Is there a management system in place for monitoring the performance of providers against the model of care?	**Yes – Secondary Care Mechanism for Carmarthen QOF is recorded for Primary Care**	2-12
1.9	Does the LHB obtain the views of primary care teams, Diabetes specialist teams and support services (e.g. eye screening, foot screening etc.) on how the Diabetes services could be developed across the LHB?	**Yes**	2-12
1.10	Does the LHB give feedback to Primary care teams, Specialist (Secondary care) teams and support services on Diabetes service developments?	**Yes**	2-12
1.11	Does the LHB require that providers obtain the views of service users and the wider community on how the Diabetes services could be developed across the LHB?	**Yes Carmarthenshire has a patient reference group. Planned for October in Ceredigion**	3-12
1.12	Does the LHB give feedback to service users and the wider community about service development and service outcomes?	**Yes**	3-12
1.13	Does the LHB require that providers measure patient satisfaction?	**Yes health board wide not specific to diabetes.**	3-12
1.14	Does the LHB require that providers measure staff satisfaction?	**No not specific to Diabetes wider staff survey undertaken across the HB**	N/A

Section 2 – Policy and strategy			**NSF** standard
2.1	Has the LHB developed a Strategic plan to ensure full compliance with Diabetes NSF by 2013?	**No**	1-12
2.2	Has the LHB developed and documented a Delivery plan to map the activity and milestones (goals for the diabetes service) to ensure full compliance with Diabetes NSF by 2013?	**yes**	1-12
2.3	Are the LHBs Delivery plan in line with diabetes NICE guidance?	**Yes -model of care**	1-12
2.4	Has the LHB assessed the needs of all sections of the population (i.e. adults, children and young people, elderly, minority ethnic groups etc.)?	**Yes for adults**	1-12
2.5	Has the LHB Delivery plan taken into account a comprehensive population needs assessment?	**Yes**	1-12
2.6	Does the LHBs model of care make explicit the roles of the various providers (e.g. primary, secondary, intermediate and community care) in delivering Diabetes services?	**Yes (model of care)**	2-12
2.7	Does the LHB have clear guidelines directing referral to and discharge from Specialist Diabetes services (Secondary Care)?	**Yes for Specialist services (foot, neuropathy, renal).**	4-9
2.8	If so does the LHB require that all providers adhere to the model of care for referral to and discharge from specialist Diabetes services (Secondary Care)?	**No**	4-9
2.9	Does the LHBs strategy include addressing the requirement that all people with diabetes should be offered a personalised care plan?	**No**	3-12
2.10	Does the LHB provide a range of services that support people with Diabetes in making changes to their lifestyle that are based on feedback from care plans?	**No**	3-12
	If yes - Menu of services offered:		
2.11	Does the LHB run a NICE compliant structured education for people with Type 1 Diabetes (newly diagnosed and ongoing)?	**No Programme available but not NICE compliant**	3
If yes:	Name programme:	**Structured Education**	
	Is programme accessible to people in all geographical areas covered by the LHB?	**No**	

	Which professions' input into the programme?	Dietetics	**Yes**	
		Medical	**No**	
		Nursing	**Yes**	
		Podiatry	**No**	
	How many programmes were delivered last year / reporting period?		**5**	
	How many people completed the programme?		**40**	
	Does the LHB have the capacity (number of places) to meet the requirements of:			
			2 - 5%	
	What is the average waiting time to access the programme (weeks)?		**Currently no waiting list**	
2.12	Does the LHB run a NICE compliant structured education programme for people with Type 2 Diabetes (newly diagnosed and ongoing)?		**Yes**	3
If yes:	Name programme:		**Xpert Education Programme**	
	Is programme accessible to people in all geographical areas covered by the LHB?		**No- it is now available in each county but not within each locality:**	
	Which professions input into the programme:	Dietetics	**Yes**	
		Medical	**No**	
		Nursing	**Yes**	
		Podiatry	**No**	
	How many programmes were delivered last year / reporting period?		**Carms: 5 Cere:5 Pembs: 1**	
	How many people completed the programme?		**Carms: Cere: 61 Pembs:5**	
	Does the LHB have the capacity (number of places) to meet the requirements of:		**No**	
			2 - 5%	
	What is the average waiting time to access the programme (weeks)?		**6**	
2.13	Does the LHB require that all providers have access to accurate and consistent patient education materials?		**Yes**	3

2.14	Does the LHB require that policies, protocols and guidelines developed and/or used by all providers are based on evidence and/or accepted good practice?	**Yes**	2-12
2.15	Does the LHB have a performance management system in place to identify variation in the quality of service provision?	**No**	2-12
2.16	Does the LHB have a plan to address variation in the quality of service provision?	**Yes -action plan in place**	2-12
2.17	Does the LHB have a system to identify barriers to equitable service provision?	**Yes**	2-12
2.18	Does the LHB have a plan to overcome barriers to inequitable service provision?	**Yes**	2-12
2.19	Does the LHB require that, where necessary, providers make interpreters/care coordinators available to support patient consultations and education programmes?	**Yes**	3-6

Section 3 - Staff			**NSF** **standard**
3.1	Are there clear arrangements for the co-ordination of all staff involved in the Diabetes services to deliver the LHBs model of care?	**Yes**	2-12
3.2	Does the LHB require that providers have professional development plans in place for all staff involved in the delivery of the Diabetes services?	**Yes**	2-12
3.3	Does the LHB require that providers have a programme in place that provides continuing professional education to ensure the effective delivery of the model of care?	**Yes**	3-12
3.4	Does the LHB require that providers of Diabetes specialist services (Secondary care) take an active role in delivering and coordinating education programmes for all health care professionals who come into contact with people with Diabetes?	**Yes**	3-12
3.5	Does the LHB specify the competencies and accreditation required by service providers to deliver Diabetes care at each level of the Primary care service?	**Yes**	4-12
3.6	Does the LHB specify the competencies and accreditation required by specialist service providers (Secondary care) to deliver Diabetes care?	**Yes**	4-12
3.7	Does the LHB require that clinical staff involved in the Diabetes services are trained in techniques to support self care?	**Yes**	**3-12**
3.8	Does the LHB require that clinical staff involved in the Diabetes services are trained to support personalised care planning?	**No**	**3-12**
3.9	Does the LHB require that clinical staff involved in the Diabetes services are trained to help patients make changes in their lifestyles?	**Yes**	**3-12**

Section 4 - Prevention of Type 2 Diabetes					**NSF** **standard**
4.1 Does the LHB have a programme for raising awareness of the risk factors for Diabetes amongst its population? AS in paper copy				**No - in progress work ongoing to implement the LES.**	1
If yes:	By what means:		Promotional campaign	**Yes / No**	
			Educational leaflets	**Yes / No**	
			Other: specify	**Yes / No**	
	Is it evaluated?			**Yes / No**	
4.2 Does the LHB have a programme for improving diet and nutrition targeted at sub-groups of the population at increased risk of developing Diabetes?				**Yes**	1
If yes:	Groups with established		Cardiovascular disease	**Yes within cardiac rehab**	
			Cerebrovascular disease	**Yes – dietetic input to stroke services**	
			Family history	**No**	
			Gestational Diabetes	**Yes – input as required on referral from primary or secondary care**	
			Hypertension	**No**	
			Obesity	**Yes not equitable provision but plans in place to deliver equitably**	
			Peripheral vascular disease	**No**	
			Pre-Diabetes	**With workforce as part of Hywel's Health**	

			only	
		Renal disease	**No**	
		Other: specify	**No**	
	Uptake?			
	Is it evaluated?		**Yes where programmes / service are delivered**	
4.3	Does the LHB have a programme for reducing overweight and obesity targeted at sub-groups of the population at increased risk of developing Diabetes?		**No but will be addressed using the LES for diabetes and obesity pathway group has been established**	**1**
If yes:	Groups with established	Cardiovascular disease	**No**	
		Cerebrovascular disease	**No**	
		Family history	**No**	
		Gestational Diabetes	**No**	
		Hypertension	**No**	
		Obesity	**Yes**	
		Peripheral vascular disease	**No**	
		Pre-Diabetes	**No**	
		Renal disease	**No**	
		Other: specify	**No**	
	Uptake?		**Uptake limited by capacity to deliver**	
	Is it evaluated?		**Yes for MD specialist intervention**	
4.4	Does the LHB have a programme for increasing physical activity targeted at sub-groups of the population at increased risk of developing Diabetes?		**Yes**	1

If yes:	Groups with established	Cardiovascular disease	**Yes**	
		Cerebrovascular disease	**Yes**	
		Family history	**Yes**	
		Gestational Diabetes	**No**	
		Hypertension	**Yes**	
		Obesity	**Yes**	
		Peripheral vascular disease	**Yes**	
		Pre-Diabetes	**Yes**	
		Renal disease	**No**	
		Other: specify		
	Uptake?		**Limited by resource/ Unsure**	
	Is it evaluated?		**Yes**	
4.5 Are the LHBs Diabetes and Cardiovascular disease risk factor management programmes complementary?			**Yes for staff** **No for patients**	1
4.6 Does all information and communication with the local population regarding prevention of Type 2 Diabetes take into account cultural sensitivities, language barriers and people with special needs?			**No**	1
4.7 Does the LHB undertake periodic surveys to test public awareness to ensure that public education programmes are correctly focused?			**No - some work occurs in one county at annual update on X-pert diabetes education programme**	1

Section 5 – Identification of people with Type 2 Diabetes				**NSF standard**
5.1 Does the LHB have a programme for raising awareness of the signs and symptoms of Diabetes amongst its population?			**No**	2
If yes:	By what means:	Promotional campaign		
		Educational leaflets		
		Other: specify		
	Is it evaluated?			

No.	Question			Response	Score
5.2	Does the LHB require that health and other professionals most likely to come into contact with people with undiagnosed Diabetes are aware of the signs and symptoms of Diabetes?			**Yes**	2
5.3	Does the LHB require providers to follow-up and regularly test people who have previously been found to have impaired glucose tolerance?			**Yes**	2
	If YES for how many:				
				26 - 50%	
5.4	Does the LHB require providers to have guidelines for follow-up and regular testing of women with a history of gestational Diabetes?			**Yes**	2
	If YES for how many:				
				76 - 100%	
5.5	Does the LHB have a programme for screening other individuals at risk of developing Diabetes?			**No in one county there is a project supporting this. The development of the LES should address this.**	2
	If YES who :	Groups with established:	Cardiovascular disease		
			Cerebrovascular disease		
			Family history		
			Gestational Diabetes		
			Hypertension		
			Obesity		
			Peripheral vascular disease		
			Pre-Diabetes		
			Renal disease		
			Other: specify		
		Uptake?			
		Is it evaluated?			

Section 6 – Initial management			NSF standard
6.1 Do the LHBs providers use NICE compliant guidelines for the initial assessment and care of adults presenting with Diabetes in health care settings?		**Yes**	3,4
6.2 Does the LHB monitor the use of NICE compliant guidelines for the initial assessment and care of adults presenting with Diabetes in health care settings?		**No**	3,4
6.3 Does the LHB require that people with newly diagnosed Diabetes receive Specialist dietary advice?		**Yes**	3,4
If YES for how many:			
		76 - 100%	
6.4 Is NICE compliant structured education offered to people newly diagnosed with Diabetes?		**Yes for Type 2 diabetes only**	3
If YES for how many:			
		2-5%	
6.5 Does the LHB require the agreement of personal care plans with all people newly diagnosed with Diabetes?		**No**	3
6.6 Are psychological support services available to people with diabetes at diagnosis and whenever necessary?		**No**	3
If Yes which of the following are available:	Counseling		
	Motivational interviewing		
	Cognitive behavioural therapy		
	Consultation with Psychologist		
6.7 Do all information/education materials provided for people newly diagnosed with Diabetes take into account cultural sensitivities, language barriers and people with special needs?		**Yes**	3
6.8 Does the LHB have a system for monitoring whether people with newly diagnosed Diabetes are offered a structured education programme?		**No**	3

No.	Section 7 – Annual review			NSF standards
7.1	Does the LHBs model of care require that all people with Diabetes are offered an annual review (or more frequent reviews where clinically indicated)?		**Yes**	4,5,10,11
7.2	Does the LHB require that the annual review includes the following key components of Diabetes care:	Body mass index?	**Yes**	4,5,10,11
		Dietary management?	**Yes**	
		Physical activity?	**Yes**	
		Tobacco consumption?	**Yes**	
		Alcohol consumption?	**No**	
		Perception, comprehension and priorities of Diabetes care?	**No**	
		Psychological wellbeing?	**No**	
		Glycated haemoglobin and target level?	**Yes**	
		Blood pressure and target level?	**Yes**	
		Blood lipids and target level?	**Yes**	
		Urinalysis for microalbuminuria?	**Yes**	
		Urinalysis for proteinuria?	**Yes**	
		Serum creatinine?	**Yes**	
		eGFR?	**Yes**	
		Foot examination for neuropathy, peripheral vascular disease, foot deformity, pathology and neglect?	**Yes**	
		Eye examination including visual acuity and fundus examination by a means or technique recommended by the National Screening Committee?	**Yes**	
		Individualised target approach?	**Yes**	
7.3	Does the LHB require providers to have a policy that encourages re-engagement with people who do not attend for annual reviews (DNA)?		**No**	4,5,6,10, 11
7.4	Does the LHB monitor the uptake of influenza and pneumococcal vaccination by people with Diabetes?		**Yes**	4
7.5	Does the LHB require that providers agree and update annual care plans with people with Diabetes under their care?		**No**	4-5
7.6	Do the LHBs providers share results of annual reviews (e.g. biomedical results etc.) with people with Diabetes, in advance of their consultation?		**No**	4-5
7.7	Do the LHBs providers, when undertaking reviews, assess biomedical measures, e.g. HbA1c, against previously recorded levels?		**Yes**	4-5

