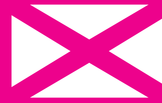

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# Evaluation of the Implementation of the Framework for the Prevention, Early Detection and Intervention of Type 2 Diabetes

HEALTH AND SOCIAL CARE

# Evaluation of the Implementation of the Framework for the Prevention, Early Detection and Intervention of Type 2 Diabetes

Final Report

February 2022

Blake Stevenson Ltd

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# List of acronyms

**BMI –** Body Mass Index

**BGC** - Blood Glucose Control

**CPP –** Community Planning Partnership

**DIP –** Diabetes Improvement Plan

**DPP –** Diabetes Prevention Programme

**EDRIS –** Electronic Data Research and Innovation Service

**FFiT –** Football Fans in Training

**GDM –** Gestational diabetes mellitus

**HbA1c –** Glycated haemoglobin

**IFHG –** Impaired Fasting Hyperglycaemia

**IGT –** Impaired Glucose Tolerance

**IJB –** Integrated Joint Boards

**IVF –** In Vitro Fertilisation

**MCN –** Managed Clinical Networks

**NES –** NHS Education for Scotland

**OGTT** – Oral Glucose Tolerance Test

**PCOS –** Polycystic ovary syndrome

**PBPP –** Public Benefit and Privacy Panel

**SCI Diabetes –** Scottish Care Information – Diabetes Collaboration

**SDG –** Scottish Diabetes Group

**TDR –** Total Diet Replacement

# Executive Summary

The Scottish Diabetes Survey 2020, shows that, in Scotland, 5.8% of the population (317,128) diagnosed with diabetes were recorded on local diabetes registers at the end of 2019 of which 87.7% (278,239) had type 2 diabetes.

The incidence and prevalence of all types of diabetes has been steadily growing in Scotland, as in many other countries, in part due to better care and better detection. For type 2 diabetes, also in part due to unhealthy diet, low levels of physical activity and an increase in levels of obesity. Excess weight is the most significant modifiable risk factor for type 2 diabetes.

## The Framework for the Prevention, Early Detection and Intervention of Type 2 Diabetes

The evidence about preventing or delaying the diagnosis of type 2 diabetes (or promoting remission) through targeted weight management interventions[1], combined with the cost to the NHS for the treatment of people with type 2 diabetes, helped to inform the decision to create the framework.

The Framework for the Prevention, Early Detection and Intervention of Type 2 Diabetes (referred to throughout this report as "the Framework") builds on the prevention work within the 2014 Diabetes Improvement Plan[2] (DIP). It is designed to provide guidance to NHS boards and other delivery partners on the implementation of a specific weight management pathway for those at risk or those diagnosed with type 2 diabetes.

## Early adopter sites

Three early adopter areas were approached to implement the framework ahead of the national rollout. These were, NHS Ayrshire & Arran, NHS Lothian, NHS Fife and NHS Borders working in partnership as the East Region, and NHS Tayside. They agreed, with additional support from Scottish Government funding and professional advisors[3], to begin work ahead of other board areas to redesign and deliver services in line with the Framework. Any learning from these would then be shared with other boards to inform the general roll out of the Framework.

The Framework identified the actions that boards and others needed to take to develop an integrated system. This included: the scoping of services delivery; agreeing local approaches to co-production and service re-design; agreeing the delivery of programmes under each tier and funding allocation; and how data and evidence would be used to identify, target and reduce local health inequalities. It

[1] Lean MEJ, Leslie WS, Barnes AC, et al. (2017) Primary care-led weight management for remission of type 2 diabetes (DiRECT): an open label, cluster randomised trial. Lancet. Dec 4. pii: S0140-6736(17)33102-1. doi: 10.1016/S0140-6736(17)33102-1

[2] Scottish Government (2014) Diabetes Improvement Plan

[3] These are registered dietitians seconded to Scottish Government to support Health Boards and lead the implementation of the Framework across Scotland

also recommended the adoption of a tiered approach to weight management for those at risk of and with type 2 diabetes.

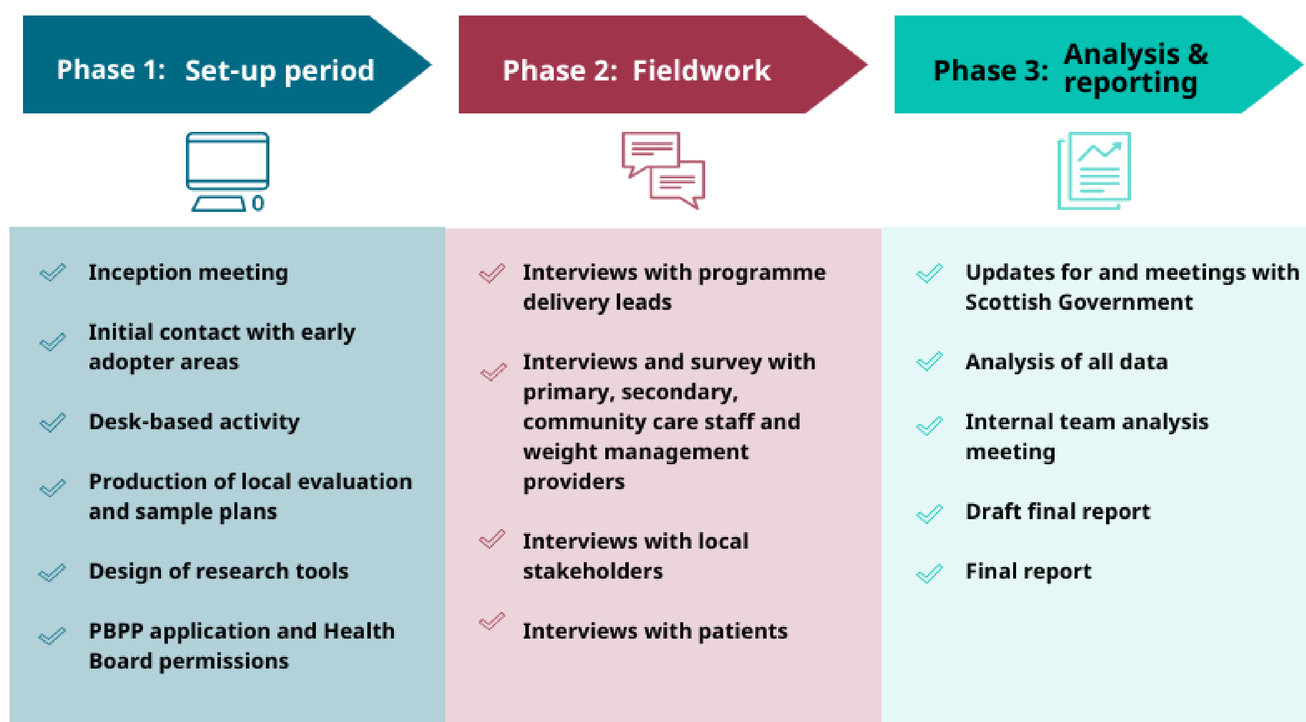
## Evaluation

In November 2019, the Scottish Government commissioned Blake Stevenson to carry out an independent qualitative process evaluation of the adoption and implementation of the Framework in the three early adopter areas to contribute to the first stage of the evaluation of the Framework, in parallel with the national monitoring of patient outcomes. The work aimed to:

- assess whether the Framework was delivered as intended
- identify effective strategies for reaching target groups
- identify potential barriers to implementation as well as enablers of success
- identify the impacts to implementation caused by COVID-19 and the steps taken to adapt services.

The methodology used to evaluate the early adopter sites is captured in the diagram below.

**Figure E1: Approach to the evaluation**




This process evaluation of the implementation in the early adopter areas was intended to inform the future rollout of the Framework. However, delays associated with the requirement for Public Benefit and Privacy Panel (PBPP) approval and the COVID-19 pandemic meant that information gathering did not start until January 2021, more than a year after the evaluation was commissioned. During this time, the Framework has been rolled out across Scotland. This report has been written in year four (2021/22) and to date all (14) territorial NHS boards, and one special NHS

board have implemented the Framework. Although delayed, learning presented within this report provides valuable insights for those areas in the process of implementing this Framework, and more broadly for the roll out of other healthcare frameworks or policy that need to be implemented at a health board or partnership level. It is based on a combined total of 83 participants across the three areas, 45 health care professionals and 16 patients via interview and 22 health professional survey respondents.

## Findings - delivery

The Framework recommended two specific approaches to interventions: one was to improve structured education for those with or at risk of developing type 2 diabetes or pre-diabetes; and the adoption of a tiered approach to weight management for those at risk of or with type 2 diabetes or pre-diabetes.The early adopter areas were expected to meet the Standards for the delivery of tier 2 and tier 3 weight management services for adults in Scotland (healthscotland.scot) for weight management services so that there was some consistency. The Framework allowed areas to use outputs from local needs assessment and existing service provision to design the most appropriate services for their population.  This meant that there was variation in the implementation between areas.

Although different delivery approaches were implemented across the early adopter areas, each took steps to map services and pathways to identify gaps in provision and where further development in services was needed. Local factors played a role in how services were designed or expanded - in Ayrshire & Arran the existing midwifery service informed the delivery of gestational diabetes mellitus (GDM) services, the three NHS boards collaborative approach shaped East Region's design and a digital first approach in Tayside resulted in the Oviva suite of programmes used in that area.

The funding that accompanied the implementation of the Framework in the early adopter areas was used to fund new roles and invest in pilot programmes and tools that could be rolled out across the areas.  The diagram below summarises the key programmes introduced or expanded across each area, as a result of the Framework.

**Figure E2: Summary of key programmes introduced or enhanced across each area as a result of the Framework**

| Summary | Ayrshire & Arran | Tayside | East Region |
|---|---|---|---|
| **Level 2 Early detection and early intervention** | **Let's Prevent Diabetes** introduced, (including post-partum intervention for reducing risk in women with history of GDM)<br><br>Plans underway to pilot and expand **LEAN** beyond just East Ayrshire | Introduction of new diagnostic pathway using HbA1c (Feb 2021)<br><br>Introduction of **Oviva Prevent** pre-diabetes education programme | Planned introduction of **Let's Prevent Diabetes** across all three boards<br><br>Expansion of dietitian-led gestational diabetes post-partum treatment pathway linking into **Let's Prevent** |
| **Level 2 Weight management programmes** | **Weigh to Go** introduced | Plans in progress to introduce **Second Nature, Slimming World** and **Football Fans in Training** tier 2 weight management services | **Get Moving with Counterweight** tier 2 weight management programmes enhanced or introduced so now in all three boards<br><br>Specialist dietetic-led weight management service enhanced with additional dietetic support and leadership |
| **Level 3 Targeted intervention GDM** | Diabetes-specialist midwife and HCSW-led advice and treatment service expanded and new midwife IT platform introduced<br><br>GDM BMI threshold lowered from 35 to 30kg/m² | New midwife post developed; new GDM pathway; and new midwife IT platform introduced<br><br>**GDM Health** introduced<br><br>GDM BMI threshold lowered from 35 to 30 kg/m² | Introduction of specialist digital / virtual dietetic-led education and treatment sessions for those diagnosed with GDM<br><br>Post-partum pathway links into **Let's Prevent** and tier 2 and 3 weight management |
| **Level 3 Targeted intervention High risk** | **Counterweight Plus** introduced for type 2 diabetes remission | **Counterweight Plus** piloted Jan 2021 for type 2 diabetes remission<br><br>Expansion of staff and resourcing for general weight management services<br><br>Plans to introduce **Oviva Weigh to Wellness** | **Counterweight Plus** extended across the region for type 2 diabetes remission<br><br>Enhanced psychology service at tier 3 weight management and for remission. Increase in service leadership and dietetic resource for tier 2 and 3 weight management |

The early adopters adapted their plans to overcome the challenges presented by COVID-19, some producing virtual versions of their programmes and others fast tracking planned digitalisation. This early introduction or adaptation enabled the continuation of some services. It also meant that face to face individual and group

work moved to telephone or online platforms and, although staff adapted quickly to use the new technology, the logistics of remote delivery, IT infrastructure and information governance systems often presented problems.

