

NHS Western Isles

Follow-up Report ~ *March 2007*

Diabetes

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1 Introduction

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

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

'Met' applies where the evidence demonstrates the standard and/or criterion is being attained.

'Not met' applies where the evidence demonstrates the standard and/or criterion is not being attained.

'Not met (insufficient evidence)' applies where no evidence is available for the review team, or where the evidence available is insufficient to allow an assessment to be made.

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

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

This report presents the findings from the peer review of **NHS Western Isles**. This follow-up review visit took place on **2 November 2006**, and details of the visit, including membership of the review team, can be found in Appendix 3.

2 Overview of local service provision

The Western Isles is a 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.

Local NHS system and services

Western Isles NHS Board has the same functions as mainland NHS boards. It is responsible for improving the health of the local population and for the delivery of the healthcare required. The NHS board provides strategic leadership and has overall responsibility for the efficient, effective and accountable performance of the NHS in the Western Isles.

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

Further information about the local NHS system can be accessed via the website of NHS Western Isles (www.wihb.org.uk).

The Scottish Diabetes Survey 2005 indicated that 926 patients are registered with a recorded diagnosis of diabetes in NHS Western Isles on an integrated area diabetes register. This figure can be broken down further to: 171 patients registered with Type 1 diabetes; 749 patients registered with Type 2 diabetes; and 6 patients with other types of diabetes ('other' includes gestational or maturity onset diabetes of youth [MODY]).

In NHS Western Isles, there are 12 GP practices and health clinics. There is a diabetes centre located in the Western Isles Hospital, Stornoway. Weekly diabetes clinics are held in the Western Isles Hospital. A diabetes clinic is held every 3 weeks at Uist and Barra Hospital, Benbecula, and a clinic is held 3 times per year at St Brendan's Hospital, Barra.

3 Summary of findings

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

In 2003, NHS Western Isles met 32 out of 45 criteria. Of the remaining 13 criteria, 11 were given the assessment category of 'not met' and two were 'not met (insufficient evidence)'.

On the basis of new evidence submitted and the follow-up review visit, the review team considered that 40 out of 45 criteria are now 'met'.

Organisation

Scottish Care Information - Diabetes Collaboration (SCI-DC) Clinical (hospital-based system) is used in the diabetes clinic in the Western Isles Hospital, although it was reported that this is not used 'real time' in the clinic. It is anticipated that SCI-DC Clinical will be available in the diabetes clinic in Uist and Barra Hospital, Benbecula, by the end of 2006.

SCI-DC Network (used mainly in primary care) has been rolled out to all 12 GP practices. All patients with diabetes are registered on SCI-DC, and all GP practices have access to SCI-DC Network.

There are six GP practices throughout NHS Western Isles which do not use General Practice Administration System for Scotland (GPASS). Data entered into GPASS automatically populates SCI-DC. Five GP practices use the EMIS system and one GP practice uses Vision. It was reported that the generic importer exporter (GENIE) for EMIS has been piloted, and it is hoped that this will be rolled out by the end of the current year. This will allow extraction and transfer of information to SCI-DC Network. It was not known when a pilot of the GENIE for the Vision GP practice will commence.

The diabetes managed clinical network (MCN) was established in 2004. The NHS Western Isles diabetes strategy 2005–2010 has since been developed and this has been approved by the MCN and Western Isles NHS Board.

The local diabetes service advisory group (LDSAG) and diabetes MCN have amalgamated and this combined group now has a single shared remit and acts as an advisory group to Western Isles NHS Board. There is a reported good relationship between Western Isles NHS Board and the MCN, and strong evidence of support for the progress of diabetes services.

There are shared care guidelines between primary and secondary care, including criteria for referral to specialist services. The majority of uncomplicated patients with diabetes are seen in primary care.

Patient focus

There is adequate time to undertake one-to-one patient education sessions and ongoing education sessions with the diabetes specialist nurse, with subsequent referral to the dietitian and podiatrist as required. There is an array of continuing education initiatives.

Example of a local initiative...

In November 2006, the Pyramid Theatre Company will be touring schools across the Western Isles with a play considering the different aspects of having and living with Type 2 diabetes. This has been organised by the local council, with involvement from the diabetes service. Question and answer sessions following the play will be conducted involving a healthcare professional.

