



NHS Tayside
Managed Clinical Network
for
Adult Diabetes Services
Quality Assurance Framework 2004

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1 Introduction

The NHS Tayside Diabetes Managed Clinical Network (MCN) has been established, in line with The Scottish Diabetes Framework, the 2002 NHS Health Department Letters (HDL) 69 & 81 and the Scottish Executive Health Department's 2002 White Paper 'Partnership for Care', to co-ordinate and develop diabetes services across the NHS Tayside area. It is recognised that the success of this approach is critically dependent upon organised collaboration, structured service development and ongoing, rigorous evaluation. The MCN has therefore developed a Quality Assurance Framework incorporating four Network-specific Standards that compliment existing requirements outlined by the NHS Quality Improvement Scotland (NHS QIS) Diabetes Standards, Generic Standards and the Scottish Executive's 'Core Principles' outlined in NHS HDL (2002) 69, to all of which our MCN seeks to adhere.

This document, together with our Annual Report 2002 (appendix 1), the 2001 document 'The Case for the redesign of adult diabetes service provision in Tayside' (appendix 2), our 'NHS Tayside Diabetes MCN Strategy and Implementation Plan for managing increasing demand in adult diabetes services - 2002' (appendix 3), and the Network Continuing Professional Education and Clinical Performance Review Programmes (appendices 6 & 10), demonstrates the work that is ongoing in Tayside to ensure the delivery of a quality diabetes service, which aims to meet NHS QIS quality assurance and accreditation requirements.

Patients are an integral part of the NHS Tayside Diabetes MCN and it should be understood that all Network activities outlined in this document are undertaken as a partnership between patients, carers and health care professionals.

2 Managed Clinical Network Description

The Development of NHS Tayside Diabetes Managed Clinical Network

The model of integrated, collaborative working, now formalised as the NHS Tayside Diabetes Managed Clinical Network, has been evolving within NHS Tayside for several years:

- The Community Health Index (CHI) number has been used as the unique patient identifier for all episodes of care within NHS Tayside since the 1970s.
- Since 1990, a mobile Diabetic Eye Screening Unit has been regularly visiting General Practices across Tayside to provide photographic retinal screening.
- In 1992 a formal 'Diabetes Shared Care Scheme' was launched between Primary and Specialist Care across Tayside.
- In 1994 the widely representative and multi-disciplinary 'Tayside Diabetes Advisory Group' was formed by Tayside Health Board to advise it on strategic matters in relation to diabetes services across Tayside. This is the equivalent of a Local Diabetes Services Advisory Group (LDSAG). Patients are an integral part of this committee. This is now named Tayside Diabetes Strategic Advisory Group (TDAG).
- In 1995 the Diabetes Audit and Research in Tayside Study (DARTS) began to work with all Practices and Diabetes Clinics across NHS Tayside to develop an electronic register and database of all patients with diabetes throughout the region. This process included the regular feed-back of data to individual clinicians to allow effective audit of care.
- In 1997 Tayside Health Board funded a full-time Diabetes Data Facilitator to work with clinical colleagues throughout NHS Tayside on the maintenance and quality assurance of the DARTS database.
- In 1999 the DARTS website was developed and launched, at a major Tayside Diabetes Conference, to allow patients and clinical staff to access and share information and advice about diabetes related services and activity within the region.
- In 2000
 - Tayside Health Board funded a Diabetes Clinical Network Manager to co-ordinate the activities of the emerging Managed Clinical Network.
 - The Tayside Diabetes Handbook was devised in a collaborative project involving primary and secondary care clinicians. It contains regional protocols and guidelines and forms the agreed Diabetes Management Programme for all Tayside healthcare professionals.
 - The DARTS database was developed and made available to healthcare professionals throughout Tayside, as an electronic patient diabetes record, with active and enthusiastic use both to submit clinical findings and to access patient-specific information.
 - Other Network functions were developed including several continuing professional education programmes.
- In 2001 a multi-professional group, with patient involvement, was formed to undertake a major needs assessment exercise. As a result of this exercise, the MCN published 'Completing The Jigsaw – a Strategy and Implementation Plan for the Development of Diabetes Services within NHS Tayside' (Appendix 3).

3 Network Scope and Activities

The MCN coordinates and facilitates the delivery and development of Adult Diabetes Services to meet the diverse needs of all patients with diabetes in the NHS Tayside area. (Population of Tayside 387,420. Number of patients with diabetes 12,013. Prevalence of diabetes 3.1% on 1st September 2003), except for those 274 young people with diabetes who are under the care of the Tayside Young Peoples' Diabetes Service. The MCN co-operates closely with the Tayside Young Peoples' Diabetes Service in areas of commonality, and in particular to assure a smooth transition for teenage patients between the Young Peoples' and Adult Diabetes Services, facilitated by the use of the common diabetes clinical management system SCI-DC. Specific areas of Network responsibility include:

- Assurance of diabetes care delivery in line with NHS QIS Diabetes Standards.
- Service needs assessment.
- Strategic advice to NHS Tayside.
- Prioritisation and development of new services, including their implementation and evaluation.
- Local operation and facilitation in the use of the SCI-DC Diabetes Information Management System. This provides clinicians within the Network with:
 - a common information gateway for all members of the multi-disciplinary clinical team
 - sharing of appropriate clinical information between all health care professionals involved in supporting patients on their journey of care
 - a high level of communication between clinical colleagues and between health care professionals and their patients
 - a wide range of regularly updated Patient Information Leaflets that ensure the provision of accurate and consistent advice to patients with diabetes throughout the region
 - an online Diabetes Handbook, which contains locally adopted protocols and evidence-based guidelines for the management of all aspects of diabetes
 - a foot risk-assessment tool
 - a cardiovascular risk calculator
 - high quality clinical audit tools which provide instant feedback to clinicians
- A systematic programme to offer annual screening for diabetic retinopathy to all patients by means of digital retinal photography, in line with NHS QIS recommendations and standards.
- Educational initiatives for patients including the provision of group and individualised education programmes for patients at diagnosis and at other key times in their journey of care.
- Support and training for the multi-professional healthcare team including a University of Dundee certificate level course in diabetes care and regular evening educational Diabetes Forum meetings in each locality.
- A biennial Network Conference for both patients and health professionals where new developments and best practice are shared.
- An active policy of support and specialist input for staff and patients with diabetes who are admitted to general medical and surgical hospital wards and for those who live or work in Nursing Homes and other residential institutions.

4 Statement of Aims, Values & Principles of NHS Tayside Diabetes Managed Clinical Network

The stated **Aims** of the NHS Tayside Diabetes Managed Clinical Network are:

- To minimise premature morbidity and mortality in those with diabetes
- To maximise quality of life by detecting and treating disease and its complications at an early stage
- To provide equal access to high quality diabetes care to all the residents of Tayside
- To take forward the key recommendations of the Scottish Diabetes Framework

The following values and principles, adapted from priorities drawn up by Diabetes UK, are adhered to by NHS Tayside Diabetes Managed Clinical Network:

Care for patients with diabetes should be **patient-centred** and based on the principle of **equity**:

- **Patient-centred:** People with diabetes should be treated as individuals and given reasonable choice in the means and personnel providing diabetes care. People with diabetes must be at the centre of their care and must be enabled to have their views heard at all levels of the NHS.
- **Equity:** All people with diabetes should equally receive the best standards of care and access to care, irrespective of who they are, where they live and what complications they may have.

