



Local Diabetes Services Advisory Group And Diabetes Managed Clinical Network

Annual Report 2006 – 2007

Marina Sinclair
Diabetes Services Co-ordinator

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1. Chairman's Foreword

"Diabetes is caused by melancholy"
(Thomas Willis, 1621 - 1673)

Of course we know differently these days and knowledge into the causes of diabetes and efforts to control, or even possibly cure, the condition continue apace.

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However, the number of people in the Western Isles with diabetes has now increased to over 1000 and the challenges of providing quality diabetes care to a scattered population remain as difficult as ever.

The Local Diabetes Services Advisory Group (LDSAG) and Diabetes Managed Clinical Network (DMCN) are committed to ensuring that services are available as locally as possible to help people meet their individual needs and to try to lead a normal life.

Our main focus recently has been on the development of a robust and accessible provision for eye screening for the development of any complications due to diabetes. This service had previously been provided by a mobile screening van from Tayside region but thanks to a new arrangement with a local optometrist (R. Doig) we are able to offer much greater flexibility in appointment provision and have also been able to visit those patients who were previously unable to access the screening van. As a result, the Western Isles will have one of the highest screening rates in Scotland.

As detailed in the report, Quality Improvement Scotland carried out a review of service provision in November 2006, with the Western Isles meeting more criteria than any other Scottish Health Board. The quote at the top is appropriate here in that, in keeping with many other health board areas, there is a lack of psychological services to deal with the needs that diabetic patients can have in coping with the condition. This is an area that the DMCN hopes to concentrate on in future.

The LDSAG / DMCN regards staff training as essential to the quality of the service we provide and has been pleased to support a number of initiatives as detailed in the report. The DMCN also supported a 2 half-day symposium for health care providers held at Lews Castle College in May 2006. The event attracted a number of distinguished speakers from around Scotland and was well attended by staff from a variety of disciplines as well as lay members of the DMCN.

I would like to thank all of the people who have served on the LDSAG and also on the DMCN since its inception in 2004 when the two groups were amalgamated. Finally, I would like to thank all of the dedicated staff that contribute on a daily basis to ensuring that a high quality service is provided to people with diabetes from the Butt to Barra.

QuickTime™ and a decompressor are needed to see this picture.

Dr Andrew Senior
Chairperson, Diabetes MCN and LDSAG

2. Introduction

The Western Isles is the name covering the Outer Hebrides, an island group situated north-west of mainland Scotland. The population of around 26,370 live on 10 islands, the largest and most populous of which is the Isle of Lewis where the town of Stornoway is located. The proportion of older people in the population is above the national average, as are levels of illness and deprivation.

Travel between the islands is overland by car and ferry which involves two sea crossings between Lewis and Barra, or by plane involving two flights between Stornoway, Benbecula and Barra. The geography and a dispersed population over such a large distance presents its own unique challenges in delivering clinical services that are equitable and afford easy access.

The NHS Western Isles Diabetes Managed Clinical Network was formally established in January 2004 and over the last 3 years has made considerable progress in developing the Western Isles Diabetes Services. The first annual report of the MCN for 05/06 was published and can be viewed or downloaded from our website www.diabetes-hebrides.org.

This report is a summary of the work of the Diabetes MCN from 2006 through to the end of 2007.

In 2006 The Scottish Executive published The Scottish Diabetes Framework Action Plan which sets out a clear way forward for diabetes care in Scotland. The Western Isles Diabetes MCN has been striving to implement the recommendations to ensure that the best possible service for Western Isles diabetes service users is delivered.

In March 2007 NHS Quality Improvement Scotland did a follow-up visit from their initial visit in July 2003. Their report in 2003 showed that NHS Western Isles Diabetes Services had met 32 out of the possible 45 criteria set by the national standards. The follow-up visit in 2007 reported that NHS Western Isles have now met 40 out of the 45 criteria. This shows that we are continually working to develop the service to meet QIS standards and deliver a high standard of care.

