Scottish Parliament Cross Party Group on Diabetes

Minute of meeting: Wednesday 25th November 2014

Committee Room 6

Present

Lucille Whitehead
Debi Harris
May Millward
Bruce Knight
George Valiotis
Collette Foord
John McKnight
Stephen Thompson
Camilla Horwood
David Eadie
David Coates
Alastair Brookes
Mandy Christie
Jeff Foot
Gordon MacMillan
Emma Cartwright
Susan Chisholm
Patricia Ford
Brian Kennon
Rupert Pigot
Jane-Claire Judson
David Stewart MSP
Nanette Milne MSP
Jason Harding
Julia Platts
Sarah Ward

Apologies

Jackie Ballie MSP
Aileen McLeod MSP
Hugh Johnston
Aileen Hillis
Barry McGrory
Steve Birnie
Gerry Tosh
Dave Duff
Vicky Alexander
Terry Salt

1. Welcome

David Stewart welcomed everyone to the meeting.

2. Presentation

Dr Julia Platts, lead clinician on diabetes in Wales

There are similarities between Scotland and Wales such as incidence, complications, population health and symptoms. The 2003 standards had not come to fruition over 10 years. This culminated in a Health Service Framework review. The broad aims were similar to Scotland, key to the process was not to rerun the previous framework, therefore it was decided to deliver on incremental steps, each year was to be broken down to specific priorities:

1st year:

- Children
- Prevention
- Empowering (Education)
- Effective care
    - Feet
    - IT Informatics
    - Inpatients

The second and the third year are planned:

2nd year:

- More inpatient action
- Pumps
- Retinopathy

3rd year:

- Kidney disease
- Pregnancy

There is already a children and young person's network, concerned with healthcare professional education, the Brecon Group. This clinical network has been strengthened with a network co-ordinator in Cardiff and received money from Health Boards in Wales.

In Wales standards from England have been adopted and also a process of peer review, colleagues from England have assisted in this. To improve and standardise children's care there have been new processes implemented to ensure timely action and problem identification. Transitional care has been ad hoc with no standards but responsibility for this had been folded into the Brecon Group. Finally structured education for children, has been more challenging. Different packages are needed for different ages and their parents.

Prevention is a first year priority. There has been a doubling of the amount of people at risk of developing diabetes. Half of the energy is in identifying people at risk and half is concentrated at supporting these people. Currently there are lists of different

programmes but there is no collation. Part of the strategy involves getting Health Boards to bring the data together, gathering what is already available to bring about change.

Childhood obesity reduction has been a strong focus because of what is already being delivered through schools. Wales is examining a risk assessment tool in high street pharmacists and a GP system to flag up children (and adults) at high risk. Dr Platts is aware that there is a lot more to do, but that the rolling programme over the next three years is a good start.,

Empowerment: Dr Platts is looking recognise the small amount of people who have been on structured education, Dafne and the Welsh version, David. However there is no standardisation or quality assurance, therefore it is not as good. Health Boards must deliver Dafne, there are now targets for new patients to receive education. Addressing existing patients through Type 2 diabetes programmes particularly the Xpert programme and creating new courses.

- Peer support is being supplied by Diabetes UK Cymru and Wendy Gane.
- Foot care benchmarking will be completed by February 2015, each health board will subsequently develop an action plan.
- Informatics, Welsh Government is examining the possibility of bringing SCI Diabetes to Wales, however there are a lot of recurring costs and the debate will be ongoing.
- Inpatient care is a sizable problem in Wales. According to a recent audit medication errors were a key problem for patients in hospitals. There have also been a number of high profile cases of failures in care.
- Think Glucose is taking place in 6 of the 18 hospitals in Wales. This has achieved a reduction in negative outcomes and hypoglycaemic levels. Dr Platts wants it rolled out nationwide in 2015.

David Stewart MSP (DS) Thanked Dr Platts for her presentation and for coming to Scotland to present to the group. DS asked about the possibility of screening for Type 2 diabetes, particularly in people at high risk even though the UK Screening Committee reported that it would not be an appropriate use of resources.

Dr Julia Platts (JP) explained that it was not a problem in Wales. Looking to screen and detect “pre-diabetes”/high risk, should already be happening with in collaboration with GPs. There must be the tools to do something once it is detected and help onwards, collate the information and examine what is lacking. The example of Tower Hamlets in London and the Year of Care with gardening and walking clubs. These ideas must be gathered together.

George Valiotis (GS) asked about the broader policy context, for instance the focus on patient centred care in Scotland and what is the experience in Wales?

JP replied that there are 19 different plans that make up the strategy. Patient inclusion is fundamental. Specifically for diabetes, Dr Platts talked about the attempts to get patients involved in all levels, specifically the Diabetes Development Plan (DDP) for Wales, the delivery groups, reference groups and Diabetes UK Cymru. An example of

this was how one Health Board disbanded its reference group, patients were very disappointed and subsequently it is being reformed.

Prof David Coates (DC) inquired to the tangible improvements? What would be the top tip for Scotland?

JP replied that the paediatrics peer review process had gone well. Inpatient care is where real improvement is needed and that hopefully with the DDP in place this will happen. Beyond that the reduction in HbA1c levels has seen the amount of complications come down.

Prof John McKnight (JMcK) has used Think Glucose and is planning to do more. The challenges are to give ongoing feedback to wards, hospitals and chief executives. He has looked at different measures and asked Dr Platts what she has examined in Wales?

JP replied that they had looked at the length of stay, which was of interest to the chief executives. The chief executives understand that they will get money back from Think Glucose in the form of a reduced length of stay.

JMcK was interested in "auto downloading" meters and using this to create a run chart showing whether the correct treatment has been implemented. These are two of the four main measures for high glucose and whether the decision has been good and succeeded. Looking at the dashboard approach as the audit is just one year.