7.8	Do the LHBs providers, when undertaking reviews, assess biomedical measures, e.g. HbA1c, against NICE guideline targets?	**Yes**	4-5
7.9	Do the LHBs providers review patients frequently until they have attained their personal treatment targets?	**Yes**	4-5,11
7.10	Do the LHBs providers agree goals and action plans for self care with people with Diabetes as part of the annual care planning session?	**Yes –within model of care document**	4-5,11
7.11	Does the LHB require providers to collect and audit feedback from care planning sessions?	**No**	4-5,11

Section 8 – Metabolic management			**NSF** **standards**
8.1	Do the LHBs providers have NICE compliant guidelines for the use of oral or non-insulin injectable hypoglycaemic agents?	**Yes**	4
8.2	Do the LHBs providers have NICE compliant guidelines for commencing insulin treatment in people with Type 1 Diabetes?	**Yes**	4
8.3	Do the LHBs providers have NICE compliant guidelines for commencing insulin treatment in people with Type 2 Diabetes?	**Yes**	4
8.4	Do the LHBs providers have NICE compliant guidelines for the use of combined insulin and oral hypoglycaemic agents in people with Type 2 Diabetes?	**Yes**	4
8.5	Do the LHBs providers ensure that people with Diabetes routinely receive education regarding self management following changes in therapy?	**Yes**	4
8.6	Does the LHB provide NICE compliant insulin pump therapy services?	**Yes**	4
8.7	Do the LHBs providers have NICE compliant guidelines for glucose self-monitoring in Type 1 Diabetes?	**Yes**	4
8.8	Do the LHBs providers have NICE compliant guidelines for glucose self-monitoring in Type 2 Diabetes?	**Yes**	4
8.9	Does the LHB monitor the rates of Diabetic emergencies?	**Yes**	4
8.10	Do the LHBs providers have NICE compliant guidelines for the prevention and management of severe hypoglycaemia?	**Yes**	4
8.11	Do the LHBs providers have NICE compliant guidelines for the prevention and management of Diabetic ketoacidosis?	**Yes**	4
8.12	Do the LHBs providers have guidelines for the prevention and management of hyperosmolar coma?	**Yes**	4

Section 9 - Risk factors for cardiovascular disease		**NSF standards**
9.1 Does the LHB ensure provision of smoking cessation programmes that are delivered in accordance with Thorax Smoking Cessation Guidelines?	**Yes**	4
9.2 Do the LHBs providers have NICE compliant guidelines for the identification and management of hypertension in people with Diabetes?	**Yes**	4
9.3 Do the LHBs providers have NICE compliant guidelines for the identification and management of hyperlipidaemia in people with Diabetes?	**Yes**	4
9.4 Do the LHBs providers have NICE compliant guidelines for the identification and management of obesity in people with Diabetes?	**Yes**	4
9.5 Do the LHBs providers have NICE compliant guidelines for identifying a lack of physical activity in people with Diabetes?	**No**	4
9.6 Do the LHBs providers give weight management advice to people with Diabetes under their care who are obese?	**Yes**	4
9.7 Do the LHBs providers give advice, where appropriate, to people with Diabetes on increasing physical activity levels?	**Yes**	4
9.8 Do the LHBs providers give advice, where appropriate, to people with Diabetes on limiting excessive alcohol intake?	**Yes**	4
9.9 Do the LHBs providers have NICE compliant guidelines for the use of prophylactic antiplatelet therapy?	**Yes**	4
9.10 Do the LHBs providers have NICE compliant guidelines for the use of prophylactic lipid lowering therapy?	**Yes**	4
9.11 Do the LHBs providers have NICE compliant guidelines for the use of prophylactic ACE inhibitor therapy?	**Yes**	4
9.12 Do the LHBs providers give people with Diabetes information about the benefits of cardiovascular risk factor management in Diabetes?	**Yes**	4

Section 10 – Hospital admissions		**NSF** **standards**
10.1 Do Diabetes Healthcare teams have immediate access to the names and location of individuals with Diabetes in the Hospital at any given time?	**No**	7-9
10.2 Do the Hospitals keep an up to date list of Diabetic patients placed onto a surgical waiting list?	**No**	7-9
10.3 Do the Hospitals have NICE compliant guidelines for the management of people with Diabetes admitted for surgery?	**Yes**	8-9
10.4 Do the Hospitals have NICE compliant guidelines for blood glucose monitoring in people with Diabetes admitted to hospital?	**No**	7-9
10.5 Do the Hospitals monitor adherence to guidelines?	**No**	7-9
10.6 Do the Hospitals have guidelines for managing people with Diabetes admitted to hospital with a Diabetic emergency, e.g. hypoglycaemia, Diabetic Ketoacidosis or hyperosmolar coma?	**Yes**	7
10.7 Do the Hospitals have guidelines for managing people with Diabetes admitted to hospital for day case procedures eg Endoscopy, Barium enema?	**No**	8
10.8 On admission, do the Hospitals identify and code people with Diabetes appropriately on their information system?	**No**	7-9
10.9 Do the Hospitals have NICE compliant guidelines for the management of hyperglycaemia in patients who are acutely unwell?	**Yes**	7-8
10.10 Do the Hospitals ensure that during an inpatient stay, the person with Diabetes and the team caring for him or her receive advice from a trained multidisciplinary team with expertise in Diabetes?	**Yes**	7-9
10.11 Do the Hospitals have effective and comprehensive programmes in place to support and train ward staff in the management of Diabetes?	**No – education takes place differently across the 3 counties. A Hywel Dda education programme to be implemented**	7-9
10.12 Do the LHBs hospital providers monitor the uptake of training of ward staff in the management of Diabetes?	**No – general training programme in place which**	7-9

	incorporates diabetes	
10.13 Do the Hospitals have systems in place to monitor the acceptability / effectiveness of care and take action as appropriate?	**Yes Diabetes inpatient audit**	7-9
10.14 Do the Hospitals have systems in place to monitor significant events in people with Diabetes admitted to hospital and take action as appropriate?	**Yes**	7-9
10.15 On discharge are people with Diabetes given the contact number of who they should contact if they have any problems?	**Yes**	7-9
10.16 Do LHBs have supportive discharge strategies in place?	**Yes**	7-9

Section 11 – Eye screening	**Y**	**NSF standards**
11.1 Does the eye screening programme provide an Annual report including number offered appointments and screened by HB locality?	**No All Wales Programme**	10
11.2 Does the eye screening programme provide an Annual report including offered appointments and screened by GP practice?	**No All Wales Programme**	10
11.3 Does the eye screening programme provide an Annual report of the names of those who failed to attend for their retinal screening appointments by GP practice?	**No All Wales Programme**	10

Section 12 – Renal screening and management		**NSF standards**
12.1 Do the LHBs providers have NICE chronic kidney disease and Diabetes compliant guidelines for screening for and management of early Diabetic nephropathy?	**Yes**	10-11
12.2 Do the LHBs providers ensure referral for specialist/nephrological opinion of people with Diabetes who have an estimated glomerular filtration rate that meets the criteria stated in the NICE Chronic Kidney Disease: national clinical guideline for early identification and management of adults in Primary and Secondary care?	**Yes**	10-11
12.3 Have the LHB and its providers agreed a care pathway for the management of people with Diabetes and microalbuminuria?	**Yes**	11
12.4 Have the LHB and its providers agreed a care pathway for the management of people with Diabetes and macroalbuminuria?	**Yes**	11

12.5 Do the LHBs providers have NICE compliant guidelines that specify that all people with microalbuminuria and proteinuria are prescribed an ACE inhibitor unless there are contraindications?	**Yes**	11
12.6 Does the LHB require that all people with advanced chronic kidney disease (stages 4 and 5) have access to a multidisciplinary team?	**Yes**	11
12.7 Have the LHB and its providers agreed a care pathway for the management of people with Diabetes who have advanced kidney disease or who require renal replacement therapy?	**Yes**	11
12.8 Have the LHB and its providers agreed a care pathway (including conservative and end of life care) to support people with Diabetes who have end stage renal failure?	**No to be incorporated in the model of care**	11
12.9 Do the LHBs providers monitor performance against the markers of good practice described in the Renal NSF (Parts 1 & 2)?	**No**	11
12.10 Does the LHB provide Diabetes specific education to Health Professionals delivering Renal care?	**No**	11
12.11 Is there a person or group that has responsibility for quality assurance and clinical governance of the renal screening programme?	**No**	10

Section 13 - Foot care and lower limb complications		**NSF standards**
13.1 Do the LHBs providers have NICE compliant guidelines for the identification, management and referral of at risk feet?	**Yes**	10-11
13.2 Do the LHBs providers have NICE compliant guidelines for the identification, management and referral of Diabetic foot ulcers and their complications?	**Yes**	10-11
13.3 Do the LHBs providers have NICE compliant guidelines for the identification, management and referral of neuropathic pain?	**Yes**	10-11
13.4 Do the LHBs providers have NICE compliant guidelines for the identification, management and referral of other Diabetic foot pathologies, including Charcot neuroarthropathy?	**Yes**	10-11
13.5 Is there a comprehensive LHB-wide programme to screen for Diabetic neuropathy and peripheral vascular disease?	**Yes**	10
13.6 Is there a specialist multidisciplinary foot care team to assess and manage limb threatening Diabetic foot disease?	**Yes**	11
13.7 Are there written guidelines for Accident and Emergency teams on the assessment and initial management of people admitted to Accident and Emergency with active Diabetic foot disease?	**No**	11

13.8	Is there a documented requirement within Hospitals for a Consultant experienced in Diabetic foot disease to assess and advise on the management of patients presenting with symptoms and signs of foot infection within 4 hours of admission to Accident and Emergency?	**No- Plans are in place.**	11
13.9	Is there a documented requirement within Hospitals for a Vascular surgeon to assess and advise on the management of patients presenting with symptoms and signs of critical limb ischaemia within 4 hours of admission to Accident and Emergency?	**No- Plans are in place**	11
13.10	Is there a documented requirement within Hospitals for members of the Specialist Diabetes team to be involved in agreeing a care plan for Diabetes management for the person presenting with active Diabetic foot disease within 4 hours of admission to Accident and Emergency?	**No**	11
13.11	Is there a documented requirement within Hospitals that the care of a person presenting with active Diabetic foot disease is transferred to a team with expertise in the management of active Diabetic foot disease within 48 hours of admission?	**Yes**	11
13.12	Is there a documented requirement within Hospitals that the team providing the continuing management of the person admitted with active Diabetic foot disease works with other healthcare professionals who have the appropriate skills necessary to assess and treat foot lesions e.g. podiatrists, vascular team, orthopaedic surgeons, orthotics etc?	**Yes**	11
13.13	Are there Hospital wide antibiotic guidelines specifically for the management of diabetic foot infections?	**Yes**	11
13.14	Is there a documented requirement within Hospitals that, following the diagnosis of active Diabetic foot disease, people with Diabetes are given clear written information about what care to expect during their in-patient stay?	**No**	11
13.15	Does discharge planning from Hospitals include assessment of the other medical and social needs of the patient and their dependents?	**Yes**	11-12
13.16	Does discharge planning from Hospitals include arrangements for inspection and dressing of ulcers in the community by the patient, carer, and/or healthcare professional where appropriate?	**Yes**	11
13.17	Following discharge from Hospital is there a system in place for the long term surveillance of the person with Diabetes?	**Yes**	11-12
13.18	Is patient education provided following identification of a new foot problem?	**Yes**	3,11
13.19	Do the LHBs providers ensure that a patient's blood glucose control is optimised following identification of a new foot problem?	**Yes**	4,11
13.20	Is a patient's cardiovascular risk assessed and managed following the identification of a new foot problem?	**Yes**	4,11
13.21	Is advice on foot care an integral part of all Diabetes education programmes provided by the LHB?	**Yes**	3-5
13.22	Has the LHB agreed a care pathway with its providers to support people with Diabetes undergoing minor and major	**No**	7-8, 11-

amputation, both pre and post operatively?		12
13.23 Do the LHBs providers compare, year on year, the Diabetic lower limb pathway achievement rates on the percentage of people screened?	**No**	10
13.24 Do the LHBs providers compare the percentage of people identified as having at risk feet, year on year?	**No**	10
13.25 Do the LHBs providers compare the percentage of people identified with new ulceration year on year?	**No**	10
13.26 Do the Hospitals compare the percentage of new minor amputations year on year?	**No**	11
13.27 Do the Hospitals compare the percentage of new major amputations, year on year?	**No**	11
13.28 Do Hospitals monitor the number of admissions related to active Diabetes foot disease and those who are readmitted with recurrent ulcer?	**No**	7-8,11
13.29 Do Hospitals monitor the number of people with Diabetes who develop an avoidable foot problem?	**No**	10,11
13.30 Can the Hospitals demonstrate that it acts on the findings of its monitoring processes on inpatient management of active Diabetic foot disease?	**No**	7-8,11
13.31 Is there a person or group that has responsibility for quality assurance and clinical governance of the foot screening programme?	**No**	10

