Scottish Parliament Cross Party Group on Diabetes

Minute of meeting: Tuesday 18 September 2018

Committee Room 5

Present:

Kenneth Robertson	Ruth Chapman
Brian Kennon	May Millward
Sue Hampson	David Eadie
Billie Wealleans	Mirjam Eiswirth
Paul Nelson	Heather Ann Baxter
John Watson	Pauline Linn
Isobel Millar	Derek Beatty
Kerry Douglas	Paula Collings
Duncan Kenny	Craig Cameron
Shelia Minty	Leeanne Niklas
Marylin Bolland	Ainsley Duncan
Linda McGlynn	Rachael McLean
Rupert Pigot	Angela Mitchell
David Stewart MSP	Brain Whittle MSP

1. Welcome

David Stewart MSP (DS) opened the meeting and welcomed the group and speakers.

2. Minutes of last meeting:

DS proposed the minutes from 18 June for approval. Sue Hampson corrected a mistake where she was identified as Ros Hume. Derek Beatty (DB) seconded.

3. AGM

DS confirmed that he and Emma Harper (EH) would be willing to continue as joint conveners and be joined by Brian Whittle (BW).

Brian Kennon (BK) nominated the three conveners this was agreed through the room.

DS nominated Diabetes Scotland as secretariat, this was agreed through the room.

4. Presentations:

DS introduced Dr Kenneth Robertson (KR), recently retired paediatric consultant at NHS Greater Glasgow and Clyde (GG&C).

KR opened with the statement that there has not been a problem with being able to make progress. He used the example of Diabetter, In Holland the dutch healthcare system was problematic. A group of consultants opted out of the system with a not-for-profit clinic outside of hospital. KR and other health care professionals visited the site in Rotterdam to see their engagement with patients and families. They abolished normal transition and created a service spread over 0-25 years old. The clinic is not like a hospital and is vital for keeping patients engaged, it is based on a hub and spoke model which is similar to the West of Scotland. The main difference has been the use of technology, it is centred around the patient, they are not stuck to one supplier and have convinced insurers to take an actuarial approach to the risk and think about the future.

They are the cheapest provider in Holland and insurers believe in the system, parents and older patients have been set up as a bond. The benefit of a 0-25 service is that the longer spread means that patients do not disengage from their health care, staying with the same health care team along the corridor is vital. In Scotland we can see people disengaging in their transition and then coming back in their 30s with complications.

Glasgow has some of the best HbA1c levels in Scotland. There has been over four years of improvement in the over 15 years olds. There are three clinics a month in Yorkhill, NHS GG&C has made no moves to make this permanent. Young adult diabetes nurses have been funded but it is a struggle. In addition there is the unmet need in the psycho-social area. This is not people with diagnosed needs but about stopping problems before they happen.

In 2015 NHS GG&C publically committed to a similar 0-25 service to Diabetter for Glasgow. The clinical community and parents were very supportive. However there has been no planning. Yorkhill is to be demolished in March 2019, there are no funding models, but it is not about the funding. This is meant to be about trailblazing for the rest of Scotland. It is about breaking down the barriers between children and adult services.

5. Discussion

BW asked for clarification on Yorkhill and the paediatric team: Is there no plan to move the service into the Queen Elizabeth Hospital?

KR replied the preferred option is not to be in the hospital but something close. The reason originally as to why we are in this situation was that there was no

BW came back with what is your ask?

KR said that there needs to be a new hub that's flexible to provide for our Type 1 children and adults.

Brian Kennon (BK), Chair of the Scottish Diabetes Group and NHS GG&C consultant, mentioned that he has been involved since the inception of the plan. The pressure is on NHS GG&C in unplanned and unscheduled care so it means that care for Long Term Conditions suffer.

BW observed that the door is wide open.

KR contextualised that the problems need to be identified and there need to be a commitment from NHS GG&C.

Rupert Pigot (RP) Asked about the size of NHS GG&C and if that would be a factor in translating this to the rest of Scotland?

KR responded that the hub and spoke model is working across most Health Boards. Patients do not like arbitrary Health Board borders. There is enough evidence to show for expertise to be concentrated within large centres, maybe three in Scotland. We have proved that this can work in NHS GG&C.

DS mentioned that in the Scottish Parliament Health and Sport Committee there have been identified issues of "postcode lottery" in accessing care. In addition we are seeing regionalisation, with Health Boards coming together.

Sue Hampson returned to what is the ask? How can patient's campaign and what for?

KR admitted that he was frustrated but saw hope in people like Angela Mitchell (AM) and BW to get Health Boards to be more imaginative. We need to stop talk about panels falling off the Queen Elizabeth Hospital every day and focus on long term health. This is a model for other conditions such as renal transplants. Young people disengage as they feel better but they must look to be more complete. Health Boards need not be afraid of failure. However timing is important and we need to ask more specific questions of NHS GG&C.