Dr Brian Kennon (BK) Prevention and the many types of framework, are there any that are non-medical?

JP answered that they had not examined that so far but that social services implement what the clinicians are saying ie food in schools and activity clubs. It sits in the local authority outside of the health service. There are plans to get it to all join up. This has not come from the DDP and is seen as part of the public health element which the DDP has not touched on.

Stephen Thompson (ST) asked about Dr Platts' talk and what is "Xpert"

JP answered that Xpert is the trade name of a course for structured education for people living with Type 2 diabetes. It is based on patient empowerment written by Dr Trudi Deakin. It is evidenced based with positive outcomes such as lifestyle measures. However Dr Platts is conscious that one will not fit all, particularly BAME communities and young people, they are examining online based courses.

JMcK asked about the ability to influence this and how is it backed up?

JP explained that there is a good structure, a good minister who is also interested. Health boards report twice a year against the action points within the DDP and it goes back to the minister. It has been good to have not too many but firm outcomes. There are plans to extend this to feet as well.

BK asked where the funding for patient involvement has come from?

JP replied that it is top sliced. The one chief executive who has funded this got the other chief executives to pay later. We need to look at this and formalise it as a model.

Jeff Foot (JF) stated that in the Highlands there are a lot of remote communities that are hard to reach. He has been living with Type 1 diabetes for 38 years and is now on a pump. What have been the good delivery mechanisms in Wales?

JP acknowledged that there are different challenges from rural areas to the big cities, it is focused on the principles that can be the same. One element that is proving to be interesting is the focus on technology like pumps and the information revolution. In Wales there have been some legitimate concerns on technology, however on the whole GPs in rural communities are excellent.

BK pointed out that lots of patients were lost in transition and asked on Dr Platts thoughts.

JP acknowledged that lots of studies have been carried out on this subject. The main finding is that it is a period of transition where diabetes is not the main focus of the person. Transition services are not good enough and a lot more research needsd to be done to understand how to keep people engaged.

Jane-Claire Judson (JCJ) thanked Dr Platts and Jason Harding (of Diabetes UK Cymru) for traveling to Edinburgh to meet the group and that it is good to facilitate cross learning like the idea of peer review. Prevention is the main aim and success will come from good relations of the lead clinician, government, NHS and the third sector.

Jason Harding (JH) commented that Dr Platts has been very welcome in the position of diabetes lead in Wales and has worked closely with key stakeholders. She has been very open to the charity, promoting good dialogue, a range of objectives and goals. Key will be the framework, outcomes and measures.

JP also claimed it has been a joy to take on this role. Wales is a small country and most people already know one and other in the field. It has been very encouraging to see people who have stepped up from different areas and departments to help.

DS informed the group about his meeting with Michael Matheson (the then Minister for Public Health) about the members bill he had been working up. However it appears that there will not be enough parliamentary time, instead his team are examining the possibility of placing an amendment on procurement.

JP said this was an excellent idea.

JMck said that there are challenges in diabetes care, over the last few years there have been more people put on pumps. It is seen as expensive but in real terms it is not that expensive. He asked the group how to deal and convey this.

JP pointed out that only 5% of Type 1 patients were on pumps in Wales. Procurement is not the barrier but it is more a case of education specifically for health care professionals.

JMcK used the example of a particular health board in Scotland that was “dragging” in terms of pump figures. A programme of education for health care professionals and candidates for pumps through outreach programmes and seminars had really strong results and they have turned their situation around.

DS stated that he is a member of the Public Petitions Committee, on one of the sessions concerning pump provision with a member of the health board, it became clear that they did not believe in the science, however it was Scottish Government policy. This was creating a postcode lottery.

JMcK countered that there are elements of this but is not all about the staff.

DS asked if you can use any pump?

JMcK said that there are three choices but it has caused issues to people who want a different one. There has been good work done in the total amount of people on pumps compared to European countries but the figures are till lacking behind USA levels.

JF pointed out it is a choice for the patients not the clinicians.

DS noted that the public petition was done for people wanting pumps.

JF asked about testing and strips and how they work with the industry in Wales?

JP replied that there is a good partnership and lots of good groups to facilitate better understanding.

JF said that it was strips rather than pumps that need to be addressed, people struggle to get them. Is there any way of involving pharmaceutical companies?

JP replied that it has always floundered in Wales due to the rapid change in technology. It is the numbers rather than the type. She is campaigning in Wales to change this.

BK talked about the fact that there need to be a partnership to get people on to pumps.

GV added that it is also about getting patients to talk about pumps. There is also an element of patient empowerment and the challenge to people to figure it out.

JCJ cautioned that there is a need to careful about “silo-ing”. There are two things about strip and pumps. It is not strips that are the issue but how we deliver a service. In terms of pumps, it is a “MacGuffin” – The mystery is here but the reality is over here. Access to insulin pumps has managed to open up the discussion on structured education.

JH asked Dr Platts what she would like to learn from Scotland?

JP answered: Procurement, pumps, there has been lots of really good stuff. How did you get the pumps improvement to come about?

JMcK it was patients, articulate groups, a willing minister and cabinet secretary. An idea of “we can deliver success”. There was some things that were very hard to swallow, you have to get the right people saying you can do this. You must pick something that is doable.

DS there was cross party support and a minster who was very forceful in response to failure.

JMcK diabetes data came from CEL (Chief Executive Letter) and a lot of the good work on the register. In 2012 it had a big effect and Dr Platts should examine this possibility for Wales.

JCJ added that it is important to be politically engaged. The pump case clarified that, politics is everywhere be positive to use the leverage.

DS Thanked everyone for attending.

Meeting closed.