Section 14 – Children and young people with Diabetes		**NSF standards**
14.1 Does the LHB require that providers of services for children and young people with Diabetes have NICE compliant guidelines?	**Yes**	5-6
14.2 Upon diagnosis is the child or young person referred the same day to a paediatrician who has a special interest in diabetes?	**Yes**	5
14.3 Is the long term care of children and young people with Diabetes managed by a Paediatrician who has a special interest in Diabetes?	**Yes**	5
14.4 Do children and young people with Diabetes have access to a paediatric trained Diabetes specialist nurse?	**Yes**	5
14.5 Do children and young people with Diabetes have access to a Paediatric dietitian who has a specialist interest in Diabetes?	**Yes**	5
14.6 Do children and young people with Diabetes have access to a Paediatric trained psychologist /counsellor if needed?	**No**	5-6

14.7	Do providers of services for children and young people, including young persons' clinics, measure patient satisfaction with and the appropriateness of services?	**Yes but not consistently**	5-6
14.8	Do providers of services for children and young people, including young persons' clinics, encourage the active participation of service users/carers in service development?	**Yes but not consistently**	5-6
14.9	Does the LHBs model of care clearly define what care children and young people with Diabetes and their families should expect to receive, where, when and how?	**Yes**	5
14.10	Is there a structured education programme for newly diagnosed children and young people with Diabetes and their families?	**No**	3,5
14.11	Is education adjusted to the development stage of the child or young person and repeated regularly?	**Yes, but not as a structured education programme**	3,5
14.12	Do providers of Diabetes services for children and young people provide education and written protocols for school staff regarding the identification and management of children and young people with Diabetes?	**No, but work has been undertaken to develop joint guidance with education in 1 county which will then be used as a template for HB wide approach**	5
14.13	Do hospital providers have NICE compliant guidelines for the management of children and young people admitted with Diabetic ketoacidosis?	**Yes**	7
14.14	Do providers of Diabetes services for children and young people have NICE compliant guidelines for optimising glycaemic control towards normal levels?	**Yes**	5-6
14.15	Do hospital providers have NICE compliant guidelines for the management of children and young people with Diabetes requiring surgery?	**Yes**	5-6,8
14.16	Do the hospitals monitor adherence to guidelines?	**No**	5-6,8
14.17	Do children, young people with Diabetes and their families have access to 24 hour per day emergency telephone contact?	**Yes**	5-6
14.18	Are all children and young people with Diabetes reviewed at least annually and followed up at least three times a year?	**Yes**	5-6
14.19	Do all children and young people with Diabetes have an HbA1c measurement at each review visit (at least three times per year)?	**Yes**	5-6

Question	Response	NSF standards
14.20 Does the LHB require that providers of Diabetes services for children and young people adopt a care planning approach that encourages the child/young person and carer to discuss particular issues and ask questions at each review?	**No**	5-6
14.21 Does the LHB ensure provision of NICE compliant insulin pump therapy services for children and young people with Diabetes?	**Yes**	5-6
14.22 Do all young people with Diabetes over the age of 12 have their eyes screened annually as part of a systematic programme that meets National Screening Committee standards?	**Yes**	5-6,10
14.23 Do all young people with Diabetes over the age of 12 years have their urine tested for microalbuminuria (overnight AER or first morning ACR) annually?	**Yes**	5-6,10
14.24 Do all young people with Diabetes over the age of 12 years have their blood pressure measured annually?	**Yes**	5-6
14.25 Are children and young people with Diabetes screened for thyroid and coeliac disease in line with NICE guidance?	**Yes**	5-6
14.26 Do providers of services for children and young people, including those following transition, have a policy that encourages re-engagement with children and young people who do not attend for annual reviews?	**No**	5-6
14.27 Is there ongoing local audit of the structures, processes and outcomes of care for children and young people with Diabetes?	**Being developed as part of the HDHB paediatric diabetes group**	5-6
14.28 Do the services for children and young people with Diabetes participate in the National Diabetes Audit?	**Yes and Brecon Group audit**	5-6
14.29 Do providers of services for children and young people ensure there is planned and agreed (with the young person) transfer of the young person with Diabetes from the paediatric Diabetes service to the adult Diabetes service?	**Yes – approach varies across the HB sites**	5-6
14.30 Does the local adult Diabetes specialist team run a young persons clinic following transfer?	**Yes but not in all sites**	6

Section 15 - Pregnancy		**NSF** **standards**
15.1 Do the LHBs providers have NICE compliant guidelines on the provision of pre-conception advice for all women with Diabetes of child bearing age?	**No**	9
15.2 Do the LHBs providers have guidelines on the provision of contraceptive advice and counseling for younger women with Diabetes on the problems of teenage pregnancy?	**No**	9

15.3	Do the LHBs providers have NICE compliant guidelines for detecting women who develop abnormal glucose tolerance in pregnancy (gestational Diabetes)?	**Yes**	9
15.4	Do the LHBs providers offer frequent medical and obstetric consultation to every pregnant woman with Diabetes in accordance with NICE guidance?	**Yes**	9
15.5	Do the LHBs providers advise all women with Diabetes who are planning to become pregnant to take folic acid (5mg/day) until 12 weeks of gestation?	**Yes**	9
15.6	Does the LHB ensure the provision of insulin pump therapy services for pregnant women with insulin-treated Diabetes who cannot achieve adequate glycaemic control with multiple daily injections of insulin?	**No**	9
15.7	Do the Hospitals ensure that all women with Diabetes have regular access to a specialist dietitian and dietary advice related to their cultural and personal circumstances, before and during pregnancy?	**Not before Yes during but limited ability to respond in a timely way**	9
15.8	Do the Hospitals screen for acceleration of Diabetic complications during pregnancy?	**Yes**	9
15.9	Do the Hospitals have NICE compliant guidelines for the detection and management of neonatal hypoglycaemia and other neonatal complications in babies born to women with Diabetes?	**Yes**	9
15.10	Has the LHB agreed a care pathway with its providers to support women with Diabetes who have a stillbirth or a child with a congenital abnormality?	**No**	9
15.11	Does the LHB require that all women with Diabetes/gestational Diabetes are followed up postpartum?	**Yes**	9
15.12	Does the Diabetes/Obstetric service participate in national or regional collaborative audit of the processes and outcomes of Diabetes pregnancy care?	**Yes**	9

Section 16 - Elderly			**NSF standards**
16.1	Does the LHBs model of care include arrangements for the diagnosis and care of people with Diabetes who are housebound or who live in residential and nursing homes?	**Yes**	4,12
16.2	Does the LHBs model of care require that people with Diabetes who are housebound or living in nursing or residential homes have access to annual review?	**No**	4,12
16.3	Are there systems in place in the hospitals to ensure that Diabetes specialist team support is available to the hospital Care of the Elderly team when they are caring for people with Diabetes?	**Yes**	8
16.4	Do the hospital Care of the Elderly team and the Diabetes specialist team have joint plans for managing elderly people with Diabetes?	**No**	8

16.5	Does the LHB's model of care require that advice and training is provided to proprietors/matrons of nursing and residential homes in the management of people with Diabetes?	**Yes**	4,12
16.6	Does the LHBs model of care require that people with Diabetes who are housebound or living in nursing and residential homes are set individualised treatment targets that take into account the person's general health and wellbeing?	**No- to be incorporated into model of care for Hywel Dda**	4,12
16.7	Does the LHB provide services (including transport) that ensure people who are housebound can access appropriate Diabetes care?	**Yes**	4,12
16.8	Does the LHBs model of care require that people with Diabetes who are living in nursing or residential homes are provided with a healthy diet?	**Yes**	4,12
16.9	Does the LHBs model of care require that advice and training is provided to cooks working in nursing and residential homes on dietary management in Diabetes?	**No**	12
16.10	Does the LHB work with other agencies to ensure that there are programmes in place to promote physical activity for older people?	**Yes**	12
16.11	Does the LHB require that people with Diabetes living in nursing and residential homes have access to the eye screening programme?	**Yes**	4,12
16.12	Does the LHB require that people with Diabetes living in nursing and residential homes have access to foot screening and where need is identified, ongoing foot care?	**Yes**	4,12

Section 17 – Clinical Information systems			**NSF** **standards**
17.1	Has the LHB provided Primary care with Patient management systems facilitating integrated Diabetes care?	**No Available in one county currently**	4,5,6,8
17.2	Has the LHB provided Secondary care with Patient management systems facilitating integrated Diabetes care?	**No Available in one county currently**	4,5,6,8
17.3	Does the LHB require that all providers (including Primary and Secondary care services for adults and children and young people with Diabetes) participate in the National Diabetes Audit?	**No**	4,5,6,8
17.4	Does the LHB specify the precise diagnostic terms and codes to be used within practices and Secondary care for recording information on the care of people with Diabetes?	**No**	4,5,6,8
17.5	Does the LHB specify the use of national Diabetes dataset standards for the exchange of electronic patient record information between general practice, community and specialist Diabetes care providers (Secondary care)?	**No -Available in one county**	4,5,6,8

17.6 Does the LHB require that providers have guidelines for call/recall?		**Yes**	4,6
17.7 Has the LHB enabled fully integrated sharing of Diabetes related Electronic Patient Record information between care providers?		**No**	4,5,6,8
17.8 Does the LHB recommend that practices use computerised templates for managing people with Diabetes?		**Yes**	4
17.9 Does the LHB offer support to practices in developing and using computerised templates?		**Yes**	4
17.10 Does the LHB recommend an integrated approach to the use of practice-based information systems for Diabetes, Coronary heart disease and Cerebrovascular disease?		**No**	10-12
17.11 Are there processes in place to ensure that all providers of care (e.g. eye screening, specialist team etc.) feed information back to Primary and Secondary care?		**Yes**	10-12
17.12 Does the LHB review at least annually the incidence of the following complications of Diabetes and compare these rates with other LHBs (e.g. via participation in the National Diabetes Audit):	Myocardial infarction?	**No**	4,6,8,10, 11
	Stroke?	**No**	
	Angina?	**No**	
	Minor amputations (below ankle)?	**No**	
	Major amputations (ankle and above)?	**No**	
	Laser retinal photocoagulation?	**No**	
	Blindness?	**No**	
	End stage renal failure?	**No**	
	Death?	**No**	
17.13 Does the LHB require that regularly updated integrated personal Diabetes care records are made available for all people with Diabetes?		**No**	4-12
17.14 Does the LHB have a plan for an IT system that allows patients to access their own clinical records and associated communications (e.g. clinical letters)?		**No**	3
17.15 Does the LHB's approach to integrated communications between care providers include support for the process of care planning and sharing the care plan with patients?		**No**	3
17.16 Does the LHB have a complete repository of the names of individuals with Diabetes within their area?		**Yes**	2
If not:	Who does?		
	Are there any obstacles to sharing this information?	**No**	
	If Yes – specify		
17.17 Do Hospital IT systems ensure Diabetes Healthcare teams have access to the names and location of all individuals with Diabetes in the Hospital at any given time?		**No**	5-9

Our Ref: JP/lb

Please contact: Judith Paget
Direct Line: 01495 765016

21 September 2012

Mark Drakeford AC/AM
Chair
Health and Social Care Committee
National Assembly for Wales
Cardiff Bay
CARDIFF CF99 1NA

Dear Sir

Implementation of the National Service Framework for Diabetes in Wales and its Future Direction

I am writing on behalf of Aneurin Bevan Health Board in response to your letter of 26 July 2012, to contribute to the Health and Social Care Committee inquiry into the implementation of the National Service Framework for Diabetes in Wales and its future direction.

As chair of the Diabetes Planning and Delivery Group, I confirm that representatives of the Health Board would be prepared to give oral evidence to the inquiry if requested to do so, with reasonable notice.

Progress on implementing the National Service Framework

The Diabetes Planning and Delivery Group have formed in Gwent following the NHS reconfiguration with a remit of developing service provision and taking forward the NSF.