Within the context of these two Principles the following are held as fundamental requirements for The Tayside Diabetes Network:

- **Information and Education:** All people with diabetes and all members of the multi-disciplinary team who care for them should be provided with up-to-date, consistent and ongoing information and education
- **Access:** All people with diabetes in Tayside should have access to integrated diabetes services that meet their individual needs
- **Standards and Quality Assurance:** All people with diabetes should have access to a uniformly high standard of patient-centred care, assured through regular performance management.
- **Communication and Co-ordination:** Systems should be in place that ensure a high level of communication and co-ordination of diabetes care between professionals across primary, secondary and tertiary care, to ensure seamless movement between different parts of the system for all patients.
- **Resources:** The system must be appropriately resourced to achieve these aims and to enable clinicians to cope, at all levels (Primary, Community & Secondary Care) with the increasing burden of diabetes care within Tayside.

In addition to these principles the NHS Tayside Diabetes Managed Clinical Network has sought to adhere to the following five fundamental Health Care Development Principles laid down by the World Health Organisation.

Thus, within our Managed Clinical Network, we should seek to assure:

- **Equity** - by ensuring that the appropriate care is delivered to patients with local accessibility
- **Empowerment** - by enabling a clinically led and developed service which is sensitive to patients' needs
- **Co-operation** - by delivering a seamless service jointly delivered by primary and secondary care
- **Participation** - by including patient representation and all disciplines who are currently involved in the delivery of care
- **Primary health care** – by, where appropriate, enabling a shift in the point of delivery of care from secondary to primary care

Operational Objectives:

The Diabetes Managed Clinical Network aims to deliver a high quality, integrated and equitable diabetes service. Through the framework of a Managed Clinical Network it seeks to promote effective collaboration across traditional professional and organisational boundaries and to facilitate health professionals to work in partnership with patients to ensure the best use of resources, facilities, knowledge and experience. The MCN will operate in line with the core principles set out by the Scottish Executive NHS HDL (2002) 69.

It is our objective to meet this challenge through;

- Increased emphasis on the development of **patient focused** services
- The implementation of evidence-based care **guidelines**
- **Monitoring** of progress as part of a structured evaluation programme which incorporates an integrated clinical governance strategy
- Increased professional and patient **education**
- Effective **communication** via an advanced clinical information system (SCI-DC)
- Effective and efficient **co-ordination** of effort across traditional professional boundaries

5. Tayside Diabetes Network Clinical Governance Principles

Clinical Governance can be defined as a framework through which NHS organizations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

The Tayside NHS Diabetes Managed Clinical Network adheres to the Clinical Governance Arrangements laid out in HDL (2002) 69 Appendix 3, and to the following principles defined by Scally and Donaldson (Scally G, Donaldson LJ. Clinical governance and the drive for quality improvement in the new NHS in England. *BMJ*; 317: 61-5):

- Avoiding risk through having properly trained staff, good procedures and a safe environment.
- Coherence, by ensuring good communication within clinical teams so that everyone is clear about what they should be doing and why.
- Infrastructure, by having adequate access to evidence, training and education, and aids such as IT systems that support clinical practice, not just counting how many patients have been seen.
- Quality methods that enable clinicians to objectively assess the quality of their care, learn from mistakes and support evidence-based protocols.
- Identifying poor performance, intervening effectively and ensuring that everyone knows how well they are performing.
- A culture that is open, where there is good leadership and team working, high quality education and effective partnership with patients.

With reference to the Clinical Governance Arrangements laid out in HDL (2002) 69 Appendix 3, in Tayside, the primary and secondary care co-chairs of Tayside Diabetes Strategic Advisory Group will be responsible for analysis of, and reporting to the Clinical Governance Committees of NHS Tayside Board or its Operating Divisions, of any critical or significant events occurring within the service provided by the Network.

6 Development of a Quality Assurance Framework

The Managed Clinical Network's quality assurance framework has been developed in an open and inclusive process by Tayside Diabetes Strategic Advisory Group (TDAG) (appendix 5), which has representation from patients, all professional groups involved in delivering diabetes services, Public Health and NHS Tayside Board.

Development Process

Patient Involvement

A variety of mechanisms have been used to involve lay and professional people to inform the development of these standards including: patient focus groups, patient questionnaires, local Diabetes UK group meetings and multiple group discussions throughout the region.

Multidisciplinary Involvement

TDAG identified four key areas where Network specific standards are necessary to compliment and re-emphasise the disease specific and generic standards already produced by NHS QIS. The areas identified are:

- clinical quality assurance, audit and data reporting
- communication and knowledge management
- professional education
- patient involvement

These are outlined and presented in the following standard format, using the template developed by NHS QIS:

- Each standard has a **title**, which summarises the area on which that standard focuses.
- This is followed by the **standard statement**, which explains the level of performance to be achieved.
- The **rationale** section provides the reasons why the standard is considered to be important.
- The standard statement is fleshed out in the section headed **criteria**, where it states exactly what must be achieved for the standard to be reached.

Measures of Improvement - Process and Outcome Indicators

Within the Network Standards, indicators of clinical outcome and service measures have been identified as key elements of the quality assurance program, against which service quality and improvement will be effectively monitored year on year. We have identified areas of priority based on current SIGN guidelines, NHS QIS standards for diabetes, NHS QIS generic standards and locally agreed priorities identified by TDAG, together with results from a patient satisfaction survey which achieved 81% response rate from a sample of 475, randomly selected, adult patients from across the NHS Tayside area. The indicators identified have been endorsed by all members of TDAG, including patient representatives. Where goals have been set these are challenging but attainable and believed to be of fundamental value of the Network.

Review of Standards and Implementation of Recommendations

TDAG, and in particular its Network Implementation Group, will be responsible for the formal annual review of Network progress against the standards. This review will form part of the NHS Tayside Diabetes MCN Annual Report which is widely circulated, including to all Trust and NHS Tayside Board stakeholders, openly available on the Network worldwide website (www.diabetes-healthnet.org.uk) and will be submitted to NHS QIS.

TDAG's established Network Sub-Groups will implement any recommendations in response to findings with leadership from the Network Manager and Lead Clinician.

Communication

Following NHS QIS accreditation, this Quality Assurance Framework will be circulated widely on paper and electronically to promote delivery of services that meet Network and National standards.

NHS Tayside Diabetes Managed Clinical Network Standards

STANDARD 1 – Clinical Quality Assurance, Audit and Data Reporting

Standard Statement	Rationale	Criteria
<p>1a using data collected as part of routine clinical care The MCN will implement a diabetes specific integrated programme of audit and clinical performance review across NHS Tayside, facilitating the monitoring and assurance of clinical quality and service improvement.</p> <p>1b A MCN Annual Report is prepared and openly available.</p>	<p>Information is at the core of diabetes care – for individuals, and for the organisation planning and delivering services. Data collection and audit facilitate effective healthcare since outcomes can be monitored and lead, where necessary, to improvements in the quality of care. Clinical Governance ensures that quality of care is an integral part of service delivery. It serves to ensure that high standards of care are delivered, good practice is supported and under-performance identified and addressed.</p> <p><i>- Working Group on IT to Support Shared Care in Diabetes, September 2000</i></p> <p><i>National Diabetes Minimum Dataset (2002)</i></p> <p><i>St Vincent Declaration. WHO Regional Office for Europe (1997).</i></p> <p><i>Partnership for Care – Scotland’s Health White Paper, 2003</i></p> <p><i>NHS MEL (1998)75</i> <i>HDL (2000)29</i> <i>NHS MEL (1999) 10</i></p>	<p>1a Essential</p> <ol style="list-style-type: none"> 1. Data routinely collected as part of delivering quality diabetes care, and conforming to the agreed National Diabetes Core Dataset, are accessible via the clinical management system on a continuous basis, to facilitate audit and clinical effectiveness 2. Data collected are quality assured by both electronic and manual processes. (appendix 7&8) and systems and procedures are inspected by NHS Tayside and Fife Computer Audit and Management Services. 3. Clinical user groups are independently able to prepare audit reports (appendix 9) 4. Clinical priorities are incorporated into a Network wide ‘Clinical Performance Review Programme’ (appendix 10) that is formally linked to wider NHS Tayside and national clinical governance and data reporting initiatives. 5. Process and outcome indicators are selected based, where available, on National criteria. 6. Realistic but stretching performance targets are agreed based on National guidelines (where available) and reviewed at yearly intervals. 7. Results are reviewed within the MCN as part of a continual process of quality improvement. 8. A strategy for diabetes service development is agreed to address variation in performance at the individual, Practice, clinic and organisational level. 9. All Practices and clinics co-operate with the programme. 10. Individual Practice audit results indicating examples of good practice will be shared across the MCN <p>Desirable:</p> <ol style="list-style-type: none"> 1. The Clinical Network will contribute to and support local research and development initiatives <p>1b Essential</p> <ol style="list-style-type: none"> 1. A formal Annual Report, documenting service development and regional process and outcome indicators is circulated to all stakeholders and openly available to public and health care professionals via the Network website.