Paediatric care of patients with diabetes is to be extended. Discussions are under way to establish a diabetes clinic in Uist to avoid the necessity of patients having to travel to Stornoway. Agreement has also been reached in principle for an extra 'virtual' paediatric clinic in Benbecula. A video-conferencing facility will enable patient consultation with the visiting consultant paediatrician based in Stornoway. Families will be accompanied by the diabetes specialist nurse. At the time of the follow-up review, this proposal was awaiting formal approval from the medical director.

NHS Western Isles confirmed that it actively encourages and promotes the involvement of lay representatives in diabetes services. There remains extensive patient representation on the LDSAG/MCN. The diabetes lay members group also meets as a separate body.

There is no dedicated clinical psychology service for patients with diabetes in NHS Western Isles.

Clinical review

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

In 2003, Criterion 4.1 was graded as 'not met' as there was no single NHS board-wide clinical management system in NHS Western Isles. Consequently, there were difficulties surrounding the recording of figures to indicate that patients had been offered an annual review of clinical and lifestyle/well-being factors.

The review team was satisfied that the QOF data submission verified that all clinical indicators noted within Criterion 4.1 had been recorded in the previous 15 months as part of patients' annual reviews.

Clinical management

Eyes:

NHS Western Isles has a contractual agreement with NHS Tayside to provide retinal screening and image grading. At the time of the follow-up review, it was reported that a new local method of retinal screening was being negotiated. The major change to the current system will be where capture of the retinal image is undertaken, which was previously done by the mobile retinal screening unit provided by NHS Tayside. Fixed cameras will be available in Stornoway and Benbecula, together with a mobile screening unit. Two local optometrists and an assistant have undergone additional retinal screening training.

Grading of the retinal images will continue to be undertaken by NHS Tayside. Referral for consultant ophthalmologist review will continue to be provided by NHS Western Isles to visiting consultants from NHS Highland.

It is anticipated that this new system for retinal screening will be operational by December 2006, and phased in over 12 months.

Cardiovascular status:

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

At the time of the follow-up review, all protocols were being updated and reformatted for inclusion within a diabetes handbook. The handbook was out for consultation, with an anticipated implementation date of November 2006.

Feet:

Example of a local initiative...

A dual retinal/podiatry screening programme was undertaken in 2004. This was a one-off pilot exercise to ensure capture of all patients with diabetes. Annual foot screening was undertaken by a podiatrist within a 6-week timeframe at adjacent GP practices in conjunction with patients undergoing retinal screening with the Tayside mobile retinal screening unit.

A rapid referral protocol is used across primary and secondary care to ensure appropriate patient referral to the foot ulcer clinic for review by a diabetes foot specialist. Digital cameras are available for all podiatrists, with cameras used at the initial patient assessment. Local protocols for drug and pressure relief treatment for diabetic foot ulceration are in place.

Glycaemia:

All criteria for this standard were 'met' in 2003 and the review team was satisfied that they remain 'met'.

Renal:

Discussions are to take place with the renal physician from NHS Highland in relation to new referral criteria for estimated glomerular filtration rate (eGFR).

A renal dialysis unit is being established at the Western Isles Hospital. This is being led by a renal specialist nurse with support from a renal physician from NHS Highland. This has been a patient-driven initiative in order to avoid the necessity for excessive travelling by renal patients.

Acute management:

All criteria for this standard were 'met' in 2003 and the review team was satisfied that they remain 'met'.

4 Detailed findings against the standards

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

Standard Statement

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

NHS Western Isles

Essential Criteria

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

STATUS: Met

In 2003, this criterion was graded as 'not met' as there was no up-to-date population-based electronic clinical management system of people with a recorded diagnosis of diabetes. The Lanarkshire Diabetes Care System was in use in secondary care. At the time of the review, NHS Western Isles was planning to implement Scottish Care Information - Diabetes Collaboration (SCI-DC) Clinical (hospital-based system) and SCI-DC Network (used mainly in primary care) by August 2003.

SCI-DC Clinical is used in the diabetes clinic in the Western Isles Hospital, Stornoway, although it was reported that this is not used 'real time'. Following the patient's clinic appointment, information is retrospectively entered by administrative staff at the same time as generating the patient letter for the GP. It is anticipated that SCI-DC Clinical will be available in the diabetes clinic in Uist and Barra Hospital, Benbecula, by the end of 2006.

SCI-DC Network has been rolled out to all 12 GP practices. All patients with diabetes are registered on SCI-DC, and all GP practices have access to SCI-DC Network. It was reported that some GP practices use SCI-DC extensively, whilst others use it simply as a reference tool.