Significant progress has been made in some areas, and a summary is related to the original NSF standards below. This is not an exclusive list, but provides a flavour of the actions required and taken

Standard 1-The NHS will develop, implement and monitor strategies to reduce the risk of developing Type 2 diabetes in the population as a whole and to reduce inequalities in the risk of developing Type 2 diabetes

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Bwrdd Iechyd Aneurin Bevan yw enw gweithredol Bwrdd Iechyd Lleol Aneurin Bevan
Aneurin Bevan Health Board is the operational name of Aneurin Bevan Local Health Board

i) *Ensure that action to improve diet, nutrition, increased physical activity, reducing overweight and obesity and mo0nitor healthy weights are integrated into national and local strategies with particular emphasis on ethnic and vulnerable groups and children*

A needs assessment of the population has been undertaken led by Public Health, and the Aneurin Bevan Health Board's Public Health Strategy identifies a range of actions required to support a reduction in Type 2 diabetes. The Local Authority specific Local Service Boards, Health, Social Care and Wellbeing and Children and Young Peoples plans also reflect the relevant elements of the Public Health Strategy, with implementation and monitoring of progress carried out through those forums, and this will be carried forward in the developing Single Plans.

ii) *Reduce the risk of Type 2 diabetes consistent with the CHD NSF, through increased awareness and support*

The Cardiac Disease NSF, also covers key actions required to improve population health, including for example the development of NICE compliant guidelines for the identification and management of obesity in people with diabetes. Implementation of weight management programmes, coronary heart disease programmes and diabetes education programmes is however still largely around the former LHB footprints, and the need to standardise across Gwent has been identified by the Diabetes Planning and Delivery Group and recognised as a key priority.

iii) *Ensure continuous professional development for health care professionals and others particularly in Primary Care to support and update knowledge and skills in risk factor management of at risk groups*

CPD opportunities have been identified and prioritised, with a focus on socially excluded groups, care homes, custodial settings and minority ethnic groups. As one of the Neighbourhood Care Network (Setting the Direction) GP leads, I have a lead role for development of diabetes practice in primary care and chair the Diabetes Planning and Delivery Group, and have led a number of initiatives in developing services within Primary Care. Membership of the Primary Care Diabetes Society is encouraged for all GPs and there has been a range of educational events.

Standard 2 - Identification of People with Diabetes

i) *Raise awareness of the signs and symptoms of diabetes amongst health and other professionals most likely to come into contact with people with undiagnosed diabetes*

Comprehensive programmes are in place to support and train staff in the management of diabetes. Aneurin Bevan Health Board is engaged with community pharmacies in undertaking a screening programme that could be used in pharmacies to detect people at risk of developing diabetes.

ii) *Strengthen the identification, monitoring and benchmarking systems in high risk individuals*

Systems are in place to follow up and regularly test people who have previously been found to have impaired glucose tolerance and the uptake of influenza and pneumococcal vaccination by people with diabetes. Policies are in place to encourage re-engagement from people who do not attend for annual reviews (DNA).

iii) *To improve diet, weight management and physical activity, particularly among children, ethnic minority & other vulnerable groups*

This is covered under Standard 1 above.

Some parts of Gwent have British Heart Foundation funded weight management programmes promoting heart health by physical activity and healthy diet to manage weight.

Standard 3 - Empowering people with diabetes All children, young people and adults with diabetes will receive a service which encourages partnership in decision-making, supports them in managing their diabetes and helps them to adopt and maintain a healthy lifestyle. This will be reflected in an agreed and shared care plan in an appropriate format and language. Where appropriate, parents and carers are fully engaged in this process.

i) Develop Programmes to strengthen & support self care management, to help empower all people with diabetes to maintain a healthy lifestyle, involving families and carers

There is Aneurin Bevan Health Board wide access to education and self management programmes for Adults and Children with both Type 1 and Type 2 diabetes. There is not yet consistency across Gwent in the delivery of the programmes, with different areas using different programmes, and Blaenau Gwent residents accessing programme delivered by neighbouring boroughs. An evaluation is being carried out, and plans being developed to standardise the delivery across the Health Board.

ii) *Develop partnership with active involvement of parents, carers and people with diabetes in the development of local service and care plans.*

Diabetes Planning and Delivery Group established and functioning, with patient and Voluntary Sector representation.

Standard 4 - Clinical care of adults with diabetes. All adults with diabetes will receive high-quality care throughout their lifetime, including support to optimise the control of their blood glucose, blood pressure and other risk factors for developing the complications of diabetes.

i) Develop, implement and audit protocols for initial assessment and continuing care and monitoring of people with diabetes.

Regularly updated integrated personal Diabetes care records are made available for all people with Diabetes. Blood Glucose testing guidelines have been developed across Aneurin Bevan Health Board, the Diabetes work programme includes analysis of the prescribing of insulin analogues especially in relation to their place in the management of type 2 diabetes (NICE).

A comparison, year on year: the Diabetic lower limb pathway achievement rates on the percentage of people screened; the percentage of people identified as having at risk feet; percentage of people identified with new ulceration; the percentage of new minor amputations;the percentage of new major amputations; the number of admissions related to active Diabetes foot disease and those who are readmitted with recurrent ulcer; the number of people with Diabetes who develop an avoidable foot problem has been completed.

ii) *Review local provision of diabetes services to identify gaps and areas for service development.*

This work is ongoing, and a detailed action plan being developed to identify the next steps. Models of care make explicit the roles of various providers via care pathways. Guidelines are in place to direct referral and discharge from specialist diabetes services in secondary care. A GP survey has just been conducted to identify their perceptions of primary and secondary care service provision.

Standard 5- All children and young people with diabetes will receive consistently high-quality care and they, with their families and others involved in their day-to-day care, will be supported to optimise the control of their blood glucose and their physical, psychological, intellectual, educational and social development.

i) *To ensure that diabetes services for children and young people are of a high standard and appropriately adapted to meet their needs*

The NSF has been superseded by specific guidance for the management of children with diabetes, which is implemented and subject to separate Welsh Government scrutiny.

ii) *Support the needs of children & families with diabetes*

Education is adjusted to the development stage of the child /young person and repeated regularly

Standard 6 - All young people with diabetes will experience a smooth transition of care from paediatric diabetes services to adult diabetes services, whether hospital or community-based, either directly or via a young people's clinic. The transition will be organised in partnership with each individual and at an age appropriate to and agreed with them.

i) *To ensure the smooth transition from paediatric to adult services*

Dedicated Young Persons Diabetes clinics are in place, the Adult diabetes team runs a young person clinic following transfer from children's team. There are also designated handover clinics between the Paediatric and Adult Diabetes teams, in both Nevill Hall and Royal Gwent Hospitals.

Standard 7 - Management of diabetic emergencies The NHS will develop, implement and monitor agreed protocols for rapid and effective treatment of diabetic emergencies by appropriately trained health care professionals. Protocols will include the management of acute complications and procedures to minimise the risk of recurrence.

i) Strengthen the recognition & management of diabetic emergencies.

Guidelines in place for diabetic ketoacidosis and Hypogyclaemia, and periodic audits are conducted. Further policy for management of Intravenous Insulin waiting to be launched

Standard 8 - Care of people with diabetes during admission to hospital All children, young people and adults with diabetes admitted to hospital, for whatever reason, will receive effective care of their diabetes. Wherever possible, they will continue to be involved in decisions concerning the management of their diabetes

i) *Effective care & self management of diabetes in a hospital setting.*

Measures are being put in to have a dedicated Diabetes Inpatient Care team to advise on the care of people admitted with diabetes. Staff involved in diabetes services are trained in techniques to support self care, personalised care planning and to help patients make changes with their lifestyle. Supportive discharge strategies are in place

NICE Guidance followed for; The initial assessment and care of adults presenting with Diabetes in health care settings;

Written guidelines for Accident and Emergency teams on the assessment and initial management of people admitted to Accident and Emergency with active Diabetic foot disease

All three acute hospitals in Aneurin Bevan Health Board participate in the National Diabetes Inpatient Audit, conducted annually

Standard 9 - Diabetes and pregnancy The NHS will develop, implement and monitor policies that seek to empower and support women with pre-existing diabetes and those who develop diabetes during pregnancy to optimise the outcomes of their pregnancy

i) Ensure effective management of pregnant women with diabetes.

NICE compliant guidelines are in place for follow-up and regular testing of women with a history of gestational Diabetes. NICE compliant guidelines on; the provision of pre-conception advice for all women with Diabetes of child bearing age; the provision of contraceptive advice and counselling for younger women with Diabetes on the problems of teenage pregnancy; detecting women who develop abnormal glucose tolerance in pregnancy (gestational Diabetes); the detection and management of neonatal hypoglycaemia and other neonatal complications in babies born to women with Diabetes.

Weekly joint antenatal/diabetes clinics take place both at Nevill Hall and at Royal Gwent Hospitals. Insulin pump service available for patients who need it during pregnancy

Standard 10 - Detection and management of long-term complications - all young people and adults with diabetes will receive regular surveillance for the long-term complications of diabetes.

i) *Ensure all people with diabetes are receiving regular surveillance for long term complications of diabetes.*

This is covered under the Quality and Outcomes framework for primary care, and through follow up arrangements for patients with complex diabetes related problems treated in secondary care.

Standard 11 The NHS will develop, implement and monitor agreed protocols and systems of care to ensure that all people who develop long-term complications of diabetes receive timely, appropriate and effective investigation and treatment to reduce their risk of disability and premature death

i) *Detection, management & timely referral / diabetic complications*

Responsibility of patient, Primary and Secondary Care clinicians to refer onwards appropriately. Diabetic retinopathy service operates independently, appropriate referral process in place, and an annual report is required including; the number offered appointments and screened; the names of those who failed to attend for their retinal screening appointments by GP practice

It is proposed to review at least annually the incidence of the following complications of diabetes and compare rates via participation in the National Diabetes Audit MI; Stroke; Angina; Minor Amputations (below ankle); Major Amputations (ankles & above); Laser retinal photocoagulation; Blindness; End stage renal failure & death.

Standard 12 - All people with diabetes requiring multi-agency support will receive integrated health and social care

i) *Ensure effective multi –agency support between health & social care.*

Compliance with this standard varies across Gwent, and will be picked up through the Diabetes Action Plan. There is much evidence of multi-agency support, and work has been done to improve joint working. Discharge planning from Hospitals includes assessment of the other medical and social needs of the patient and their dependents. Advice and training is provided to nursing/residential homes in the management of people with Diabetes but this is not yet consistent.

Adequacy and Effectiveness of the National Service Framework in preventing and treating diabetes in Wales

The existing National Service Framework is, in the view of the professional staff driving the agenda forward now outdated, as much has moved forward in the field in the last nine years and many of the standards in the NSF have been supplemented by additional requirements, such as NICE Guidance, a diverse range of revised and improved professionally driven initiatives to improve care as well as adherence to the Public Health Strategy and requirements of the Health, Social Care and Wellbeing and Children and Young Peoples partnership priorities.

In the interim period a comprehensive local action plan is being developed, and the Health Board would welcome a revised national Service Framework or successor document to help drive forward change.

Yours sincerely

Dr D K Minton
Chair ABHB DPDG

Health and Social Care Committee
Inquiry into the implementation of the National Service Framework for diabetes in Wales and its future direction
DB 19 Cardiff and Vale UHB

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Cardiff and Vale UHB
Headquarters,
Whitchurch Hospital,
Cardiff,
CF14 7XB.

12th August 2012

Committee Clerk,
Health and Social Care Committee,
National Assembly for Wales,
Cardiff Bay,
CF99 1NA.

Dear Sirs,

I am writing on behalf of the Cardiff and Vale University Health Board in response to the National Assembly for Wales' inquiry into the implementation of the National Service Framework for Diabetes in Wales and its future direction.

Given that there are estimated to be 160,000 people in Wales with diabetes and 66,000 who have the condition but do not know it, improving the care and treatment of those with diabetes is one of the UHB's clinical priorities, and we therefore welcome Welsh Government's focus on this client group.

In the absence of a template our response has been completed as a structured return in line with the stated NSF Quality Standards.

Standard 1 – The NHS will develop, implement and monitor strategies to reduce the risk of developing type 2 diabetes in the population as a whole and to reduce the inequalities in the risk of developing type 2 diabetes.

- The Health Board has already implemented a number of local strategies including an obesity strategy, early year's school nutrition, and exercise on prescription. The Health Board has a Local Public Health Strategic framework with accompanying action plans many of which directly relate to prevention and health promotion activity. These activities are monitored and feature in the boards monthly performance report. In addition a number of initiatives have been activated by Public Health Wales.

Standard 2 – The NHS will develop, implement and monitor strategies to identify people who do not know they have diabetes.

- Screening for type 2 diabetes is not currently undertaken in Cardiff and Vale.

- Opportunistic identification of people who have had acute coronary syndrome (ACS) and acute stroke occurs within the hospital environment. The move to using HbA1c as a diagnostic marker for diabetes may facilitate this, as many people will no long require an oral glucose tolerance test.

- The UHB has produced a Diabetes Delivery Plan. Embedded within the plan is the requirement to undertake periodic surveys to test public awareness to ensure that public education programmes are correctly focused. This work will be undertaken in partnership with the Health, Social Care and Well Being strategy and surveys undertaken through local authority.

- The UHB participates and supports campaigns through community pharmacy

Standard 3 – All children, young people and adults with diabetes will receive a service which encourages partnership in decision-making, supports them in managing their diabetes and helps them to adopt and maintain a healthy lifestyle. This will be reflected in an agreed and shared care plan in an appropriate format and language. Where appropriate, parents and carers should be fully engaged in this process.

- Type 1 education is not currently available in Cardiff and Vale.

- Type 2 education is available in small numbers through locally run XPERT education programmes. There is a NICE-compliant structured education programme offered to people with newly diagnosed with diabetes.

- Secondary care identifies individualised patient targets and communicates this to GPs at discharge. The community diabetes model will further enhance this work.

