

NHS Tayside

Follow-up Report ~ *April 2007*

**Diabetes**



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# 1 Introduction

Following the initial round of diabetes reviews in 2003 to assess performance against the Clinical Standards for Diabetes (2<sup>nd</sup> ed.), the national overview and local reports were published in March 2004. NHS Quality Improvement Scotland (NHS QIS) is now undertaking a programme of follow-up reviews to each NHS board to reassess all criteria assessed as either 'not met' or 'not met (insufficient evidence)' during the 2003 reviews.

Each review team assesses performance using the categories 'met', 'not met' and 'not met (insufficient evidence)', as detailed below.

- **'Met'** applies where the evidence demonstrates the standard and/or criterion is being attained.
- **'Not met'** applies where the evidence demonstrates the standard and/or criterion is not being attained.
- **'Not met (insufficient evidence)'** applies where no evidence is available for the review team, or where the evidence available is insufficient to allow an assessment to be made.

A final category **'not applicable'** is used where a standard and/or criterion does not apply to the NHS board under review.

An NHS QIS diabetes steering group was established in May 2006 to provide advice and support to NHS QIS on appropriate methodology to review (see Appendix 2) against the existing standards. The group is chaired by Dr Mike Small, Consultant Physician, NHS Greater Glasgow and Clyde. Membership of the diabetes steering group includes both healthcare professionals and members of the public (see Appendix 4).

This report presents the findings from the peer review of **NHS Tayside**. This follow-up review visit took place on **18 January 2007**, and details of the visit, including membership of the review team, can be found in Appendix 3.

## 2 Overview of local service provision

Tayside is situated in the east of Scotland and has a population of around 389,707. Many of the population live in urban areas, of which Dundee and Perth are the largest in the region, although a significant proportion live in rural areas. The proportion of older people in the population is higher than the national average, whereas levels of illness and deprivation are close to the national average.

### Local NHS system and services

Tayside NHS Board is responsible for improving the health of the local population and for the delivery of the healthcare required. It provides strategic leadership and has responsibility for the efficient, effective and accountable performance of the NHS in Tayside.

At the time of the review visit, NHS Tayside operated through one single delivery unit and three community health partnerships (CHPs). Each CHP covers a geographical area and is a way of organising non-acute care where an NHS board maximises its ability to support integration across health services and between these and other agencies such as social services.

The NHS board is also accountable for both continuously improving the quality of health services, and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish (framework of clinical governance).

Further information about the local NHS system can be accessed via the website of NHS Tayside ([www.nhstayside.scot.nhs.uk/](http://www.nhstayside.scot.nhs.uk/)).

The Scottish Diabetes Survey 2005 indicated that 14,639 patients are registered with a recorded diagnosis of diabetes in NHS Tayside on an integrated area diabetes register. This figure can be broken down further to: 1,521 patients registered with Type 1 diabetes; 12,708 patients registered with Type 2 diabetes; and 228 patients with other types of diabetes ('other' includes gestational or maturity onset diabetes of youth [MODY]). There are 182 patients whose type of diabetes is not recorded or is not known.

In NHS Tayside, there are 71 GP practices and health clinics. A diabetes centre is located at Ninewells Hospital, Dundee. Specialist clinics are also held in Perth Royal Infirmary; Arbroath Infirmary; Stracathro Hospital, Brechin; Whitehills Health and Community Care Centre, Forfar; and Montrose Links Health Centre.

## 3 Summary of findings

A summary of the findings from the review, including examples of local initiatives drawn to the attention of the review team, is presented in this section. A detailed description of performance against the standards/criteria is included in Section 4.

In 2003, NHS Tayside met 37 out of 45 criteria. Of the remaining eight criteria, seven were given the assessment category of 'not met' and one was 'not met (insufficient evidence)'.

On the basis of new evidence submitted and the follow-up review visit, the review team considered that 37 out of 45 criteria are now 'met'.

However, two former 'met' criteria have since been regraded 'not met' and one former 'met' criterion has been regraded 'not met (insufficient evidence)'.

### Organisation

Scottish Care Information - Diabetes Collaboration (SCI-DC) Network (used mainly in primary care) and SCI-DC Clinical (hospital-based system) remain in use throughout NHS Tayside. At the time of the follow-up review, an updated version of SCI-DC Clinical (4.3) was being rolled out across NHS Tayside.

At the time of the follow-up review, 59 GP practices used General Practice Administration System for Scotland (GPASS). Data entered into GPASS automatically populates SCI-DC Network. As part of its eHealth strategy, NHS Tayside is transferring 85% of its GP practices to the Vision system by mid-2007. Links will be created to allow the electronic transfer of data from Vision to SCI-DC. It is envisaged that all GP practices will then be importing data to SCI-DC.

The diabetes strategy and implementation plan is currently under review, at the request of the CHPs. A series of meetings has been held with the CHPs, and it was reported that there have been no significant changes to the basis of the strategy, pathway of care and priorities.

The NHS Tayside diabetes network board has responsibility for providing the strategic lead for diabetes services across NHS Tayside. There are a high number of lay representatives on the strategic board.

The SCI-DC patient-held summary record was formally launched on the day of the follow-up review. This will allow patients to obtain a printed summary of their personal information held within their SCI-DC patient record, including results and targets. The patient-held summary record was designed with input from patient representatives. This will also be nationally available for all NHS boards to access through SCI-DC for their patients.

## Patient focus

At the time of the follow-up review, evidence was provided of improved formal educational provision for newly diagnosed patients.

### Example of a local initiative...

A centralised booking system for patient education is in operation through SCI-DC, whereby any healthcare professional in the GP practice can book patients onto an education session. This online booking system is being further developed to improve functionality and also provide information on attendance rates and waiting times.

The NHS Tayside diabetes handbook continues to be updated regularly and is made widely available through the NHS Tayside diabetes managed clinical network (MCN) website and links within SCI-DC. Patient information leaflets developed by the diabetes MCN are also made widely available via the website and have been widely used by other NHS boards.

There are access issues relating to podiatry, dietetic and psychology services. In particular, there is variable access to podiatry and dietetic services provision across NHS Tayside. There remains appropriate access to specialist nursing services, although NHS Tayside reported that demand is increasing. This is impacting on the provision of group education for patients.

## Clinical review

For the purposes of the follow-up reviews, the Quality and Outcomes Framework (QOF) data were used to assess and support the recording of the relevant indicators noted in Criterion 4.1. It was agreed that a 90% recording achievement rate would be acceptable, with the exception of retinal screening which should be assessed at 80% in line with the NHS QIS Clinical Standards for Diabetic Retinopathy Screening (March 2004).

At the time of the follow-up review, QOF data stated an 85% achievement rate for microalbuminuria testing.