3. Retinal Screening

Since 1998 Western Isles NHS has contracted with NHS Tayside to provide Diabetic Retinopathy Screening for all diabetic patients over the age of 12 years resident in the Western Isles. This service comprised of a fully equipt mobile van which visited 13 sites throughout the Western Isles for a period of 8 weeks, screening patients basically on their doorstep. This service has been very successful with attendance figures never falling below 80%. However in 2005 NHS Tayside indicated that the service traditionally provided to us would no longer be available due to a number of internal and external influences. This meant that NHS Western Isles had to consider how this service was to be provided, looking for the best model to fit our population's needs and to take account of our geography. Whilst the previous service model, an annual block screening service, was very successful it was inadequate to meet the needs of all our patients, eg patients who were absent from the island during the visit of the mobile van, patients with mobility problems who were unable to access the van and patients who required a 6 month re-screen.

In 2005 A sub-group of the Diabetes MCN/LDSAG was established to look at the re-design of current retinal screening Project. The group made recommendations aimed at delivering a patient centred diabetes service for the Western Isles working on the principle that care should be delivered locally in the community wherever possible. Amongst many other factors the group had to consider the 3 main elements of the service –

1. Image Capture
2. Grading and Reporting
3. Call and Recall

An option appraisal was prepared which examined all the possibilities for each of the three elements of the service. At the same time a national programme developing Sorian (Nationally commissioned IT programme for retinal screening) was also being developed and the requirements for this system had to be taken into account in our option appraisal.

The service re-design has been undertaken and implemented as of April 2007

Image Capture

Image capture is provided locally by Robert Doig Optometrist Ltd who has 2 cameras, one in Stornoway and one in Benbecula. Both cameras can be decanted to provide screening to rural practices and home visits. This means there is an all year round flexible screening service and patients who were not being screened because of mobility are being screened in their homes.

Grading & Reporting

The stringent requirements for quality assurance, practical and financial issues dictate that grading will be undertaken from a regional centre. Boards are required to share the resources of one of 5 regional centres and due to the good historical working relationship Western Isles has had with Tayside, we have established a Service Level Agreement with them to provide our grading up to level 3.

Once images have gone through the grading process, they are picked up using the national DRS system Soarian and distributed via the Diabetes Resource Centre.

Call & Recall

The implementation of the national screening IT system, Soarian is in place in the Diabetes Centre and the co-ordination of call/recall is carried out here.

The Diabetes Register which is held on SCI-DC Network feeds into Soarian to provide us with an up to date list of all patients who are eligible for screening. Patients are systematically invited to make an appointment for their eye screening. Once they have had image capture the patient status is updated and a recall date set one year on. Soarian is checked daily to ensure patients are called, recalled and their results delivered on time.

Annual Attendance Figures

Year	Patients Booked	Patients Attended	Attendance %
1998	536	497	93%
1999	394	349	89%
2000	NO SCREENING		
2001	698	573	82%
2002	671	580	86%
2003	755	605	80%
2004	846	702	83%
2005	872	741	85%
2006	Service Re-Design	No Screening	
	Invited		
2007	928	886	95.47%

Notes

- ◆ 1999 screening numbers reduced as only patients who did not attend the eye clinic in the previous 12 months were called
- ◆ 2000 no screening due to screener staff shortages in NHS Tayside
- ◆ 2001 onwards invited all patients for screening regardless of attendance at the eye clinic.
- ◆ 2007 patients who attend eye clinic are temporarily excluded from the DRS programme until discharge from eye clinic
- ◆ 2007 figures run from 1/4/07 to 31/3/08

4. Diabetes Foot Screening

In 2004 the podiatry department undertook a pilot to accompany the retinal screening van at 2 sites to screen patients feet after they had had their eye screening carried out. This pilot received excellent feedback.

The Diabetes MCN supported the pilot recommendation to carry out “tandem” screening on all diabetic patients during 2005. This entailed 2 members of the podiatry team accompanying the Retinal Screening van to all 13 sites throughout the Western Isles and offering foot screening to patients who had attended for retinal screening also. 86% of all diabetic patients over the age of 12 years old had foot screening carried out that year. A risk category was established for all diabetic patients assessed in 2005. As a result of this plans were implemented locally to address future screening needs.

