Scottish Parliament Cross Party Group on Diabetes

Minute of meeting: Wednesday 18th June 2014

Committee Room 6

Present

David Stewart MSP
Cara Hilton MSP
Roderick Campbell MSP
Rupert Pigot
Pamela Taylor
Sarah Ward
Jane-Claire Judson
Megan Lott
Emma Cartwright
Nicole Robertson
Ainsley Duncan
Gemma Thomson
Claire Heslin
Joanne Jervis
Karen Utting
Colette Marshall
Lucille Whitehead
Melanie Littlewood
Sandi McKenchie
Bruce Knight
Julie Donald
Stephen Doherty
Alison Savman
Mandy Christie
Ian Glover
Marion Graham
Paul Stevens
Susan Fletcher
Morag Maillie
Jane Cook
Diane Smith
Brian Forbes
Marie Brown
Hugh Brown
David Cline

Apologies

Vicky Alexander
May Millward

Marylin Boland
Ken MacIntosh MSP
Alistair Brookes
Bob McQueen
Michael Mahoney
Gerry Tosh
Jenny Fairbairn
David Coates
Collette Foord
Clare Adamson MSP
Enid Barker
Kirsty MacLennan
Sir Michael Hirst
Kenneth Gibson MSP

1. Welcome

David Stewart welcomed everyone to the meeting. DS apologised for Nanette Milne absence due to medical reasons

2. Minutes of Last Meeting

Minutes from the meeting 25 Febrauary. Presented and agreed

3. Presentation

Professor John McKnight, chair of the Scottish Diabetes Group

Presentation “Diabetes in Scotland”

DS Thanked JM for his presentation. DS said that he was examining the possibility of a Member’s bill to help prevent Type 2 diabetes, looking at methods of controlling sugar in diet through regulation foods.

JM added that this is a Public Health issue and that there are other factors at play. For instance we must look at other things like fat content. If you remove sugar from drink and people have a bar, it is just transferring a problem.

DS welcomed the increase in the use of insulin pumps. However he pointed out that there are problems in his constituency in the Highlands where some people do not agree with the science. What work has been done to help health boards to meet their targets?

JM has been involved with helping health boards to understand what pumps can do for people with diabetes. An example is in one health board which had previously not seen a great uptake of insulin pumps, the lead clinician met with 3 people who had pumps and seen the benefit it brought to their lives. This feedback is what makes it work and the funding for making it available.

Mandy Christie (MC) asked: How does the Scottish Government plan to tackle the growing number of people at serious risk of diabetes in Scotland?

A Diabetes UK Roadshow in Dundee last week carried out 250 Risk Assessments over 2 days. 139 people (56%) were found to be at a moderate or high risk of developing diabetes and were asked to contact their GP Practice.

JM: We have to approach this very carefully, for instance in Finland there has been a very successful government led campaign to encourage a change of lifestyle and be healthier. I am not sure how we get that to happen here. There are a number of factors; for instance it is a “Public Health” issue, it is also the responsibility of individuals and finally a need for political leadership.

MC: Obesity is closely linked with Type 2 diabetes. 90% (approximately) of people with diabetes are Type 2. How can the Scottish Government support people to lose weight and maintain that loss?

JM: There is the need for the right education, we can give advice but how do you increase exercise, change the food that is available? There is no simple answer, however there is a need for the individual to take responsibility. There is the work of Professor Lean and the low calorie diet, can we talk people into losing weight? This is a public health issue.

DS: I wanted to ask about the use of statins and find out what is your view?

JM: Well I find this easy to answer; if 20% of people with diabetes are at risk of a cardiovascular event they should be on statins. It reduces cardiovascular risk by 25-30%. The case must be made on a population basis. Statin therapy has dramatically reduced people risk.

Julie Donald (JD): Could there be more funding for medical detection dogs for children and adults who lives can be completely transformed with a diabetic alert dog. We recently had a meeting and our guest was from the charity Medical Detection dogs. There is currently only one dog allocated to a brittle type 1 patient in Scotland. The main training centre is in Milton Keynes.

I feel there should be more focus on this charity as these dogs can transform and give people back their lives.

JM: Dogs are an interesting issue, however it is up to the charities to provide this service. However another method to help would be Continuous Glucose Monitoring (CGM).

JD: Is CGM far off and does it make the quality of life better?

JM: We are actively pushing for development on this and its inclusion in the refresh of the Action Plan.

Kirsty MacLennan (submitted via email): In view of the fact that there is a clear established link between psychological factors and the ability of people with diabetes

to effectively self-manage their condition, can Professor McKnight please let us know if he has any plans to increase the amount of permanently funded psychology time to adult diabetes services?

JM: Clinical psychology is useful and important for supporting people with diabetes, however I do not hold the budgets for the health boards. I have been in touch with a psychologist and will take into consideration their thoughts for the refresh.

Sandi McKenchie (SM): Why are we not providing cheaper services other than psychologists?

JM: How you decide on priorities is a tough call for instance insulin pumps are not expensive for their benefit. It's about how to enable this to happen locally.