NHS Tayside Diabetes Managed Clinical Network Standards

STANDARD 2 – Communication and Knowledge Management

Standard Statement	Rationale	Criteria
<p>Patients and professionals are readily able to access accurate and timely information.</p> <p>Knowledge is created, shared and effectively disseminated and applied in the MCN.</p>	<p>High quality patient services are promoted by effective professional communication. Consistent, up to date professional advice is important to patients and their families.</p> <p>MCNs are knowledge rich environments with the potential to deliver improvements in patient care through effective knowledge management.</p> <p><i>Hearing the voices of people with diabetes in Scotland -Partners in Change 2002</i></p> <p><i>Scottish Diabetes Framework 2002</i></p> <p><i>Partnership for Care – Scotland’s Health White Paper, 2003</i></p>	<p>Essential</p> <ol style="list-style-type: none"> 1. Health professionals contribute to and refer to the SCI-DC electronic patient record to facilitate quality patient care, avoiding unnecessary duplication or omissions in care. 2. Usage of the various parts of the Network website and Clinical Information System is electronically audited. These Data are monitored by the Network Data Governance Sub-Group to ensure increasing use. 3. Information is tailored and provided for vulnerable patient groups including pregnant patients and those from ethnic minorities. 4. A communication strategy is developed and implemented to ensure access to high quality information for all health care professionals, patients and carers. A policy of openness is adopted wherever appropriate and information is accessed via the NHS-Net and Network w.w.w.-site. 5. Tayside Diabetes Strategic Advisory Group Information Sub-Group has operational responsibility for developing, updating, disseminating and reviewing patient and professional information used across the MCN and contributing to wider NHS Tayside information requirements. 6. A procedure for the updating of the regionally agreed guidelines and protocols contained in the Tayside Diabetes Handbook, published on the Network website, and of the related Patient Information Leaflets, is implemented (appendix 11). 7. A comprehensive, up to date, database of professional and patient representative Network contacts is developed and maintained by the Network Administrator and updated on a six monthly basis. 8. A variety of methods are adopted to disseminate relevant information and best practice, including the NHS Tayside Diabetes Clinical Network Website, quarterly Newsletters, quarterly Professional Forums and other educational initiatives and e-mail and postal contact lists. 9. Opportunities are constructed to facilitate multiprofessional knowledge sharing through social engagement between Network members 10. Comments or suggestions submitted by IT system users on the content or functionality of the Network website or SCI-DC Clinical Management System, are read, prioritised and responded to within 48 hours by the Network IT Facilitator.

NHS Tayside Diabetes Managed Clinical Network Standards

STANDARD 3 – Professional Education

Standard Statement	Rationale	Criteria
<p>All patients receive safe and effective care and treatment wherever they engage with the service. All health professionals in the MCN have access to continuing professional educational opportunities and are facilitated to participate. Integrated diabetes team learning is supported by the MCN.</p>	<p>The MCN requires an appropriately qualified multidisciplinary team to meet the complex needs of patients with diabetes. Continuing professional development is an essential requirement for all health professionals. Teamworking is an essential competence for members of the MCN.</p> <p><i>Learning Together NHS HDL (2000) 01</i></p> <p><i>NHS QIS Clinical Standards: Generic. (2002)</i></p> <p><i>A Competency Framework for the Care of a Person with Diabetes (2003)</i></p>	<p>Essential</p> <ol style="list-style-type: none"> 1. A multiprofessional education and training strategy is in place (Appendix 6), which reflects the needs of the diabetes team (specialist and non specialists), including hospital and community based staff, GP locums and non-Principals and staff of Nursing Homes and the Scottish Prison Service. The uptake of educational opportunities by Network members is monitored. Attendance records are centrally maintained and additional survey data is used to complement this. (Appendix 1) 2. All members of the diabetes team maintain a Continuing Professional Development record in line with appropriate professional colleges and regulatory bodies. 3. All professional members of the MCN are facilitated to access further relevant education and to develop personal and professional competencies in relation to role. 4. All educational activities delivered by the MCN provide opportunities for integrated learning which reflects the commitment to cross professional and organisational boundaries. 5. Professional education is delivered in a wide variety of ways to facilitate access and inclusivity e.g. outreach seminars (Primary and Secondary Care), formal accredited courses, evening Forum meetings, conferences, on-line education, distance learning packages, ward seminars. (appendix 6) <p>Desirable</p> <ol style="list-style-type: none"> 1. All professional members of MCN are encouraged to contribute to diabetes related research activities

NHS Tayside Diabetes Managed Clinical Network Standards

STANDARD 4 – Patient Involvement

Standard Statement	Rationale	Criteria
<p>All people with diabetes and their carers will be given information and education to allow them to meaningfully contribute to decisions about their care and to the development of diabetes services to meet local needs.</p>	<p>Patient care outcomes are improved when patients and their carers are involved in clinical care decisions. Encouraging patients to contribute provides a valuable patient perspective to inform decisions about service development.</p> <p><i>Our National Health: A plan for action a plan for change. Scottish Executive 2000</i></p> <p><i>Partnership for Care – Scotland's Health White Paper, 2003</i></p> <p><i>NHS QIS Clinical Standards: Generic. (2002)</i></p> <p><i>TPCT Clinical Governance Strategy 2000-2002</i></p> <p><i>TUHT Clinical Governance Strategy 2001</i></p>	<p>Essential</p> <ol style="list-style-type: none"> 1. Patients and carers are offered the opportunity to play an active role in their personal care and in the development of services and are actively encouraged to provide input and feedback via a variety of mechanisms – questionnaires, website 'comments' boxes, Patient Reference Groups, Patient Conference 2. Patients are provided with adequate information to empower them to effectively contribute to their own self management 3. Patient involvement is integral to service development. Strong patient representation is maintained on TDAG and its Sub-Groups. 4. Results of formal patient consultation exercises are openly shared and incorporated in future policy. 5. Complaints are managed constructively in line with NHS Tayside policy and inform future service developments. 6. The MCN actively strengthens existing partnerships with local and national diabetes patient representative groups e.g. Diabetes UK 7. Network educational programmes are designed with a central focus on the needs of patients 8. A patient survey, reflecting the integrated service is undertaken and results made openly available. 9. 'Expert Patients' are involved in the professional educational programmes and in the education, mentoring and support of other patients. 10. Arrangements are in place to ensure that vulnerable groups including institutionalised and housebound patients and those from ethnic minorities are able to contribute to decision making processes, about their own care and about the wider diabetes Service, eg/ by formal links between the Network and established advocacy and translation arrangements and appropriately facilitated focus groups.