## Findings - Perceptions and experiences of the services

Although not a representative sample, the perspectives of patients who accessed the programmes provided some insights to patient experiences. They described the key motivations for joining the programme: a diagnosis of pre-diabetes, and referral or recommendation by a professional; the concerns of the impact of COVID-19; pregnancy and an overall desire to improve their health.

The patients also identified various factors that deterred their take up or completion of programmes, for example work and care commitments that reduced the time available to attend services, their established eating habits and discomfort with group settings.

Overall, the patients interviewed were positive about their experience and the health changes that they made by participating in the programmes and receiving tailored support and advice. This resulted in weight loss and behaviour change so that they made more informed choices about their diet and physical activity.

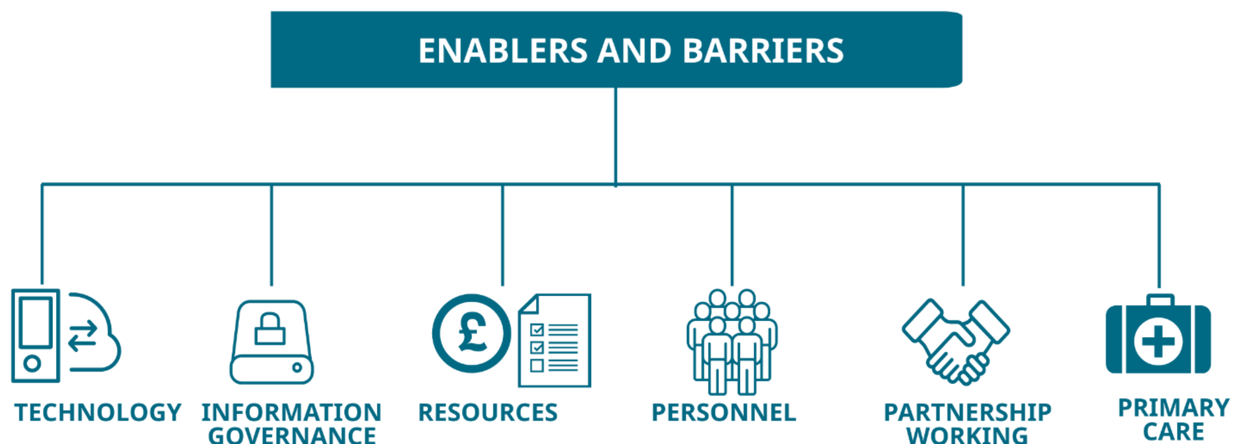
These experiences, and the experiences of those delivering services, provided some key learning about the weight management programmes. These included:

- consideration of a wider range of evidence-based programmes for managing type 2 diabetes to meet varying needs and preferences
- recognising the established culture of unhealthy eating and its impact on eating habits
- the valuable role of psychological support, both for patients and staff in the programmes and ensuring the appropriate balance between psychology and dietitians
- the importance and need for more general support groups to increase motivation to continue with a programme.

## Enablers and barriers to Framework implementation

Early adopters implemented the Framework in ways that best met the needs and existing infrastructure of their areas. Whilst this produced similar and differing programmes, there was commonality of enablers and barriers across all the areas. The key factors that influenced implementation are summarised in the diagram below.

**Figure E.3 Enablers and barriers to implementation**




## Technology

Technology was an important element in the implementation of the Framework in the early adopter areas. All three areas used digital technology to enhance service delivery, especially once the pandemic hit. Some of these initiatives, such as the Oviva programmes in Tayside, were already at the planning stage before COVID-19 but in other areas the pandemic accelerated their introduction.

## Information governance

Information governance acted as a barrier. Although one area was able to obtain approval relatively quickly for some of its programmes, others experienced extensive delays. Such delays to approval to use IT packages or to establish information sharing agreements with weight management providers meant having to find workarounds in the interim period, like staff delivering the equipment to patients.

## Resources

The funding, documentation and the role of the professional advisors were valuable resources that supported the early adopter areas to implement the Framework. The main challenge was the allocation of funding on a year-on-year basis and its impact on retaining staff and long term planning.

## Personnel

Key personnel involved in the Framework's implementation played pivotal roles in service development or motivation and encouragement of partners in each area and were key enablers. However, the challenge of staff turnover experienced by all areas also impacted on implementation and delivery of services. This was caused in part by redeployments during COVID-19 but also when posts were for a fixed term.

## Partnership working

The design and delivery of the Framework required formalised structures and processes to plan and deliver the programmes from across a multi-disciplinary team and across primary and secondary care. Navigating these relationships and

strengthening partnership working could be a challenge and this was amplified when working across more than one local authority area, health and social care partnership or NHS board. Although challenging, the implementation of the Framework created opportunities to build and strengthen partnership working, increase interactions and collaboration across different teams and disciplines and share learning across areas and regions.

### Primary care

The role of primary care professionals emerged as a key determinant of success for effective referral pathways. As part of implementation of the Framework it was important to build the relationships with primary care and in each area various methods were used to do this. A need was recognised to continue to communicate with GPs to clarify referral pathways, provide feeback on patients referred and to help maintain the profile of type 2 diabetes programmes. Some felt that additional levers were needed to encourage this engagement and maintain GP involvement in order to drive forward the changes associated with the Framework's delivery.

## Conclusions and considerations

The learning from the implementation of the Framework in the early adopter areas has provided insights to the design and delivery of weight management services, and some wider considerations for implementing the Framework and introducing change on this scale across primary and secondary care. Key areas that would improve implementation or increase consistency across services related to:

- a wider range of programme options – the 2019 weight management standards and gap analysis tool were viewed as helpful, but more choice of evidence-based programmes for managing type 2 diabetes was requested. Guidance was also wanted on the level and type of evidence required to provide robust information about the outcomes for individuals on weight management programmes
- financial support - the resources and financial support enabled the areas to redesign services and work with colleagues to develop programmes. However, the short term nature of the funding restricted future planning and recruitment and retention of staff. A longer financial commitment would provide the security to embed changes and maintain staffing levels
- partnership working - the early adopter areas had clear guidance as to the steps needed to develop an integrated system. Completing these steps needs to be robust with meaningful co-production and service redesign with the key stakeholders and deliverers. This was the most effective way to ensure a shared vision and common understanding of the new pathways and service
- systems – all areas experienced challenges in relation to information governance and sharing information with weight management providers when introducing or adapting services. A better understanding of what would be needed and the time required to develop appropriate agreements would have reduced some of the delays created by the information governance

requirements and there was a plea for a national solution to the information governance challenges

- building relationships with primary care - the importance of effective working across primary and secondary care was highlighted in the redesign of services and pathways and the continued strengthening of relationships and understanding across teams. The key role of GPs and Practice staff in effective delivery of services emphasised the need to engage primary care and ensure understanding and buy-in to the new pathway and their role within it.

## A common approach across Scotland

The early adopter areas welcomed the opportunity to vary their approach to implementation but also valued the Framework and national standards for promoting consistency between and across areas. However, there were different views about what should have been delivered and how much influence the Scottish Government should have had over implementation.

Some wanted more autonomy to choose programmes and approaches, others were frustrated that areas appeared to be doing things differently when a common approach could have generated more learning, led to national approaches to procurement and avoided repetition. There were particular frustrations about the IT platforms that could be used in one NHS board but not another and more clarity and consistency about IT platforms across Scotland was requested by some.

The aspiration in Scotland to promote and embed best practice in healthcare through a Once for Scotland approach is relevant to these discussions. The tension between local and regional approaches that reflect the context and population needs and a national approach that supports consistency was evident. There was no consensus.

The Modernising Patient Pathways programme aims to identify best practice, understand and, where appropriate, address variation, collectively review and optimise current service pathways and associated primary/secondary care communication across key clinical areas. Although type 2 diabetes is not a speciality network for this programme, the work of the early adopter areas and the further rollout of the Framework provides opportunities to draw together collective experiences and knowledge and highlight where key challenge areas still exist.

# 1. Introduction and context

This report presents the findings from a qualitative process evaluation of the implementation of the framework for the prevention, early detection, and early intervention of type 2 diabetes in three early adopter areas.

## 1.1 Introduction

The Scottish Diabetes Survey[4] 2020, shows that, in Scotland, 317,128 people diagnosed with diabetes were recorded on local diabetes registers at the end of 2020. This represents 5.8% of the population. When considering the type of diabetes:

- 10.7% (34,087) of all registered people were recorded as having type 1 diabetes
- 87.7% (278,239) of all people registered with diabetes were recorded as having type 2 diabetes
- 1.5% (4,802) of all people registered with diabetes were recorded as having other types of diabetes, for example pre-diabetes, gestational diabetes.

The incidence and prevalence of all types of diabetes has been steadily growing in Scotland, as in many other countries, in part due to better care and better detection. For type 2 diabetes, this has also been in part due to unhealthy diet, low levels of physical activity and an increase in levels of obesity. Excess weight is a modifiable risk factor for type 2 diabetes.

The evidence about preventing or delaying the diagnosis of type 2 diabetes (or promoting remission) through targeted weight management interventions[5], and the cost to the NHS budget for the treatment of people with type 2 diabetes, helped to inform the decision and policy to address the avoidable risks associated with weight and type 2 diabetes.

## 1.2 A Healthier Future – Framework for the Prevention, Early Detection and Early Intervention of type 2 diabetes

A Healthier Future: type 2 Diabetes prevention, early detection and intervention: framework - gov.scot (www.gov.scot) (known throughout this report as the "Framework") was produced in collaboration with specialists in diabetes, dietetics, maternal health, public health, primary care and obesity. It builds on the prevention work within the Diabetes Improvement Plan[6] (DIP) and is designed to provide guidance to Integration Joint Boards (IJBs), NHS boards and Community Planning Partners (CPPs), and other delivery partners on the implementation of a specific

[4] The Scottish Diabetes Survey 2020 collates information submitted by all 14 NHS boards

[5] Lean MEJ, Leslie WS, Barnes AC, et al. (2017) Primary care-led weight management for remission of type 2 diabetes (DiRECT): an open label, cluster randomised trial. Lancet. Dec 4. pii: S0140-6736(17)33102-1. doi: 10.1016/S0140-6736(17)33102-1

[6] Scottish Government (2014) Diabetes Improvement Plan

weight management pathway for those at risk or those diagnosed with type 2 diabetes.

The Framework sets out the pathway, which sits within wider national policy, 'A Healthier Future – Scotland's Diet and Healthy Weight Delivery Plan (2018)' aimed at tackling high levels of overweight and obesity. The Framework details:

- the approach to prevention, early detection, and early intervention for type 2 diabetes (action to reduce health inequalities, collective leadership and partnership, co-production, person-centred approach and value-based care and being sensitive to stigma and discrimination)
- the actions that would be taken at a national level in terms of the awareness campaign, targeted core messages, and the resources that would be developed to ensure consistency in weight management and lifestyle interventions
- the actions at a local level to promote understanding of the risk levels amongst individuals, the development of pathways of care, psychological support, and a comprehensive tiered approach to weight management programmes.