Ainsley Duncan (AD): In school education children are not being taught about food. Children should know about fruit. It is important to know how to cook. Type 2 is about eating habits and eating healthily. Teaching children about food from a young age can really address this issue.

JM: A lot of this is associated with deprivation and is linked with people's upbringing. This is a tough issue and goes back to public health.

Brian Forbes (BF): Type 1 details and targets (as mentioned in the presentation), are there similar plans to look at data worldwide on Type 2?

JM: Sweden and Norway have similar data but beyond this there is not much for a comparison. We are trying to get the original data published.

DS: If Type 2 is being described as a diabetes epidemic with all the hard work that is being put forward to address this what do you feel is the biggest priority for Type 1?

JM: We are linking Type 2 diabetes to being overweight but there is a strong genetic link which must be bore in mind for instance not all overweight people have diabetes.

For Type 1 the aim is to try and get HbA1c reduced through methods of engaging services as 18 – 26 year olds are challenging.

Paul Stevens (PS): How do we get industry to partner in this?

JM: There has been some good work done with the Scottish Diabetes Industry Group on education, Steve Birnie is leading the Paediatric Group, again it is a challenge.

Jane-Claire Judson (JCJ): Psycho-social is the Cinderella of the NHS. Scottish Government and Diabetes Scotland are looking at the House of Care to address this. It is good to talk to a clinician, Pid Pad was an example of the prevention of complications. The data was really positive and gives us the tools to address this, we need to not be talking about targets but how people feel. Services need to be redesigned and think of someone as a person.

Food, kids and education. The wider environment affects kids for instance people's weight is increasing with people with Type 1 following the general population. However we sometimes do not acknowledge how clever kids are. Like kids learning how to cook cous cous in school, the main problem is down to leadership, the journey is from before diagnosis. Inpatient care is something we still need to improve, however I am hopeful that the refreshed Action Plan will improve this.

DS: Are there any plans for screening people that are at high risk of Type 2 diabetes? For instance if you are overweight and over 45. I understand that we look to the guidance from the UK Screening Council but there would be thousands of people coming to see their GPs which if they could be identified before diagnosis then it could lead to avoiding complications and cost later.

JM: I am not expert on the cost effectiveness of screening. There is screening on diabetic retinopathy that has borne results but this is a matter for public health, who will look at this.

The UK perspective study examined this. The delay in diagnosis with people who already have early onset retinopathy was examined and has been improving in Scotland since screening was introduced. As to the amount of people undiagnosed in Scotland, 50,000 I am looking to update this figure but in the case of people diagnosed we are seeing fewer people with complications which indicates that we are diagnosing earlier.

Emma Cartwright (EC): In Tayside on the subject of transition for 18- 25 year olds. The problem is that nothing is the same on transition services, there is no unified system. What can the lead clinician do?

JM: It is a major difference in the type of service, there are more people with Type 2 after 18. There has been work and it was shared on harmonisation of the 14 – 18 year olds services. However when many people become 18 they move to university or to get a job. So whatever happens here there will be a change in services and a need to establish new relationships with health care providers. We are looking at what to do about this for the Action Plan refresh.

EC: Could this all be on the same train ie develop the paediatric service to go to the age of 25?

JM: There is an aspect here of training patients on how to interact with the health service.

Megan Lott (ML): Training people to speak for themselves? There must be training for health care professionals to enable them to speak to patients.

JM: Consulting is a two way process, talking and establishing a relationship with the patient is vital. Engaging with them such as when I was seeing a young girl and talking about her dog. It was trying to get a bit of chat going to engage the patient.

ML: What if you are diagnosed with Type 1 later in life, what are we to do to ensure that service needs are met?

JM: Patients changing areas is challenging when we are trying to provide person centre care added with the difficulty of having 30 – 40 people coming into a clinic means that devoting the time to build up that relationship can be hard.

Diane Smith (DS): I am a Managed Clinical Network Manager. Patients and clinicians need to have these conversations. We have a programme for patients to promote self-management and also make sure that patients meet their clinicians; the two have to meet together where patients can discuss their experiences of self-management and how clinicians can support them.

SM: Getting young people to discuss their condition when they feel uncomfortable can be very hard. Health care professionals need the skills to make patients feel at ease.

DS: We need to work in partnership such as helping young doctors who don't yet have the skills to develop them.

JM: I have invested in video cameras to review appointments and learn how to better interact with patients, there is a lot still to be learnt. We have been awarded £10,000 from Scottish Diabetes Group to take this round Scotland.

AD: When I was 15 and I was doing my exams I had to go to hospital. One of the health care professionals said I'll be looking after you in adult services, because of this interaction and approach I developed a really good relationship with this person. Perhaps we could examine the possibility of introductions via email so that the patient is prepared to meet their health care professional.

JD: I would like to echo what has just been said, when I was diagnosed at 14 in 1982 it was very different then and difficult to deal with.

DC: Just knowing your name is vitally important.

JCJ: The relationship with a clinician never feels equal. We need to examine how we support patients and health care professionals, training clinicians in conversations and learning about the relationships.

JM: I do not disagree but we all do things differently. Achieving that personal connection has to be done through more than superficial means.

DS: Many thanks to Professor McKnight.

Meeting ends.