7 Conclusion

Tayside Managed Clinical Network is committed to providing clinically effective, relevant and up-to-date services, which are delivered in line with Sign Guideline 55, NHS QIS clinical standards for diabetes, diabetic retinopathy screening and generic standards, in response to patients' needs and preferences and in line with the findings and priorities defined by the needs assessment exercise and resultant Diabetes Strategy (Appendix 2&3). The ongoing evolution, evaluation and refinement of our Managed Clinical Network will ensure that we meet the challenges of delivering effectively managed, equitable, high quality, multidisciplinary care. As part of maintaining this commitment, this Quality Assurance Framework will be reviewed in line with NHS QIS recommendations or as indicated in line with any significant advance in clinical knowledge or practice. Our MCN Annual Report will be widely disseminated, including to NHS QIS.

8 Glossary

Term	Definition
Audit	Systematic review of the procedures used for: diagnosis, care, treatment, and rehabilitation, examining how associated resources are used and investigating the effect care has on the outcome and quality of life for the patient.
BP	Blood pressure
Clinical Governance	A framework through which NHS organisations are accountable for both continuously improving the quality of their services, and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish.
Clinical Management System	A clinical management system is the software that supports the clinical management of patients. This includes a collection of core information from the individuals, which relates to their care and allows ongoing useful clinical information to be recorded for use in direct patient care and service audit. Abbreviated as CMS
Continuing Professional Development	An ongoing commitment to learning in various forms, which maintains and enhances professional standards of work.
DARTS	Diabetes Audit and Research in Tayside Study
Diabetes UK	The National diabetes patients' charity
DiabNet	a Managed Clinical Network for young peoples' diabetes services across Tayside, Fife and Forth Valley areas.
DSN	Diabetes Specialist Nurse
essential (criterion/criteria)	A criterion that should be met wherever a service is provided.
generic standards	Standards that apply to most, if not all, clinical services.
HbA1c	Glycated haemoglobin = a marker of long term blood glucose control
healthcare professional	A person qualified in a health discipline.
IT	Information Technology
Local Diabetes Service Advisory Group (LDSAG)	A strategic planning group of local diabetes service users, carers and providers who advise NHS Scotland Boards in matters relating to services for individuals with diabetes.
LHCC	Local Health Care Cooperative
Managed Clinical Network (MCN)	A formally organised network of professionals concerned with delivering care based on standards and guidelines, with the aim of improving healthcare across traditional professional and organisational boundaries
Multidisciplinary team	A multidisciplinary team is a group of people from different disciplines (both healthcare and non-healthcare) who work together to provide care for patients with a particular condition. The composition of multidisciplinary teams will vary according to many factors. These include: the specific condition, the scale of the service being provided, and geographical/socio-economic factors in the local area.
multidisciplinary system of working	A method of working in a multidisciplinary team with protocols in place for most, if not all, eventualities.
National Guidelines	Instructions defined at a national level.
National Standards	Principles defined at a national level.
NHS Board	NHS Boards (or Unified Health Boards) replaced the separate Board structures of Health Boards and NHS Trusts. The NHS Boards cover the same geographical area as the old Health Boards. The overall purpose of unified NHS Boards is to ensure the efficient, effective and accountable governance of the local NHS system, and to provide strategic leadership and direction for the system as a whole, focusing on agreed outcomes.

NHS Quality Improvement Scotland (NHS QIS)	NHS Quality Improvement Scotland is a statutory body, established as a special Health Board in April 1999. Its role, in line with the Scottish Executive's commitment to quality, openness and public accountability, is to promote public confidence that the services provided by the NHS are safe and that they meet nationally agreed standards. It also demonstrates that, within the resources available, the NHS is delivering the highest possible standards of care.
outcome	The end result of care and treatment and/or rehabilitation. In other words, the change in health, functional ability, symptoms or situation of a person, which can be used to measure the effectiveness of care and treatment, and/or rehabilitation.
patient	A person who is receiving medical treatment (especially in a hospital). Also, a person who is registered with a doctor, dentist, etc and is treated by him/her when necessary. Sometimes referred to as user.
patient journey	The pathway taken through the NHS by the patient and as viewed by the patient.
quality assurance	Improving performance and preventing problems through planned and systematic activities including documentation, training and review.
SCI-DC Clinical management System	The National diabetes information technology system for Scotland
Scottish Diabetes Survey	A Scottish Executive initiative attempting to build a national register of people with diabetes and to monitor diabetes care, with the aim of facilitating better healthcare.
Scottish Intercollegiate Guidelines Network (SIGN)	SIGN was established in 1993 by the Academy of Royal Colleges and Faculties in Scotland, to sponsor and support the development of evidence-based clinical guidelines for NHSScotland. Where a SIGN guideline exists for a specialty or service for which NHS QIS is setting standards, it will be referenced. For further information relating to SIGN guidelines or the methodology by which SIGN guidelines are developed, contact: SIGN Secretariat, Royal College of Physicians, 9 Queen Street, Edinburgh EH2 1JQ. Website address: www.sign.ac.uk/
St Vincent Declaration	The main aim of the St Vincent Declaration is to reduce the serious health problems linked to diabetes, such as blindness, renal failure, amputation and coronary heart disease, through governmental and healthcare team initiatives.
standard statement	An overall statement of desired performance.
TDSG	Tayside Diabetes Strategic Advisory Group
Type 1 (insulin-dependent) diabetes	Type 1 diabetes develops if the body is unable to produce any insulin. This type of diabetes usually appears before the age of 40. It is treated by insulin injections and diet.
Type 2 (non-insulin dependent) diabetes	Type 2 diabetes develops when the body can still make some insulin, but not enough, or when insulin that is produced does not work properly (known as insulin resistance). This type of diabetes usually appears in people over the age of 40, though it often appears before the age of 40 in the South Asian and African-Caribbean population. It is treated by diet alone or by diet and tablets or, sometimes, by diet and insulin injections.
UKCC	United Kingdom Central Council = the nursing regulatory authority
WHO	World Health Organisation
www.diabetes-healthnet.org.uk	the NHS Tayside Diabetes MCN website.

9 Appendices

- 1 **NHS Tayside Diabetes Managed Clinical Network Annual Report 2002**
- 2 **The case for the redesign of adult diabetes service provision in Tayside**
- 3 **NHS Tayside Diabetes MCN Strategy and Implementation Plan for managing increasing demand in adult diabetes services – 2002**
- 4 **a. Tayside Diabetes Strategic Advisory Group**
b. Network Implementation Group
- 5 **Network Organisation and Accountability Framework**
- 6 **NHS Tayside Diabetes MCN Continuing Professional Education Programme**
- 7 **Manual Data Validation**
- 8 **Electronic Data Quality Assurance**
- 9 **Audit Tool**
- 10 **Clinical Performance Review Programme**
- 11 **Diabetes Network Handbook – Update Procedure**

**Appendix 1 –NHS Tayside Diabetes Managed Clinical Network
Annual Report 2002**

See Tayside Diabetes Clinical Network Website:

(intranet) <http://darts.tayside.scot.nhs.uk/tayside/>

(www) <http://www.diabetes-healthnet.ac.uk/>

Under “Network Organisation” section

Appendix 2 – ‘The Case for the redesign of adult diabetes service provision in Tayside’

See Tayside Diabetes Clinical Network Website:

(intranet) <http://darts.tayside.scot.nhs.uk/tayside/>

(www) <http://www.diabetes-healthnet.ac.uk/>

Under “Network Organisation” section

Appendix 3 –‘NHS Tayside Diabetes MCN Strategy and Implementation Plan for managing increasing demand in adult diabetes services - 2002’

See Tayside Diabetes Clinical Network Website:

(intranet) <http://darts.tayside.scot.nhs.uk/tayside/>

(www) <http://www.diabetes-healthnet.ac.uk/>

Under “Network Organisation” section

Appendix 4A - Tayside Diabetes Strategy Group

Dr Alisdair Dutton	General Practitioner, Perth (Co-Chair)
Mrs Charlotte Anderson	Diabetes Specialist Nurse
Dr Geraldine Brennan	Consultant Physician
Mr Brian Christie	Podiatry Manager
Mr Gregory Colgan	Patient Representative, Dundee
Dr Alan Connacher	Consultant Physician
Mrs Gillian Costello	Tayside Diabetes Clinical Network Manager
Dr Ellie Dow	Consultant in Biochemical Medicine
Dr John Ellis	Consultant Ophthalmologist
Dr Alistair Emslie-Smith	General Practitioner, Dundee & Network Lead Clinician
Ms Betty Evans	Patient Representative, Dundee
Mr William Gillies	Patient Representative, Angus
Dr Steven Greene	Consultant Paediatric Diabetologist
Professor Roland Jung	Consultant Physician
Dr Margaret Kenicer	Consultant in Public Health Medicine
Dr Graham Kramer	General Practitioner, Montrose
Dr Graham Leese	Consultant Physician (Co-Chair)
Ms Vivien Mann	Patient Representative, Perth
Dr Kay MacCallum	General Practitioner, Forfar
Ms Gladys McMurtie	Practice Nurse, Dundee
Professor Andrew Morris	Professor of Diabetic Medicine
Dr John Petrie	Senior Lecturer in Medicine
Ms Sheila Phillips	Strategy & Performance Manager, NHS Tayside Board
Ms Theresa Torrance	Diabetes Specialist Nurse
Ms Angela Timoney	Patient Representative, Dundee
Dr Drew Walker	Director of Public Health Medicine
Miss Edith Walters	Senior Dietitian
Mrs June Williams	Patient Representative Dundee
Dr Sandy Young	General Practitioner, Alyth
Carer Representative	(currently vacant)

Appendix 4B – Network Implementation Group

Professor Andrew Morris	Professor of Diabetic Medicine (Chair)
Dr Alan Connacher	Consultant Physician
Mrs Gillan Costello	Tayside Diabetes Clinical Network Manager
Dr Alistair Emslie-Smith	Network Lead Clinician
Mr Kenny Hill	Network IT Facilitator
Dr Graham Leese	Diabetes Specialist Clinical Team Leader
Mr Ritchie McAlpine	Network Data Facilitator
Mrs Mary Robertson	Diabetes Specialist Nurse
Ms Angela Timoney	Patient Representative
Dr Sandy Young	General Practitioner

Appendix 5 - Network Organisational Structure and Accountability Framework

- **NHS Tayside Diabetes Strategic Advisory Group (TDAG)** is charged by NHS Tayside Board with the responsibility of providing the strategic lead for diabetes services across NHS Tayside, for setting service development objectives and for assuring the clinical and operational governance of the NHS Tayside Diabetes Service, including the provision of agreed standards of service across the Tayside Diabetes Network. Its membership includes broad representation from Primary Care, including all three Local Health Care Co-operatives, Secondary Care, Diabetes Specialist Nursing, Allied Health Professionals, Public Health Medicine, Health Service Management and service users. The Group reports to the Chief Executive of NHS Tayside Board. It has joint Chairs from Primary and Secondary Care who are the responsible officers for diabetes services in Tayside, reporting to the Medical Director and Chief Executive of NHS Tayside, who have ultimate responsibility for the delivery of such services. The co-chairs are responsible for analysis of any critical or significant event occurring within the service provided by the Network brought to their attention by the Data Governance Sub-Group or other parties and, if required, would report this to the Clinical Governance Committees of NHS Tayside Board or its Operating Divisions. TDAG meets quarterly. Administrative support for meetings of the Group is provided by NHS Tayside Board.
- **Tayside Diabetes Network Implementation Group** is charged with providing clinical and managerial leadership for the Tayside Diabetes Network, with assuring the implementation and monitoring of services in line with NHS QIS Diabetes Standards and the implementation of agreed strategic developments, and with assuring the smooth day-to-day running of the Network, including specific responsibility for IT provision. Its members include the Network Lead Clinician, the Network Manager, the Network Data Facilitator, the Network IT Facilitator and representation from General Practice, the Diabetes Specialist Nursing Team, the Diabetes Consultant Team and our patients. Their work is supported by a full-time Network Administrator. The Network Implementation Group is accountable to the co-chairs of Tayside Diabetes Strategic Advisory Group.
- **Network Core Staff**. Certain core staff have been employed by NHS Tayside and appointed to the Network. The Network Manager (full-time) and the Network Lead Clinician (3 sessions / week) are operationally accountable to the co-chairs of Tayside Diabetes Strategic Advisory Group. Their human resource and personal development issues are managed through the Medical Director of NHS Tayside. The Network Data Facilitator is responsible for the maintenance and validation of the Network clinical database and for facilitating Network members in its use. The Network IT Facilitator is responsible for the maintenance and development of the local aspects of the Tayside SCI-DC system and for the Network Website. The Network Administrator provides administrative support to the Network Lead Clinician and Manager and to the work of the Network as a whole. These three staff are operationally accountable to the Network Lead Clinician and the Network Manager.
In addition, also appointed to the MCN are the Retinal Screening Team, including the Team's Administrator, Photographers and Graders. They are operationally accountable to the chair of Tayside Diabetes Strategy Group's Retinopathy Sub-Group. Their human resource and personal development issues are managed through the Medicine and Cardiovascular Directorate of Tayside University Hospitals Trust.

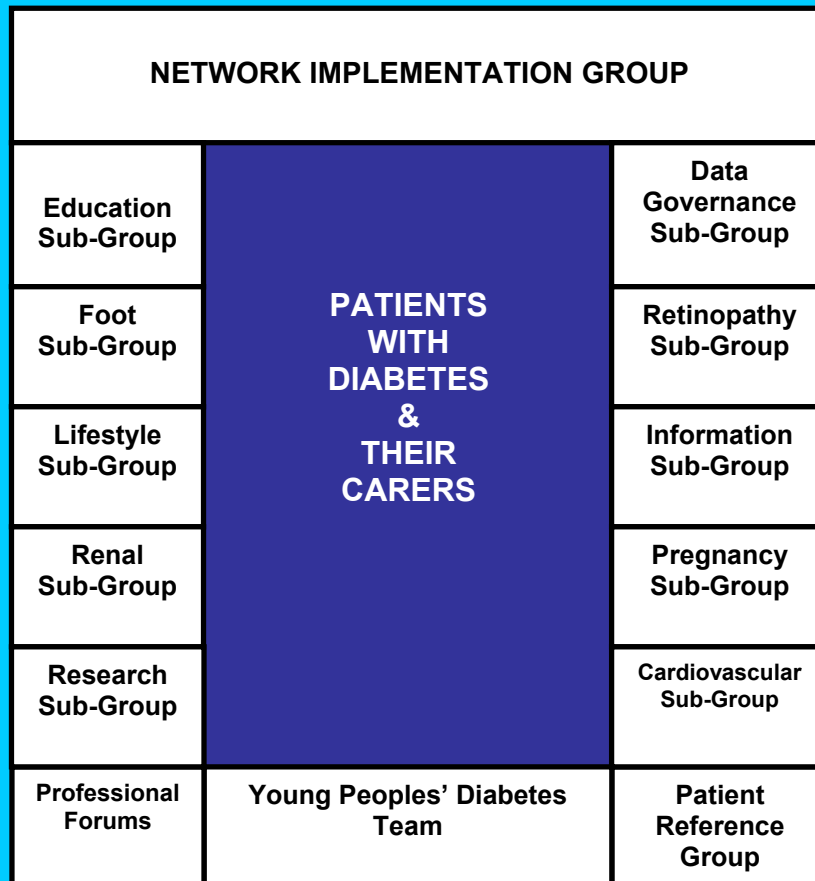
- **Tayside Diabetes Network Sub-Groups** are permanent, task-specific groups formed from the membership of the Tayside Diabetes Strategic Advisory Group and from other members of the Tayside Diabetes Network with appropriate skills and experience, including, where appropriate, patients. They are responsible, within their given area, for the development and maintenance of the services provided within the Network. They are supported and facilitated by the Network Manager and are accountable to the co-chairs of Tayside Diabetes Strategic Advisory Group. They meet as regularly as is required to effectively carry out their remit.