- Patient representatives sit on the diabetes planning and development group from Cardiff and the Vale, but we have limited engagement of younger patients with diabetes.

- At the present time there is no specific psychological support for our diabetes patients, although a generic community liaison service is available..

Standard 4 – All adults with diabetes will receive high-quality care throughout their lifetime, including support to optimise the control of their blood glucose, blood pressure and other risk factors for developing the complications of diabetes.

- The Health Board's new Community Model will further raise the standards of care for diabetic patients. Its implementation began at the beginning of September. . It will improve education to GPs, support to practices and practice nurse. It will enable, mentoring and quality assurance of care across Cardiff and Vale.

Standard 5 – All children and young people with diabetes will receive consistently high-quality care and they, with their families and others involved in their day-to-day care, will be supported to optimise the control of their blood glucose and their physical, psychological, intellectual, educational and social development.

- Quality Standard points 1, 2, 3, 4 5, 6, 7, 9, 10, 11, 12, 13, 15, 16, 17, 18, 19, 20, 22, 23, 24, 25, 26, 27, 28, 29, 30 have been assessed, and evidenced as complete.

- Quality Standard point 8 has been achieved in part. The UHB is actively seeking to engage young people and carers of young people with diabetes in patient reference groups to feed into the DPDG.

- Quality standard point 14 requires the UHB to have NICE compliant guidelines for optimising glycaemic controls towards normal levels for children and young people with Diabetes. This is partially complete. There is an All Wales diabetes document for the management of children and adolescents with diabetes which the UHB is using to shape services.

- Quality Standard point 21 requires the UHB to ensure provision of NICE compliant insulin pump therapy services for children and young people

with Diabetes. Partial success has been achieved with an Insulin pump service available to children.

Standard 6 – All young people with diabetes will experience a smooth transition of care from paediatric diabetes services, whether hospital or community-based, either directly or via a young people's clinic. The transition will be organised in partnership with each individual and at an age appropriate to and agreed with them.

- This standard is met in full. There are quarterly transition clinics and monthly young adult clinics supported by a DSN and dietician at the University Hospital of Wales.

Standard 7 - The NHS will develop, implement and monitor agreed protocols for rapid and effective treatment of diabetic emergencies by appropriately trained healthcare professionals. Protocols will include the management of acute complications and procedures to minimise the risk of recurrence.

- The UHB currently implement the new JBDS DKA guidelines .We have "hypo" boxes and "hypo" guidelines on all wards. In addition we have a separate insulin prescription chart.

- Quality standard points 2, 3, 4, 5, 6, 7, 9, 11, 12, 13, 14, 15, 16 30 have been assessed, and evidenced as complete.

Standard 8 – All children, young people and adults with diabetes admitted to hospital, for whatever reason, will receive effective care of their diabetes. Whenever possible, they will continue to be involved in decisions concerning the management of their diabetes.

- The national diabetes inpatient audit suggests that there are a large number of prescribing errors with insulin or oral hypoglycaemic agents. UHW in particular has particularly low rates of diabetes team review of inpatients with diabetes. Strategies to develop an in-reach service may reduce this and are currently in development.

Standard 9 – The NHS will develop, implement and monitor policies that seek to empower and support women with pre-existing diabetes and those who develop diabetes during pregnancy to optimise the outcomes of their pregnancy.

- Both the University Hospital of Wales and University Hospital Llandough have dedicated medical ante-natal clinics with support from specialist diabetologists and obstetricians. Ante natal clinics on both sites are supported fully by DSN and dietician also.

- The Diabetes/Obstetric Service participate in national and regional collaborative audits of the processes and outcomes of Diabetes care. Audit data is collected through Confidential Enquiry into maternal and Child Health (CEMCH).

- In order to achieve compliance with Point 2 the UHB have undertaken work to provide guidelines on the provision of contraceptive advice and counseling for younger women with Diabetes on the problems of teenage pregnancy. This work is partially complete.

- Pre-natal counseling and screening available through the medical ante-natal service and type 1 diabetes clinics.

- Quality standard points 1, 3, 4, 5, 6, 7, 8, 9, 10, 11 have been assessed, and evidenced as complete.

Standard 10 – All young people and adults with diabetes will receive regular surveillance for the long-term complications of diabetes.

- GPs achieve through QOFF annual review. In addition patients receive diabetic retinal screening through the All Wales service.

- The UHBs (primary and secondary care) model of care is NICE compliant and requires that all people with diabetes are offered annual review.

- At present the UHB does not require that staff share results of annual reviews (e.g. biomedical results, etc.) with people with Diabetes in advance of their consultations. Primary Care Physicians share these results with patients. However, Secondary care providers are working toward the introduction of this policy and routinely copy the clinic letter to the patient.

Standard 11 – The NHS will develop, implement and monitor agreed protocols and systems of care to ensure that all people who develop long-term complications of diabetes receive timely, appropriate and effective investigation and treatment to reduce their risk of disability and premature death.

- Quality standard points 1, 2, 3, 4, 6, 13, 16, 17, 18, 19, 21, 28.29,31 have been assessed, and evidenced as complete.

- Quality standard point 5 calls for a comprehensive UHB-wide programme to screen for Diabetic neuropathy and peripheral vascular disease. Implementation is partially complete with annual reviews in general practitioner surgeries and podiatry services in the community.

- Quality standard point 7 is partially compliant and guidelines exist for foot ulceration, ischaemia and charcot neuropathy, but not specifically for the Accident and Emergency unit.

- Quality standard points 8 and 9 cannot be met at the present time due to work pressures elsewhere.

- Quality standard points 10,11,12,14 are being actively reviewed.

- Quality standard points 15, 20, 22 are completed via our vascular multi-disciplinary team in both primary and secondary care.

- Quality standard points 23, 24, 25 will be developed as part of the adoption of NICE guidelines on diabetic foot care.

- Quality standard points 26 and 27 require the health Board to compare the percentage of both new minor and new major amputations year on year. This progress is partially complete, and audit data is available.

- Quality standard point 30 requires the ability of Hospitals to demonstrate that they act on the findings of their monitoring processes on in-patient management of active Diabetic foot disease. Current IT infrastructure does not allow this, but periodic audits are undertaken on management of diabetic foot disease.

- There is evidence of excellent multidisciplinary team (MDT) working in this field. MDT clinics are held which bring together vascular surgery, orthopaedic surgery, infectious disease/microbiology, diabetologists, podiatry and wound healing expertise. The development of the UHBs proposed community model will further support this work.

Standard 12 – All people with diabetes requiring multi-agency support will receive integrated health and social care.

- The community diabetes model will support this

The UHB is committed to achieving the Assembly Government's strategy for improving the quality of care and treatment for those living with diabetes.

Yours faithfully,

Paul Hollard
Deputy Chief Executive/Director of Planning/Interim Chief Operating Officer

Standard 1 – reduce risk of developing type 2 diabetes
GP surgeries opportunistically discuss lifestyle issues with patients attending their surgeries. Health promotion advice is available through community pharmacies.

Prevention in at risk groups
Work continues with black and minority ethnic groups to highlight the risks of diabetes such as attending conferences.

Standard 3 – partnership in decision making in managing diabetes
The Education for Patients programme provides more generic information for individuals to enable them to learn skills to live with their chronic conditions

Standard 4 – High quality care through a lifetime
Pathways are being put in place to enable patients to have seamless transition through services and to escalate them to specialist consultants and nurses when this is required. The GP remains the pivotal element in their care throughout their life.

Standard 8 – children and adults with diabetes will receive effective inpatient care
There is a team of specialist nurses who can advise ward staff on the care of individuals living with diabetes

Standard 12 – multi-agency support under integrated health and social care.
In addition the community resource teams which consist of multidisciplinary health professionals, social care and voluntary sector members can work with the specialist team to keep individuals in their own homes for longer, prevent admission and expedite discharge.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board
Ysbyty Gwynedd Ffordd Penrhos, Bangor
Gwynedd LL57 2PW

Ein cyf / Our ref: GLP/JM
Dyddiad / Date: **29th September 2012**

Mr Mark Drakeford AM/Chair
Health and Social Care Committee
Cardiff Bay
Cardiff
CF99 1NA

Dear Mr Drakeford,

Re: Implementation of the National Service Framework for diabetes in Wales and its future direction: Response from Betsi Cadwaladr University Health Board

On behalf of Betsi Cadwaladr University Health Board, we would like to thank you for this opportunity to respond to the "Implementation of the National Service Framework for diabetes in Wales and its future direction Consultation."

We have pleasure in enclosing Betsi Cadwaladr University Health Board's Response – "Progress Against Diabetes NSF Standards: BCUHB considerations for all Standards."

Yours sincerely,

Grace Lewis-Parry.

Grace Lewis-Parry
Director of Governance & Communications

Implementation of the National Service Framework for diabetes in Wales and its future direction: Response from Betsi Cadwaladr University Health Board

Progress Against Diabetes NSF Standards:

BCUHB Considerations for all Standards
Background Betsi Cadwaladr University Health Board (BCUHB) was established in 2009 and is the result of merging 9 previously separate health organisations, 3 NHS Trusts and 6 Local Health Boards. This has been an enormous task for the new organization, and for specialties such as diabetes this has highlighted the very different approaches to the delivery of services, not merely due to geographical differences and challenges but also due to historical resource availability, development, scope of practice within Specialist Care Diabetes Teams and Primary Care Services The BCUHB Diabetes Planning and Delivery Group (DPDG) was established in 2010. Due to the size of the organization and the inherited variances in service models and levels of service delivery it was decided that for the immediate future at least the 3 previous LDSAG's would remain operational to ensure that local service priorities were not lost and local focus retained. The LDSAG's report to the BCU wide DPDG, chaired by Dr Steve Stanaway, Consultant Diabetologist and Clinical Lead. The DPDG is multidisciplinary including therapies, adult and children services, pharmacy, public health, patient representatives, primary and community care. Additionally the following considerations have had a significant impact upon service delivery: • No additional funding to support delivery of the Diabetes NSF unlike Renal and Cardiac which attracted funding and services have significantly progressed as a consequence. In spite of this diabetes services have been developed and innovation implemented to ensure that resources are deployed to maximize patient services, however it is unlikely that

BCUHB will be able to fulfill all of the requirements within the Diabetes NSF by 2013. This will mean that service prioritisation will need to take place.

- The delivery of Structured Diabetes Education for people with Type 2 diabetes is currently under review in BCUHB. There is inequity in its provision and where it exists, it does not meet the criteria set out in the NSAG's Structured Education report. For Type 1 Diabetes, we have WIDAC in the East, DAFNE in the Centre and nothing in the West. Waiting lists for these programmes are not currently linked into mainstream patient pathway monitoring such as referral to treatment (RTT) monitoring. There is increasing demand to deliver more T1 programmes as these are a pre requisite for individuals considering insulin pump therapy. There are currently no agreed plans to increase provision of SDE for Type 1 or 2 Diabetes within the specialist DSN and Dietetic resource available within BCUHB

- The adult Diabetes Nursing Service structure is currently under review in BCUHB. There are 12.4 wte adult Diabetes Specialist Nurses employed to meet a population of more than 700,000. Increasing prevalence, a rise in referrals into diabetes specialist teams from Primary Care (>30% increase in 2011 in Centre and West sites compared to 2010 data), the provision of type 1 education, more sophisticated technologies, and the rising % prevalence of people with diabetes in hospital are restricting the ability of DSN's in North Wales to work towards National Strategies supporting care for people with Long Term Conditions closer to home. Service prioritisation will be part of the DSN re structure to determine where best to deploy the resource for maximum efficiency & effect.

- BCUHB Diabetes Lead Nurses are currently undertaking Primary Care Profiling in order to identify areas of exemplary practice in Primary care and where support and training can be targeted & indeed will assist the Health Board to further understand the current level of service delivery in the Primary Care sector against the NSF for Diabetes. Resource to facilitate additional support in practice has yet to be identified in some areas of BCUHB and participation / completion of the Primary Care profile is not compulsory (however the response rate to date has been high).

- Despite persistent lobbying from diabetes clinical teams in Wales, the Third Sector and the Diabetes NSAG; the Assembly has not appointed a Clinical Lead for Diabetes within its structure. If this appointment was made there would be an expert advisor who would be able to escalate and inform WG of key service pressure and issues which would then attract an increased focus.

- Striving to integrate diabetes services for the benefit of the patient and to provide a seamless approach to diabetes management is not possible without the appropriate IT infrastructure. If available the system would offer:
  - Robust Risk assessment along the trajectory of living with diabetes
  - Integrated seamless diabetes information
  - Access for people with diabetes to their health profiles
  - Improved clinical governance, audit and evaluation that is transparent

All the above would ensure an improved compliance with the requirements of the NSF and reduce inefficiencies within the system (duplication and waste) and improve patient experience.