5. SCI-DC (Scottish Care Information – Diabetes Collaboration)

The principal concept of SCI-DC Network is the creation of a single, shared electronic record, which can be accessed by all those providing care to the diabetic person. It provides 2 distinct functions

1. The maintenance of an accurate, comprehensive and up-to-date shared clinical diabetes record, to facilitate direct individual patient care.
2. A comprehensive disease register within the health board for the purpose of auditing and health service planning

The Western Isles has 13 GP practices spread over 14 sites. Every practice with GPASS and EMIS have SCI-DC implemented. The Westside Practice uses Vision and this practice should be linked to SCI-DC Network by December 07.

All the diabetic information recorded for a patient in GPASS, EMIS and Vision in primary care and CLINICAL in secondary care, automatically feed into SCI-DC Network to provide an up to date comprehensive patient record. It means when a patient sees a health professional they can bring up their record on SCI-DC and see all their past a present clinical results and current medication. Comments and outcomes can be shared between Health Care Professionals and graph trends of BMI, HbA1c etc can be printed and given to patients.

Each practice has a Diabetes Retinal Screening Register which has all their current patient eligible for screening listed. It is up to the practice to regularly check this register as it feeds into Soarian where the patient is picked up for retinal screening.

6. NHS Quality Improvement Scotland

A peer review of NHS Western Isles took place on 3rd July 2003. We were reviewed against 10 Clinical Standards of which we met 32 of the criteria out of a possible 45.

A follow-up Review Visit took place on 2nd November 2006 where a team came and assessed performance on all the “not met” standards (where the evidence provided in 2003 demonstrated that the criteria was not being attained). The formal Follow-up Report for the Western Isles was published in March 2007. The full reports for each health board area can be found on www.nhshealthquality.org

NHS Board	Total Criteria met out of a possible 45
Ayrshire	36
Borders	38
Dumfries	36
Fife	36
Forth Valley	35
Grampian	36
Lanarkshire	31
Lothian	37
Orkney	23
Shetland	38
Tayside	37
Western Isles	40

NHS Western Isles did not meet the following criteria

- **Standard 1 Criteria 2** states “Data interfaces are in place between primary and acute care such that a single date entry covers all recording needs”

At the time of the review, the EMIS practices were not linked to SCI-DC, but now are and the one remaining Vision Practice should be linked in by December 07. This would then fulfil the above criteria.

- **Criteria 4** states “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.”
- **Criteria 5** states “The computerised clinical management system is board-wide and incorporates call and recall systems for screening/review of complications
- **Standard 3 Criteria 5** states “People with diabetes have appropriate access to identified key health professionals including state registered podiatry and dietetic, nursing and psychology services.”

Although we meet all of this criteria, the lack of psychology services for our diabetic patients means we fail the criteria.

- **Standard 9 Criteria 3 states** “All people with type I diabetes, with microalbuminuria as defined in a local protocol, are prescribed an ACE inhibitor unless there are contraindications.”

This information is collected as part of the QOF data however the QOF data are unable to distinguish between patients with Type I or Type 2 diabetes so the criteria is unfortunately not met this way.

7. Scottish Diabetes Survey

The Scottish Executive requires each health board to complete and submit the Scottish Diabetes Survey. The 2005 survey was just published in February of this year and the full report can be found on www.diabetesinscotland.org .

The 2006 report has just been presented to the Scottish Diabetes Group in August and should be published by the end of the year.

Number of patients included in Scottish Diabetes Survey 2001 – 2005

NHS Board	2001	2002	2003	2004	2005
Argyll & Clyde	8,419	9,522	10,209	11,293	7,714
Ayrshire & Arran	8,279	9,026	9,664	10,641	13,717
Borders	2,686	2,929	2,986	3,662	4,046
Dumfries & Galloway	4,726	5,150	5,552	5,662	5,796
Fife	8,408	9,920	9,670	12,682	13,855
Forth Valley	7,051	6,845	8,206	8,230	10,819
Grampian	10,164	5,726	9,978	16,855	16,079
Greater Glasgow	17,861	4,191	22,842	29,547	31,818
Highland	1,930	2,156	3,614	5,141	5,545
Lanarkshire	13,708	16,358	15,976	18,252	20,380
Lothian	10,832	18,917	21,547	24,215	25,956
Orkney	377	377	377	677677	745
Shetland	394	608	345	470	752
Tayside	10,197	11,277	12,165	13,786	14,639
Western Isles	745	833	833	890	926
Scotland	105,777	103,835	133,964	162,003	172,787