Examples of these include:

- **The Data Governance Sub-Group** – responsible for the security, quality assurance, appropriate reporting and audit of all clinical data within the Tayside SCI-DC database, and for the support of clinicians in the analysis, interpretation of and response to such data.
 - **The Information Sub-Group** – responsible for the maintenance and up dating of the Tayside Diabetes Handbook, Patient Information Leaflets, Network Drug Formulary and the content of the Tayside Diabetes Network web-site.
 - **The Retinopathy Sub-Group** – responsible for the Tayside Retinal Screening Programme.
 - **The Education Sub-Group** – responsible for the delivery of appropriate patient and continuing professional educational programmes and materials across the Network.
 - **The Lifestyle Sub-Group** – responsible for the development and provision of appropriate services and support programmes in such areas as diet, exercise and smoking cessation, for both patients with diabetes and those at high risk of developing diabetes.
 - **The Research Sub-Group** – responsible for fostering and co-ordinating research activity across the Network, and for assuring Research Governance. Included under the umbrella of this sub-group is the DARTS Steering Group.
 - **The Patient Reference Group** – acting as an important guide to the needs, problems and opinions of Network users.
 - In addition to these, and other, permanent Sub-Groups (see diagram, over), **Ad Hoc, short life Working Groups** are convened, as required to take forward specific pieces of work, eg/ Conference Planning.
- **The Young Peoples' Diabetes Team** is responsible for the provision of care to all young people with diabetes in Tayside. The Young Peoples' Diabetes Service is a key component of the work of the Tayside Diabetes Strategic Advisory Group. The Tayside Young Peoples' Diabetes Team works closely with the Tayside Diabetes Managed Clinical Network, in particular where there are areas of commonality with the adult diabetes services in Tayside, and to assure a smooth transition for patients between paediatric and adult service provision. The Young Peoples' Diabetes Service is part of the *DiabNet* Childrens' Diabetes Managed Clinical Network, along with colleagues in Fife and Forth Valley Health Board areas.

NHS TAYSIDE BOARD

TAYSIDE DIABETES STRATEGIC ADVISORY GROUP (TDAG)



Ad Hoc

Short Life

Working Groups

NHS Tayside Diabetes Managed Clinical Network Organisational Structure

Tayside Diabetes Clinical Network Groups / Sub-Groups

- 1) **Tayside Diabetes Strategic Advisory Group (TDAG)**
- Co-Chairs : Alasdair Dutton, Graham Leese
- 2) **Network Implementation Group** - Chair: Andrew Morris
- 3) **Data Governance Sub-Group** – Chair: Alan Connacher
- 4) **Education Sub-Group** – Chair: Mary Robertson
- 5) **Information Sub-Group** – Chair: Geraldine Brennan
- 6) **Foot Sub-Group** – Chair: Graham Leese
- 7) **Retinopathy Sub-Group** – Chair: Graham Leese
- 8) **Lifestyle Sub-Group** – Chair: Lesley Matheson
- 9) **Renal Sub-Group** – Chair: Geraldine Brennan
- 10) **Pregnancy Sub-Group** – Chair: Alan Connacher
- 11) **Cardiovascular Sub-Group** – Chair: Geraldine Brennan
- 12) **Research Sub-Group** – Chair: John Petrie
(incorporating **DARTS Steering Group**
Co-Chairs: Andrew Morris, Sandy Young)
- 13) **Patient Reference Group** – Chair:
- 14) **Young People Sub-Group** – Chair: Steven Greene
- 15) **Angus Diabetes Forum** – Chair: Graham Sutherland
- 16) **Dundee Diabetes Forum** – Chair: Alistair Emslie-Smith
- 17) **Perth & Kinross Diabetes Forum** – Chair: Alan Connacher
- 18) Various ad hoc / short-life Working Groups

Appendix 6 – NHS Tayside Diabetes MCN Continuing Professional Education Programme

Meeting the complex needs of patients with diabetes requires the skills of an educated multidisciplinary team. There is an increasing emphasis on learning in the workplace and the use of competencies to demonstrate fitness for practice and purpose. With this comes the need for credible and appropriately designed education packages to support and advance members of the multidisciplinary team working, within a range of settings to provide an integrated, quality service for people with diabetes. The need to establish national, multidisciplinary accredited courses is identified in the Framework.

Currently, the MCN delivers a wide portfolio of Continuing Professional Educational activities, in line with the National 'Competency Framework for the care of a person with diabetes' document (2003) including:

- A Dundee University Certificate Level (level 3) Module – 'Diabetes a multi-professional perspective' available for staff who wish to undertake an accredited diabetes course.
- A 'Good Practice Study Guide' in Diabetes Management, which is a self-directed learning package for trained nursing staff, developed to facilitate flexible learning.
- Locality 'Professional Diabetes Forums' which meet quarterly in Angus, Dundee and Perth for learning together, sharing of best practice and professional networking.
- A variety of biennial Conferences including ones specifically related to Diabetic Foot Disease, Diabetes in Pregnancy and Diabetes Nursing.
- A wide variety of ongoing Training and Educational Programmes for specific Professional Groups including:
 - Trained and untrained ward-based staff
 - Specialist Medical Registrars
 - General Practice Vocational Training Scheme Registrars
 - Practice Pharmacists
 - Practice-based outreach seminars for podiatry / foot risk assessment and for IT
 - Community Nursing Services, including the Out-of-Hours Service
- Collaboration with the Training and Development Team of Tayside Primary Care Trust in ongoing IT training for SCI-DC users.



Patients & Professionals

*3rd Tayside Biennial Diabetes
Clinical Network Conference*

***Diabetes in Tayside:
Moving Forward Together***

Thursday 23rd October 2003

**Carnoustie Golf Hotel, The Links
Carnoustie**

Conference aims and objectives

To offer participants the opportunity:

- to update diabetes knowledge
- to increase understanding about the role of diet and lifestyle in preventing diabetes and improving clinical outcomes
- to explore diabetes from the patients perspective
- to develop an understanding of the contribution patients can make to service development

Provisional Programme

- 08.30-09.30** **Coffee & Registration**
- Chairperson* *Alistair Emslie-Smith,
General Practitioner and Tayside Diabetes Network Lead Clinician*
- 09.30-09.40** **Chairman's Welcome & Introduction**
Alistair Emslie-Smith
- 09.40-10.00** **Diabetes: Past, Present and Future**
Ray Newton, Consultant Diabetologist, Ninewells Hospital
- 10.00-10.40** **"Scoffing"**
- A humorous theatrical perspective on weight management in society today
Women and Theatre Group, Birmingham
- 10.40-11.00** **Power to the People: working in partnership**
- A personal perspective
Ross Kerr, Person with Diabetes & Chair of Diabetes UK Patient Involvement Project
- 11.00-11.30** **Coffee & Exhibition**
- 11.30-12.15** **Workshop Session 1**
- 12.15-13.45** **Lunch & Exhibition**
- 13.45-14.30** **Workshop Session 2**
- 14.30-15.00** **Coffee & Networking**
- 15.00-15.45** **Workshop Session 3**
- 15.45-15.55** **Re-group to the Main Hall**
- Chairperson* *Anne Jarvie CBE RGN RM BA, Director and Chief Nursing Officer,
Scottish Executive Health Department*
- 15.55-16.30** **The Big Debate: *This house believes that all overweight people should be screened annually for diabetes***
For: Roland Jung, Consultant Physician, Ninewells Hospital
Against: Sandy Young, General Practitioner, Alyth Health Centre,
- 16.30** **Closing Remarks**
Anne Jarvie, CBE