Near patient testing is undertaken in the hospital clinics, allowing results to be available at the time of the patient's consultation. The majority of GP practices now routinely undertake pre-clinic blood testing to ensure that results are available at the time of the clinic appointment. It was reported that two GP practices do not offer pre-clinic blood testing to patients.

## Clinical management

### Eyes:

At the time of the follow-up review, NHS Tayside reported that it had been unable to adopt the national diabetic retinopathy digital screening service (Soarian) as there are compatibility issues between the mobile cameras and the national Siemens software. While NHS Tayside awaits resolution of these issues, the existing local eye

screening service continues to be used as an interim measure. This screening service is compliant with the Health Technology Board for Scotland (HTBS) grading recommendations.

**Cardiovascular status:**

All appropriate cardiovascular protocols had been implemented during the 2003 review. These criteria remain 'met'.

**Feet:**

Protocols for referral, drug and pressure relief treatment of diabetic foot disease remain in place. However, there are issues in relation to appropriate access to podiatry services.

A programme is being developed to provide intensive one-to-one education for low risk patients enabling them to self-manage their own foot care. Additional measures are under way to refer existing low–moderate risk patients back to the community for management of their condition, with the opportunity to rapidly refer patients to specialist secondary care as and when required.

In NHS Tayside, it is not routine practice to photograph all diabetic foot ulcers.

**Glycaemia:**

Processes are in place to tailor drug and insulin therapy for patients with Type 1 or Type 2 diabetes. This includes a locally developed intensive insulin management course which is being rolled out across NHS Tayside.

**Renal:**

NHS Tayside is moving towards implementing estimated glomerular filtration rate (eGFR) referral criteria to assist in the referral between diabetes and renal services.

**Acute management:**

Protocols remain in place for the acute management of people with diabetes who experience an acute diabetic emergency.

Although information on patients admitted to hospital with diabetes-related conditions is available through the Scottish Morbidity Record (SMR) system, NHS Tayside reported that there is no ongoing routine mechanism for monitoring the type of diabetic emergency admission.

## 4 Detailed findings against the standards

### Standard 1: Organisation: IM&T, Clinical Management Systems, Audit and Monitoring

#### Standard Statement

*All people with diabetes, with appropriate consent, are placed on a clinical management system which contains core information about their care and allows ongoing useful clinical information to be recorded for use in direct patient care and service audit.*

#### NHS Tayside

#### Essential Criteria

1: *There is an up-to-date population-based electronic clinical management system of all people with a recorded diagnosis of diabetes in the area which covers: initial diabetes diagnosis; development of significant diabetes micro- and macrovascular co-morbidities; year of onset of co-morbidities; measurement of ongoing modifiable risk factors; long-term medication for diabetes and other chronic conditions.*

#### STATUS: Met

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

Scottish Care Information - Diabetes Collaboration (SCI-DC) Network (used mainly in primary care) and SCI-DC Clinical (hospital-based system) remain in use throughout NHS Tayside. At the time of the follow-up review, it was reported that an updated version of SCI-DC Clinical (4.3) is currently being rolled out across NHS Tayside.

At the time of the follow-up review, 59 GP practices used General Practice Administration System for Scotland (GPASS). Data entered into GPASS automatically populates SCI-DC Network. It was reported that, as part of its eHealth strategy, NHS Tayside is transferring 85% of its GP practices to the Vision system by mid-2007. Links will be created to allow the electronic transfer of data from Vision to SCI-DC. It is envisaged that all GP practices will then be importing data to SCI-DC.

All appropriate healthcare professionals have been issued with passwords and can access SCI-DC. Only a very small percentage of staff have no immediate access to SCI-DC due to a lack of computers, for example community podiatrists or staff working in specialised hospital clinics, eg antenatal. This is to be addressed through the eHealth strategy's rolling programme by the end of the current financial year.

It was confirmed that there are clear restrictions and built-in safeguards on accessing patient-specific data. For example, accounts are self-limiting, only allowing access to

a GP practice's own data; or in secondary care, access by healthcare professionals is only to patients attending a relevant secondary care clinic. A data protection audit trail facility has been built in to audit usage of data and access to the system, which is controlled through the data governance subgroup.

There were no reported issues with patient consent for inclusion on SCI-DC. NHS Tayside complies with all national guidance in relation to data included within SCI-DC.

On the day of the follow-up review, the patient representative reported confidence in the security of data and found the SCI-DC system both helpful and purposeful in the ongoing management of diabetes.

2: *Data interfaces are in place between primary and acute care such that a single data entry covers all recording needs.*

**STATUS: Not met**

In 2003, this criterion was graded as 'not met' as there were no data interfaces in place so that one single data entry populated the primary and secondary care information systems.

At the time of the follow-up review, there was no facility to back-populate data from SCI-DC Clinical into the primary care systems, resulting in double data entry.

As a result, this criterion will not be 'met' until the national SCI-DC Network system fully interfaces with all other relevant NHS information systems.

3: *The Board participates in the Scottish Diabetes Survey.*

**STATUS: Met**

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

4: *Data are collected using the clinical management system on a continuous basis to facilitate regular audit and quality assurance. The quality of the data is also regularly audited.*

**STATUS: Met**

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

At the time of the follow-up review, the review team commended the data quality assurance process in place. The system has a built in algorithm that looks for the most reliable source of data. An open communication system and no blame culture

exists; if inaccurate or incorrect data is spotted, staff can amend themselves or contact the managed clinical network (MCN) data facilitator. The MCN data facilitator has been in full employment for 10 years to look at data validations.

Data collected through SCI-DC is used to measure service quality and improvement. Data is continually audited and validated. Information collected is contained within the diabetes MCN annual report. The MCN reports annually on progress against objectives to NHS Tayside's improvement and quality subcommittee. It was highlighted that any use of data, for example, for research purposes, provides an opportunity to simultaneously quality assure, review and validate.

### **Desirable Criterion**

5: *The computerised clinical management system is Board-wide and incorporates call and recall systems for screening/review of complications.*

### **STATUS: Not met**

In 2003, this criterion was graded as 'not met' as the SCI-DC clinical management systems did not incorporate call and recall systems for screening/review of complications.

At the time of the follow-up review, it was noted that the national SCI-DC system still does not have a call and recall function; as a consequence, this criterion cannot be 'met'.

Primary and secondary care utilise their own call/recall systems. A robust, centralised call/recall system is in place to ensure that all patients on SCI-DC are called for retinal screening.