There are six GP practices throughout NHS Western Isles which do not use General Practice Administration System for Scotland (GPASS). Data entered into GPASS automatically populates SCI-DC. Five GP practices use the EMIS system and one GP practice uses Vision. It was reported that the generic importer exporter (GENIE) for EMIS has been piloted, and it is hoped that this will be rolled out by the end of the current year. This will allow extraction and transfer of information to SCI-DC

Network. It was not known when a pilot of the GENIE for the Vision GP practice will commence.

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

STATUS: Not met

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

At the time of the follow-up review, double data entry was required for the non-GPASS GP practices. The diabetes services co-ordinator inputs information onto SCI-DC on receipt of hard copies of information from the Vision GP practice. The EMIS GP practices either undertake double data entry themselves, or information is submitted to the diabetes services co-ordinator for input.

Additionally, it was reported that the link between SCI Store (which holds X-ray and laboratory test results) and SCI-DC is not nationally available. Double data entry is, therefore, necessary in relation to test results. As a result, this criterion will not be ‘met’ until the national SCI-DC Network system fully interfaces with all other relevant NHS information systems.

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

STATUS: Met

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

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

STATUS: Not met

In 2003, this criterion was graded as ‘not met’ as there had been no regular audit of the quality of data and, consequently, no validation of data by primary care was undertaken.

At the time of the follow-up review, it was reported that information extracted from SCI-DC has been used for inclusion in the diabetes managed clinical network (MCN) annual report and diabetes strategy, and used to inform planning and development of services. Information was used in primary care to assist development of the retinal

screening programme. Information was also used to inform the proposal for the purchase of continuous glucose monitoring machines.

The diabetes service reported that it is still exploring the use of data held on SCI-DC, and wishes to be confident of reliable data, before using for audit purposes.

The diabetes services co-ordinator undertakes quality assurance of all data entered onto SCI-DC Network every 3 months, through use of parameter fields to identify inaccurate data entry. It was reported that advice is being sought from NHS Western Isles' data department to implement an additional system to ensure accuracy of the data and data analysis as a forerunner for other IT systems across NHS Western Isles.

Desirable Criterion

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

STATUS: Not met

In 2003, this criterion was graded as 'not met' as there was no NHS board-wide clinical management system.

Although SCI-DC is implemented across NHS Western Isles, it was noted that the national SCI-DC system does not have a call and recall function; as a consequence, this criterion cannot be 'met'.

All GP practices have their own call/recall systems in place.

Call/recall is initiated through the hospital-based outpatients system in secondary care.

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

Standard Statement

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

NHS Western Isles

Essential Criteria

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

STATUS: Met

In 2003, this criterion was graded as 'not met' as there was no formal strategy and implementation plan for diabetes services in NHS Western Isles. At the time of the review, a diabetes services co-ordinator had recently been appointed (on a part-time secondment for 2 years) to take forward the development of a local strategy and implementation plan. In addition, the diabetes services co-ordinator would have responsibility for the development of a diabetes MCN.

The diabetes MCN was established in 2004. The NHS Western Isles diabetes strategy 2005–2010 has since been developed and this has been approved by the MCN and Western Isles NHS Board.

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

STATUS: Met

In 2003, this criterion was graded as 'not met' as although a local diabetes service advisory group (LDSAG) was established, and was accountable to Western Isles NHS Board, the review team had not considered the group to have a clear function or robust links with the NHS board. The remit of the LDSAG was under review at the time of the review.

The LDSAG and diabetes MCN have since amalgamated and this combined group now has a single shared remit and acts as an advisory group to the NHS board. There is a reported good relationship between the NHS board and the diabetes MCN.

The director of public health is the NHS board's lead officer for diabetes and is a member of the LDSAG/MCN. The planning and development manager is a

member of the LDSAG/MCN and deputises for the director of public health. The director of nursing is also a member of the LDSAG/MCN.

At the time of the follow-up review, the review team noted the enthusiasm for the progress that has been made through the LDSAG/MCN, and the positive direction and focus the diabetes service is taking.

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

STATUS: Met

This criterion was 'met' in 2003 and, as a result of the follow-up review, the review team was satisfied that this criterion remains 'met'. However, it had been noted that many patients with Type 2 diabetes routinely attended annual reviews in secondary care.

Practice has since changed, and there are clear guidelines for the review and treatment of patients with Type 2 diabetes in primary care. The majority of uncomplicated patients with diabetes are seen in primary care. The diabetes nurse specialists work across both primary and secondary care.