NSF Standard	BCUHB Progress	Challenges to service delivery	Innovation	Considerations for Improvement / Concern
1	Standard 1			
2	• CVD Risk Local Enhanced Service Level Agreement which includes Oral Glucose Tolerance screening test to detect Type 2 Diabetes in subjects at risk, but previously	• Not compulsory therefore Primary Care uptake is variable • Register, coding and active recall of	• P Care profile will provide information to direct standard approach to coding and recall of at risk individuals	• No requirement within QOF to screen at risk individuals or maintain register of those identified of being at risk – this

	undiagnosed	at risk individuals not standardised		would be helpful to facilitate the delivery of this standard.
3	• BCU has inherited a variety of approaches to delivering patient education, ranging from one to one education in some areas to structured group education programmes. • Type 2 SDE – X-PERT is the preferred programme • The Central area of BCUHB is accredited to offer DAFNE for adults with Type 1 Diabetes • The East area currently delivers WIDAC for individuals with Type 1 Diabetes based upon the Bournemouth model • Paediatric education varies across BCU however the	• The variability and equitable access to Structured Diabetes Education programmes in BCUHB is currently under review • Limited or no access to such programmes remains a significant and unresolved concern among Patient reference groups • X-PERT delivery rates varied from 0 – 4.4% of Type 2 population in 2011	• X-PERT Health – In 2011 Conwy was a category winner for the greatest impact upon cardiovascular risk factors • Following development in the Deeside Locality, individuals newly diagnosed with Type 2 diabetes can access a 2 hour group education session which signposts participants to X-PERT. The model will be rolled out across N Wales and has demonstrated reduction in 1:1 dietetic episodes & engaged individuals with diabetes to the concept of group	• The delivery of X-PERT is currently suspended pending executive decision as to the future plan to offer the programme within the Licence agreement • DPDG currently reviewing scope to offer one SDE programme for Type 1 Diabetes

	majority is delivered on a 1 2 1 basis in collaboration with carers/families. There is a structured programme for children over the age of 12 in East and all centres offer education for pump therapy on a one to one basis.	• No Type 1 or 2 programme exists in Gwynedd or Anglesey • Type 1 educator resource insufficient to meet demand in particular the dietetic element • Where they occur, DAFNE & WIDAC are pre requisites for individuals considering Insulin Pump therapy	education as an expected approach to diabetes care	
4	• BCUHB Diabetes Lead nurses are mapping current diabetes education provision across BCU primary, community and secondary care to identify gaps in education provision and where good examples can be shared	• There is no additional Specialist Nursing resource identified to meet increased training education requirements that will arise form the Primary Care profile and	• From April 2012 - A PG-Cert developed in partnership with Bangor University in Diabetes Management, validated for multi-disciplinary health professionals involved in the delivery of diabetes care. This has enabled the	

	• Long standing collaboration with local academic institutions and Diabetes Specialist Nurses enables the ongoing delivery of diabetes education at degree level for RGNs. • All 3 DGH's participate in annual national diabetes inpatient audit. • Primary Care Participation in the National Diabetes Audit is promoted, however the uptake was <55% across	Education mapping for Diabetes in BCUHB • WBL funding is not available in Flintshire & Wrexham, therefore alternative funding sources will be explored so as not to exclude this considerable area within our health Board • National Diabetes Audits - There is a need for this information to feed back into the work of the DPDG to	decommissioning of external programmes in favour of a Locally driven MSc level award • As an innovation WBL (work based learning approach) developed by Diabetes Lead Nurses in line with designed for competency methodology and in collaboration with UWB; RGN's and HCSW's who work in the independent care setting can undertake an accredited module for diabetes care. This accredited programme will be available from 2013 and will be delivered across BCUHB.	• The Community Diabetes Lead Nurses (where they exist) will work with primary care support unit and locality leads to try to influence an increased uptake in

	North Wales this year. • <u>Insulin Pump Service:</u> • Access to pump therapy is available to adults and children with type 1 diabetes. Structured education (where it occurs in BCUHB) is a pre requisite for adults. Increasing demand for this NICE approved technology is adding to the waiting list for Structured Type 1 Diabetes Education	ensure services are evaluated and improved and that the organisation learns from the audit results. PDSN: patient ratio is already > recommended levels therefore implementing CSII in Central Specialist site has become a significant resource pressure for PDSN and Specialist dietician time to meet The Central Specialist site now takes West referrals for CSII	• <u>Insulin Pump Service</u> - There is now an annual update which is mandatory for all adults wishing to remain on insulin pump therapy in BCUHB. This has been implemented in all 3Specialist Centres	NDA in the future. • IT infrastructure in Wales lacks sophistication necessary to robustly analyse the data <u>that is available</u> in order to determine clearly the target areas for improvement, especially risk assessment, integrations between Specialist Centres and Primary care and moreover where there is potential for people with Diabetes to access their health profiles

	• Treatment pathways have been validated & are available on the BCU intranet site. Developed in order to reduce the referrals to Secondary Care diabetes teams for newer treatment initiation and to offer a standard effective approach to managing Self Monitoring	following a safety analysis of the West site Specialist resource to continue to provide this service. A risk evaluation is underway to assess safety for the West to maintain management of existing pump therapy patients • The challenge is to roll out training for both pathways equitably across BCU where there		

	of Blood Glucose • GLP-1 (including Primary Care Initiation • Blood Glucose Monitoring Guidance	are specialist resource pressures in some localities. This will affect the application and implementation		
5	• BCU Paediatric Diabetes Service Sum			
6	• Consultant-led young adult clinic (YAC) are provided in Central and East with Paediatric DSN support for patient transferring from paediatric diabetes clinic for a structured handover	• Long waiting list for DAFNE which should be offered to YAC patients before leaving home/starting university etc. • Insulin pump training required for DSNs in YAC services to ensure full range of treatment options can be addressed	• Email communication for YAC clinic attendees is offered to enable communication with their named DSN	

		• Lack of resources in West = No dedicated YAC service in the West & paediatric services required to hold on to young adults with diabetes who would otherwise progress through a transition service		
7	• DKA protocol in place in each area • Hypo boxes in all ward areas • Hypo training Mandatory for all staff in East • Audit undertaken recently by pharmacy re correct management of Hypos • Driving and Hypo leaflet developed and disseminated	• Lack of Nursing resource in West has made it difficult to undertake training required re the hypo boxes and the implementation of the DKA protocol • Hypo boxes not available in Central Acute site	• Central DSN's have implemented a rapid response for GP admissions to Acute Medical Unit – Audit awaited	• Establish hypo education as mandatory training in all areas for BCUHB staff • Standardise hypo boxes across the area • Hypo education was mandatory for all nursing staff in the Central Health Board area and

	across North Wales
	
	• Data pertaining to 999 call outs to treat a Blood Glucose below 4 mmol/L over a 6 month time period are currently being examined In collaboration with Welsh Ambulance
	
	• Podiatry and Orthotic services provide acute Diabetic foot ulcer and high risk care at 4 sites across BCUHB
	  • Wrexham Maelor
	  • Ysbyty Gwynedd
	  • Deeside Community hospital
	  • Ysbyty Glan Clwyd.
		• Working across agencies will require collaboration in the service design
		
		• Anticipated that additional staff resource and training would be required to meet the patient need in immediate post hypoglycaemic period
		
		• At present limited but services within Central have seen a 200% rise in referral rates due to media liaison and staff awareness
			Work in relation to this will either be undertaken as part of a research project or clinical service improvement design	was incorporated into mandatory training for all nurses up until Jan 2012 when it was suspended to allow for other service users to incorporate training in this way.

	• All sos and foot ulcer cases are seen within a 48hr period. Ongoing care and liaison via the MDT occurs throughout community sites and internally with the newly developed intermediate foot services. There is equity of provision across BCUHB			
8	• PDSNs provide diabetes education to relevant ward teams • Consultant led education for junior clinical staff is provided • Diabetes Inpatient Specialist nurses deliver training either in groups or on a one-to-one basis for Health Professional colleagues • Central DSN team provide Bi Annual training day for ward based RGN's Safe use of insulin	• Releasing ward staff to attend education sessions is often difficult • Lack of Nursing resource in West has made it difficult to undertake diabetes education for staff • Awaiting guidance on use of insulin		• Utilise data collected form inpatient audit to inform educational requirements • Implement E learning module on safer use of insulin

	• Currently reviewing and exploring ways for patients to administer insulin within hospital environment	passports – A Task & Finish group deployed by the DPDG is addressing this issue		across BCU area • Posters to be designed and displayed in ward areas • Review feasibility of insulin as a Community Pharmacy audit for 2013
9	• Antenatal diabetes clinics have existed in the Centre and East Specialist sites. This service has also commenced in Jan 2012 in West.	• Lack of medical, nursing and dietician resource • Increasing numbers of antenatal patients	• Central site-Group education is provided for Women with Gestational DM attending the High Risk Antenatal Service on their first visit • Community midwife training in the Centre has enabled diagnosis of Gest DM within 24-48 hrs of testing, education for SMBG and basic dietary advice is provided prior to the first clinic appointment	

10	• QOF data reviewed to highlight areas where practices are under achieving and clinical support offered to those practices • Foot screening provided by podiatry assistant in central and Flintshire areas and utilises a risk stratifying model with referral into Podiatry ongoing care and intermediate services or acute services • Diabetes education focusing on the annual diabetes review and diabetes management has been provided for District Nursing teams in East • A Glyndwr Uni District Nurse Rolling programme incorporates Diabetes Education • A work based learning programme for the Independent Sector is in	• Lack of community diabetes service in West to follow up poor QOF performance • Lack of community service in West and size of area covered by one facilitator in East • Foot screening provided by practice nurses in West and Wrexham areas with no liaison with podiatry re risk stratification and ongoing care needs	• A work based learning programme is currently under development by the Lead DSN's in collaboration with UWB (Utilising designed for competency	• No mechanism in place to support under performing practices as no community service in West • DSN service currently under review • Following recent discussions and WG paper it has been suggested that foot screening should be undertaken as part of the diabetes annual review within the GP practice and reported via QOF. Discussions underway regarding the future of these services at Health board level

	development by the DSN's and will focus on: ➢ Appropriate Blood Glucose Monitoring ➢ Hypoglycaemia recognition and treatment ➢ Function of Annual Review ➢ Carbohydrate awareness		methodology). This will provide the opportunity for RGN's and HCSW's working in the independent care setting to undertake an accredited module in diabetes care	• WBL programme to be delivered from 2013 across whole BCUHB area by Lead DNS's
11	• A primary care questionnaire has been compiled for completion by GP practices to establish diabetes service level within primary care	• Participation is not compulsory therefore Primary Care completion has been variable		• Lack of resources to address highlighted gaps in service provision
12	• Links established with Locality Leadership Teams (LLT) • Links established with social services and case managers. • Education and support is provided to social service, Integrated service teams, case managers and district	• LLT's are in early stages of development in some areas • Lack of community service in west to support LLT's	• Pilot project using diabetes manager software is being undertaken in Conwy East within 2 GP practices • District Nurses in central area have access to diabetes education as part of a rolling programme that has	

	nursing teams within each area • BCUHB Communication hub in development and links established via LLT meetings		accreditation with Glyndwr University	

Health and Social Care Committee
HSC(4)-31-12 paper 6
Inquiry into the implementation of the National Service Framework for diabetes in Wales and its future direction - Cwm Taf Health Board

INQUIRY INTO IMPLEMENTATION OF DIABETES NSF

CWM TAF HEALTH BOARD RESPONSE

STANDARD	PROGRESS	STATUS
Standard 1 The NHS will develop, implement and monitor strategies to reduce the risk of developing Type 2 diabetes in the population as a whole and to reduce the inequalities in the risk of developing Type 2 diabetes.	Within Cwm Taf the following progress has been made in relation to lifestyle management strategies which assist in reducing the risk of developing Type 2 Diabetes amongst and other chronic conditions. **SMOKING:** • A variety of community based Stop Smoking groups available via Stop Smoking Wales. • Packs of Credit card sized contact detail cards available for distribution to patients if required. • 29 pharmacies in Cwm Taf offering Stop Smoking services – info leaflets available. • Brief intervention training for staff available as part of Stop Smoking Wales Training calendar (also Alcohol Brief Intervention available). • On line e-training programme available to NHS staff via Stop Smoking Wales. • Making every contact count is a priority for all staff. Our aim is to ensure that all staff are able to provide the appropriate advice on local services to all patients, and refer where appropriate to the Stop Smoking Wales Community based sessions, community Pharmacies and via the in house Health Board service. **EXERCISE:**	

	• Well controlled diabetics can access NERS for 16 week programme. • Merthyr NERS currently linking with a GP Practice to pilot a system of providing info and considering referral for every diabetic patient undergoing their annual check. **WEIGHT MANAGEMENT:** • Community based weight management classes currently being set up in a number of Communities First areas. • Funding being sought to develop a comprehensive weight management programme pilot from Oct to March 2013 looking at nutrition, cookery skills and exercise delivered by a new team of staff across a variety of community settings linking to the NERS programme. This will initially be for orthopaedic patients but if successful would hope to look for a way to open out to a wide range of conditions. • Local Obesity Strategy currently out to consultation. • The public health team has been working in partnership with a number of Community First areas to provide their staff with the training and resources to set up a number of informal, community based weight management groups. There are also a number of activities such as walking groups attached to their areas. • Also a recent evidence review conducted by Public Health Wales highlighted that although the long term effectiveness of commercial weight loss programmes is currently unclear two commercial weight loss programmes (Weight Watchers and Slimming World) comply with current NICE guidelines. Both are diet based programmes led by the individual and promote physical activity. They offer participants with the opportunity to weigh weekly and both charge membership fees. • Potential forthcoming projects include the opportunity to use the exercise referral scheme to undertake weight management programmes using a programme developed by a working group of dieticians lead by WG together with the existing exercise component.	
Standard 2	**RAISING AWARENESS:**	

The NHS will develop, implement and monitor strategies to identify people who do not know they have diabetes	• Annual Diabetes in primary care course; Formal medical lectures; core training hospital junior medical staff; dedicated Diabetes inpatient teams which also deliver "Think glucose" education package for ward staff. • The Health Board support Diabetes UK in their annual campaigns which seek to raise awareness of Diabetes and the risk factors. The 2012 and 2011 campaigns were particularly successful. **SCREENING:** Cwm Taf LHB has developed a comprehensive diabetes strategy that includes identifying patients in high risk groups and then screening for diabetes. Work is ongoing to include screening for diabetes as a component of the 'over-50 health check'. Patients with cardiovascular disease and hypertension are tested annually for diabetes in most practices.	
Standard 3 All children, young people and adults with diabetes will receive a service which encourages partnership in decision-making, supports them in managing their diabetes and helps them to adopt and maintain a healthy lifestyle. This will be reflected in an agreed and shared care plan in an appropriate format and language. Where appropriate, parents and carers should be fully engaged in this process.	**CHILDREN & YOUNG PEOPLE:** The Health Board has made good progress in relation to this standard for example: • As part of All Wales programme all families encouraged to be involved in care and treatment. • All paediatric patients encouraged to become involved in the management of their condition. • Information provided to patients and families with regard to healthy lifestyles. • Shared care plans in place for all Paediatric patients. **ADULTS:** **Programmes to strengthen and support self care management:** Structured Diabetes Education (SDE): • DAFNE Type 1 SDE program available in both PCH and RGH. Available to 6% Type 1 Diabetic population per annum. • XPERT Type 2 SDE. Limited availability in Cwm Taf. Available to 1% Diabetic population per annum.	