## Standard 2: Organisation: Pathway of Care, Teamworking and Integration of Services

### Standard Statement

*There is an agreed area-wide structured programme of care which clearly defines: reporting arrangements and accountability; the care that people with diabetes should expect to receive; the processes of care that will be followed after diagnosis (including pre- and perioperative management); the protocols and guidelines that determine which clinician is responsible for the delivery of specific aspects of care; criteria for referral.*

### NHS Tayside

#### Essential Criteria

1: *There is a local strategy and implementation plan for diabetes services that covers diagnosis, screening for complications, treatment and care.*

#### STATUS: Met

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

At the time of the follow-up review, it was reported that the diabetes strategy and implementation plan was currently under review, at the request of the community health partnerships (CHPs). A series of meetings has been held with the CHPs, and it was reported that there have been no significant changes to the basis of the strategy, pathway of care and priorities.

Approximately 50% of patients with diabetes continue to attend hospital clinics as part of their diabetes care. The diabetes MCN has developed and agreed a patient pathway to ensure patients receive appropriate care in the appropriate place. However, it was reported that this pathway has yet to be fully implemented. This is being considered as part of strategy discussions with CHPs.

2: *There is an effective, well-organised strategic planning group including stakeholders: a Local Diabetes Service Advisory Group (LDSAG), or equivalent, which is accountable to the NHS Board.*

#### STATUS: Met

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

The NHS Tayside diabetes network board has responsibility for providing the strategic lead for diabetes services across NHS Tayside. The review team noted the high number of lay representatives on the strategic board.

3: *There are agreed guidelines for shared care and referral and discharge between primary care teams and diabetes specialist care teams, which are regularly and jointly reviewed. These include protocols for the management of diabetes during other illnesses and procedures.*

**STATUS: Met**

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

The NHS Tayside diabetes handbook continues to be updated regularly and is made widely available through the NHS Tayside diabetes MCN website and links within SCI-DC.

Challenges were highlighted, however, in relation to ensuring guidelines remain up to date in light of changing legislation and the significant IT resource and dedicated time required for website programming.

4: *All people with diabetes have an individualised plan of care including mutually agreed targets based on Clinical Standards and the Scottish Diabetes Framework.*

**STATUS: Met**

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

The SCI-DC patient-held summary record was formally launched on the day of the follow-up review. This will allow patients to obtain a printed summary of their personal information held within their SCI-DC patient record, including results and targets. The patient-held summary record was designed with input from patient representatives.

NHS Tayside will now embark on a publicity and awareness campaign to ensure patients and staff are aware this facility. It will also be nationally available through SCI-DC for all NHS boards to access for their own patients. There is recognition, however, that this will be an evolving process while the facility beds in and becomes routinely utilised.

5: *There are identified lead clinicians for diabetes in acute and primary care.*

**STATUS: Met**

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

6: *There are robust fail-safe arrangements for identifying and following up people with diabetes who default from clinics, which take into account patient choice and responsibility for their care.*

**STATUS: Met**

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

## Standard 3: Patient Focus

### Standard Statement

*All people with diabetes have equitable access to information and multidisciplinary programmes of education, which are tailored to individual needs and specific client groups.*

### NHS Tayside

#### Essential Criteria

1: *All people newly diagnosed with diabetes are offered at least one appropriately tailored formal educational session about their condition and are provided with written material to reinforce that education.*

#### STATUS: Met

In 2003, this criterion was graded as ‘not met (insufficient evidence)’ as there was no evidence provided to the review team to indicate that there was a formal, widespread, systematic approach to education for newly diagnosed patients in secondary care. Similarly, there was no systematic approach to education for newly diagnosed patients in primary care.

At the time of the follow-up review, the review team noted the improved formal educational provision for newly diagnosed patients. This includes the Tayside Diabetes Education Programme (TDEP) which provides structured group education for patients newly diagnosed with Type 2 diabetes. There are two models of this programme used, either delivered by secondary care diabetes specialist nurses, or practice nurses mentored by diabetes specialist nurses. Issues do exist, however, in relation to the availability of suitable accommodation and manpower. It was recognised that this programme has built on the enthusiasm and commitment of staff. Action plans are to be agreed with the CHPs on the roll-out of the programme to ensure it is accessible for all patients across NHS Tayside.

The review team commended the central booking system for patient education in operation through SCI-DC, whereby any healthcare professional in the GP practice can book patients onto an education session. It was reported that the online booking system is being further developed to improve functionality and also provide information on attendance rates and waiting times.

There are a variety of patient information leaflets available to healthcare professionals and patients through SCI-DC and the NHS Tayside diabetes MCN website.

There are a wide range of healthcare professionals providing patient education. As a consequence, NHS Tayside recognises the commitment required to ensure appropriate quality assurance and training of the educators. It was reported that the diabetes MCN has approached the University of Dundee to develop an accredited course in group education skills. Additionally, it was reported that the diabetes specialist nurses are developing a standardised workbook to ensure the education

programme delivered is consistent across NHS Tayside, ensuring every patient receives the same information. This will also allow for peer evaluation.

2: *Educational programmes continue after diagnosis and include diet, foot care and eye care as well as day-to-day management of diabetes.*

**STATUS: Met**

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

3: *There are specific care programmes for different client groups in the population including children, adolescents, adults, elderly, preconceptional and pregnant women with diabetes, women with gestational diabetes, ethnic and vulnerable groups.*

**STATUS: Met**

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

4: *People with diabetes are involved in consultation on service development.*

**STATUS: Met**

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

At the time of the follow-up review, it was reported that the diabetes MCN has worked collaboratively with other long-term condition MCNs in NHS Tayside to develop an induction pack for lay representatives of MCN strategic groups. This provides background information on NHS Tayside, MCNs and expectations of MCN members. Additionally, a training programme for lay representatives is being developed.

**Desirable Criteria**

5: *People with diabetes have appropriate access to identified key health professionals including state registered podiatry and dietetic, nursing and psychology services.*

**STATUS: Not met**

In 2003, this criterion was graded as 'not met' as there was no full-time specialist diabetes dietetic service in Perth & Kinross. It was reported that a redesign project

had been undertaken to consider the availability of dietetic provision in primary and secondary care. Additionally, there was no dedicated adult diabetes psychology service available. There was good access to specialist nursing and podiatry services.

At the time of the follow-up review, there were access issues relating to podiatry, dietetic and psychology services. There remains appropriate access to specialist nursing services, although NHS Tayside reported that demand on this service is increasing.

There is variable access to podiatry services provision across NHS Tayside, across both primary and secondary care. There is one full-time diabetes specialist podiatrist within NHS Tayside. Levels of podiatry resource available vary by CHP area, as funding is held within the CHP budgets.

Efforts are being made to target high risk patients, including the development of specialist access criteria and a risk stratification matrix to increase the recording of foot score. It was reported that approximately 37% patients on SCI-DC have a foot score recorded.

It was noted that a podiatry practitioner post has been created to address some of the inequity of care delivered across NHS Tayside. This involves two podiatrists with a specific interest in diabetes, seconded for a 2-year period. This post will include provision to assist patients with basic foot care and maintenance education, backfill staff in foot clinics, and provide an educational role.