NHS Western Isles Diabetes Register

1992	230 approx
1998	536 approx
2001	698
2002	833
2004	890
2005	926
2006	1006
2007	1012 (as at 1 st Sept 07)

8. Training and Education

The MCN acknowledges that to ensure delivery of a high standard diabetes service investment has to be made in training and education of all staff. The MCN has funded various training courses for health professional and administrative staff throughout 06/07. Plans are also under way for Insulin Pump Training, The Warrick Diabetes Diploma and Foot Ulcer module to be delivered in 2008 to community and hospital based staff.

BIDAC Training

The Diabetes Team in Stirling hosted a 2 day course in April 07 which was entitled BIDAC (Bournemouth's Insulin Dose Adjustment Course). The training was delivered by a Specialist Dietitian and Diabetes Specialist Nurse from Bournemouth. Two of our Diabetes Nurses, Peigi Macleod and Mairead Macdonald, along with our Senior Dietitian Margretta Macleod attended.

The aim of the course was to provide knowledge, information, training and skills to enable Health Professionals to teach carbohydrate counting and insulin dose adjustment to patients with Type 1 Diabetes on multiple dose injection insulin therapy.

Over the 2 day course staff were able to practice counting the carbohydrate content of meals and matching this with the correct dose of insulin.

The ability to count or assess the quantity and quality of carbohydrate in a meal is desirable for people on basal bolus insulin and essential for those on insulin pumps. This is also the approach which is used in DAFNE (Dose Adjusted For Normal Eating).

Carbohydrate counting and insulin adjustment is a method of management for Type 1 Diabetes we, as a Diabetes Team, hope to explore, to assess if there is a demand for it and how it would be best provided locally.

Childhood Diabetes in Scotland Study Day

The Diabetes MCN funded the Senior Diabetes Nurse to attend this study day. The programme for the day was varied, encompassing children of all age groups from the very young child with diabetes to the teenager with diabetes and their challenging needs in each age range.

Speakers delivered a comprehensive talk on their individual topics which generated a lively discussion as the members of the audience discussed what was specific to their own area.

The challenges of adolescent diabetics in Scotland is the same country wide with a high rate of non-attendances, poor compliance of treatment and the consequences of this which often results in admission with diabetic ketoacidosis. No clear answers were given as to how to improve compliance except to continuing supporting the youngsters through these difficult years and be available for them when they want assistance and support. The topic of transition from paediatric to adult clinics generated a lot of discussion and the age of transition varies across Scotland. The conclusion generally was that age banded clinics alone were not the answer. It had been suggested that flexibility

of clinic i.e. timing, venue, having the appropriate information available, attitude of clinic staff, faith in the system and a realistic multi disciplinary approach may go some way to make it easier for adolescents to attend and continue to do so. The services of a psychologist would be important as it was stated that the prevalence of mental health problems is double in patients with chronic conditions than with their peers. In the absence of psychology services access to social work staff may be necessary but not always acceptable. The challenges of transition are to be realistic and be deliverable with available resources. There are no guidelines for transitional care; however increasing the age of transfer to 18 years should be considered by more centres – this was the view expressed by one of the speakers. Timing of the transfer may be linked to the length of time of diagnosis was another view suggested by another speaker. (PS in the Western Isles transition is generally between the age of 16-18 years depending on the child, the demands on the paediatric clinic and the discretion of the Consultant Paediatrician).

There were many questions raised during this discussion, some of them left unanswered as the debate continues on the management of diabetics in this age group.

Diabetes in the very young

This interesting topic was presented by Dr Ragnar Hanes when he discussed the risks for the child when developing diabetes in the early years of life. There are many risks connected with both hyperglycaemia and hypoglycaemia in the very young. Dr Hanes spoke about the goals we as health professionals set for glycaemic control – HbA1C 7.5%-8.0%. However in achieving this target the child is at risk of hypoglycaemia in the very young. The effects of hyperglycaemia on brain development was also discussed in his presentation. He raised many questions in his talk about how far should we as health professionals push for metabolic control in the very young.