	Partnership and active involvement: • Patient Reference groups established. • RCT CBG monitoring diaries which includes ability to record other results (e.g. BP, lipids etc) and current treatment issued throughout Cwm Taf. • No single shared care plan at present.	
Standard 4 All adults with diabetes will receive high-quality care throughout their lifetime, including support to optimise the control of their blood glucose, blood pressure and other risk factors for developing the complications of diabetes.	The Health Board has made steady progress against this standard. The increasing prevalence of Diabetes however will present issues in relation to capacity and resources available to support the Diabetic population in Cwm Taf. • Cwm Taf LHB has developed a comprehensive diabetes strategy to ensure that services are delivered to the right patient in the right place at the right time by the right people. The Annual Review assessment takes place in Primary Care and general practice teams are to be reminded of the current standards expected at Annual Review in a forthcoming Newsletter. Patients with complex clinical problems are managed by Speciality Teams. Training is being planned for appropriate practices within each of the four Clusters in Cwm Taf to support "expert" general practitioners and practice nurses so that the "Cluster Network" model can be implemented. Similar training is being developed and disseminated for improving patient education within general practice. • The Health Board piloted a Diabetes Community Team for a 2 year period. Evaluation of the pilot demonstrated good outcomes (reduction DNA rate, significant reduction in secondary care referral rate, provision of high quality local care, upskilled primary care staff, high rates of patient and Primary care HCP satisfaction, practice based SDE) however the model was not sustainable to roll out across Cwm Taf. The Health Board are now developing an alternative model based on specialised federated model to support more integrated working between primary and secondary care and increase the skills and knowledge base within primary care. • A Diabetes Nurse Facilitator is based within the community and covers the Cwm Taf area. There are 3 key elements to this role:	

	○ Training and Education (students, health/social care staff and patients) ○ Facilitation and Supervision (for example, sitting alongside a Practice Nurse to provide shared care until such a time that the Practice Nurse has developed the required clinical competencies) ○ Direct Clinical support and professional advice to the District Nursing service, GP Practices, Care Home staff and Community Hospital staff regarding the clinical management of a patient presenting with Diabetes The Health Board would like to develop this role further. • Clinical Pathway Agreed by Diabetes Group and Local Medical Committee. • Patient hand held records available. • Dietetic Capacity Grant Scheme has been extended to include nutrition training for people working with older people. Potential to train staff from nursing/residential settings. • DAFNE programme in place in both DGH sites. • X-PERT available in both DGH sites. • Think Glucose pilot site for Wales. This is focusing on education and training to ward staff. Insulin prescription charts now on all acute wards which support staff in the administration, dosage and monitoring of insulin. • QOF provides template for annual assessment of Diabetic patients for many but not all aspects of Diabetes care. • Educational support via Diabetes in primary care course run annually. • GP practices have recall system for non-attendees. • Audit + - participation in annual National Diabetes audit poor. The Health Board is engaging with practices to improve uptake. • Diabetic (medical) e mail advice project planned. • T1DM SDE and CSII service introduced in PCH. • Diabetes inpatient team pilot demonstrated significant reduction in average length of stay for inpatients with Diabetes. 2 WTE reduction in DSN posts reduced provision of inpatient service.	
Standard 5 All children and young people with	Steady progress has been made against this standard however gaps remain.	

diabetes will receive consistently high-quality care and they, with their families and others involved in their day-to-day care, will be supported to optimise the control of their blood glucose and their physical, psychological, intellectual, educational and social development.	• Not all patients receive psychological support due to limited psychology resources • Additional Paediatric Diabetes Nurse Specialist and Dietetic capacity required to support caseload of patients. • Nurse-led and Consultant clinics in place. • Education offered to all patients on an on-going basis not just on diagnosis. • Additional capacity would allow for audit of quality of care provided. • Structured education guidance "Successful Diabetes – Developing and Delivering Self Management Education". Integrated approach to education. Course being rolled out across Wales. Cwm Taf team involved in this programme. Review of capacity required in order to roll out such education programmes. • Parents of children with Diabetes group running. Provides support, advice and guidance. • Peer support group for paediatric patients with Diabetes runs bi-monthly. • CSII therapy now available for children. • No Dietetic support for children.	
Standard 6 All young people with diabetes will experience a smooth transition of care from paediatric diabetes services to adult diabetes services, whether hospital or community-based, either directly or via a young people's clinic. The transition will be organised in partnership with each individual and at an age appropriate to and agreed with them.	Steady progress has been made against this standard however gaps remain. • Guidelines required with regard to optimal transition age. Currently led by available capacity within local services. Currently transition discussed with patient and family at 16. • Transition normally takes place age 17 and 18. • Paediatric and adult service work together to support transition. • Joint multidisciplinary Paediatric-Adult transition clinics established in Cwm Taf. Transition tailored to individual.	
Standard 7 The NHS will develop, implement and monitor agreed protocols for	The Health Board has made good progress in this area. Of note: **Recognition:**	

rapid and effective treatment of diabetic emergencies by appropriately trained health care professionals. Protocols will include the management of acute complications and procedures to minimise the risk of recurrence.	• Taught as part of Undergraduate training in nursing and medical schools Diabetes in primary care course. • Think Glucose project in both Hospitals. **Management:** • Acute hyperglycaemia guidelines in process of being updated. • Hypoglycaemia guidelines introduced. • Diabetic foot pathway to be updated.	
Standard 8 All children, young people and adults with diabetes admitted to hospital, for whatever reason, will receive effective care of their diabetes. Wherever possible, they will continue to be involved in decisions concerning the management of their diabetes.	Steady progress has been made against this standard however gaps remain. Of note: • Cwm Taf LHB is working with Diabetes UK and other LHBs to discern how the Royal College of General Practitioners "Care Planning" model (http://www.rcgp.org.uk/clinical-and-research/clinical-resources/care-planning.aspx) can be adapted to the Welsh NHS. The model builds upon the lessons learnt from the Diabetes Year of Care project in England. • Diabetic team informed of admission / diagnosis immediately. • Diabetic would follow-up patient on the ward. • Diabetic team commence planning for home management. • Training undertaken with ward staff in relation to Diabetes awareness. However protected time for training not in place therefore identified as an issue for improvement. **Recognition:** Taught as part of Undergraduate training in nursing and medical schools Think Glucose project in both Hospitals. **Management:** Diabetes inpatient team pilot demonstrated significant reduction in average length of stay for inpatients with Diabetes.	

	Foot screening of PWD on admission to hospital not established. Updated glucose monitoring and insulin prescribing charts including the management of hypoglycaemia implemented. Hypoglycaemia management boxes (hypoglycaemia treatment & management algorithm) introduced all clinical areas Hospital.	
Standard 9 The NHS will develop, implement and monitor policies that seek to empower and support women with pre-existing diabetes and those who develop diabetes during pregnancy to optimise the outcomes of their pregnancy.	Good progress has been made against this standard. Of note: • Midwifery/DSN pre-conception and pregnancy clinics established RGH. • Joint Diabetic/obstetric antenatal clinic established. • Protocols for management of Diabetes during pregnancy & labour established.	
Standard 10 All young people and adults with diabetes will receive regular surveillance for the long-term complications of diabetes.	Steady progress made against this standard, for example: • Cwm Taf LHB has developed a comprehensive diabetes strategy to ensure that services are delivered to the right patient in the right place at the right time by the right people. The Annual Review assessment takes place in Primary Care and general practice teams are to be reminded of the current standards expected at Annual Review in a forthcoming Newsletter. Patients with complex clinical problems are managed by Speciality Teams. Training is being planned for appropriate practices within each of the four Clusters in Cwm Taf to support “expert” general practitioners and practice nurses so that the “Cluster Network” model can be implemented. Similar training is being developed and disseminated for improving patient education within general practice. • All annual reviews to be performed in primary care • All practices participate in QOF and have access to Audit+. Health Board is engaging with Primary care to increase Audit+ uptake to undertake NDA. • DRSSW needs to inform each General Practice of patients who DNA retinal screening. •	

Standard 11 The NHS will develop, implement and monitor agreed protocols and systems of care to ensure that all people who develop long-term complications of diabetes receive timely, appropriate and effective investigation and treatment to reduce their risk of disability and premature death.	Steady progress has been made in this area. Of note: • Cwm Taf LHB has developed a comprehensive diabetes strategy to ensure that services are delivered to the right patient in the right place at the right time by the right people. The Annual Review assessment takes place in Primary Care and general practice teams are to be reminded of the current standards expected at Annual Review in a forthcoming Newsletter. Patients with complex clinical problems are managed by Speciality Teams. Training is being planned for appropriate practices within each of the four Clusters in Cwm Taf to support "expert" general practitioners and practice nurses so that the "Cluster Network" model can be implemented. Similar training is being developed and disseminated for improving patient education within general practice. • Referral guidelines established • Discharge guidelines established • Diabetic (medical) e mail advice project planned • All Wales Consensus guidelines established (available online)	
Standard 12 All people with diabetes requiring multi-agency support will receive integrated health and social care.	The Health Board has very good working relationships with its Local Authority partners. However we acknowledge that further progress could be made and a considerable amount of work is underway at present particularly in relation to a more integrated approach to discharge planning, access to Reablement services and multi-disciplinary / multi- agency community teams for frail elderly patients. A number of this patient group will have Diabetes. Specifically within the area of Diabetes, the Diabetes Nurse Facilitator provides direct clinical support and professional advice to Care Homes to support the management of patients with Diabetes. The Health Board also has a Local Enhanced Service for Care Homes which supports regular monitoring of Care Home patients.	

Health and Social Care Committee

HSC(4)-31-12 paper 7

Inquiry into the implementation of the National Service Framework for diabetes in Wales and its future direction – Public Health Wales and 1000 Lives Plus

Public Health Wales welcome the opportunity to respond to the request of the Health and Social Care Committee, National Assembly for Wales for comments on the implementation of the National Service Framework for diabetes in Wales[1] and its future direction.

Public Health Wales was established as a NHS Trust on 1 October 2009 and provides an expert public health resource as part of the NHS in Wales. Public Health Wales works in partnership with a number of key organisations, which include the Welsh Government, Health Boards, NHS Trusts, Local Authorities, Universities and Third sector bodies.

Diabetes can have a significant impact on the quality of life of an individual, their dependents and family. Long term complications may include cardiovascular disease, neuropathy, retinopathy and nephropathy.

The National Diabetes Inpatient Audit[2] is commissioned by the Healthcare Quality Improvement Partnership. The report provides evidence against the National Service Framework (NSF) for diabetes (Wales)[1] standard 8, which outlines the requirement for all patients with diabetes admitted to hospital to receive effective care for their diabetes and be involved in decisions on the management of their diabetes. It also provides information for the NSF standards 10, 11 and 12 which aim to minimise the impact of long term complications of diabetes by early detection and effective treatment.

The results, published in 2012, illustrate that there are problems with the implementation of some of the NSF standards for diabetes.

- The audit shows that 37.1% of diabetes consultant's time is spent on the care of people with diabetes with only 13.7% on inpatient care.

- The majority of sites (55.6%) stated that they did not have any specialist dietician time for inpatient care for people with diabetes.