## Implementation of the Framework

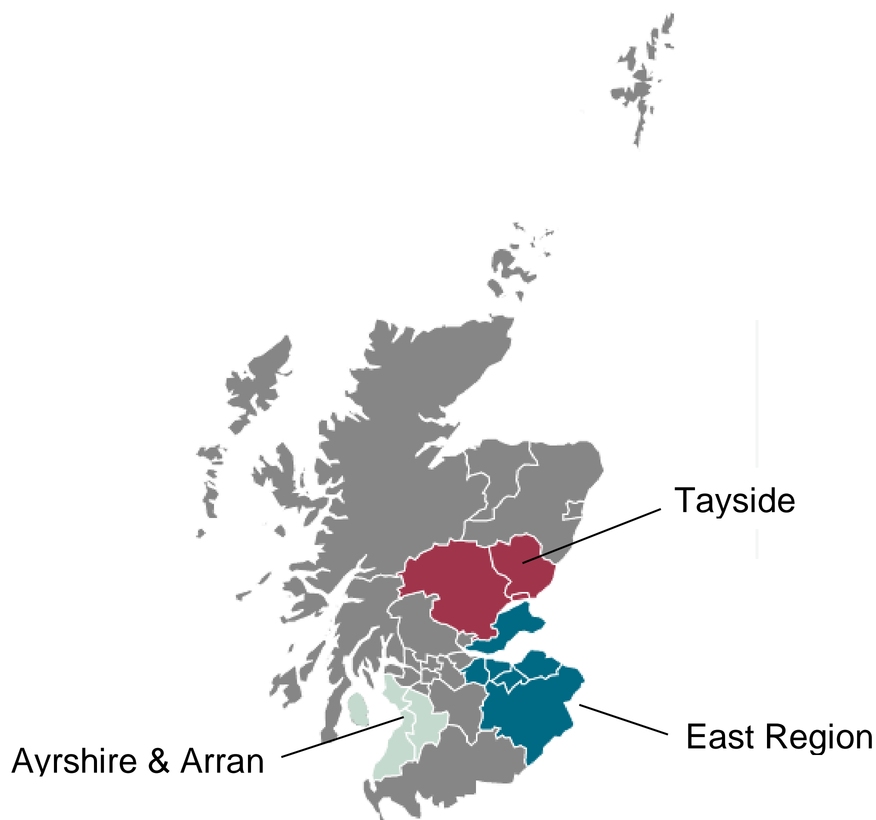
For the first year of implementation, three early adopter areas were approached and supported by a professional advisor - registered dietitians seconded to Scottish Government to support NHS boards and lead the implementation of the Framework. This included building the necessary strategic and operational partnerships and service re-design. Given the ambitious overhaul of services recommended by the Framework, a co-production approach to implementation was taken in the first year, creating opportunities for early adopter health boards to identify and tackle practical and systemic barriers.The intention was that the learning from the early adopter areas during their first year of implementation would be shared with the remaining IJBs and NHS boards throughout the year to help inform the wider roll-out.

The roll-out to other areas was to be staggered over five years in order to facilitate effective implementation and create opportunities for improvement.

## Early adopter areas

The three early adopter areas were NHS Ayrshire & Arran, NHS Tayside, and the East Region (a partnership between NHS Lothian, NHS Fife and NHS Borders). They agreed, with additional support from Scottish Government funding and the professional advisors, to begin work to redesign and deliver services in line with the Framework. The early adopters were selected according to their readiness to re-design and deliver services in line with the national guidance and to represent a broad selection of population demographics and geography. More detail on early adopter sites is presented in Chapter 3.

**Figure 1.1 Map of early adopter areas**




## Monitoring the Framework

An Evaluation Advisory Group (EAG) was convened to co-produce a monitoring and evaluation framework in collaboration with the early adopter areas. Short, medium and long-term outcomes within a logic model were agreed to help understand the impact of the implementation of the Framework. These helped to identify a series of measurable indicators of success and appropriate data sources. As part of the workshops, the EAG also identified a set of research questions, detailed in appendix 1.

The evaluation was to take place in two stages. As part of the first stage, a qualitative process evaluation was to be carried out after the first 12 months post-implementation (Sep 2018 to Sep 2019). This aimed to identify barriers and enablers in the implementation of the Framework in early adopter areas. It was to run in parallel with, and complement, the development of national monitoring of patient outcomes, the core dataset.

The second stage will be a light-touch outcome evaluation to be carried out over a five-year period, post-implementation, in order to establish whether the Framework is achieving its aim of improving population health by reducing the incidence of type 2 diabetes associated with overweight and obesity.

## 1.3 Purpose of this report

In November 2019, the Scottish Government commissioned Blake Stevenson to carry out an independent qualitative process evaluation of the adoption and implementation of the type 2 diabetes prevention framework in the three early adopter areas. This was to contribute to the first part of the evaluation work alongside the national monitoring of patient outcomes through the core dataset.

Delays associated with the requirement for Public Benefit and Privacy Panel (PBPP) approval and the COVID-19 pandemic meant that information gathering started in January 2021, more than a year after the evaluation was commissioned. During this time the Framework has been rolled out to more areas. This report has been written in year four (2021/22) and to date 14 territorial NHS boards and one special NHS board have implemented the Framework. Although delayed, learning presented within this report provides valuable insights for those areas in the process of implementing the Framework, and more broadly for the roll out of other healthcare frameworks or policy that need to be implemented at a health board or partnership level.

# 2. Evaluation approach

The aim of the evaluation was to offer the Scottish Government and its delivery partners an in-depth understanding of the Framework's implementation in the first year. In particular, the work aimed to:

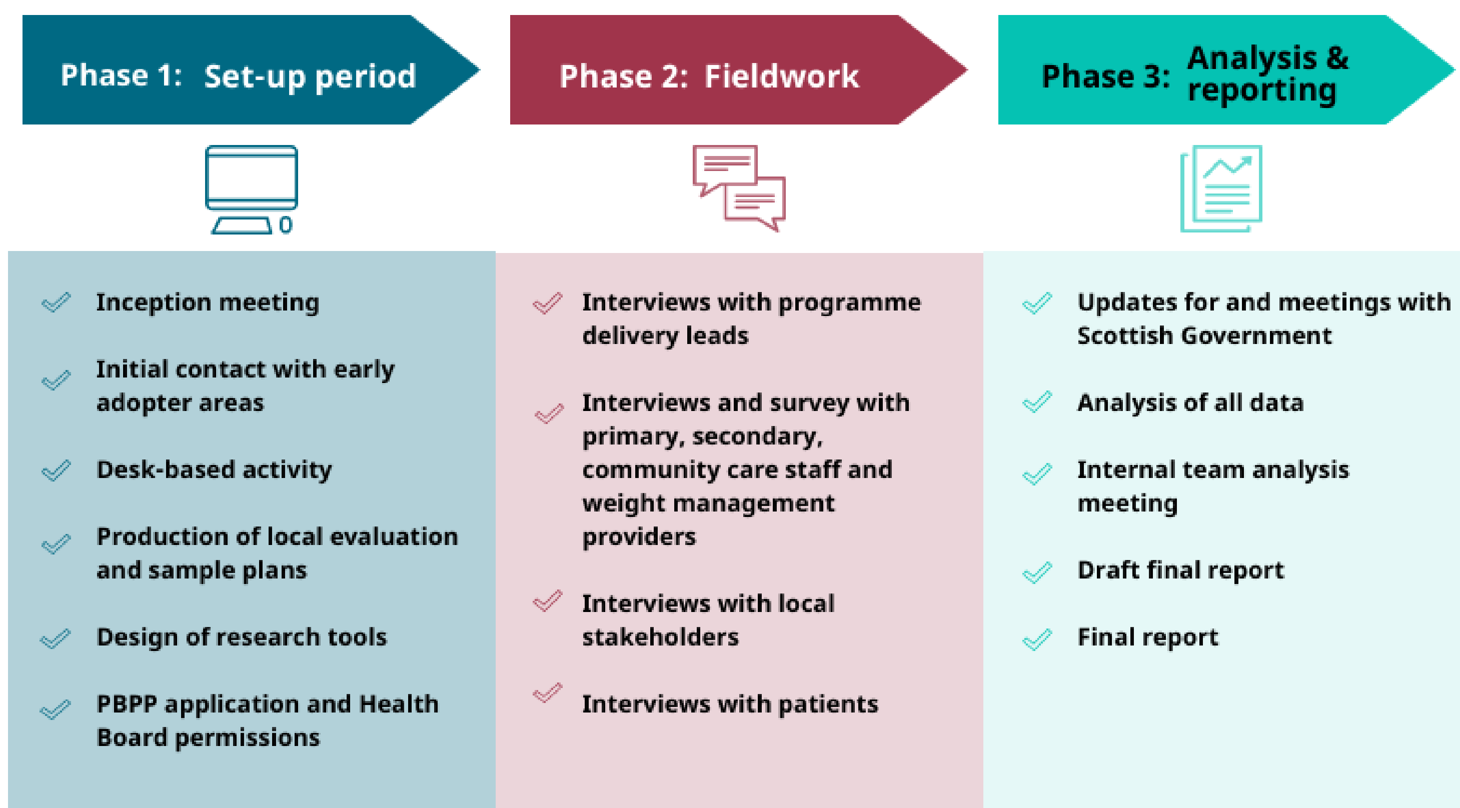
- assess whether the Framework was delivered as intended
- identify effective strategies for reaching target groups
- identify potential barriers to implementation as well as enablers of success.

An additional aim was included as a result of the COVID-19 pandemic:

- identify the impacts to implementation caused by COVID-19 and the steps taken to adapt services.

The researchers were also invited to consider the detailed questions developed by the EAG (see appendix 1). The approach to undertaking this evaluation is described in this chapter and summarised in the diagram below.

**Figure 2.1 Methodology**



## 2.1 Phase 1: Set-up period

The first phase involved initial contact, meetings and discussions with local leads in each early adopter area to gather details of the plans for the implementation of the Framework and progress so far.

To prepare for the design of the evaluation plans, background documentation was reviewed to provide details of progress and plans in each of the three areas. The evaluation and respondent sampling plans were agreed with each area setting out the type and number of interviewees that would be engaged in the evaluation. Research tools, such as surveys and interview schedules for various stakeholders were produced alongside privacy notices.

Before the fieldwork could begin, approval from the Public Benefit and Privacy Panel (PBPP) had to be obtained. An application was submitted in December 2019 with final approval only received in late November 2020. PBPP approval came with stipulations on the methodology in terms of recruitment of participants, the questions that were to be asked and the data that could be collected. Following subsequent approval from local NHS board research and information governance teams, fieldwork commenced in January 2021.

### Impact of the COVID-19 pandemic on the evaluation

As a result of COVID-19, fieldwork for non-essential research was paused. In addition,there were significant personnel changes in each of the early adopter areas as staff were re-deployed and responsibilities for certain roles changed, with some key staff moving to other organisations. Often, it was not possible to interview these people before they left their role.

The current study was not designed to be a comprehensive service audit or service mapping exercise. The information gathered about the services delivered or planned within a given adopter area was dependent on the role and knowledge of the individual/s interviewed for that area. Some staff were new in post when interviewed and so were not necessarily able to provide comprehensive information about activities delivered. Therefore, while the data gathered provides a sound overview of changes brought about by the Framework, it it is not intended to provide full details of all weight management services and programmes in all adopter areas.

## 2.2 Phase 2: Fieldwork

The fieldwork included interviews with patients; health care staff (in primary, secondary and community settings) and weight management providers; programme delivery leads and other local stakeholders who supported delivery. To improve access to staff working on the frontline, who may have found it difficult to make time for an interview, an online survey was also included. This was aimed at primary care staff and weight management providers involved in the delivery of weight management programmes.

A total of 83 individuals contributed their views to the evaluation.

**Table 2.1: Evaluation participants**

| Area | Patients | Health care staff & weight management providers (interviews) | Health care staff & weight management providers (survey) | Programme delivery leads | Local stakeholders |
|---|---|---|---|---|---|
| Ayrshire & Arran | 7 | 14 | 12 | 2 | 1 |
| East Region | 3 | 12 | 6 | 4 | 1 |
| Tayside | 6 | 4 | 4 | 3 | 4 |
| **Total** | **16** | **30** | **22** | **9** | **6** |

As a result of COVID-19 restrictions, all interviews took place remotely via telephone or Microsoft Teams.

### Programme delivery leads

Nine programme delivery leads across the three early adopter areas were interviewed. These included programme managers/leads, project managers/leads and clinical leads. Discussions covered key areas about delivery and implementation of the Framework.

### Healthcare staff and weight management providers

30 staff working in primary, secondary or community care or weight management providers were inteviewed. In line with the PBPP requirements, local leads identified the interviewees and sent an invitation to take part along with information about the evaluation. Through these interviews, issues were explored around the implementation of the Framework in the early adopter area, the changes and activity that were taking place, perceptions and experiences of implementation, lessons learned and the impact of COVID-19.

Engaging health professionals is always a challenge in evaluations like this because their clinical responsibilities and time pressures limit their opportunities to take part in interviews. This situation was exacerbated by the additional pressures caused by COVID-19 thus an online survey was introduced covering the same topics as in interviews. Local leads promoted the survey through direct emails to staff, social media and newsletters and 22 responses were received.

### Local stakeholders

Six local stakeholders took part in interviews as part of the evaluation. These interviewees included representatives of organisations that supported delivery such as health and social care partnerships (HSCPs), universities and third sector bodies.