There is variable access to dietetic provision across NHS Tayside. Dedicated diabetes dietitians are available only in Dundee and Angus. The provision of dietetic services is to be considered as part of the diabetes strategy review in collaboration with the CHPs and acute services. It was reported that the diabetic subgroup of the Tayside nutrition and dietetics network is developing NHS board-wide access criteria for appropriate access to dietetic services.

There is no dedicated diabetic psychology service. The service can refer to general psychology services; however, waiting times can often be lengthy. In Dundee, there is an informal arrangement with psychiatry services and appropriate patients will be seen in about 2 weeks. There is 0.1 whole time equivalent (WTE) psychology support for the paediatric service.

6: *Members of the diabetes team who are involved in patient education have access to a training programme.*

#### **STATUS: Met**

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

At the time of the follow-up review, it was confirmed that training and education continues to be an ongoing process through the locality forum groups in each of the CHP areas. This includes quarterly educational evening events.

A professional learning module (Dundee diabetes course) is run jointly by the NHS Tayside diabetes MCN and the University of Dundee.

A conference is organised every 2 years by the diabetes MCN, which was reported to be well attended. The next conference is planned for 2007.

The review team noted good access for healthcare professionals to local, national and international training and education.

## Standard 4: Clinical Review

### Standard Statement

*All people with diabetes are offered annual or more frequent examination, where clinically indicated, to monitor the management and progression of their condition. There is intervention as required and support for the modification of lifestyle risk factors.*

### NHS Tayside

#### Essential Criteria

- 1: *There is a protocol to ensure that all people with diabetes are offered review of the following indicators on an annual basis, or more frequently where clinically indicated, from diagnosis.*

#### *Clinical*

*Glycated haemoglobin (HbA1c); Blood pressure; Random total cholesterol; Eye examination for diabetic retinopathy according to HTBS recommendations; Urinalysis for microalbuminuria and proteinuria; Serum creatinine; Foot examination for ischaemia, neuropathy and general foot care; Review of medication.*

#### *Lifestyle/Well-being*

*Body Mass Index (BMI); Dietary intake; Physical activity; Tobacco consumption (smoking habit); Perception and understanding of condition; Psychological well-being; Sexual health.*

#### STATUS: Not met

In 2003, this criterion was graded as 'not met' as low returns for urinalysis for microalbuminuria and proteinuria were noted. In addition, low figures were recorded for foot screening.

Since publication of the NHS Quality Improvement Scotland (NHS QIS) Clinical Standards for Diabetes (2<sup>nd</sup> ed.), it should be noted that the Quality and Outcomes Framework (QOF), part of the new General Medical Services (nGMS) contract, now allows a 15-month period for annual patient review.

The QOF, introduced in 2004, is a system to remunerate general practices for providing good quality care to their patients and to help support work to further improve the quality of healthcare delivered. QOF includes evidence-based indicators and disease prevalence rates for specific diseases or conditions. This includes 18 diabetes clinical indicators which relate to patients with Type 1 or Type 2 diabetes. For the purposes of the follow-up reviews, QOF data were used to assess and support the recording of the relevant indicators noted in this criterion. It was agreed that a 90% recording achievement rate would be acceptable, with the exception of retinal screening which should be assessed at 80% in line with the NHS QIS Clinical Standards for Diabetic Retinopathy Screening (March 2004).

At the time of the follow-up review, QOF data stated an 85% achievement rate for microalbuminuria testing.

There are appropriate initiatives in place to discuss and manage lifestyle and well-being factors, such as exercise referral schemes and smoking cessation services.

2: *Patients are informed of their results and offered support to manage lifestyle risk factor changes.*

#### **STATUS: Met**

In 2003, this criterion was graded as 'not met' as, where results were not immediately available, patients were only informed if results were found to be abnormal. At the time of the review, patient-held diabetes summary sheets were to be piloted.

At the time of the follow-up review, it was confirmed that near patient testing is undertaken in the hospital clinics, allowing results to be available at the time of the patient's consultation.

The majority of GP practices now routinely undertake pre-clinic blood testing to ensure that results are available at the time of the clinic appointment. It was reported that two GP practices do not offer pre-clinic blood testing to patients.

If test results are not available at the time of the clinic appointment, patients are informed by telephone, letter or contacted with a further appointment.

The SCI-DC patient-held summary record was formally launched on the day of the follow-up review. This will allow patients to obtain a printed summary of their personal information held within their SCI-DC patient record.

#### **Desirable Criterion**

3: *Referring practitioners (including optometrists, with patient consent) are given feedback regarding the outcome of their referrals.*

#### **STATUS: Met**

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

## Standard 5: Clinical Management: Eyes

### Standard Statement

*All people with diabetes who have identified signs of developing diabetes-related, sight-threatening retinopathy, are referred to an ophthalmologist for assessment, and, if necessary, treatment.*

### NHS Tayside

#### Essential Criteria

1: *There is a referral process to a consultant ophthalmologist-led service for people with diabetes with identified signs of developing diabetes-related, sight-threatening retinopathy according to HTBS grading recommendations.*

#### STATUS: Met

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

At the time of the follow-up review, NHS Tayside reported that it had been unable to adopt the national diabetic retinopathy digital screening service (Soarian) as there are compatibility issues between the mobile cameras and the national Siemens software. The majority of the eye screening service in NHS Tayside is undertaken using mobile cameras, with one fixed camera in use in Ninewells Hospital, Dundee.

While NHS Tayside awaits resolution of these issues, the existing local eye screening service continues to be used as an interim measure. This screening service is compliant with the Health Technology Board for Scotland (HTBS) grading recommendations. NHS Tayside stressed that it recognises the advantages of the Soarian system, and is willing to fully utilise the new system when locally possible.

Good communication was reported between the eye screening service and SCI-DC Network.

NHS Tayside undertakes grading of retinal images for NHS Orkney and NHS Western Isles, with images downloaded and transferred to NHS Tayside overnight. These retinal images are graded using the Soarian system.

2: *All people whose eye examination has revealed retinopathy have their glycaemic control and blood pressure reviewed and treated as clinically indicated.*

#### STATUS: Met

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

3: *All people with active proliferative diabetic retinopathy are offered laser treatment.*

**STATUS: Met**

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

## Standard 6: Clinical Management: Cardiovascular Status

### Standard Statement

*All people with diabetes who have identified associated cardiovascular problems are managed according to locally agreed protocols and are considered for referral and additional treatment as clinically indicated.*

### NHS Tayside

#### Essential Criteria

1: *Where blood pressure is consistently greater than 140 systolic and/or 80 diastolic (140/80mmHg), attempts are made to lower the blood pressure according to locally agreed protocols.*

#### STATUS: Met

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

At the time of the follow-up review, it was reported that there is a good working relationship between the diabetes and coronary heart disease MCNs, and rapid referral to cardiology services when required.