PROFESSIONAL WORKSHOP SESSIONS

1	Moving Points in Diabetes <i>New therapeutic developments, new evidence, and search for a cure</i>	Alan Connacher Consultant Physician, Perth Royal Infirmary
2	Diabetes and the Young <i>Developments in clinical care, “digital” diabetes and camps</i>	Steve Greene and Team Tayside Institute for Child Health, University of Dundee
3	Can we prevent an epidemic? <i>The public health challenge</i>	Paul Ballard Health Promotion, NHS Tayside
4	Diabetes Research in Tayside <i>Update on current research projects – big and small</i>	Andrew Morris/Dario Alessi University of Dundee Michael Sykes TARPC/ Allyson Macdonald Diabetes Specialist Nurse
5	Gadgets & Devices	Tayside Diabetes Specialist Nurses
6	Metabolic Syndrome – drugs, drugs and more drugs <i>Hypertension & Dyslipidemia</i>	John Petrie Consultant/Senior Lecturer, Department of Medicine, Ninewells
7	Meet the Patient <i>Share the patient’s view</i>	Ray Newton Consultant Physician, Ninewells Hospital

PATIENT WORKSHOP SESSIONS

1	Exercise – What’s Right for You? <i>Information & discussion sessions</i>	Dorothy Dobson/ Charlotte Anderson/ Anne Kirk / Christine Sturrock
2	Food: Facts and Fallacy/ Diabetes UK Buddy Project	Rhona Peters / Lesley Grant (25mins) Georgie Milliken/Debbie Voigt (15mins)
3	Healthy Feet will Travel <i>Holiday advice</i> <i>Foot care</i>	Graham Leese / Vicky Green / Theresa Torrance



in partnership with



**DIABETES MELLITUS:
A MULTI-PROFESSIONAL PERSPECTIVE**

<p>Day 1 Thursday 21st November 2002 Braeknowe, 430 Blackness Road, Dundee</p>
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Introduction to diabetes

Understanding the problem

9.15	am	Registration with coffee	
9.30	am	Getting to know you	Mary Robertson
9.45	am	Introduction Philosophy and aim of course Programme explained Assessment explained Portfolio explained Reflection and reflective writing	Kevin McFarlane
10.45	am	Coffee	
11.00am		Diabetes Network	Karen Hunter Managed Clinical Network Co-ordinator
12noon		TARPC	Michael Sykes Audit Facilitator
1.00 pm		Lunch	<i>Courtesy of SKB</i>
2.00 pm		Overview of Diabetes Diagnosis	Fiona Green SPR

Classification

		Aetiology/Epidemiology Morbidity/Mortality	
3.00 pm		Tea Break	
3.15 pm		Principles of management The Multidisciplinary Team What skills are required?	Kevin McFarlane/Mary Robertson
4.00 pm		Personal experience Small group discussion	
4.30	pm	Discussion re day	
5.00 pm		Finish	

<p>Day 2 Monday 16th December 2002 McIntosh Hall, Ashludie Hospital, Monifieth</p>
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**Adjusting to diabetes
Treatment Options**

9.15 am	Registration with Coffee	
9.30 am	How are things? Small group discussion	
10.00 am	Coming to terms with diabetes Lifestyle Culture Attitudes and Beliefs	David Gordon Hospital Chaplin
11.00 am	Coffee Break	
11.15 am	Diabetes Quiz	Mary Robertson
11.45 am	Patients Personal Experience Discussion	
12.15 pm	Lunch	<i>Courtesy of SKB</i>
1.30 pm	Type 2 Diabetes Pathophysiology Presentation	Daniel Cuthbertson SPR
2.45 pm	Tea Break	
3.00 pm	Type 2 diabetes Treatment options	Diane Walker DSN
4.00 pm	Discussion re day	
4.30 pm	Finish	

Day 3
Thursday 23rd January 2003
McIntosh Hall , Ashludie Hospital, Monifieth

Treatment options

9.15 am	Registration with coffee	
9.30 am	How are things? Small group discussion	
10.00 am	Type 1 diabetes Pathophysiology Presentation Treatment	
11.00 am	Coffee	
11.15 am	Nutrition	
12.30 pm	Lunch	<i>Courtesy of SKB</i>
1.30 pm	Practical management Monitoring Insulin Pens Devices	Mary Robertson
2.45 pm	Tea	
3.00 pm	Insulin management What insulin to choose Insulin adjustment	
4.00 pm	Discussion re day	
4.30 pm	Finish	

Day 4
Thursday 20th February 2003
McIntosh Hall, Ashludie Hospital, Monifieth

Prevention and Management of Complications

9.15 am	Registration with Coffee	
9.30 am	How are things? Small group discussion	
10.00 am	Acute Complications Hypoglycaemia Illness Infection Case Studies/Small Groups	
11.00 am	Coffee	
11.15 am	Acute Complications DKA HONK Clinical Investigations Surgery Case Studies/Small Groups	
12.30 pm	Lunch	<i>Courtesy of SKB</i>
1.30 pm	Long Term Complications Neuropathy autonomic/peripheral Patients experience Case Studies/Small Groups	
3.00 pm	Tea	
3.15 pm	Footcare Practical Session Foot examination The 'at risk' foot The Foot Clinic and how to refer	
4.30 pm	Discussion re day	
5.00 pm	Finish	

<p>Day 5 Thursday 27th March 2003 McIntosh Hall, Ashludie Hospital, Monifieth</p>

Diabetes across the Age Spectrum
Psychosocial/Cultural/Legal/Ethical Issues

9.15am	Registration with Coffee	
9.30 am	How are things? Small Groups	
10.00 am	Diabetes Across the Age Spectrum Pregnancy Pre-pregnancy Counselling Gestational Diabetes Children and Adolescents Older People People with Learning Difficulties Care of the Terminally Ill Case Studies/Small Groups	
12 noon	Lunch	<i>Courtesy of SKB</i>
1.00 pm	Psychosocial and Cultural Issues Detecting psychosocial issues Promoting behaviour change Problem solving strategies and coping	
2.00 pm	Legal and Ethical Issues Patients rights Occupation and restrictions Driving Research	
3.00 pm	Tea	
3.15 pm	Teamwork Integrated Care Role of the patient/family/carer	
4.00 pm	Discussion re day	
4.30 pm	Finish	

Day 6
Thursday 24th April 2003
McIntosh Hall, Ashludie Hospital, Monifieth

Prevention and management of complications

9.15 am	Registration with Coffee	
9.30 am	How are things? Small Groups	
10.00 am	Eye Screening	
11.00 am	Coffee	
11.15 am	Erectile Dysfunction	Charlotte Anderson DSN
12.15 pm	Lunch	<i>Courtesy of SKB</i>
1.30 pm	Cardiovascular Disease Nephropathy Case Studies/Small Groups Patient's Experience Discussion	Geraldine Brennan Consultant Diabetologist
3.00 pm	Tea	
4.15 pm	Discussion re day	
4.45 pm	Finish	

Appendix 7 – Manual Data Validation

Few databases are complete and almost none are error-free. Poor data quality can be due to a number of factors including the inappropriate recording of outcomes, misunderstandings in data definitions, misunderstandings of the wider implications of erroneous data outwith a local setting, database shortcomings and poor training in general. Experience in Tayside has shown that accurate data requires a formal validation process at Practice level.