### Patients

There were 16 interviews with patients who were at risk of or had been diagnosed with type 2 diabetes. In line with the PBPP requirements, the local lead approached potential interviewees to request their participation and provided information about the evaluation and their role so that they could give informed consent to take part. Individuals who were willing to participate either contacted Blake Stevenson directly, or early adopter site staff sent their contact details securely, with their permission, to Blake Stevenson. Due to the PBPP stipulations, no personal data, such as demographic characteristics, was captured from patients.
These discussions covered patients' views and experiences of the support and advice that they had received with type 2 diabetes and any education or weight management programmes that they had taken part in.

The number of patients interviewed was lower than intended. This was partly a result of COVID-19 pressures and delays resulting in lower numbers taking part in programmes, which limited the pool of potential participants. It was also partly due to the process of recruitment as a result of information governance requirements which relied on patients making contact with the team.

It is important to note, this was a qualitative evaluation and qualitative research is not intended to be representative. The patients raised valid issues but these cannot be taken as representative or an indication of how widespread. Those that did engage with this research were likely to be more engaged in the programmes and hence overall were more likely to be more positive about experiences.

## 2.3 Phase 3: Analysis and reporting

The qualitative data gathered from the interviews and survey were analysed in line with the research questions and any other emerging themes.

This involved a process of coding responses to identify key and recurring themes as well as any differences in viewpoints among different groups of participants or areas. The online survey responses were coded and analysed in the same way as for the interviews and incorporated alongside the interview data. The research team held a team meeting to explore the themes and issues emerging and design the report outline for discussion and agreement with the Scottish Government team. There was also a process for fact-checking the information in the draft report.

The findings are presented thematically and aligned to the three main aims of the evaluation and include an overview of the journey of each early adopter area.

Quotes from respondents have been included to illustrate key points, attributed to the type of respondent and area where this does not risk confidentiality.

# 3. Findings - delivery of the Framework in the early adopter areas

## 3.1 Introduction

The Framework identified the actions that the early adopter areas needed to take to develop an integrated system. This included the scoping of services delivery, agreeing local approaches to co-production and service re-design, agreeing the delivery of programmes under each level and funding allocation and how data and evidence would be used to identify, target, and reduce local health inequalities.

For those at risk of and diagnosed with type 2 diabetes, the Framework recommended the adoption of a tiered approach to weight management which relates to the level of risk for an individual.

**Figure 3.1 Levels of a tiered approach**

| Tiered approach to weight management services for those at risk and with type 2 diabetes | |
|---|---|
| **Level 1**<br>**Public health awareness and early detection** | **Universal services, health promotion and early detection of type 2 diabetes through:**<br>• Public health campaign<br>• Targeted messaging with core messages<br>• 'At risk' stratification<br>• Case finding<br>• Local level action |
| **Level 2**<br>**Early detection and early intervention** | **Early detection and early intervention for those at moderate or high risk through:**<br>• Pre-diabetes education programmes<br>• Metabolic antenatal clinics<br>• Maternal and infant nutrition pathways<br>• Weight management programmes |
| **Level 3**<br>**Targeted intervention** | **Targeted intervention for those diagnosed with type 2 diabetes, at high risk, with pre-diabetes or gestational diabetes:**<br>• Structured education for those with diabetes<br>• Intensive weight management for remission<br>• Weight management programmes<br>• Psychological support |
| **Level 4**<br>**Complex case management** | **Advanced weight management input and specialist interventions:**<br>• May include the use of drugs as part of intensive weight management<br>• Considers bariatric surgery |

Diagram adapted from chart and assosicated information in ***A Healthier Future, Framework for the Prevention, Early Detection and Early Intervention of type 2 diabetes***, pg 25-32.

The tiered approach was expected to be delivered as part of a broader weight management pathway which also incorporated: programmes for those not at high risk but with higher BMIs; psychological support; child healthy weight interventions; and the provision of wider support to enable people to manage their health conditions.

The introduction of population-level health promotion (Level 1) was on hold pending the implementation of services for the other levels; therefore levels 2-4 were within the scope of this evaluation. During interviews, respondents focussed only on Levels 2 and 3, thus no information is provided on Level 4 in the remainder of the report.

A key aim of the evaluation was to understand the experience of implementing the Framework; this chapter summarises the approach taken in each of the early adopter area to target high-risk target groups, deliver services, and the impact of COVID-19 on delivery plans.

## 3.2 Targeting high-risk groups

Each area took steps to improve the targeting of those at risk of type 2 diabetes.

Reducing inequalities is one of the Framework's guiding principles and so interviews with stakeholders and those delivering weight-loss programmes explored the strategies being used to engage those most at risk. Actions included:

- high deprivation groups - focusing the initial rollout of the new diabetes prevention pathway in seven GP practices in areas of higher deprivation in Ayrshire & Arran
- pregnant or planning pregnancy - supporting women with or at risk of gestational diabetes mellitus (GDM) across all three early adopter areas, for example in Ayrshire and Arran, women at risk who attended an oral glucose tolerance test (OGTT) then took part in a group education session
- men - football clubs within Ayrshire and Arran were commissioned to deliver additional Weigh to Go for men. Football Fans in Training (FFiT) programme in Tayside was planned but delayed due to the pandemic
- ethnic minority groups - in East Region, work was underway to remove literacy and language barriers by translating key resources and the delivery of a Let's Prevent Diabetes group specifically for the Polish community was trialled with three patients. Oviva resources in Tayside were available in 22 languages.

Interviewees recognised the need to do more to engage those who may not be accessing services (for example, homeless and traveller populations). Equality impact assessments were expected to identify whether additional targeting was needed.

## 3.3 Delivering services

The early adopter areas were expected to meet the minimum standards for weight management services so that there was some consistency in referral criteria, referral pathways, provision, length and frequency of follow-up, quantity and type of dietary and physical activity intervention, behavioural change components and provision of specialist interventions. However, the prevention Framework did not prescribe the type and content of the interventions which allowed for variation in implementation between areas. The next section looks at each adopter area in turn and summarises their approach, delivery under the Framework and the impact of COVID-19 in each area.

## 3.4 Ayrshire & Arran

### Local context

Planning and delivery in Ayrshire & Arran were shaped by the existing gaps and access to weight management provision. There are three HSCPs in the region, East Ayrshire, North Ayrshire, and South Ayrshire. This was widely perceived to have created a difference in the weight management provision.

Although there was no level 3 provision in the region, East Ayrshire offered an enhanced level 2 weight management programme: Lifestyle, Exercise and Nutrition (LEAN). This dietitian-led programme offered support for those with higher BMIs and more complex health needs, but an equivalent service was not available to residents outside East Ayrshire.

More broadly, the lack of a level 3 weight management programme in Ayrshire & Arran was identified as a risk in the weight management standards gap analysis. The lack of support from a multidisciplinary team meant that appropriate provision could not be provided for all patients with complex needs. As the following quote illustrates, the absence of psychology input in particular meant that psychological comorbidities could not be reduced:

> *"The key difference is psychology input, if they're not resolved or strategies given to deal with them, when they try and follow a programme that requires them to fight against their feelings and thoughts, it's almost like you are setting them up to fail. You're not treating the issue, it's not about diet and exercise, more deep-rooted psychological issue that needs addressed. That's why they keep yo-yoing. Can't be sustained, so weight goes back on and in constant dieting cycle because underlying issue never resolved."*
> Health and social care staff, Ayrshire & Arran

### Weight management implementation post-framework

Taking account of the local factors, implementation in this early adopter area centred on three workstreams:

- people at high risk
- women with GDM

- a total diet replacement (TDR) pilot.

There was no diabetes prevention pathway prior to the early adopter status being granted, but there were plans for its development and these plans provided the foundations for the implementation of the high risk workstream. For women with GDM, the Framework was used to expand and develop what was already an established and award winning service[7]. A specialist midwifery team supported women with GDM throughout their pregnancy and because they held prescribing qualifications, all care was provided within one service. The approach used a combination of support and advice from midwives and health care support workers (HCSWs) alongside encouragement and tools for women to self-manage their health.

The third workstream, a small TDR pilot, was introduced following guidance from the professional advisor supporting the early adopters and was new to the region.

The diagram summarises what changes were made in Ayrshire & Arran as part of the Framework's implementation.

**Figure 3.2 Key changes as a result of Framework implementation in Ayrshire & Arran**

| Ayrshire & Arran | Pre-framework | Current |
|---|---|---|
| Level 2<br>Early detection and early intervention | Plans were in place for the development of a diabetes prevention pathway<br><br>**LEAN**, an enhanced weight management programme, in East Ayrshire | **Let's Prevent Diabetes** (Including post-partum intervention for reducing risk in women with a history of GDM)<br><br>**Weigh to Go**<br><br>Plans underway to pilot and expand **LEAN** beyond East Ayrshire |
| Level 3<br>Targeted intervention GDM | A diabetes specialist midwifery service was in place, steered by a lead midwife for diabetes | Diabetes-specialist midwife service expanded and further supported with HCSW-led advice and treatment service and new midwife IT platform introduced<br><br>GDM BMI threshold lowered from 35 to 30kg/$m^2$ |
| Level 3<br>Targeted intervention High risk | None | **Counterweight Plus** for type 2 diabetes remission |

[7] In 2019, the diabetes midwifery service won an Innovation in Practice award from the British Journal of Midwifery and the RCM Excellence in Pregnancy Award

### The impact of COVID-19 on service delivery

The Framework helped to shape the development and delivery of the services. Some were being piloted before the pandemic hit and others were in development.

The delivery of workstream 1, that focused on people at high risk, was limited to seven GP practices piloting the Let's Prevent Diabetes programme pre-COVID. From September 2020 the referral pathway opened up to all 54 GP practices who could then refer patients with a pre-diabetes diagnosis to diabetes prevention dietitians. Where appropriate to patient needs and preferences, patients were referred to Let's Prevent and, following its completion, Weigh to Go. Delivery of these programmes throughout COVID-19 had been via online and telephone methods.

A delay in securing psychology input meant that workstream 3 (TDR pilot) had not yet commenced but delivery of the small TDR pilot began in January 2021 with three GP practices invited to refer patients with type 2 diabetes to the Counterweight Plus programme. Initially the 1:1 appointment took place via telephone then shifted to NHS Near Me virtual clinic option.

In contrast, delivery of GDM – which built on an established specialist midwifery service – began in May 2019. The Framework was used to increase the capacity of the service to meet the additional demand created by the reduction of the BMI criteria from 35 to 30 $kg/m^2$ for GDM screening. Although the service continued throughout the pandemic, some elements were changed – most notably, the group education for all women attending an OGTT was stopped. Instead, fasting bloods were used to diagnose women and any with GDM were then invited to participate in a 1-1 education session. These women were then supported by the specialist midwives throughout their pregnancy through regular telephone calls.

### Future plans

At the time of the fieldwork, plans were being developed to use the funding from the Framework to carry out a small test of change in East Ayrshire and expand the existing specialist level 2 service (LEAN). Additional psychology and dietetic hours had been secured and the recruitment of physiotherapy was underway. Following the test of change, the programme team planned to develop a business case to secure the funding for a pan-Ayrshire service.

## 3.5 East Region

### Local context

The East Region brings together three health boards: NHS Lothian, NHS Fife and NHS Borders. The partnership evolved from initial multi-agency work undertaken in the Borders and a wide-ranging change management programme led by the then Chief Executive of Scottish Borders Council. The three NHS boards, six IJBs and six local authorities in the East Region agreed to work collaboratively for a major prevention and reversal partnership for type 2 diabetes. The multi-level approach was driven by leadership from all senior officers across these organisations. It built

on work already underway in different parts of the region and capitalised on the leverage that regional collaboration could bring.

### Weight management implementation post-framework

When the East Region became an early adopter area, the programme team was created so that the Partnership provided effective strategic oversight and joint decision making with representation from public health, diabetes specialist teams, weight management services and other health and social care partners. The Partnership established a number of workstreams[8] to take forward the programme of work to support the prevention, early intervention and reversal of type 2 diabetes. The first of these was the weight management workstream which held two workshops in Autumn 2018 to develop proposals that would reflect the different levels described in the Framework. A parallel aim was to support a common approach to weight management services and pathways across the East Region, reflecting regional priorities and seeking to maximise outcomes.

As part of the weight management workstream, four intervention programmes were delivered across the region to standardise programmes.