2: *There is a local protocol for the management of consistently high cholesterol (>5mmol/l).*

#### STATUS: Met

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

3: *There is a local protocol for the management of angina.*

#### STATUS: Met

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

It was noted this protocol is due to be reviewed following publication of an updated Scottish Intercollegiate Guidelines Network (SIGN) angina guideline in February 2007.

4: *All people with diabetes who have been diagnosed with acute myocardial infarction are offered clinical care as detailed in the CSBS Clinical Standards for Secondary Prevention following Acute Myocardial Infarction.*

**STATUS: Met**

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

5: *The Joint British Societies Coronary Risk Prediction Chart, or recognised equivalent, is used to assess coronary heart disease risk in primary care.*

**STATUS: Met**

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

## Standard 7: Clinical Management: Feet

### Standard Statement

*All people with diabetes who have identified associated foot problems are referred for specialist assessment and, if necessary, treatment.*

### NHS Tayside

#### Essential Criteria

1: *There is a rapid referral process for people with diabetes with associated foot problems. The referral protocol states clearly whether referral is to primary or secondary care. In particular, conditions not responding to treatment provided by primary care are referred to secondary care.*

#### STATUS: Met

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

At the time of the follow-up review, it was reported that low–moderate risk patients are being referred back for management in the community, with the opportunity to rapidly refer patients to specialist secondary care as and when required. Patients are informed of the reason for discharge to primary care.

Additionally, a programme is being developed to provide intensive one-to-one education for low risk patients enabling them to self-manage their own foot care.

At the time of the follow-up review, it was reported that a podiatry patient-held record was being piloted in Perth.

2: *All people with diabetes have appropriate access to state registered podiatry services.*

#### STATUS: Not met

This criterion was 'met' in 2003. However, please refer to Criterion 3.5. At the time of the follow-up visit, the review team noted the inequitable access to podiatry services.

3: *There is a local protocol for drug and pressure relief treatment of diabetic foot disease.*

#### STATUS: Met

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

## Desirable Criterion

4: *All people with diabetic foot ulcers are reviewed by a diabetes foot specialist, using digital camera photographs for comparison.*

### STATUS: Not met

In 2003, this criterion was graded as 'not met' as, despite the availability of digital cameras, it was not routine practice to photograph all diabetic foot ulcers, only where there was a perceived problem.

At the time of the follow-up review, it was reported that it is not routine practice to photograph all diabetic foot ulcers. Staff reported a lack of national guidance in relation to use of digital cameras, resolution of photographs, size of image, etc.

Issues were noted with the printing of digital photographs and electronic storage of photographic images.

It was reported that the Texas foot ulcer classification grading system is to be piloted in the coming months to document and monitor diabetic foot ulcers.

## Standard 8: Clinical Management: Glycaemia

### Standard Statement

*All people with diabetes have HbA1c measured and recorded as clinically indicated.*

#### NHS Tayside

#### Essential Criteria

1: *Drug and insulin therapy is tailored to achieve the best possible glycaemic control without frequent or severe hypo/hyperglycaemia, and there is specific guidance for children and pregnant women.*

#### STATUS: Met

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

NHS Tayside has developed a local intensive insulin management course which is being rolled out across the NHS board area.

Following a trial of the use of insulin pump therapy, funding has been secured in support of children and adults using insulin pump therapy. Local criteria have been developed based on National Institute for Health and Clinical Excellence (NICE) guidance. As at January 2007, there were 42 people on insulin pump therapy in NHS Tayside. The usage of insulin pump therapy continues to be monitored on an ongoing basis.

2: *A DCCT compatible assay is used for the measurement of HbA1c.*

#### STATUS: Met

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

3: *Sequential HbA1c measurements are used to identify people with diabetes who have poor glycaemic control. Specific targets are agreed for each individual patient.*

#### STATUS: Met

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

4: *The incidence of hypo/hyperglycaemia is monitored and the results are discussed with the patient.*

#### **STATUS: Met**

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

However, at the time of the follow-up review, NHS Tayside reported difficulties with monitoring incidences of hypoglycaemia which are either treated at home or in the accident and emergency department. Subsequently, if patients are not admitted to hospital, the diabetes team may not be informed.

Issues were also highlighted with the inability to monitor and audit collective incidences of acute diabetic ketoacidosis from the information contained within SCI-DC.

#### **Desirable Criterion**

5: *HbA1c measurements are made available to colleagues in the diabetes (primary and secondary care) team and sent to patients.*

#### **STATUS: Met**

In 2003, this criterion was graded as 'not met' as, following an appointment in primary care, patients were only informed by letter, telephone or through face-to-face discussion of abnormal results. In the hospital clinics, results are available at the time of the consultation.

At the time of the follow-up review, it was noted that the majority of GP practices now routinely undertake pre-clinic blood testing to ensure that results are available at the time of the clinic appointment.

If test results are not available at the time of the clinic appointment, patients are informed by telephone, letter or contacted with a further appointment.

## Standard 9: Clinical Management: Renal

### Standard Statement

*All people with diabetes and identified associated kidney problems are referred for specialist assessment and, if necessary, treatment.*

### NHS Tayside

#### Essential Criteria

1: *All people with identified abnormal renal function serum creatinine (greater than 150 micromols/l) are considered for referral to a renal clinic.*

#### STATUS: Met

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

At the time of the follow-up review, it was reported that NHS Tayside is moving towards implementing estimated glomerular filtration rate (eGFR) referral criteria to assist in the referral between diabetes and renal services.

2: *All people whose urinary albumin concentration is greater than 300mg/l (ie albuminuria which is thought to be due to diabetic nephropathy), have blood pressure, glycaemic control and serum cholesterol levels reviewed as clinically indicated.*

#### STATUS: Met

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

3: *All people with Type 1 diabetes, with microalbuminuria as defined in a local protocol, are prescribed an ACE inhibitor unless there are contraindications.*

#### STATUS: Not met (insufficient evidence)

This criterion was 'met' in 2003. However, at the time of the follow-up review, information on the number of people with microalbuminuria or proteinuria who have been prescribed an ACE inhibitor was collected as part of QOF data. The QOF data submission presented to the review team recorded 80% of eligible patients have been prescribed an ACE inhibitor. It was noted that QOF requires exception reporting for patients not prescribed an ACE inhibitor.

However, QOF data are unable to distinguish between patients with Type 1 or Type 2 diabetes.

## Desirable Criterion

- 4: *All people with proteinuria and a reduced glomerular filtration rate are offered dietetic intervention to review dietary protein intake and to assess the nutritional adequacy of their diet.*

### STATUS: Met

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

There is dietetic input at the weekly combined diabetic renal clinic held in Ninewells Hospital.

