HEALTH AND SPORT COMMITTEE

WHAT SHOULD PRIMARY CARE LOOK LIKE FOR THE NEXT GENERATION?

SUBMISSION FROM DIABETES SCOTLAND

Diabetes Scotland welcomes the Health and Sport Committee inquiry into “What should primary care look like for the next generation”.

Diabetes is one of the most common conditions for seeking a GP or practice nurse consultation. The amount of people with diabetes has increased by nearly 40 per cent over the last ten years. With over 300,000 people with diabetes in Scotland and around 1 million at increased risk of developing Type 2 diabetes this means that one in five people have diabetes or at risk of developing the condition. This increasing prevalence of diabetes puts more and more pressure on all NHS Scotland services but there is a particular pressure on primary care: over the last decade the number of primary care contacts because of diabetes has risen by a quarter to an estimated 800,000 contacts per year.

It is not surprising, therefore, that diabetes costs NHS Scotland around £1 billion each year, of which 80 per cent (£800 million) is spent treating potentially avoidable complications. This cost will increase as more people develop the condition and because diabetes is an innovative field with the technological offering such as insulin pumps, blood glucose monitoring systems, continuous glucose monitoring systems, and the current focus on taking Type 2 diabetes into remission through weight loss. All this is helping people to self-manage their diabetes and people put their Type 2 diabetes into remission. Many of these needs will place additional pressure on primary care which is why there needs to be a strong focus on preventative spending.

1. Considering the Health and Sport Committee’s report on the public panels, what changes are needed to ensure that the primary care is delivered in a way that focuses on the health and public health priorities of local communities.

   • Multi-disciplinary teams to ensure delivery of all nine processes of care and an appointment system that works for patients and primary care
   • Emotional, psychological and mental health supported in primary care
   • Primary Care to proactively have conversations relating to obesity & awareness of type two diabetes risk factors
   • A move towards remission as the primary goal following diagnosis of Type 2

Multi-disciplinary teams & appointment system

Currently people with diabetes receive their checks through a disparate amount of services and locations and we know from what people tell us that there are a high rate of cancellations due to lack of primary care resource. Only 41 per cent of the 267,000 people with Type 2 diabetes are receiving all their nine processes of care as recommended by NICE and best practice in the SIGN guidelines. In addition there are nearly 9,000 people with Type 2 diabetes who have completely disengaged from their diabetes care and are not receiving any health checks.
The Scottish Government Primary Care Outcomes Framework details that “Primary care provides a model of care and support that builds on people’s expertise in living with their conditions and the resources available to support them in their own communities”. Looking at the annual survey data, Diabetes UK surveys and feedback from Diabetes Scotland engagement events, people living with diabetes tell us this is not happening. From what we are hearing it is clear that there are problems with the appointment processes and cancellations due to lack of resource in primary care.

There is scope to consolidate the appointments process and make for a more efficient service that benefits the patients and the healthcare professionals through a hub and spoke model. This has the potential to bring together services and we must ensure that there are multi-disciplinary teams spanning strands of primary care including podiatrists, ophthalmology services and primary care nurses.

Emotional, psychological and mental health supported in primary care

The Scottish Government Mental Health Strategy 2017 - 2027 identifies emotional and physical health are crucially linked and yet people are not being given the opportunity to access these services. A recent survey by Diabetes UK found that three quarters of people living with diabetes who wanted specialist mental health support couldn’t get it and 30% of health care professionals agreed they weren’t doing enough. We would like to see the emotional and psychological impact of diabetes to be recognised in all primary care, through systematic care, support planning and better conversations.

Prevention and remission of type two

Recent studies have shown that GPs and primary care nurses are reluctant to raise the topic of weight in general practice. This is down to a variety of factors such as: uncertainty about obesity, concerns about alienating patients and feeling unable to raise the topic within the constraints of a 10 min consultation. Primary care professionals need to have the time and tools with which to engage and support people who are at high risk of developing Type 2 diabetes. The Diabetes UK Know Your Risk tool is an effective tool which can support positive conversations about the main risk factors.