[8] adult weight management, children and young people, employers and whole systems.

**Figure 3.3 Key changes as a result of Framework implementation in East Region**

| East Region<br>Borders, Fife and Lothian | Pre-framework services | Current programmes |
|---|---|---|
| Level 2<br>Early detection and early intervention | No structured education programmes for pre-diabetes or those at moderate or high risk<br><br>No structured education programmes for pre-diabetes or those at moderate or high risk<br><br>No structured education programmes for pre-diabetes or those at moderate or high risk. Antenatal metabolic clinic with specialist dietitian and multi-disciplinary team (MDT) | Planned introduction of **Let's Prevent Diabetes** (pre-diabetes structured education) in all three boards<br><br>Expansion of dietitian-led gestational diabetes post-partum treatment pathway linking into **Let's Prevent** |
| Level 2<br>Weight management | **Weigh to Go** and specialist dietetic-led multi-disciplinary weight management service in place at tier 3 weight management level<br><br>Patients triaged to general dietetics and specialist dietetic-led multi-disciplinary weight management service in place at tier 3 weight management level<br><br>**Get Moving with Counterweight** and specialist dietetic-led multi-disciplinary weight management service in place at tier 3 weight management level | **Get Moving with Counterweight** tier 2 weight management programmes enhanced or introduced so now in all three boards<br><br>Specialist dietetic-led multi-disciplinary weight management service enhanced with additional dietetic support and leadership |
| Level 3<br>Targeted intervention GDM | No specialist GDM or post-partum education service in any board<br><br>GDM managed in secondary care in all boards<br><br>No post-partum pathway | Introduction of specialist digital / virtual dietetic-led education and treatment for those diagnosed with GDM<br><br>Post-partum pathway links into **Let's Prevent** and tier 2 and 3 weight management |
| Level 3<br>Targeted intervention intensive weight management for remission | No type 2 diabetes remission programme in any board | **Counterweight Plus** for all three boards<br><br>Enhanced psychology service at tier 3 weight management and for remission.<br><br>Increase in service leadership and dietetic resource for tier 2 and 3 weight management |

## Level 2 programmes

The Let's Prevent programme, a lifestyle improvement programme for people at risk of developing type 2 diabetes, was planned to be introduced in all three NHS boards in the region. This evidence-based education programme run by Leicester Diabetes Centre aims to increase healthy eating and physical activity and reduce weight to prevent or delay type 2 diabetes. The East region used SCI diabetes[9] to identify those eligible for Let's Prevent.

[9] SCI-Diabetes provides a fully integrated shared electronic patient record to support treatment of NHS Scotland patients with Diabetes

All three NHS boards established service level agreements (SLAs) with sport and leisure providers in the region to run Get Moving with Counterweight, an evidence based and efficient weight management programme. A core component of the Tier 2 programme is physical activity, and a weekly physical activity group session was provided for all patients within the first 12 weeks, normally in the same venue as the Counterweight education sessions.

NHS Lothian had pre-existing SLAs with leisure providers and the revised SLAs set out requirements for an enhanced service. NHS Fife established an SLA with Fife Sport & Leisure to provide the programme in their area and NHS Borders did the same with Live Borders. Referrals were sent to the weight management team in each NHS board (GPs provided information on suitability for physical activity) and a senior dietitian triaged and then forwarded details on to leisure providers.

### Level 3 programmes

The third intervention introduced across the region was the GDM programme, community-based education sessions for women diagnosed with GDM, and a subsequent programme for pregnant women with a BMI>30 kg/m$^2$ to minimise weight gain. Dietitians worked closely with midwifery services to identify and treat GDM and to promote optimal blood glucose control during pregnancy. They also provided postpartum assessment and ongoing weight management support. By expanding dietitian-led metabolic antenatal clinics it was hoped that this would also support pregnant women with BMI>40 kg/m$^2$ or with polycystic ovary syndrome (PCOS).

The final programme extended across the region was Counterweight Plus, a proven weight loss programme delivered by health professionals for managing severe and complicated obesity. This 12-month programme provides people with the skills to lose and then maintain a low weight. It starts with total diet replacement to help with weight loss and is followed by food reintroduction and behavioural techniques to support the maintenance of the lower weight.

## The impact of COVID-19 on service delivery

As in other areas, staff were redeployed during the pandemic and delivery plans had to be revised to ensure that patients already participating in programmes continued to receive support.

For Get Moving with Counterweight the group classes delivered in leisure centres were cancelled and instead non-interactive, pre-recorded sessions on YouTube were offered along with a follow up call with a health coach for 1:1 support. Those that had enrolled but not yet started a programme were signposted to motivational materials and a national self-directed online 12-week programme.

For those on GDM group or 1:1 sessions, these moved online to non-interactive, pre-recorded sessions on YouTube with follow up calls with the dietitian for 1:1 support, pharmacies also provided support to manage medicines.

Counterweight Plus programmes, that were delivered 1:1 in a variety of venues pre-COVID, moved online using Attend Anywhere/Near Me, or Skype for Business when restrictions came into place. Education materials and meal replacements were delivered directly to participants from Counterweight. Equipment, like scales, blood pressure monitors and blood glucose monitors, was ordered and distributed to patients to facilitate self-monitoring at home.

Despite these challenges, staff interviewees described how COVID-19 created an opportunity to overcome some of the difficulties associated with the multi-area approach. The pandemic presented a common challenge, and the NHS boards came together to find a solution. The shift to remote delivery was new for all areas and enabled a shared approach to be implemented.

The break in service provision was also used as an opportunity to set up a new database and data dashboard to help manage delivery. The improved data management enabled staff to identify gaps in referrals and therefore enable more targeted approaches to awareness raising.

## 3.6 Tayside

### Local context

The approach to implementation of the framework in Tayside was informed by an extensive co-production process using service design methodologies with the Digital Health and Care Innovation Centre (DHI). This reflected a desire to take a service user needs and service design approach to identifying the needs and solutions in Tayside. The reports from the co-production process identified a range of user needs and new pathways of care including in digital solutions and key recommendations around improved digital information and resources, education and weight management support, lifestyle interventions, prevention and supporting health professionals.

While the co-production process continued to inform the redesign of pathways, initial work focused on enhancing existing pathways by, for example, increasing physiotherapy and psychology input into weight management. The calculation of Know your Risk scores in Nutrition and Dietetic clinics was also introduced in the earlier stages of delivery but paused from March 2020, once patients were being seen remotely.

## Weight management implementation post-framework

**Figure 3.4 Key changes as a result of Framework implementation in Tayside**

| Tayside | Pre-framework | Current |
|---|---|---|
| Level 2 Early detection and early intervention | People are diagnosed with impaired glucose tolerance using fasting glucose or OGTT at GP and offered **Tayside Diabetes Education Programme** (TDEP) | New diagnostic pathway using HbA1c (introduced Feb 2021)<br>**Oviva Prevent** pre-diabetes education programme<br>Plans made for introduction of tier 2 weight management services with **Second Nature**, **Slimming World** and **Football Fans in Training** (FFiT) |
| Level 3 Targeted intervention GDM | Anyone diagnosed with GDM offered the chance to attend group education<br>All called weekly to discuss blood glucose monitoring.<br>BMI threshold 35 kg/m2 | Development of midwife post, new GDM pathway and new midwife IT platform introduced to give access to information on GDM<br>**GDM Health**<br>GDM BMI threshold lowered to 30kg/m2 |
| Level 3 Targeted intervention High risk | Tier 3 general weight management services<br>**Tayside Diabetes Education Programme** (TDEP) | Expansion of staff and resourcing for general weight management services<br>Plan to implement **Oviva Weigh to Wellness***<br>**Counterweight Plus** piloted from Jan 2021 for type 2 diabetes remission |

*The co-production process identified changes to pathways that were sometimes funded from within Board's own budget rather than funding attached to the Framework e.g. GDM health (a remote health pathway) and Oviva Weight to Wellness for remote Tier 3 weight management services.

Patients newly diagnosed with type 2 diabetes could be referred to the 12-week Oviva Diabetes Support programme, an interactive digital programme. In the early stages of the programme those recently diagnosed with type 2 diabetes received a letter from the Diabetes Managed Clinical Network (MCN) to promote the new programme and then the Nutrition and Dietetics team followed up to sign them up to the programme. This temporary approach enabled the MCN to pick up patients diagnosed since October 2019. More recently the process shifted from GP referrals to the Nutrition and Dietetics team.

GDM pathways were revised so that women diagnosed with GDM could receive timely support:

- the BMI criteria for a glucose tolerance test was reduced from 35 to 30 kg/m$^2$ in 2019
- the midwifery service's new IT platform BadgerNet was used to provide access to videos and information on GDM

- post-natal letters were sent to women (copied to GP) to encourage six weeks fasting glucose test uptake.

### The impact of COVID-19 on service delivery

To support those at higher risk of type 2 diabetes, the nine-month digital Oviva Diabetes Prevention programme was introduced for patients with pre-diabetes. This was piloted with six GP practices in Dundee and Angus during COVID-19 and has now been rolled out to all GP Practices in Tayside. GPs identified patients using the HbA1c test and referred them to the Nutrition and Dietetics team who then referred the patients to Oviva.

The Tayside Diabetes Education Programme (TDEP) group education sessions were paused during COVID-19 and women with a GDM diagnosis received education on a 1:1 basis supported by videos and online information. Women were diagnosed via fasting bloods, rather than an OGTT. Following an initial 1:1 education session delivered by a health care assistant, women were supported throughout their pregnancy via frequent telephone calls by the specialist midwife team.

### Future plans

Remobilisation of services began in late 2020 as staff returned to their posts and saw the start of a new service, Counterweight Plus. Patients diagnosed within six years were referred from the weight management waiting list and 34 started this TDR programme in January 2021. They were supported via Near Me rather than in a group setting.

More recently, the early detection work was broadened to include a pilot programme based in community pharmacies to identify people at high risk of type 2 diabetes. This workstream will include three phases, encompassing point-of-care HbA1c testing, appropriate referral to services, evaluation of staff and user acceptability and assessment of how HbA1c results compare with the Diabetes UK risk tool.

The co-production process identified family-based interventions as a potentially valuable approach and opportunities to deliver these through the extension of the Scottish Professional Football League's (SPFL's) Football Fans in Training (FFiT) programme were being explored but, because of the pandemic, were not in place at the time of the evaluation's fieldwork. Similarly, a new Slimming World programme (its offer was to include a specialist programme for pregnancy) and Second Nature programme will also be commissioned once the information governance issues about sharing patient information can be resolved.

## 3.7 The impact of COVID-19 on delivery across the early adopter areas

The restrictions imposed by COVID-19 had a profound impact on service delivery. Pilots were paused and those not already on programmes re-directed to self-

management material, while existing programmes moved to remote support. This section reviews in more detail the challenges and opportunities faced by the early adopters in redesigning their delivery plans.

### Group work

Enabling a shift to remote delivery was the most significant challenge brought about by COVID-19. Group work had been a key feature of the planned approach for many of the programmes and the early adopters have had mixed success in retaining this via the new online approach.

The lack of an appropriate group IT platform was a key limitation here; Near Me was most commonly used to continue the delivery of programmes but participation was limited to much smaller groups of two to four patients. This meant that group interaction, and the peer support this provided, was restricted, which was a concern for some:

> *"We're actually removing something that we know is so valuable."*
>
> Health and social care staff, Ayrshire & Arran

Although group programmes were not the preferred delivery approach for all patient interviewees, others commented that they would have benefited from an IT platform that allowed more group interaction. The smaller numbers participating in each group also meant that the programmes' throughput was reduced, as emphasised by one staff member:

> *"[We are] drowning because we can't mobilise to operate in a most effective way."*
>
> Health and social care staff, Tayside

### Information governance restrictions

Information governance policies were highlighted as restricting the use of a more appropriate platform for online delivery. For example, a weight management provider reported that they could not download Zoom onto a local authority laptop and had to purchase a new laptop to enable them to deliver a weight management programme. Permission to use Microsoft Teams took several months to secure and therefore further delayed delivery. In contrast though, Tayside interviewees described how COVID-19 had meant that the use of Oviva was approved at "*unheard of*" speeds.