Dr Hanes continued his talk on insulin treatment on the very young where different methods of insulin delivery are used, from single injections, multiple injections or insulin pumps. This was a very challenging talk reminding us as health professionals the importance of looking at the individual child, their individual requirements and be prepared to adjust and change treatment as often as necessary to keep glucose levels under control and especially to keep them safe.

The afternoon session of this study day was assigned to case study presentations by different presenters. The case presentations were stimulating and all were challenged by many questions presented to the panel regarding the issues raised in each case presentation. However there is no right or wrong answer to the challenges presented by diabetes but it is reassuring meeting with colleagues from other areas who all face the same questions and difficulties wherever we work.

Development in the Management of Diabetes in Pregnancy

The Diabetes MCN funded 1 diabetes nurse and 2 midwives (one from the Western Isles Hospital and one from community in Uist) to attend this study day in Stirling. It was attended by a cross section of medical and nursing staff involved with diabetic women in pregnancy. The audience from a wide geographical area included obstetricians, diabetologists, GPs, midwives and diabetes nurses. The speakers came from Denmark, Belfast and Edinburgh

The first speaker from Denmark delivered a stimulating talk on Renal Disease in Pregnancy, blood pressure (BP) must be controlled and the use of some drugs may be necessary. ACE inhibitors and Angiotensin Receptors antagonists should not be used due to the high risks of abnormalities. For some patients diuretics and/or beta blockers, which are reportedly safe, can be used in pregnancy if necessary, patients must be closely monitored. Renal function already in decline prior to pregnancy risks further deterioration and a very high risk of developing nephropathy. Close monitoring of renal function during pregnancy is paramount with checking BP, creatinine and urinary microalbuminuria. The risk of pre-eclampsia in the second stage of pregnancy is greater with the presence of proteinuria and an elevated BP (the target BP for pregnancy should be 120/70). Strict metabolic control is essential for the benefit of baby and mother. The speaker reported on some case histories she had been dealing with in Denmark and generated discussion from the obstetricians and diabetologists in the audience, some of whom were unsure of the risks using diuretics in pregnancy.

Dr Daniel McCance from Belfast delivered a stimulating and challenging talk when he emphasised the importance of optimum glycaemic control, pre-conceptual target HbA1C 6.5%-6.8%. We as health care professionals must get this across to our diabetic patients who are planning a family. At what age should pre-conceptual advice be discussed with young girls who are diabetic? No clear answers given. High glucose levels at conception and in the first three months of pregnancy are STRONGLY linked to foetal abnormalities. In terms of outcome this applies equally to Type I and Type II. High glucose levels are linked to birth weight. Planned pregnancies have a lower HbA1C and less congenital malformations. The risks of hypoglycaemia were highlighted with a target HbA1C of 6.5%, however the risks of hyperglycaemia are much greater to the baby than with hypoglycaemia. Regular glucose monitoring is important both pre and post meals, pre-meal target between 3.0-5.8mmol/l, post meal 7.2mmol/l 1 hour post meal and 6-7mmol/l 2 hours post meal.

Some of the topics discussed:

- ◇ Metformin appears to be safe in pregnancy – Type II diabetes and it is a useful adjunct to insulin
- ◇ Swift achievement of good glucose control in Type II diabetes is mandatory
- ◇ Big doses of insulin is the norm

These topics were further discussed in the afternoon workshops as well as the difference in insulins currently in use in pregnancy.

Fast acting analogues e.g. Novorapid and Humalog and long acting analogues e.g. Levemir and Lantus reportedly gave less hypos. Fast acting analogues give a smaller post and pre-meal excursion compared to the regular soluble insulins e.g. Actrapid and Humalin S; which are being used less and less in most areas. Insulin requirements vary widely between individuals and are related to maternal weight at booking clinic and weight gain during weeks 20-29. According to one study in 2001 it was reported insulin dose requirements often fall from weeks 8-14. Large insulin requirements remain unexplained and may not be associated with placental failure. Insulin treatment to achieve tight glycaemic control can be managed using insulin pump, which are safe and effective before and during pregnancy or by multiple dose injections i.e. 4 or more daily.