## Standard 10: Clinical Management: Acute Management

### Standard Statement

*All people with diabetes who experience an acute diabetic emergency including severe hypoglycaemia, diabetic ketoacidosis (DKA) or hyperosmolar non-ketotic state are rapidly assessed and managed according to local protocols.*

### NHS Tayside

#### Essential Criteria

1: *There is a local protocol for the acute management of people with diabetes who experience an acute diabetic emergency including severe hypoglycaemia, diabetic ketoacidosis (DKA) or hyperosmolar non-ketotic state.*

#### STATUS: Met

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

At the time of the follow-up review, it was noted that NHS Tayside has implemented the recent updated nationally agreed protocol for diabetic ketoacidosis.

2: *People with diabetes who are admitted to hospital with diabetic ketoacidosis are reviewed by a specialist diabetes physician or nurse prior to discharge.*

#### STATUS: Met

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

#### Desirable Criteria

3: *People with diabetes who experience severe hypoglycaemia are referred, on recovery, to specialist diabetes services for advice on psychological, clinical and lifestyle aspects of their care.*

#### STATUS: Met

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'.

4: *The rate of diabetic emergencies is monitored for all those with diabetes in the area.*

**STATUS: Not met**

This criterion was 'met' in 2003. At the time of the follow-up review, information on patients admitted to hospital with diabetes-related conditions was available through the Scottish Morbidity Record (SMR) system. However, NHS Tayside reported that there is no ongoing routine mechanism for monitoring the type of diabetic emergency admission. NHS Tayside stated that potential mechanisms to address this are being explored.

The review team noted the use of biochemistry data to monitor incidences of hyperglycaemia.

## 5 Progress against the national overview recommendations (March 2004)

At the time of the follow-up reviews, NHS QIS took the opportunity to ask NHS boards to provide an update on progress against the recommendations identified in the diabetes national overview (March 2004).

### Standard 1: Organisation: IM&T, Clinical Management Systems, Audit and Monitoring

**NHS boards should develop a formal project plan for the local implementation of SCI-DC.**

<b>Progress:</b>	SCI-DC Network and SCI-DC Clinical are in use across primary and secondary care. The updated version 4.3 of SCI-DC Clinical is currently being rolled out across NHS Tayside.
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### Standard 2: Organisation: Pathway of Care, Teamworking and Integration of Services

**NHS boards should be engaged in the strategic planning for diabetes services, through the development of MCNs for diabetes. There should be evidence of support from the Board, and incorporation into the Board's local health plan.**

<b>Progress:</b>	<p>At the time of the follow-up review, it was reported that the diabetes strategy and implementation plan was currently under review in collaboration with the CHPs and acute services.</p> <p>The NHS Tayside diabetes network board has responsibility for providing the strategic lead for diabetes services across NHS Tayside, and reports to Tayside NHS Board through the improvement and quality subcommittee.</p> <p>NHS Tayside's diabetes MCN was formally accredited by NHS QIS in 2004.</p> <p>The diabetes MCN is included in NHS Tayside's local health plan as part of improving healthcare through redesign.</p>
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**NHS boards should develop methods to routinely record and implement mutually agreed individual care plans for patients.**

<b>Progress:</b>	<p>The SCI-DC patient-held summary record was formally launched on the day of the follow-up review. This will allow patients to obtain a printed summary of their personal information held within their SCI-DC patient record.</p> <p>This facility will also be nationally available through SCI-DC for all NHS boards to access for their own patients.</p>
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<b>Standard 3: Patient focus</b>	
<b>NHS boards should work together to provide a comprehensive range of standardised diabetes patient information materials.</b>	
<b>Progress:</b>	<p>Patient information leaflets developed by the diabetes MCN are made widely available via the MCN's website and have been widely used by other NHS boards. The diabetes MCN also makes use of nationally developed leaflets where available.</p>
<b>NHS boards should offer a programme of initial and continuing patient diabetic education, which should detail educational content, provider, and the initial and continuing training requirements for those delivering it.</b>	
<b>Progress:</b>	<p>A range of education is provided for patients with diabetes at various stages of the care pathway. This includes TDEP for newly diagnosed patients with Type 2 diabetes; the Tayside Intensive Insulin Management Programme for patients with Type 1 diabetes; and group insulin starts for patients with Type 2 diabetes. The diabetes MCN is working to ensure all patients have access to these programmes and to review continuing education requirements.</p> <p>The diabetes MCN is working with the long-term conditions programme in NHS Tayside which is developing a self-care framework incorporating community-based programmes and education materials for patients and carers.</p>
<b>NHS boards should ensure that all people with diabetes are offered advice about reducing the long-term complications of diabetes and about the purpose and importance of medication.</b>	
<b>Progress:</b>	<p>TDEP and the Tayside Intensive Insulin Management Programme both include specific information and advice on reducing long-term complications. There is recognition, however, that these programmes need to become available across NHS Tayside.</p> <p>Patients are also continually provided with information and advice during annual reviews and clinic visits.</p>
<b>NHS boards should ensure that provision of dietetic, nursing and psychology services are such that they meet the needs of the local diabetic population.</b>	
<b>Progress:</b>	<p>There is variable access to podiatry and dietetic services provision across NHS Tayside. This will be considered as part of the diabetes strategy review in collaboration with the CHPs and acute services.</p>

**NHS boards should ensure that effective staff training is provided to maintain standards of healthcare, and to ensure consistency in care delivery and education.**

<b>Progress:</b>	<p>The diabetes MCN works to provide ongoing support and training for the multi-professional healthcare team. This includes a University of Dundee certificate-level course in diabetes care and regular evening educational diabetes forum meetings in each locality.</p> <p>A network conference for health professionals is held every 2 years to allow sharing of new developments and best practice.</p>
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**Standard 4: Clinical review**

**NHS boards should provide a co-ordinated, structured, formalised annual review process for all people with diabetes. Clinical/lifestyle/well-being indicators may not necessarily need to be reviewed on the same day.**

<b>Progress:</b>	<p>The NHS Tayside diabetes handbook details the indicators and time period for annual review, ensuring a continuing structured and co-ordinated review process is in place for all people with diabetes.</p>
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**All patients with diabetes should be informed of both normal and abnormal test results in a timely fashion.**

<b>Progress:</b>	<p>Near patient testing is undertaken in the hospital clinics, allowing results to be available at the time of the patient's consultation. This includes HbA1c, serum creatinine levels and urinalysis results.</p> <p>The majority of GP practices now routinely undertake pre-clinic blood testing to ensure that results are available at the time of the clinic appointment. It was reported that two GP practices do not offer pre-clinic blood testing to patients.</p> <p>If test results are not available at the time of the clinic appointment, patients are informed by telephone, letter or contacted with a further appointment.</p> <p>The SCI-DC patient-held summary record was formally launched on the day of the follow-up review. This will allow patients to obtain a printed summary of their personal information held within their SCI-DC patient record.</p>
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**Standard 5: Clinical management: Eyes**

**NHS boards should implement HTBS grading recommendations.**

<b>Progress:</b>	<p>While NHS Tayside awaits resolution of compatibility issues with the national diabetic retinopathy digital screening service (Soarian), the existing local eye screening service continues to be used as an interim measure. This screening service is compliant with the HTBS grading recommendations.</p>
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<b>Standard 6: Clinical management: Cardiovascular Status</b>	
<b>NHS boards should implement area-wide protocols for identified associated cardiovascular problems in people with diabetes.</b>	
<b>Progress:</b>	All protocols for diabetes and associated problems are standardised across NHS Tayside. Protocols are contained within the NHS Tayside diabetes handbook.