Staff interviewees recognised the unprecedented demands faced by local information governance teams during the pandemic and, reflecting this, there was consensus that a national solution should be put in place to enable the continuation of group education online.

| **Consideration: better understanding of information governance requirements and a possible national approachThe logistics of remote delivery** |
| --- |

Logistical challenges were also created; firstly, the presentation content had to be amended to ensure its suitability to online delivery and more limited group

interaction. In one of the early adopter areas, a WMP described how it took several months to adapt and then pilot the new presentation content to ensure its suitability.

Staff also had to identify a means of providing patients with the equipment needed to support remote delivery. For example, patients taking part in Counterweight Plus had to be closely monitored throughout the programme but instead of doing this via face-to-face appointments, scales, blood pressure monitors and blood glucose monitors were sent to patients' homes. This was perceived to have the unexpected benefit of enabling patients to self-manage from the outset of the programme.

### Patient engagement

There were mixed views on how the shift to online delivery affected patients. It was recognised as a barrier for those with low levels of digital skills; reported action to address this included walking patients through the log in process. In contrast, for those patients with work commitments or who lived in a more rural area, the removal of the need to travel to an appointment or session was thought to have enabled participation, as a respondent described:

> *"A very positive impact with patients being allowed to attend appointments virtually in work's time without the need to travel to an appointment."*
>
> Health and social care staff, Tayside

Online delivery was also perceived by staff interviewees to benefit those patients who may be uncomfortable in a group setting, a view which was echoed by a few patients:

> *"If there was no COVID, I would have been invited to go to Kilmarnock for weight sessions. I don't know if would have, I'm actually happy with what's happened… I don't know if I'd have been keen to have gone on a group. I'd suggest that they maintain this way for people like me who are happy to do it this way rather than a group."* Patient, Ayrshire & Arran

However, different views were expressed by staff on how remote delivery could support those patients with more complex needs:

> *"Weight is such an emotive topic, it's easier to do it when they're in a safe and confidential environment and knowing that they are supported when they leave. You don't know what's going on when people are at home."*
>
> Health and social care staff, East Region

In contrast, another interviewee from the same NHS board felt that remote support may be appropriate for patients with body image issues:

> *"Working on the phone really suits people, particularly if they are very concerned and have unhelpful thoughts about what they might look like. Done some intense work that's been made possible on the phone. It's about offering different ways of working with people that meets where they are."*
> Health and social care staff, East Region

This highlights how experiences of delivering during COVID-19 have reinforced the importance of a person-centred approach and that there was no 'one-size-fits' all approach.

### Reduced footfall in GP practices

In addition to the challenges early adopter areas faced in engaging patients via online platforms, the reduction in footfall in GP practices throughout the pandemic meant that opportunities to identify those at risk were reduced.

### Wider use of IT

In each early adopter area, adjustments to programme delivery and a move to online support enabled patients to access services during the pandemic. Those changes have been described throughout this chapter and include examples like the new app in Ayrshire & Arran.  Although planned pre-COVID, it was perceived by staff to have been particularly valuable to enhance wider weight management activity. Various teams could manage their own tile in the app, and the family activity challenges set by the children’s team was highlighted as being particularly successful. The digital Oviva programmes in Tayside, again planned before the pandemic, became a workable solution to continue delivery. Even existing platforms like YouTube were used to deliver some content in East Region and Tayside.

# 4. Findings: perceptions and experiences of services delivered under the Framework

## 4.1 Introduction

The Framework forms part of the Scottish Government's Diet and Healthy Weight Delivery Plan and specifically outcome 3: people have access to effective weight management services. The logic model for the Framework's implementation sets out a series of short-, medium- and longer-term outcomes to achieve this. Although assessing the achievement of these outcomes was beyond the scope of this process evaluation, where appropriate, consideration is given to how the changes made to weight management services might contribute to the shorter-term outcomes. These outcomes reflect the Scottish Government's ambition to achieve:

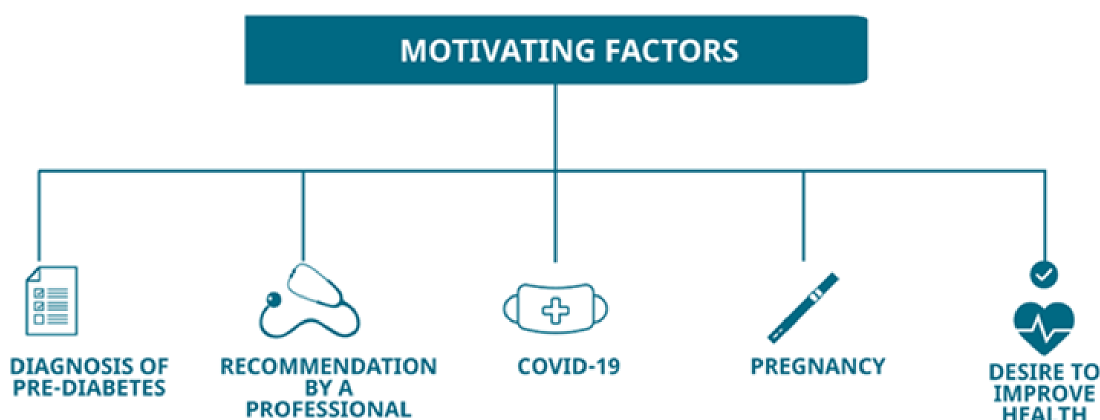
- better identification of pre-diabetes and gestational diabetes
- better access to specialist care and weight management services
- higher quality of care for those at risk of type 2 diabetes, with gestational diabetes (or a history of GDM), and newly diagnosed with type 2 diabetes.

This chapter focuses on the experiences of patients who accessed the programmes implemented as part of the Framework, considering what motivated them to join a programme, how effective they were, what prompted people to drop out and maintenance of support. Their views and experiences provide valuable insight, particularly to the quality of care. As a small sample of those more likely to be positive and committed, the views cannot be considered representative.

## 4.2 Motivating factors

The interviews with patients and providers explored the factors that motivated patients to take part in weight management programmes and other support services for type 2 diabetes. Figure 4.1 summarises these key motivations.

**Figure 4.1 Motivating Factors**



### A diagnosis of pre-diabetes

For some patients, the diagnosis of pre-diabetes was the motivation to engage with weight management programmes. One patient explained:

> ***"****It's a disease I'd like to steer clear of and I was a bit surprised when I was told I was pre-diabetic. I wouldn't have thought my lifestyle would have led me down that road, so I've taken steps to ensure I don't develop [type 2 diabetes****]."***
> Patient, Ayrshire & Arran

However, staff interviewees described how, for others, a 'drip feed' approach was needed to ensure the consequences of a pre-diabetes diagnosis were understood and the need to make changes recognised – particularly where an unhealthy relationship with food was well established. Interviewees emphasised the importance of reiterating the message over time:

> ***"****Having that consistency of seeing the nursing team, it helps to reiterate key messages. It's about picking away at the surface until you can reach the stage where they want to do more****."***
> Health and social care staff, Ayrshire & Arran

### Professional recommendation or referral

Referral from a GP can play an important role in providing information to motivate patients to take part, and some health and social care interviewees noted that a referral from a professional could give patients additional motivation to participate.

However, some weight management providers cautioned that patients who felt compelled to attend following a referral might not complete the programme. They noted that the readiness of patients to participate was essential and so self-referral or opt-in would be a more successful approach.

### COVID-19

Whilst several staff members in the early adopter areas highlighted that COVID-19 had led to an increase in people's BMIs, as a result of reduced exercise and poorer eating habits during lockdown, others noted that the pandemic had stirred people into action. The fact that underlying health conditions like obesity and diabetes often negatively impacted on the outcomes of those with COVID-19 influenced the decision of some to lose weight:

> *"[COVID-19] played its part in my journey to where I am today****."***
> Patient, Tayside

This patient had breathing problems and, although tested negative for COVID-19, was diagnosed with type 2 diabetes and asthma and was referred to the Oviva support programme.

Other patients noted that COVID-19 created conditions that made it easier to change their lifestyle. A few of those accessing programmes reported that they found it easier to maintain a disciplined routine and eat healthily and exercise whilst the restrictions were in place. Similarly, another patient in Ayrshire & Arran said that lockdown had helped because she was not eating out with friends and went for a walk everyday. This patient felt that maintaining their current diet and exercise as

restrictions eased would be a challenge and therefore declined the invitation to take part in Weigh to Go after Let's Prevent Diabetes:

> ***"**When COVID ends, life starts to take over again. I'll be out and about doing things that I've not been allowed to for a long time. The walk would disappear**.** I was fortunate that I got this opportunity at the right time for me and the world situation came at the right time as well. Had it not been for a pandemic and you weren't allowed to leave the house and do things, I might have had a different experience**."***
> Patient, Ayrshire & Arran

Health and social care staff also acknowledged the likely role of the pandemic and challenges with restrictions lifting and habits changing:

> ***"**I get the feeling, and we haven't done an audit, after initial lockdown, it affected people pretty well, it was seen as opportunity for people with pre-diabetes to exercise more or eat differently but now it's gone on too long. Now we're seeing people with pre-diabetes having tipped into diabetes**."***
> Health and social care staff, Ayrshire & Arran

## Pregnancy

Pregnancy was also identified as providing a platform to engage and educate women at a time when their motivation to change their behaviour was high:

> ***"**They are fed up with hearing about their weight. Sometimes we need to turn it around and not focus on their weight but on the changes to baby and protecting them… If they can make changes, they're more likely to continue after the baby is born."*
> Health and social care staff, Ayrshire & Arran

One woman supported by the midwifery service after a GDM diagnosis reinforced this view:

> ***"**Being pregnant, you don't want to put baby at risk… The long-term health implications you don't normally think about... [the information] gives you the jolt that you need. Also the eating advice given, it's really easy to follow. So I'd say I've done numerous diets before, e.g. Slimming World. It's not maintainable longer term, the information I've been given during pregnancy is more sustainable really.**"***
> Patient, Ayrshire & Arran

Patients in Tayside echoed the importance of issues related to pregnancy. One in particular said she was motivated to take part in Counterweight Plus to lose weight in order to be eligible for IVF.

## Desire to improve health

A patient in East Region noted that she was motivated to take part in total diet replacement in an attempt to eliminate the need for type 2 diabetes medication which was having unpleasant side effects for her. Others in the East Region and Tayside said that they wanted to improve their health so they could *"be around"* for their children and grandchildren.

## 4.3 Effectiveness of the programmes

In general, the patients were very positive about the programmes they had taken part in and felt they had met their needs. Their feedback is summarised below.

### Pre-diabetes education

The five patients in Ayrshire & Arran who took part in Let's Prevent Diabetes valued the information and support provided towards reaching their own health goals:

> ***"****I've been happy with information and support I've been given; my weight loss has slowed down but I'm still losing. That's the main target.****"***
> Patient, Ayrshire & Arran

> ***"****It wasn't new to me but it kind of spelt out what I [was] doing wrong****."***
> Patient, Ayrshire & Arran

### Weight management

Participants in the Oviva support programme in Tayside were also positive about their experience. In particular, the tailored support and advice from dietitians and psychologists had helped them to make more informed choices about their eating habits:

> ***"****They have made a terrific difference – I am seriously thinking about what I eat."*
> Patient, Tayside

### GDM specialist care

Two of the patients in Ayrshire & Arran had been diagnosed with GDM and both had high praise for the specialist care they received. One interviewee recognised that they might not have been diagnosed if the BMI criteria for a glucose test had not been lowered and were grateful that they had the opportunity to make positive changes. Both interviewees felt the midwifery team provided reassurance and support throughout pregnancy:

> ***"****It's probably exceeded my expectations. Because of COVID, you kind of assume you're going to get less to it because of the way things are, but I felt very supported on phone or in person. Always encouraged to bring partner so he had info as well. I definitely didn't think I'd be as supported or as encouraged as I was. They're really positive about the changes that I've made, really encouraging."*
> Patient, Ayrshire and Arran

Supporting the perception that pregnancy provides an opportune platform to bring about sustainable change, one also commented that it:

> ***"[****Got] the message across that it's not just about pregnancy but lifetime change."*
> Patient, Ayrshire & Arran

### Total diet replacement

Three of the people taking part in the total diet replacement programme in the East Region and two in Tayside took part in the evaluation. Interviewees were very positive about the support provided, with regular meetings with a dietitian taking

place online throughout the programme, and additional text and email support in between meeting:

*"[Dietitian] was always there to answer. Never at any point in the whole process have I felt lost or abandoned or unsure of anything. There's always been an answer to any question that I might have."* Patient, East Region

Interviewees compared the programme favourably to others they had been involved with and reported outcomes including sustained weight loss and reduced blood glucose levels:

*"[The programme is] structured, really easy to follow… I lost 25kg."* Patient, Tayside

Another patient in Tayside noted that her polycystic ovary syndrome (PCOS) symptoms had reduced as a result of taking part.