The A Healthier Future: type 2 Diabetes prevention, early detection and intervention: framework has a focus on primary care and sees working with GP clusters as a key platform for the prevention and early intervention of Type 2 diabetes, envisioning all forms of primary care to play significant role in identifying at risk individuals. However there is scope to expand the role of community pharmacists particularly in respects to identification and referral of high risk patients.

The latest findings of the Diabetes Remission Clinical Trial (DiRECT) have revealed that more than a third of people with Type 2 diabetes who took part in the weight management programme, delivered in primary care, are in remission two years later. Remission is closely linked to weight loss: 64 per cent of participants who lost more than 10 kilos were in remission at two years. As well as resulting in remission for some people, there appear to be additional benefits to taking part in a weight management programme overall. These include a reported better quality of life, improved blood glucose levels and a reduced need for diabetes medications. The Healthier Future type two framework will be scaling up the weight management offering within health boards but the response from primary care on
engagement with the framework has been disappointing. There is a clear evidence base from the DiRECT study and primary care must be an integral part of the delivery and care for people trying to take their Type 2 diabetes into remission with a move towards remission as the primary goal following diagnosis of Type 2.

2. What are the barriers to delivering a sustainable primary care system in both urban and rural areas?
   - The current infrastructure is a barrier for Primary care to deliver consistently for all of Scotland
   - Health and Social Care Partnerships to have diabetes in their strategic plans
   - Primary care to enable more people use MyDiabetesMyWay & emerging technologies

Primary Care Infrastructure

Population density is varied across Scotland and ranges from 8 persons per square kilometre in Highland Council area to 3,298 persons per square kilometre in Glasgow City Council area. NHS Highland has the land mass the same size as Belgium. It is a very rural service and can be challenging to access. The demography means that 45 per cent are over 55 years old in rural areas and this has implication for the rates of Type 2 diabetes. The service has adapted and developed a video conference clinic in NHS Highland however there have been issues of consistency, for instance it has not worked in Thurso but the service in Skye was excellent.

It's essential that primary care has the infrastructure to enable healthcare professionals to deliver consistent care for people with diabetes particularly in regard to accessibility. Currently there is inconsistent care across Scotland. The latest figures available show that the amount of people with Type 2 diabetes receiving all their care processes vary from 58 per cent down to 35 per cent across health boards. This highlights that people across Scotland with Type 2 diabetes are not getting the health checks and level of care through primary care that they should be receiving. This increases risk of complications such as kidney disease, amputation and blindness which will have a significant cost to the NHS in the longer term. Barriers to this can be addressed by increased use of IT systems and hub and spoke models that can bring together services and be flexible so that more people will be getting their checks and this will help healthcare professionals.

Health and Social Care Partnerships

Diabetes Scotland believes that the understanding and approach to diabetes taken by Integration Authorities has been fragmented and inconsistent. Diabetes Scotland carried out an analysis of Integration Authorities first strategic plans in 2016. Only seven out of the 31 referenced diabetes and there was nothing about prevention in any of the strategic plans. In addition there was no consistency in the provision and access to weight management. 2017 has seen some improvements in focus and creation of models of primary and secondary care working together.

There are good models of work being carried out at Community Health and Care Partnerships (CHCPs) showing both primary and secondary healthcare involved in prevention. In Midlothian Diabetes is a key driver and in Argyll and Bute exploratory work has been carried out with a working group created to bring the Integration Authority and the Managed Clinical Network (MCN) together. However this is more the exception than the rule. IJB’s need to include in their plans prevention and the need for technology-enabled diabetes care – in their
e-health plans, their workforce plans, their plans for the implementation of the Modern Outpatient agenda and in longer-term financial plans, not including this is missing a key opportunity to look at care strategically.