Workshops in the afternoon focussed on:

- ◇ Insulin management during pregnancy
- ◇ Obstetric monitoring during pregnancy
- ◇ Case studies

The importance of obstetrics and diabetologist combined consultation was emphasised, the importance of good communication between each team plus the services of paediatrics and neonatal facilities which require to be available at the time of delivery.

Interaction at the workshops between groups was excellent with staff from different areas raising issues and also making suggestions to some of us who have not the same experience because of low numbers in this age group.

The clear message for me from this valuable study day was the importance of good glycaemic control pre-conception and the consequences for mother and baby if control is sub-optimal.

Diabetic Foot Screening Training

Funded from the Diabetes MCN/LDSAG the following project took place earlier this year;

After the successful Diabetic Foot Screening Project in 2005 we were able to establish risk categories for all those who were screened and these were identified as Low, Moderate, High and Active Foot Disease. Building on this initiative an audit of all areas currently offering foot screening was undertaken, using questionnaires to establish existing knowledge of elements of screening and foot care advice.

In order to make Diabetic Foot Screening standardised, sustainable and comply with national guidelines (SIGN, NICE etc) where,

'...suitably trained healthcare professionals...'

would carry out diabetic foot screening the Podiatry Dept adopted a modified training model/package from NHS Lothian which aimed to train appropriately selected healthcare professionals in all GP Practices in the WIHB Region.

The training was developed to meet the needs of all practice areas. A selection of training dates were offered and all practices were given the opportunity of training, including Barra and the Uists which took place in UBH.

The training was carried out by two Podiatrists and involved a well established systematic model of training and covered issues such as screening, risk category identification, referral pathway, appropriate and inappropriate footwear and foot care advice. This training covered theory of diabetic foot screening and practical hands-on session. The funding allocated was also used to provide all practices with a guide to diabetic foot screening and the equipment required to carry out an effective diabetic foot screening.

The training was well received with very positive feedback, '*excellent session , clarified all areas of concern*', '*very good training, informative and thorough, now feel confident in screening for foot problems in diabetes*' were among some of the comments received.

The podiatry department plan to hold annual updates on diabetic foot screening.

European Computer Driving Licence

The Diabetes Service Administrator has begun the widely recognised ECDL course at The Lews Castle College. This course comprises of 7 modules covering , spreadsheets, database, presentations ect all of which will be an addition asset to the diabetes administrative services.

9. Diabetes Awareness

The Pyramid Theatre Company

The Western Isles Council (New Community Schools) in partnership with NHS Western Isles hosted the Pyramid Theatre Company during 2006. This company was founded in 1993 as a specialist Theatre-in-Health Education company, covering health issues in a humorous but serious way. Funding from the Department of Health allowed the company to commission a new play on Diabetes. The production aims to raise public awareness of type 2 diabetes, encourage testing and allow service providers to give information on prevention and on managing this condition.

The play was called "All Shook Up" and it performed at all secondary schools throughout the Western Isles. Two evening performances were held to allow the public to attend, one in Uist and one in Stornoway. Diabetes Nurses, GPs and other health care professionals attended these performances and were part of the panel for the "hot seat" question session. The full report can be found on our website www.diabetes-hebrides.org.

Diabetic Retinopathy Screening Roadshow

Diabetes UK Scotland/RNIB Scotland are running a retinopathy screening awareness campaign which is being rolled out across Scotland from June 2007. Following the publication of a joint report on the take-up of retinopathy screening, a campaign road show is going to every health board area in Scotland. A copy of this report can be obtained from http://www.rnib.org.uk/xpedio/groups/public/documents/PublicWebsite/public_070611report.pdf The road show aims to work with local MCNs, retinopathy screening providers, pharmacists and optometrist as well as media and politicians to promote the importance of eye screening at a local level.