A few interviewees described how the impact of the programme had gone beyond physical health benefits and included positive impact in terms of improved wellbeing, self-esteem and lifestyle:

*"I feel better about myself… it has totally changed my lifestyle… it has made me feel my age rather than an old wifey."*
Patient, Tayside

*"It's life-changing… My whole attitude to food has changed… I'm not wasting money on junk food [any more]."*
Patient, Tayside

Similarly, one patient in the East Region reported that the programme had enabled them to re-evaluate their lives:

*"It made me realise the last 10-15 years how badly things had slipped, it's made me realise how I'd got there."*
Patient, East Region

## 4.4 Reasons for drop-out

There were multiple factors that service users identified as deterring the take-up and completion of weight management programmes. These included:

- work and care commitments that reduced the time available to attend services
- life-long established relationships with food – as one patient said, "*food is my go-to comfort*" and others described turning to food during stressful times
- a preference for self-management
- lack of awareness of services
- discomfort with a group setting (which was perceived to be related to body image for some)
- poor mental health.

During COVID-19, a dislike or inability among some to access online groups also emerged as a deterrent, although others enjoyed the online provision.

## 4.5 Support mechanisms at maintenance phase

At the stage of the evaluation, when the data was collected, many patients had not yet entered the maintenance phase so this report is limited on information about patients' experience of support at maintenance phase. However, there were some examples of activity to help patients during this phase.

Staff in Ayrshire & Arran reported that participants in Let's Prevent Diabetes received three, six, nine and 12 monthly follow up appointments with a dietitian. Referrals to a weight management programme were discussed at each of these intervals (where a referral was not made upon completion of Let's Prevent Diabetes) to help maintain their progress.

As Weigh to Go is a three month programme (with six, nine and 12 monthly follow ups), there was the potential for a further extension to support. Following this, it would be expected that GP practices would invite all those patients with a pre-diabetes diagnosis to attend an annual review so that there is a "*continuum*" of support available to them. In addition, weight management providers reported offering other exercise classes to those completing Weigh to Go.

In East Region, one weight management provider felt that support was required beyond the 12 weeks and developed a physical activity class specifically for those patients completing Get Moving with Counterweight (for a fee of £3.60 a week). The intention was to run the class in the gym and introduce participants to staff so that they would be confident to come into the gym in the future. However, only a few sessions were delivered before the pandemic. For patients on the TDR programme, a 12 week food re-introduction period followed the 12 weeks of diet replacement and interviewees noted that it was expected that support would be available for up to two years afterwards, and overall, patients reported that they were receiving all the support they needed.

In Tayside, Oviva Diabetes Support programme participants commented that the subscription was only funded for one year, although access to basic aspects of the app continued after that for free. However, these patients were happy with this arrangement – they felt that they had learned enough during their engagement with the paid-for aspects of the programme to continue at their own pace once the subscription finished.

## 4.6 Learning

From the experience of patients and deliverers, there was some key learning about the weight management programmes, identified during the evaluation:

- The importance of considering a wide range of evidence-based programmes for managing type 2 diabetes. Interviewees felt that TDR was not the only way to achieve remission and not for everyone so increasing the choice of other routes to remission should be considered.
- The need to recognise the established culture of unhealthy eating and the importance of an increased public health focus to promote healthy choices at a younger age to help establish good eating habits.

- The important role of psychological support, both for patients and staff in the programmes and ensuring that there is more balance between psychology and dietitians. Interviewees explained the value of understanding when best to use that input and gave examples of critical points on the TDR programme, like food reintroduction, when people often struggled and issues around food came up. In response to this, one area had introduced a support group that focused on emotional eating and by doing so, expected to streamline much of the 1:1 work that was carried out.
- More general support groups to increase motivation to continue with a programme. A few providers reported setting up WhatsApp groups to encourage participants to communicate regularly out with the group. These groups were also being used to set up Strava walking challenges to encourage people to increase their daily exercise.

**Consideration: ensure more options are available for evidence-based programmes for managing type 2 diabetes to cater for different needs and preferences**

# 5. Barriers and enablers to effective implementation

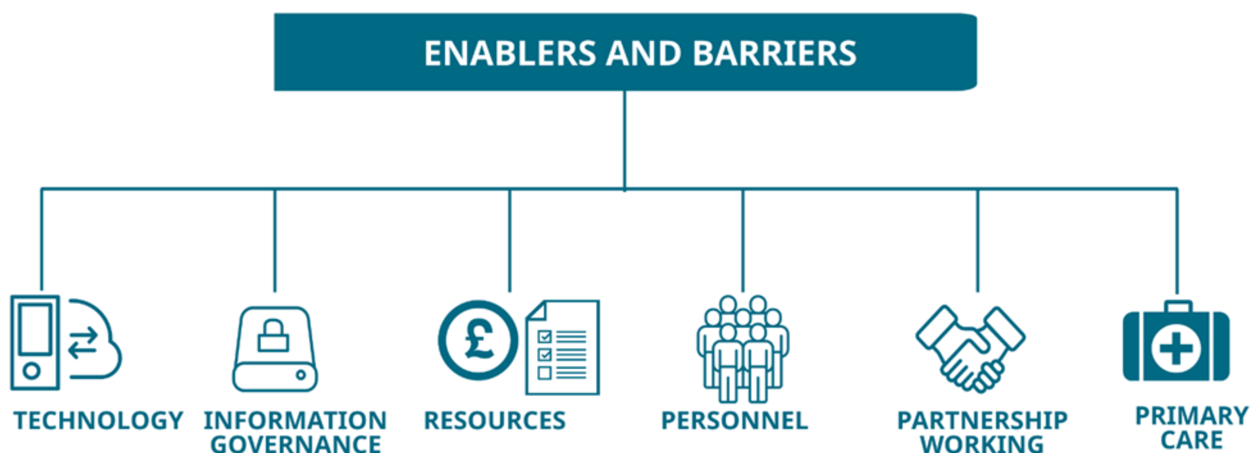
## 5.1 Introduction

Early adopter areas had the freedom to implement the Framework in ways that best met the needs and existing infrastructure of their areas. Whilst this produced contrasting approaches or differing programmes, there was commonality of enablers and barriers across all the regions. These are summarised in this section.

## 5.2 Enablers and barriers

The key factors are summarised in the diagram and discussed in more detail.

**Figure 5.1 Enablers and barriers to implementation**




### Technology

Technology was an important element in the implementation of the Framework in the early adopter areas. All three areas used online programmes and platforms to enhance service delivery, especially once the pandemic hit. Examples included:

- a weight management app developed in Ayrshire & Arran, with individual content being owned and updated by different groups including Early Years, Dietetics and Bariatrics
- use of NHS Near Me video conferencing to deliver 1:1 sessions during the COVID-19 pandemic
- use of the interactive digital Oviva programmes in Tayside
- introduction of Microsoft Teams as a platform for group sessions
- posting videos on YouTube to explain how equipment worked
- using IT platforms like BadgerNet, enabled notifications and information to be sent to women with a recent history of GDM

- Zoom was chosen by one East Region weight management provider to deliver Get Moving with Counterweight
- use of geocoding data about patients on the programme to identify the best location to hold the clinics in East Region.

Some of these initiatives, such as the Oviva programmes in Tayside, were already at the planning stage before COVID-19 but in other areas the pandemic accelerated their introduction.

The reliance on technology did create barriers for those patients and staff for whom some IT was unfamiliar and for others who were digitally excluded because of a lack of internet connectivity or appropriate devices.

### Information governance

Information governance was a barrier. As noted in Chapter 3, the process for obtaining approval for the use of the Oviva platform in Tayside was completed promptly. In contrast there were delays in the other areas in receiving approval to use Microsoft Teams for group sessions. In East Region, it took over a year for the Information Governance team to approve a process for delivering resources directly to patients. During that period staff members had to load up their own cars and drive around their NHS board area, delivering the equipment.

Another aspect was data reporting requirements related to the Framework. This meant that new information sharing agreements were needed between weight management providers and the NHS board. Some interviewees reported that establishing these agreements took far longer than expected. In Tayside the introduction of some of the programmes like Second Nature and Slimming World were delayed whilst this was resolved. There was also a practical challenge about data transfer, with one provider explaining that they had to print out the data and physically hand it over in order to work within the restrictions.

### Resources

There were a number of resources that supported the early adopter areas to implement the Framework; funding, documentation and the professional advisors.

Funding provided by the Scottish Government enabled service delivery, providing resources for local teams to recruit new staff members and deliver new services.

For example, in Ayrshire & Arran, funding was used to pay for five psychology sessions a week and the involvement of psychology was described by staff as an important shift towards multi-disciplinary weight management. However, the allocation of funding on a year-on-year basis was identified as a challenge because it meant that staff were appointed on short term contracts, creating recruitment, retention issues and higher training costs. More broadly though, it restricted longer term planning:

> **"***As with many of these things, a lot of the times we're dealing with finite pockets of resource for limited period of time which makes meaningful change different. I guess Scottish Government have to do it that way, but it's frustrating not to have mainstream funding for these interventions."*
> Project staff, Tayside

In terms of other support available to early adopter areas, there was a suite of resources designed to support implementation of the Framework. These included Public Health Scotland's '[Standards for the Delivery of Tier 2 and Tier 3 Weight Management Services in Scotland']. Some staff in project teams found this document helpful in planning and designing services and in ensuring consistency across areas both regionally and nationally and others felt that the document gave a *"credibility and value"* to the work they were carrying out.

Interviewees also identified close links with professional advisors at the Scottish Government as important enablers providing practical support like help in designing services and a dedicated source of advice. Representatives of the early adopter areas also met regularly with the advisors, particularly in the earlier stages of the Framework's implementation, and this provided an opportunity to work to solve some of the "*teething problems"* and share their learning and experiences.

**Consideration: a longer financial commitment would provide security to embed changes and maintain staffing levels**

## Personnel

Several interviewees identified key personnel involved in the Framework's implementation as playing a pivotal role in either service development or motivation and encouragement of the team and colleagues. For example, the Midwifery Lead for Diabetes in Ayrshire & Arran had created a midwife-led service for women with GDM prior to the Framework's implementation, which was a strong foundation upon which to expand the programme.

In the East region, several interviewees identified the programme lead as instrumental in driving change and facilitating agreement on a common approach:

***"****There was an excitement here, I think that came from people who led it. It was the way that [the lead] commanded that room when there were some massive egos… Success because of some initial leadership. It blew me away. It was a sense of, we've got this money, we can do something different****."***

Project team, East Region

However, while the importance of individual staff was identified, several interviewees across all areas noted challenges in staff turnover. This was caused, at least in part by redeployments during COVID-19, but also when posts were for a fixed term. Staff sometimes then moved into permanent posts or into teams that were part of a core structure rather than a partnership model.

The staff capacity to deliver elements of the programme either at a management or service delivery level as a result of staff turnover or vacancies was acknolwedged by interviewees across all areas. This was then exacerbated with the high demand for diabetes support services, sometimes as a result of the more effcient referral pathways leading to more referrals plus COVID-19 delays that contributed to the backlog.

Interviewees described how the implementation was planned to try to manage the balance between the promotion of the programmes and the capacity to deliver. The at risk pathway in Ayrshire & Arran, for example, was meeting patient needs at the

time of data collection but the programmes had not been actively promoted since remobilisation because of the concerns about meeting any increased demand. Furthermore, one of the three Diabetes Prevention dietitians was leaving their post and this gap, alongside an increasing number of patients reaching their three and six month follow up appointments, meant that the service was now perceived to have reached a *"tipping point".*

An interviewee in East Region described a similar challenge:

> "*It's a balancing act about singing it from the roof tops and getting everyone referred. It's working at the moment; word is getting out and there's a steady stream and we can manage that. If there's a mass influx, there would be a waiting list for assessments and for them to start on the programme. At the moment, the balance seems to be working.*"
>
> Health and social care staff, East Region

### Partnership working

The design and delivery of the Framework required formalised structures and processes to plan and deliver the programmes from across a multi-disciplinary team spanning primary and secondary care. The programme teams worked closely with colleagues in primary and secondary care, not only to increase awareness of the Framework and its implementation, but also in the co-production and re-design of services.