MyDiabetesMyWay

Scotland has world leading data on people with diabetes in SCI Diabetes. My Diabetes My Way (MDMW) is NHS Scotland’s information portal for diabetes that gives patients access to their records, test results, clinical letters and treatment plans. It is a valuable resource in helping people self-manage their condition and can help with the consistency of care across Scotland. As of 2017 there were over 16,500 people actively using MDMW but out of a total cohort of over 300,000, this is not enough. The eHealth Strategy 2014 – 2017 says patients will be able to use a patient portal to access their own Personal Health Record and make their own contributions to the record by 2020. Recent analyses have shown that results such as HbA1c, weight, and blood pressure improve following use of MDMW. Patients also report improved knowledge of diabetes and motivation to manage it effectively. However, integration of MDMW with primary, community and acute hospital records is key. There is a need to improve the uptake of MDMW; ensuring primary care support and enable people use this service is key.

In addition, we need to see strategic investment in staff training for emerging technologies to ensure they can support people living with the condition. Different Health Boards can have different responses and timescales to emerging technology, for instance Flash Glucose Monitoring was approved by the Scottish Health Technologies Group and used extensively in urban boards such as Lothian and yet uptake in the Highlands has been far behind. The 2014 Diabetes Improvement Plan sets out no targets for the development of relevant staffing or skills in Scotland and we think that MCNs should have specific primary care training programmes.

3. **How can the effectiveness of multi-disciplinary teams and GP cluster working be monitored and evaluated in terms of outcomes, prevention and health inequalities?**

   - Primary care engagement across all Diabetes Managed Clinical Networks
   - Regular, clear and (publicly) published reporting
   - Address the drop in people taking and recoding of annual screening services

The Scottish Diabetes Improvement Plan stipulated there should be quarterly reporting on 12 measures and an annual report prepared by the Health Board Diabetes MCN. However MCN representation is mostly made up of secondary care members and this can mean a lack of primary care engagement with reporting. Diabetes Scotland is concerned that primary care is not engaging with the Diabetes Improvement Plan.

Evidence is not always in the public domain and is hard to access. As previously mentioned the MCN quarterly reports on the Diabetes Improvement Plan are not publically available. These reports should be published so that we can understand and evaluate diabetes care. NHS Scotland produces annually the Scottish Diabetes Survey which gives a snap shot of the entire population with diabetes, this includes the amount of people with diabetes getting their BMI recorded and the breakdown between underweight and obese. However this is quantitative data and does not give the qualitative understanding of underlying reasons and does not give a clear breakdown across the NHS.
Since Scottish Government dismantled the Quality and Outcomes Framework (QOF) and replaced this with the pay-for-performance scheme there has been a drop in people taking or recoding of nine care processes, especially for people living with Type 2 diabetes. The 2018 General Medical Services Contract in Scotland details that the guiding principles for primary care are:

• Contact – accessible care for individuals and communities
• Comprehensiveness – holistic care of people - physical and mental health
• Continuity – long term continuity of care enabling an effective therapeutic relationship
• Co-ordination – overseeing care from a range of service providers

These principles are not being achieved in respect for people living with diabetes.

About Diabetes Scotland
Our vision is of a world where diabetes can do no harm. As Scotland’s leading diabetes charity, our mission is that by bringing people together to work in partnership, we will support those living with diabetes, prevent Type 2 diabetes, make research breakthroughs, and ultimately find a cure.

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i SPICe Briefing Primary Care in Scotland
https://www.parliament.scot/S5_HealthandSportCommittee/General%20Documents/SB_19_32_Primary_Care_in_Scotland.pdf

ii Scottish Government Diabetes Improvement Plan

iii SDS 2017

iv ibid

v Raising the topic of weight in general practice: perspectives of GPs and primary care nurses, BMJ 2015
https://bmjopen.bmj.com/content/5/8/e008546