<b>Standard 7: Clinical management: Feet</b>	
<b>NHS boards should ensure digital photography is available for the monitoring of diabetic foot problems, and photographs are integrated into the patient record.</b>	
<b>Progress:</b>	Although digital photography is available, it is not routine practice to photograph all diabetic foot ulcers. Issues were noted with the printing of digital photographs and the electronic storage of photographic images. Images cannot be stored onto the patient's SCI-DC record.

<b>Standard 8: Clinical management: Glycaemia</b>	
<b>NHS boards should work towards establishing pre-clinic blood testing or near patient testing to allow HbA1c results to be made available to the patient at the time of the clinic appointment.</b>	
<b>Progress:</b>	Near patient testing is undertaken in the hospital clinics, allowing results to be available at the time of the patient's consultation.  The majority of GP practices routinely undertake pre-clinic blood testing to ensure that results are available at the time of the clinic appointment.  If test results are not available at the time of the clinic appointment, patients are informed by telephone, letter or contacted with a further appointment.

<b>NHS boards should ensure that all patients with diabetes have access to specialist diabetes advice to ensure best possible glycaemic control is achieved.</b>	
<b>Progress:</b>	Patients are referred to the diabetes team as clinically indicated to ensure best possible glycaemic control is achieved. Primary care clinicians and patients can contact the specialist diabetes team by telephone for advice, as required.

<b>Standard 9: Clinical management: Renal</b>	
<b>NHS boards should ensure that mechanisms are in place to identify and best manage people during early, established and late stages of diabetic renal disease.</b>	
<b>Progress:</b>	Protocols are contained within the NHS Tayside diabetes handbook to identify and manage people with diabetic renal disease.

**NHS boards should define agreed management guidelines between renal and diabetes services to identify the pathway of care, ensuring consistency of referral.**

<b>Progress:</b>	<p>Protocols are contained within the NHS Tayside diabetes handbook to identify the pathway of care, ensuring consistency of referral between renal and diabetes services. NHS Tayside is moving towards implementing eGFR referral criteria to assist in the referral between diabetes and renal services.</p> <p>A weekly combined diabetic renal clinic is held in Ninewells Hospital.</p>
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**Standard 10: Clinical management: Acute management**

**NHS boards should develop mechanisms whereby patients admitted to A&E departments with acute diabetic emergencies receive specialist diabetes review.**

<b>Progress:</b>	<p>Any adult diabetic patient admitted to the acute medical admissions unit is automatically referred to the specialist diabetes team. All paediatric diabetic admissions are automatically referred to the specialist diabetes paediatric team.</p>
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**NHS boards should improve the audit and monitoring of diabetic emergencies, both at local and national level.**

<b>Progress:</b>	<p>Although information on patients admitted to hospital with diabetes-related conditions is available through the SMR system, NHS Tayside reported that there is no ongoing routine mechanism for monitoring the type of diabetic emergency admission.</p> <p>NHS Tayside stated that potential mechanisms to address this are being explored.</p>
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**To develop a link nurse network where diabetes teams of one or two individuals exist. These link nurses, although not expected to be experts in diabetes care, would be able to promote and facilitate the care of patients with diabetes as an additional support to the diabetes specialist nursing team.**

<b>Progress:</b>	<p>Rather than establishing a link nurse network, NHS Tayside has encouraged nursing staff to attend diabetes training courses, with attendance from a wide range of areas. For example, a number of ward nurses have attended the Dundee diabetes course, which is run jointly by the diabetes MCN and University of Dundee.</p> <p>A project has commenced in Perth Royal Infirmary to provide diabetes education to staff nurses within the medical unit; staff nurses are seconded for 2-week periods to work alongside the diabetes specialist nurses. Additionally, the diabetes specialist nurses run training sessions for nursing home staff, district nurses, social work and other community staff.</p>
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	<p>The diabetes specialist team is contributing to and participating in the Institute of Healthcare Improvement Safer Patients Initiative. This is a national initiative designed to improve the quality and safety of healthcare in the UK by encouraging the uptake and spread of best practices. Small cycles of change are being introduced to staff in NHS Tayside to influence change in practice, increase diabetes awareness, educate staff and patients, and reduce the risk of hospital-acquired complications of diabetes.</p>
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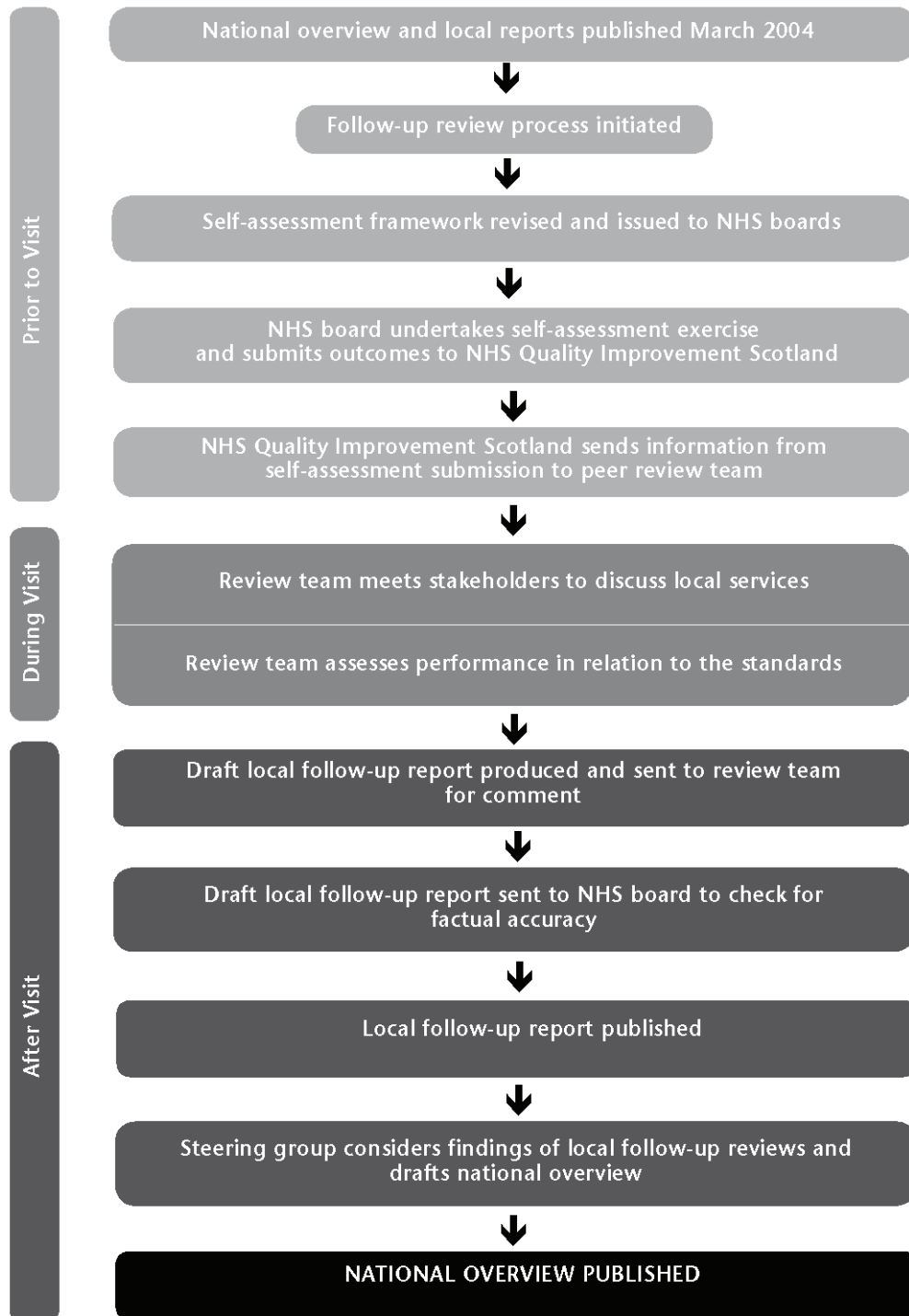
## Appendix 1 – Glossary of abbreviations