DS commented that the committee is there to be a check on the executive. All the parliamentarians on the Health and Sport Committee want to hold the health service to account. It is a extremely large organisation and is a very slow ship to turn around. Sometimes there is need to change.

Linda McGlynn (LM) asked is there are role for Integrated Joint Boards (IJBs) in this hub and spoke model?

KR responded that it hadn't been examined but that did not mean that there is not a role. We need to get the Glasgow house in order and it needs to be seen as not just Glasgow. It is a good place to start testing a new model, it does not have to be all about the location but the idea is to provide a template for the rest of Scotland to take and adapt.

AM asked if the NHS GG&C leadership will be coming to the Health and Sport Committee?

DS replied that NHS GG&C had already appeared and had been a very useful session. The Health and Sport Committee meets every week and there are specific questions for each board that has been organised by the clerks of the committee and following the committee work programme.

BK interjected that it is not just NHS GG&C but how do you challenge current standards in an inclusive and supportive manner? Are there other routes to explore?

BW answered that the Petitions Committee is currently looking at Continuous Glucose Monitoring (CGM). In the first instance a petition on a 0-25 service would be a good avenue to explore. The Petitions Committee has eyes that can put it on other committee's agendas.

DS echoed this as he used to be chair of the petitions committee> in addition there is the idea that the CPG could create a report.

BW commented that it could be pushed for a member's debate to try and bring it to the chamber.

DB reflected that a few months ago he was sitting down and thinking about issues with sad stories and he came to the opinion that with 10% of the NHS budget going on diabetes care and the problem of getting new funding and avenues for clinical trials and that it is interesting what Asencia have been doing to get young people involved, we have a Prime Minister in Westminster who is Type 1, we should push this forward now, we need a full public enquiry on care for Type 1 and Type 2 diabetes. The Dutch solution is welcome and must ask for a public enquiry.

BW responded that our approach in health needs a different perspective. Look at Type 2 diabetes to be disconnected from health. In my view we need to look at a much bigger picture: Health inequality, town planning, access to fast food and alcohol.

DB added that metal health issues are associated with diabetes and can be connected to fluctuating blood glucose levels. 25 years ago he was very depressed as I was on a level of insulin 9 times more than he should have been on. He asked how can we account for this and convince Health Boards that they should try something new?

KR answered that he spent a long time thinking about the cost and there is a need to take a multi agency approach. Glasgow led the world in tackling TB and AIDS. It must encompass education, nutrition and pregnancy – the whole thing at the very least.

Leeanne Nicklas (LN) from NHS Scotland said she supported all that KR had said. There are barriers in funding physical and mental health services.

BK said that we cannot escape the idea that the Dutch model worked as it is insurance based, in England there have been similar that have brought about change. There is a large amount of money spent on diabetes – how do we find out the best way to spend it? We need to understand that cost as insurance companies are not charities, health boards will not take this on board, we need to examine why.

KR replied that there is little waste, better IT could improve this.

SH pointed out that the two individuals leading the Dutch model are very charismatic. Holland is a small country, similar to Scotland. Both of the Dutch remortgaged their houses to set the project up, it was set up as not for profit, shortly after it was started and took off it was underwritten by Medtronic.

LM commented that we had heard the economic benefits for the insurers but has there been any work done on the patient's quality of life?

BW agreed with LM saying that we need to be looking at quality of life and putting that data together. Politicians are not very good at that as we focus on a four year cycle. We need to make a case for long term planning. If you save "x" amount of money, you don't get to see it as it is used in other budgets.

BK said that there is not resistance for using influence about genuine transformational care.

RB explained that in the 1990s mobile scanners were used for eye tests throughout Scotland that saw a uptake in retinopathy screening. It might help to breakdown the idea of a 0-25 service to been seen to stop people disengaging.

RM asked if Yorkhill is closing what will happen?

KR replied that it looks as though there will be another delay.

RM asked if it would be possible for a charity to take this on?

KR replied that NHS GG&C lost £500,000 as the Health Board did not take this on and due to the financial crash planning was stopped.

Craig Cameron asked what priority is given to diabetes?

KR responded that the Health Board could say that diabetes has been given a fair crack of the whip over time. A specialist does the best for their area.

DS commentated that the chief executive of NHS Shetland went to Scottish Government to go for brokerage over on loan staff and high costs. No one senses that any of this is simple.

DS Thanked KR for his presentation.

Mandy Christie asked about prevention of Type 2 diabetes.

DS echoed this.

RP the next meeting will be on 11th December on Diabetes Education.

DS Closed the meeting.