The campaign, which is being funded by the Scottish Diabetes Group, has three main aims:

- Raising awareness and understanding of the link between diabetes and site loss.
- Raising awareness of the availability of retinopathy screening in Scotland
- Encouraging people with diabetes to attend for regular eye screening

The Roadshow visited the Western Isles in November 07, visiting Uist & Barra Hospital and then The Stornoway Town Hall. The Stornoway event was combined with the local branch of Diabetes UK Scotland hosting a coffee morning and awareness event. There were a wide range of leaflets for the public and diabetes nurses were offering random blood glucose testing. Out of 17 people tested that morning 4 showed results that indicated a referral to their GP.

10. Public Involvement

The Diabetes MCN has a healthy 10 lay members between Lewis, Uist and Barra. Not all attend monthly MCN meetings but can do at any time. This lay group is made up of service users and a parent of a child with diabetes, it is chaired by Mairi Bremner. Recently one of the members Helen Maclean has been selected to represent the Western Isles on the National Diabetes Care Focus Group.

11. Finances

The Community and Primary Care Division held the DMCN budget for 2006-07 and was not available to the DMCN' and therefore this report cannot account for the disposal of that budget. It has been agreed that the budget will transfer back to the Public Health Division for 2007-08.'

12. Plans for 2008

Training Needs Analysis

A Diabetes Training Needs Questionnaire has been drawn and will be distributed to all health care professionals in NHS Western Isles. This will help us identify the training needs and inform future plans for training in 2008. The training needs analysis will also inform our Diabetes Education Strategy.

Retinopathy Screening Questionnaire

It is planned to select a random 100 patients and distribute a survey to find out how they feel about the "new" service and if any improvements are needed.

Insulin Pump Training

Plans are underway for Insulin Pump Therapy training for all nurse and doctors in both community and hospital. This training will be an introduction to the pumps which will allow staff to familiarise themselves with the equipment. Following this more intensive training will be provided for the Diabetes Nurses and Consultants.

Diabetes Diploma

The Warrick Diabetes Diploma is to be offered to 20 members of staff based in either the community or hospital. The Diabetic Foot Ulcer module is to be undertaken by 3 Podiatrist.

SCI-DC Training

Podiatrist and Dietitians are to be offered SCI-DC Network training. Update training is to be offered to all GP Practice staff within the health board area.

Anticipatory Care Bid

A requirement within the Diabetes Action Plan 1.4 states “Improve access to services for people with diabetes from disadvantaged groups and disadvantaged areas.... MCNs should develop plans to describe the provision of services to meet their needs in terms of diabetes care.” Full plan can be viewed at www.scotland.gov.uk

Meetings have been held with the Health Promotion Department to discuss how we address the needs of disadvantaged groups and groups in deprived areas. It is recognised that the national indicators for deprivation does not accurately identify these groups living in our own community so using a local deprivation study, an Anticipatory Care bid (currently in draft) has been prepared and is soon to be submitted to the North of Scotland Planning Group that will identify and address the needs of these groups.

The proposed project which, in partnership with the CHD and Stroke MCNs will conduct a health screening exercise to identify people at risk from Diabetes, Cardiovascular Disease and other health factors and refer for preventative management, for people in disadvantaged areas for all people over the age of 40. This is further augmented by the Mens Health Initiative and other projects that will identify people under the age of 40 who are at risk of diabetes or have undiagnosed diabetes.

The MCN approved £10k per year for the two years of the project (£20k) however it is dependent upon additional funding from the Board and approval from the North of Scotland Planning Group for the bulk of the funding £70k per year.

Reclaiming Lives...bring Hope to your future

The Diabetes MCN will host the above company who plan to deliver a 3 day course on Cognitive Behavioural Therapy. This has been offered to all Practice Nurses and staff who daily deal with diabetic patients. The course will be delivered during August and September 08

“Doing Diabetes – Making Life Easier for Everyone”

Following significant concern about the lack of psychological support for people with diabetes during the review of the Scottish Framework, the Scottish Diabetes group set up a working group to investigate the extent and nature of psychology provision in Scotland. Their recommendations included delivery of training courses for health professionals working in diabetes services. The course will develop skill in communication with patients and negotiation and delivery of behavioural change interventions. This course will run in the Western Isles over 3 separate days between November and December 08