### Abbreviation

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<b>A&amp;E</b>	accident and emergency
<b>ACE</b>	angiotensin converting enzyme
<b>CHP</b>	community health partnership
<b>DCCT</b>	Diabetes Control & Complications Trial
<b>DKA</b>	diabetic ketoacidosis
<b>eGFR</b>	estimated glomerular filtration rate
<b>GP</b>	general practitioner
<b>GPASS</b>	General Practice Administration System for Scotland
<b>HbA1c</b>	glycated haemoglobin
<b>HTBS</b>	Health Technology Board for Scotland
<b>LDSAG</b>	local diabetes service advisory group
<b>MCN</b>	managed clinical network
<b>MODY</b>	maturity onset diabetes of youth
<b>nGMS</b>	new General Medical Services
<b>NHS QIS</b>	NHS Quality Improvement Scotland
<b>NICE</b>	National Institute for Health and Clinical Excellence
<b>QOF</b>	Quality and Outcomes Framework
<b>SCI-DC</b>	Scottish Care Information - Diabetes Collaboration
<b>SIGN</b>	Scottish Intercollegiate Guidelines Network
<b>SMR</b>	Scottish Morbidity Record
<b>TDEP</b>	Tayside Diabetes Education Programme
<b>WTE</b>	whole time equivalent

## Appendix 2 – The follow-up review process



## Appendix 3 – Details of review visit

The follow-up review visit to NHS Tayside was conducted on 18 January 2007.

### Review team members

**Dr Alistair Noble (Team Leader)**

General Practitioner (retired), NHS Highland

**Dr Alan Jaap**

Consultant Diabetologist, NHS Lothian

**Mr Jim McLaughlan**

Chief Podiatrist, NHS Forth Valley

**Mrs Dorothy McMenemie**

Diabetes Specialist Nurse, NHS Greater Glasgow and Clyde

**Mrs Alison Anderson**

Diabetes MCN Manager, NHS Ayrshire & Arran

**Mr William Reid**

Public partner, Lothian

### NHS Quality Improvement Scotland Personnel

**Miss Jan Nicolson**

Project Officer

**Mr Steven Wilson**

Team Manager

During the visit, members of the review team met with medical and nursing staff, allied health professionals, IT and audit staff, and patient representatives.

## Appendix 4 – NHS QIS diabetes steering group members

### Chair

#### **Dr Mike Small**

Consultant Physician, NHS Greater Glasgow and Clyde

### Steering Group Members

#### **Mr David Cline**

Programme Manager – Diabetes, Scottish Executive Health Department

#### **Mrs Alison Crooks**

MCN Diabetes Project Manager, NHS Dumfries & Galloway

#### **Ms Margaret Doyle**

Podiatry Service Lead South Community Health Partnership, NHS Ayrshire & Arran

#### **Dr Malcolm Kerr**

General Practitioner, NHS Ayrshire & Arran / Primary Care Advisor, NHS QIS

#### **Dr John McKnight**

Consultant Physician, NHS Lothian

#### **Miss Mary Scott**

Diabetes Network Manager, NHS Lothian / Project Manager, NHS QIS

#### **Ms Anna Thomson**

Public Partner, Forth Valley

#### **Mrs Debbie Voigt**

Diabetes Specialist Nurse, NHS Tayside

Support from NHS QIS was provided by **Ms Jan Warner** (Director of Performance Assessment and Practice Development), **Mr Steven Wilson** (Team Manager), **Mrs Fiona Russell** (Senior Project Officer), **Miss Jan Nicolson** (Project Officer), **Mrs Wendy Forbes** (Project Officer) and **Mr Alan Ketchen** (Project Administrator).

## Appendix 5 – Timetable of review visits

Organisation reviewed	Visit date(s)
NHS Ayrshire & Arran	20 December 2006
NHS Borders	24 January 2007
NHS Dumfries & Galloway	8 February 2007
NHS Fife	10 October 2006
NHS Forth Valley	17 April 2007
NHS Grampian	1 March 2007
NHS Greater Glasgow and Clyde*	29 March 2007
NHS Highland*	13 March 2007
NHS Lanarkshire	8 March 2007
NHS Lothian	5 April 2007
NHS Orkney	16 November 2006
NHS Shetland	30 November 2006
NHS Tayside	18 January 2007
NHS Western Isles	2 November 2006

\* A meeting also took place with Argyll & Clyde diabetes managed clinical network (MCN) as integration with NHS Greater Glasgow and Clyde and NHS Highland was in early stages at the time of these follow-up reviews.



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