One proven method of facilitating data quality is manual data validation:

The Data Validation Role

The role of a data validator consists of three fundamental parts:

1. Arranging a validation and facilitation visit
2. The visit to practice
3. The follow-up

1. The arrangement

Practices are first asked to consent to the data collection process. A signed consent form is completed permitting the data Validator to access and extract data from patient's paper and computer records. These forms are filed centrally.

Validators are required to sign a confidentiality statement in addition to working within their UKCC professional code of practice.

2. The visit

Validators visit Practices, providing identification as appropriate. During the visit Validators check electronic data is validated against paper records and entered onto a security encrypted laptop which is backed-up centrally at regular intervals. Additional data not available from electronic sources is entered onto the SCI-DC Network validation system.

3. The follow-up

Any data queries are highlighted giving the Practice the opportunity to clarify patient status e.g. where a diagnosis of diabetes or type of diabetes appears uncertain.

Appendix 8 – Electronic Data Quality Assurance

SYSTEM ARCHITECTURE: To deal with issues of electronic data quality, SCI-DC clinical management system (based on SQL Server 7) records detailed information about each data source that it uses in summarising each patient's record on a nightly basis. SCI-DC records a value representing the ability of one database to deliver data regarding any particular aspect of a patient's condition over another. With this knowledge at hand, SCI-DC can display the information from the BEST data source and indicate where ambiguity exists. A simplified algorithm for non-event-based data is used.

In the case of event-based data, it is the LATEST data from the BEST data source for that day which is used. Biochemistry or blood pressure results are examples of this.

As a result of the nightly summary of each aspect of each patient's care, SCI-DC has the ability to minimise error. In the first instance, users of the SCI-DC web site can take immediate advantage of the summarised view they have of the data – without requiring to know anything about the mechanism behind it. In addition, the knowledge of potential errors gives SCI-DC the ability to feed this information back to its original source. Any alterations made at source as a result cascade through and so complete a negative feedback, quality control loop.

Appendix 9 – Audit Tool

The 'Practice Audit' section of the SCI-DC System allows Practices to search for all patients falling within certain parameters.

GENERAL AUDIT

The General Audit allows all practice users to find all patients whose Biochemistry Results, BMI, etc is above any defined value

To use this section, a type of Diabetes and type of record to audit must be selected.

In addition to these required entries, an age range can be entered along with a number indicating that you wish to see all patients whose reading is greater than or equal to this value. If left blank, this value is ignored. No matter what value is entered, the general audit will **always** display patients who have never had the selected value recorded.

The final selection, which can be made, is a selection, which can be set to find all patients who haven't had the chosen measurement taken within a certain time period. If this value is ignored then each patient's latest recorded value of the chosen type will be displayed.

PATIENT CONTACT AUDIT

The Patient Contact Audit allows all practice users to find all patients records of Review Attendances or Mobile Eye Unit visits, and latest eye or foot screening dates.

To use this section, a type of Diabetes and type of clinic or visit to audit must be selected.

In addition to these required entries, an age range can be entered along with a time period over which the patient hasn't received the specified review or screening. If this value is ignored then each patient's latest record at the chosen appointment will be displayed.

DETERIORATING VALUE AUDIT

The Deteriorating Value Audit allows all practice users to find all of the patients whose specified records are worsening.

To use this section, a type of record to audit must be selected along with an optional deterioration value. If left blank, this will simply show all patients and their corresponding deterioration value.

Patients will only be shown if they have at least 2 records of the specified type and if the gap between readings is 3 months - 5 years for BMI and 6 months - 2 years for HbA1c.

Appendix 10 - Clinical Performance Review Programme

The Clinical Performance Review Programme is managed by the Data Governance Sub-Group of TDAG. A rolling, year on year programme of selected process and outcome variables are agreed, at least 3 years in advance, by the Group, with the agreement of the Clinical Governance Committees of all NHS Tayside organizations. They, in turn, act as the diabetes Clinical Quality Assurance markers for the data reporting requirements of these committees.

Taking cognicence of the fact that, when the Programme began in 2001, there was significant variation in performance across the MCN, these performance indicators are set to be challenging but attainable by clinicians and to provide goals for year on year improvement in clinical quality. By 2005 the Programme's data targets will be in line with, or tighter than, National targets based on SIGN 55 and the Quality Indicators in the new General Practice Contract. From 2006, they will also include targets relating specifically to specialist care activity. Historical data is held on the Network NHS intranet site to allow year on year comparison.

Data are made available to individual clinicians/ Practices, and in aggregate form to LHCCs and Trusts for Clinical Governance reporting purposes. The Sub-Group provide peer support to clinicians in terms of the interpretation of data and the planning of action at Practice / Clinic level to facilitate future improvements.

	2001	2002	2003	2004	2005
BP	Average % measured within 6 months	Average % > 150/90. % on treatment > 150/90	Average % measured within 6 months	Average % >150/90 % therapy change within 1 year if >150/90	Average % > 130/80
HbA1c	Average: Type 1 Type 2	Average: Type 1 Type 2 % HbA1c >8.5 with treatment change within 1 year	Average: Type 1 Type 2	Average: Type 1 Type 2 % HbA1c > 8.5 with therapy change within 1 year	Average: Type 1 Type 2
Cholesterol (MI)	Average: Type 1 Type 2	Average: Type 1 Type 2 Annual incidence MI	Average: Type 1 Type 2 %>6.5 on lipid lowering therapy	Average: Type 1 Type 2 Annual incidence of MI	Average: Type 1 Type 2 %>6.5 on lipid lowering therapy
Eye Screening (Laser)	Annual fundal examination %	Annual fundal examination % Laser treatment incidence	Annual fundal examination %. Breakdown of screening modality	Annual fundal examination %	Annual fundal examination %. Laser treatment incidence

Appendix 11 - Diabetes Network Handbook - Update Procedure

The Tayside Diabetes Network Handbook provides clinical staff working in the NHS Tayside Diabetes Managed Clinical Network with regionally agreed guidelines, protocols and information concerning all aspects of the management of diabetes. It is available in both printed format and via the NHS Tayside Diabetes Network website. The printed version was published in November 2000. The Managed Clinical Network has an obligation to ensure the quality and relevance of the information contained in this document if it is to remain a reliable source of reference for all health professionals caring for patients with diabetes in Tayside. We therefore outline our procedure for updating the handbook and identify the individuals with key responsibility for meeting this requirement. Where the handbook is used outwith Tayside, responsibility for maintenance lies with the local clinical Team.

A specific advantage of using website technology to share information is the potential to respond to change in a dynamic way. It has been agreed that only the web-based version will be routinely updated.

Update Mechanism

Responsibility for reviewing the Handbook lies with the Network Information Sub-Group. This Group is chaired by a consultant diabetologist, currently Dr Geraldine Brennan, and comprises multidisciplinary representation from both primary and secondary care. A formal process of revision/updating of the entire Handbook will be undertaken on a two yearly basis. In addition, in the light of new evidence or developments, the following procedure will be followed whenever a possible change is identified.

- Submissions will be considered from anyone involved with the care of patients with diabetes in Tayside.
- All proposed updates or additions will be submitted to the Information Sub-Group Chair, for consideration.
- The Information Sub-Group will formally review any suggested major revisions. Minor revisions will be dealt with directly by the Information Sub-Group Chair.
- An appropriate member of the Network will be nominated to prepare a draft of any proposed major revision.
- Drafts will be circulated by e-mail to all members of the Information Sub-Group for formal approval, with a one-week response time.
- Upon agreement of any changes the Chair will provide electronic documentation to the Tayside Diabetes Network IT Facilitator, who will then update the electronic version of the Handbook within five working days.
- The Information Sub-Group Chair will maintain a log of all updates.