Navigating these relationships and strengthening partnership working could be a challenge. There were comments from health care staff about the hierarchical structure within the NHS and 'gatekeepers' of information that needed to be on board with the redesign of pathways and services. These interviewees were realistic about how long it would take for changes to embed, for relationships to develop and logistical difficulties to be overcome.

Some of these challenges were amplified in the East Region by the fact that it covered three NHS boards, six IJBs and six local authorities meaning there were several working cultures to understand and three different approaches to weight management to consider and enhance or redesign. Each NHS board had a governance group with varying levels of engagement. Even with the profile of the Framework and regular partnership working with the MCNs and diabetes groups to develop the new pathway, the relationships and activities in each NHS board required a concerted effort to sustain them. In practice, this meant that programmes came on stream at different times across the East Region reflecting the different stages of local action and ability to move things forward.

Although partnership working could be challenging, the implementation of the Framework was described by staff interviewees as having created opportunities to build and strengthen their working relationships. This was thought, by some, to have improved the quality of services:

> *"It has provided the opportunity for us all to get together (albeit more recently on teams only) to develop pathways to link our services. This can only be a positive*

*for our service users to have good communication and links being developed across different healthcare areas."*

Health and social care staff, Ayrshire & Arran

This partnership working was also important for the three health boards involved in the East Region. They worked closely together, and the frequency of communication enabled sharing of learning and experiences. An interviewee in NHS Fife explained that they had met with colleagues from NHS Lothian who provided peer support throughout the establishment and initial delivery of the Counterweight Plus. Another health and social care interviewee described how psychologists in the East Region worked together to identify how best to use psychology input into the programme.

More specific examples on the changes to partnership working included:

- new opportunities for increased interaction with dietitians and therefore a more joined up approach:

  *"It feels more robust than previously, I think it's the relationships with dietitians now, previously we had dietitians who devised the programme and would help with bits and pieces. Now we have links to diabetes prevention dietitians, we're singing from the same hymn sheet. It feels more robust, it does feel different. It's got more value now."*
  Weight management provider, Ayrshire & Arran

- improved working relationships between different disciplines and between MCN and primary care
- supportive relationships established amongst key staff through regular informal contact to share advice and work collaboratively.

**Consideration: to support development of an integrated system, allocate sufficient time and resources to enable meaningful co-production and service redesign with the key stakeholders and deliverers to ensure a shared vision and common understanding of the new pathways and service.**

## Primary Care

The role of primary care professionals emerged as a key determinant of success for effective referral pathways. Within Ayrshire and Arran, for example, GP practices maintained a register of people at risk of diabetes. Again in Ayrshire and Arran and also Tayside, the GPs carried out the HbA1c tests for patients and then identified the relevant programme to refer them on to:

*"we depended on GPs to help with obtaining biochemistries which would normally be carried out in the hospital setting."*

Health and social care staff, Ayrshire & Arran

As part of implementation of the Framework it was therefore important to build the relationships with primary care. Interviewees from the early adopter areas described the various methods used to do this, which included regular communication via bulletins, emails and meetings to explain the redesign of service and the role that GPs played in the referral process. In the East Region, dedicated

Primary Care Leads helped to develop relationships and provide relevant support, this included updating the NHS Lothian *Ref help* tool used by GPs and other clinicians to refer patients.

The important role that primary care staff play in facilitating access to the new weight management programmes has been highlighted. As described within the Framework (p34), discussing weight sensitively with patients in a way that motivates them can be challenging. Reflecting this, interviewees also made the point that more could be done to improve the confidence and the skills to undertake weight management conversations:

> "*I think we should get better at having conversations with people who are at risk. There's a sense that GPs don't like to tell people they're overweight. We need to get better at that as a society.*" Health and social care staff, East Region

Although improved relationships were reported, several interviewees recognised the need to continue to communicate with GPs in individual practices and clusters to:

- clarify referral pathways (some GPs felt that the referral pathway on SCI Diabetes was not easy to find)
- provide feedback on patients referred
- help maintain the profile of type 2 diabetes programmes.

A few interviewees involved in the work with GP practices felt that additional levers were needed to encourage them and, as the GP contract directed their work, an SLA with GP clusters would help to drive forward the changes associated with the Framework's delivery.

There was some recognition amongst health and social care staff interviewees about the time it took to build these relationships and for changes to become embedded. Indeed, there were examples of how a lack of capacity for change within one part of the integrated system could delay delivery: in one area, Counterweight Plus was on hold and in another Let's Prevent Diabetes, both because GP practices were not able to support them, reinforcing the important role of primary care and the need for good working relationship for the success of the redesigned service.

**Consideration: ensure sufficient time and opportunity to develop the relationship with primary care as vital in implementing and promoting the new referral pathways**

# 6. Conclusion and considerations

The implementation of the Framework in the early adopter areas has led to the development and expansion of existing services, as well as the introduction of specific new weight management pathways for those at risk of or those diagnosed with type 2 diabetes.

In these areas they have identified gaps in provision or where further service development was needed and:

- brought clarity to shared priorities
- built strategic and operational partnerships to enable service re-design
- identified and tried to tackle barriers to change.

Whilst the Scottish Access Collaborative[10] was not referenced by any interviewees, elements of the key principles had taken place, or were planned such as referrals via a system wide agreed pathway or a clear understanding of demand and capacity that should form the basis of redesigned services. In all three areas this focus and investment has resulted in some services continuing and expanding and new evidence-based programmes being piloted and then introduced on a wider scale.

The implementation of the Framework has brought consistency to previously fragmented approaches to delivery in or across an area. The pandemic clearly affected the momentum of implementation. It brought both obstacles and opportunities, halting or postponing some programmes but also forcing digital innovation to enable remote delivery or accelerated rolling out of online versions of programmes.

Early adopter areas have adapted and updated their plans to ensure that delivery continued amidst the ongoing challenges of COVID-19. The flexibilty of the Framework meant that some areas have used the learning from creating a digital offering to maintain a hybrid service and broadened their output and audience.

## 6.1 Considerations

The learning from the implementation of the Framework within the early adopter areas provides insights to the design and delivery of weight management services and some wider considerations for implementing the Framework and introducing change on this scale across primary and secondary care. Some of this learning is reflected in the enablers and barriers discussed in Chapter 5 but the key areas that would improve implementation or increase consistency across services related to:

### More options for evidence-based programmes

The 2019 weight management standards and gap analysis tool were viewed as helpful but there were requests for a wider range of evidence-based programme options to meet the needs of individuals for managing type 2 diabetes. Guidance was also wanted on the level and type of evidence required to provide robust

[10] The Scottish Access Collaborative Six Core Principles

information about the outcomes for individuals on weight management programmes to inform which programmes to implement.

### Financial support

The resources and financial support enabled the areas to redesign services and work with colleagues to develop programmes. However, the short term nature of the funding restricted future planning and recruitment and retention of staff. A longer financial commitment would provide the security to embed changes and maintain staffing levels and continuity.

### Partnership working

The early adopter areas had clear guidance as to the steps needed to develop an integrated system, but completing these steps needs to be robust with meaningful co-production and service redesign with the key stakeholders and deliverers to ensure a shared vision and common understanding of the new pathways and service. Sufficient time and resources need to be allocated to enable this process.

### Systems

The early adopter areas experienced challenges in relation to information governance and sharing information with weight management providers when introducing or adapting services. A better understanding of what would be needed and the time required to develop appropriate agreements would have reduced some of the delays created by the information governance requirements. There was also a call for a national solution to the information governance challenges.

### Building relationships with primary care

Primary and secondary care services must work together to ensure that support is available to people at a time when they are ready and able to engage. For these partnerships to develop, there needs to be realistic time and opportunities to build relationships, a common understanding of the new policy or practice and the resources to plan and implement the required changes. The key role of GPs and practice staff in the redesigned services highlighted the need to engage primary care and ensure understanding and buy-in to the new pathway and their role within it, to ensure the services run smoothly and effectively.

## 6.2 A common approach across Scotland

The early adopter areas welcomed the opportunity to vary their approach to implementation but also valued the Framework and national standards for promoting consistency between and across areas. However, there were different views about what should have been delivered and how much influence the Scottish Government should have had over implementation.

Some wanted more autonomy to choose programmes and approaches, others were frustrated that areas appeared to be doing things differently when a common approach could have generated more learning, led to national approaches to procurement and avoided repetition. There were particular frustrations about the IT

platforms that could be used in one NHS board but not another and more clarity and consistency about IT platforms across Scotland was requested by some.

The aspiration in Scotland to promote and embed best practice in healthcare through a Once for Scotland approach is relevant to these discussions and the tension between local and regional approaches that reflect the context and population needs and a national approach that supports consistency was evident but there was no consensus.

The Modernising Patient Pathways programme aims to identify best practice, understand and, where appropriate, address variation, collectively review and optimise current service pathways and associated primary/secondary care communication across key clinical areas. Although type 2 diabetes is not a speciality network for this programme the work of the early adopter areas and the further rollout of the Framework provides opportunities to draw together collective experiences and knowledge and highlight where key challenge areas still exist.

## Appendix 1: Research questions identified through a series of workshops with Evaluation Advisory Group members

The following research questions were identified by Evaluation Advisory Group members and are underpinned by the desired short-term outcomes of the Framework.

1. **Has the prevention framework been effectively implemented in early adopter areas?**
   - Effective implementation involves establishing effective pre-diabetes, type 2 diabetes and GDM identification mechanisms, improved access to specialist care for women with GDM and to weight management programmes for those at risk of, or with, type 2 diabetes. A detailed description of indicators of successful implementation is given in the evaluation framework attached.
   - Do weight management services meet the minimum standards for weight management?
   - Are services effectively integrated across primary and secondary care to provide comprehensive care pathways? Does information flow smoothly between services to enable effective decision-making and service improvement?

2. **What are the barriers and enablers to delivery from the perspective of patients and health professionals involved in delivering the care pathways** (namely, GPs or practice nurses, dietitians, weight management providers, type 2 diabetes consultants, midwives and consultant obstetricians)?
   - What, if any, solutions have been found to service implementation barriers?
   - What motivates/deters patients from joining weight management services when referred? What are reasons for drop-out? Do patients feel that the weight management programmes cater for their individual needs? Do patients consider that the programmes worked for them? What support mechanisms are offered at maintenance phase?

3. **How, if at all, does the implementation vary between early adopter areas?**
   - Although health boards are expected to meet the minimum standards for weight management services, the prevention framework is not prescriptive of the type, length and content of interventions, allowing for a certain degree of variation in implementation between areas.
   - How, if at all, do recruitment, staffing and services offered vary between sites?
   - What contextual factors enable or hinder the successful implementation of the framework? What, if any, solutions were found to contextual barriers?
   - What criteria do services use to allocate patients to particular interventions?

4. **What, if any, are the unintended consequences of the prevention framework for patients and/or service delivery?**
   - Unintended consequences for patients would include psychosocial (such as stigmatisation, development of body dissatisfaction, lowered self-esteem, anxiety) or economic harm (need to invest more of disposable income into commercial weight management programmes)
   - Unintended consequences for services would be increased focus of weight management services on patients with or at risk of type 2 diabetes to the detriment of other patient groups

5. **Have effective mechanisms for identifying high risk populations been identified?**
   Risk of type 2 diabetes increases with age, is higher among particular ethnic groups, those who are overweight, have high blood pressure. And women with a history of gestational diabetes. In Scotland, incidence of type 2 diabetes has stabilised in the past few years, but has increased among young men and both men and women from most deprived areas.

6. **How do services ensure effective engagement and support for people who are hard to reach?**
   Research suggests that some of the at risk groups are less likely to access services, accept referrals to weigh management and complete programmes.

7. **What changes to the framework would improve national roll-out?**

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