- There is a recommendation for the provision of a multidisciplinary foot care team. Of the 17 sites that provided an answer to the hospital characteristics information regarding the multi-disciplinary team 9 did not have a multi-disciplinary team (52.9%)

- Only 13.3% of patients included in the audit had a documented foot examination at any time during their hospital stay.

- More than a quarter (29.8%) of patients included in the audit experienced at least one medication error while in hospital. 16.6% of patients experienced at least one prescription error and 17.8% of patients experienced a medication management error.

- The most common prescription error was for insulin prescriptions where the insulin was not signed as being given. The most frequent medication management error was failure to adjust medication when the blood glucose was persistently greater than 11mmol/L and lower blood glucose levels would have been beneficial.

The National Diabetes Audit (NDA) 2010-2011, Report 1: Care Processes and Treatment Targets[3] includes data from both primary and secondary care. In 2010-2011, 85,176 patients and 49.4 % of GP practices in Wales participated. The report presents key findings on care processes and treatment target achievement rates from 2010-2011 in all age groups.

In Wales the audit reported that 60.0% of people with diabetes had records showing all nine 'core care' checks as advocated by the National Institute for Clinical Excellence (NICE)[4,5] had been completed although variation was seen between Health Boards and amongst the individual checks performed. NICE specifies treatment targets for HbA1c (glucose control), blood pressure and cholesterol based on the best current evidence. Achieving these treatment targets minimises the risk of future diabetic complications such as blindness, kidney failure, amputation, heart disease and stroke.

• 65.1% of patients had an HbA1c ≤7.5% (58 mmol/mol).

• 77.7% of patients had had a cholesterol <5 mmol/l.

• 33.9% cent of patients had blood pressure control within NICE recommended targets.

• 18.5% of patients had Hb1Ac, cholesterol and blood pressure within the target ranges above.

The diabetic retinopathy screening service is an important element in managing risk of sight loss. It is important that this service continues to demonstrate performance against the National Screening Committee key performance indicators.

Although a great deal of work is already being undertaken across the population in Wales, many cases of diabetes remain undiagnosed and as demonstrated in the national audit there is still significant room for improvement. The report identifies variation and highlighted four areas that commissioners and all providers of diabetes care should prioritise for improvement; the organisation and recording of annual reviews, the effectiveness of glucose control and cardiovascular risk reduction, services for people with Type 1 diabetes and services for younger people with both Type 1 and Type 2 diabetes.

Diabetes in Wales is almost twice as high in the most deprived areas compared to the least deprived.[6] An increased prevalence of diabetes and poorer health outcomes is found in areas of social deprivation. Many areas of Wales therefore face significant challenges in moving forward the diabetes agenda, preventing development of diabetes, identifying and treating people with undiagnosed diabetes and reducing the incidence of complications that arise from poorly controlled diabetes. Amongst other considerations, people living in areas of social deprivation are less likely to eat a healthy, balanced diet.

Obesity is also an important determinant of Type 2 diabetes. Type 2 diabetes is usually associated with people aged over the age of 40, although it is becoming increasingly common in children and young people. A recent Welsh survey[7] reported that whilst a high proportion of children were reported to have very good or good general health, over a third were estimated to be overweight or obese. Preventing diabetes in younger people would improve health and wellbeing, avoiding the additional complications that diabetes can bring as well as having the potential to reducing the burden on resources.

Future Direction

It is imperative that driving forward the diabetes agenda is integrated into routine working practice. An emphasis on continuous improvement, quality service provision, improved user experience and public health outcomes as seen in the draft Cardiac Delivery Plan that is currently

subject to consultation[8] would assist and support delivery and action towards achievement of diabetes action planning.

A diabetes delivery plan for Wales will need to incorporate actions to aid detection and prevention whilst providing support to those already living with diabetes through informative, effective and timely care. Access to and sharing of quality information is vital to the successful improvement of services for people with diabetes. Activity must also focus on narrowing the gap between the most and least deprived areas of local populations.

Enabling a healthier environment and supporting the population to make informed healthier choices is vital to move forward diabetes care in Wales. The importance of school and the workplace environment in facilitating healthy behaviour and lifestyle changes is also recognised and supported by Public Health Wales through local and national programmes and health improvement initiatives.

Collaborative partnership working and addressing key priorities as identified in the national audit will provide a firm foundation to build on and are fundamental to taking forward implementation of the diabetes agenda, assisting the prevention of further complications and evidence based utilisation of resources. Public Health Wales already has in place strong local and national teams and partnerships that can support this journey to achieve quality and excellence.

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1. National Service Framework for Diabetes (Wales) 2003

2. National Diabetes Inpatient Audit 2011

3. National Diabetes Audit 2010-2011-Report1: Care Processes and Treatment Targets

4. National Institute for Health and Clinical Excellence Clinical Guidance on Diabetes CG15: Type 1 diabetes: Diagnosis and management of type 1diabetes in children, young people and adults

5. National Institute for Health and Clinical Excellence, CG66 Type 2 diabetes: the management of type 2 diabetes (update)

6. Diabetes in the UK 2010: Key statistics on diabetes 2010

7. Welsh Health Survey 2011: Initial Headline Results May 2012. Welsh Government

8. Together For Health – A Cardiac Delivery Plan A Delivery Plan up to 2016 for NHS Wales and its Partners 2012. Consultation document; Welsh Government

1000 Lives Plus

Situation

This paper provides the response by 1000 Lives Plus to the 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.

The response is pertinent to the Committee's consideration of potential future actions that are required to drive this agenda forward.

1000 Lives Plus would be prepared to give oral evidence at the inquiry.

Background

1000 Lives Plus is the national improvement programme, supporting organisations and individuals, to deliver the highest quality and safest healthcare for the people of Wales. The programme is focussed on building capacity in improvement skills and sustaining and spreading improvements. It supports frontline staff across Wales through evidence-based 'programme areas' and provides clinical leadership through its Faculty. It is committed to engaging patients and students in improvement work and promotes an internationally-recognised quality improvement methodology[1]. There is significant work underway in primary care, led jointly with the Primary Care Quality and Information Service (PCQIS).

To provide high quality diabetes care, NICE guidance and the National Service Framework standards (NSFs) provide a strong evidence base for the delivery of effective care to people with diabetes. The NSFs provide a strong evidence base for what works.

However, the evidence shows that NSFs in general are not effective instruments of change. They set out what should be done but are not suited, of themselves, to deliver those ends. It is therefore not altogether surprising that The National Diabetes Inpatient Audit 2011 identified continued failings in areas which NSFs had previously identified as important:

[1] 1000 Lives Plus. (2011) *The Quality Improvement Guide: A method for improving public services in Wales.*

- staffing and who is looking after the person with diabetes in hospital
- the impact of medication errors
- deficiencies in foot care[2].

Assessment

The unsuitability of NSFs and many care pathway documents to drive change is underpinned by research led by Trisha Greenhalgh. She researched the determinants of effective changes in healthcare and summarised those characteristics as follows[3]:

- *It must have clear relative advantage.* The people or teams (users) who are asked to make the change part of their work must be able to see that the new method is likely to be better.
- *It must have compatibility with the user's values and ways of working.* If users find it hard to incorporate the new method, they are unlikely to do so.
- *Complexity must be minimised.*
- *Users will adopt more readily if innovations allow trialability.* Can it be tested on a small scale to allow learning and familiarity before full commitment?
- *There must be observability, that is, it must be seen to deliver benefit.* If benefits are obscure or they take a long time coming, energy will be lost.
- *Reinvention is the propensity for local adaptation.* This is the key to sustainability. A good improvement must be subsumed into the changing system and not preserved like a museum piece.

Most NSF documents fail all six characteristics. But NSFs and their associated audits can supply the evidence base to support a change initiative using improvement methodology such as that of 1000 Lives Plus. This incorporates the Model for Improvement and the use of PDSA cycles to track improvements over time; using process and outcome data for improvement, not judgement accountability or comparison. Process measures enable organisations to control variation and ensure reliability

[2] Health and Social Care Information Centre. (2012) *National Diabetes Inpatient Audit 2011*.
[3] Greenhalgh, T., Robert, G., Bate, P., Kyriakidou, O., Macfarlane, F. & Peacock, R. (2004). How to spread good ideas. *A systematic Review of the literature on diffusion, dissemination and sustainability of innovations in health service delivery and organisation*. NHS Service Delivery Organisation: London.

in their processes. Outcome measures reflect the impact on the patient or system and show the end result of an organisation's improvement work.

This approach has delivered a number of benefits in Wales[4], including:

- The number of central venous catheter related blood stream infections has fallen to a rate of less than one case per 1000 catheter days in seventeen intensive care units across the country[5].
- A zero tolerance approach to pressure ulcers and the implementation of the SKIN bundle is continuing to deliver significant results, with many hospital wards across Wales going more than a year without a single incident.
- Acute stroke services across Wales deliver reliable care by measuring adherence to evidence based "bundles" of care. There are now demonstrable improvements in stroke survival which are associated with this approach.

The work programme for 1000 Lives Plus is based on the evidence of need and the potential to deliver change. Its priorities align with the national needs of the Quality Delivery Plan and the local needs of service delivery plans. National collaborative programmes reflect NHS Wales' priorities and connect to Board agendas. Moving forward, 1000 Lives Plus governance and priorities will be led by the NHS and, if CEO's approve, the improvement methodology could be applied to diabetes care.

The inclusion of the diabetes NSF would be complementary to the work and approach taken by PQUIS as part of 1000 Lives Plus. There is also a complementary initiative by therapists in Wales who would like to reduce unnecessary amputations in Wales through a structured approach to peripheral arterial disease and diabetes. This could be usefully incorporated into a future 1000 Lives Plus programme.

Recommendations

The NSFs provide the evidence base for required improvement. Organisations need to improve diabetes care if excess hospital length of stay, long term complications, avoidable patient morbidity and mortality are to be addressed.

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[4] www.1000LivesPlus.wales.nhs.uk
[5] Welsh Healthcare Associated Infection Programme

1000 Lives Plus could provide a national methodology to implement the evidence-based changes in diabetes care outlined in the NSFs and demonstrate a measurable improvement in the care provided. Working with PCQIS, this approach would require approval by Health Board and Trust CEOs and be prioritised as a programme of work in the next financial year (2013-2014).

Gwenda Thomas AC / AM
Y Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol
Deputy Minister for Children and Social Services

Eich cyf/Your ref CSP/HVG/602
Ein cyf/Our ref SF/GT/03542/12

Kirsty Williams AM
National Assembly for Wales
Ty Hywel
Cardiff Bay
Cardiff
CF99 1NA

10th November 2012

Dear Kirsty,

I write following an issue you raised at the 3 October HSSC related to the assessment of cognition with regards to Continuing NHS Healthcare (CHC) arrangements. Time was limited on the day, and I undertook to respond in more detail following the meeting.

CHC arrangements vary between all four UK countries. Welsh Ministers issued a National CHC Framework in 2010, which set out both policy regarding CHC, and the requirements placed on health boards in implementing the Framework. Any consideration of eligibility is based upon comprehensive multidisciplinary (MDT) assessment, and it is the recommendation of the MDT that is considered by health boards when they make a decision regarding eligibility.

Included within the Framework is the Decision Support Tool (DST). This is not an assessment process. Its purpose is to capture the range of comprehensive MDT assessments undertaken, and to support MDT consideration, discussion, and the recording of a recommendation on eligibility. The domains set out in the DST do differ from those used in England. In fact the process to record assessments and capture decisions differs across the four UK Countries. Cognition features as a domain, and the MDT is able to record in some detail the issues relating to cognition. An additional domain is also included within the DST to capture any information on an individual that the MDT feels is not reflected properly within the other domains.

A review of the 2010 Framework is planned for 2013, to follow on from a Wales Audit Office report on the Framework that is due shortly and there will be an opportunity then to undertake a further assessment of this issue and to consider whether any changes are needed. Any revisions to the Framework will be subject to consultation.

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I hope I have provided clarity on this matter. On that basis I am issuing this letter to all members of the Committee.

Yours sincerely

Gwenda.

Gwenda Thomas AC / AM
Y Dirprwy Weinidog Plant a Gwasanaethau Cymdeithasol
Deputy Minister for Children and Social Services

Cc: All Members of the Health and Social Care Committee

Eitem 4b

Lesley Griffiths AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

Eich cyf/Your ref
Ein cyf/Our ref

Mark Drakeford AM
Chair Health and Social Care Committee
National Assembly for Wales
Ty Hywel
Cardiff Bay
Cardiff CF99 1NA.

12 November 2012

Dear Mark

Human Transplantation (Wales) Bill

I intend to introduce the Human Transplantation (Wales) Bill in the National Assembly for Wales 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 20 November 2012. To assist with your 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 to the National Assembly for Wales	3 December 2012
Deadline for Stage 1 Committee consideration	22 March 2013
Plenary debate on general principles and motion on financial resolution (if necessary) – end of Stage 1	16 April 2013
Stage 2 begins	17 April 2013
Earliest possible date for Stage 2 consideration	9 May 2013
Stage 2 ends - deadline for Stage 2 Committee	7 June 2013

Kind Regards
Lesley

Lesley Griffiths AC / AM
Y Gweinidog Iechyd a Gwasanaethau Cymdeithasol
Minister for Health and Social Services

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