At the time of the follow-up review, all protocols and guidelines were being updated and reformatted for inclusion within a diabetes handbook. The handbook includes criteria for referral to specialist services, and was out for consultation with an anticipated implementation date of November 2006.

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

STATUS: Met

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

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

STATUS: Met

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

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

STATUS: Met

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

Standard 3: Patient Focus

Standard Statement

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

NHS Western Isles

Essential Criteria

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

STATUS: Met

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

At the time of the follow-up review, staff confirmed that, due to the small patient numbers involved, there is adequate time for the diabetes specialist nurse to undertake one-to-one patient education sessions, with subsequent referral to the dietitian and podiatrist as required.

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

STATUS: Met

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

At the time of the follow-up review, staff confirmed that there is a reasonable amount of time for ongoing education. There is an open door policy to the diabetes centre. It was reported that consideration had been given to group patient education sessions, but this was not considered feasible, due to issues with geography, island culture and patient privacy.

The review team noted the variety of methods used to provide continuing education. In November 2006, the Pyramid Theatre Company will be touring schools across the Western Isles with a play considering the different aspects of having and living with Type 2 diabetes. This has been organised by the local council, with subsequent involvement from the diabetes service. Question and answer sessions involving a healthcare professional will be conducted following the play.

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

STATUS: Met

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

At the time of the follow-up review, it was reported that the paediatric care of patients with diabetes is to be extended. A visiting consultant paediatrician from NHS Highland holds paediatric clinics in Stornoway every 3 months. Discussions are under way to request that a clinic is also held in Uist to avoid patients having to travel to Stornoway. Agreement has been reached in principle for an extra 'virtual' paediatric clinic in Benbecula. A video-conferencing facility will enable patient consultation with the visiting consultant paediatrician based in Stornoway. Families will be accompanied by the diabetes specialist nurse. At the time of the follow-up review, this proposal was awaiting formal approval from the medical director. This proposal has been as a direct result of a family network day held in May 2006 and a patient survey conducted in the diabetes clinics.

It was reported that discussions are currently taking place between the planning and development manager and the health promotion department to address issues in relation to migrant workers.

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

STATUS: Met

In 2003, this criterion was graded as 'not met' as although there was extensive Diabetes UK patient representation on the LDSAG, there were no other formal mechanisms to involve patients in consultation on service development. The review team had also noted a lack of formal training for lay representatives on the group.

The diabetes service confirmed that it actively encourages and promotes the involvement of lay representatives in diabetes services. There remains extensive patient representation on the LDSAG/MCN. The diabetes lay members group also meets as a separate body.

The diabetes MCN hosted a public diabetes conference in 2004 to engage service users in the development of diabetes services. The conference considered public involvement, service redesign, priorities for the local diabetes strategy, and information needs and SCI-DC.

The diabetes website contains comprehensive information on planned diabetes activities. There is also a website discussion forum to encourage comments and

suggestions for the diabetes service. Minutes from the LDSAG are posted on the website.

Local and national patient satisfaction surveys have been undertaken. As a result of survey feedback, consideration is being given to reorganising diabetes clinics in order to reduce waiting times.

It was reported that discussion is under way on engaging adolescent patients with diabetes in a meaningful, relevant way.

The review team noted the work undertaken by NHS Western Isles with regard to the recruiting and training of lay members and ensuring public involvement on service development. Public involvement training for lay representatives and health professionals was provided by Diabetes UK in November 2004, to help provide understanding of their role on the LDSAG/MCN. Patient focus and public involvement follow-up training was also organised for lay representatives in November 2005.

Desirable Criteria

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

STATUS: Not met

In 2003, this criterion was graded as 'not met' as there was no psychology service provided locally. Patients, including paediatric patients, may be referred to NHS Highland for psychology input. It was also reported that there can be a delay for routine podiatry appointments.

At the time of the follow-up review, the review team noted the appropriate access to podiatry, dietetic and nursing services. In particular, the distribution of work for diabetes specialist nurse input appears more equitable. There is one full-time diabetes specialist nurse and two part-time nurses who support both primary and secondary care.

Patients requiring psychological services are referred to a clinical psychologist from NHS Highland, although the community psychiatric nurse can deal with the more straightforward cases. It was reported that there are long waiting lists for referral to the clinical psychologist. Consideration is being given to the delivery of mental health services as part of NHS Western Isles' service redesign.

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

STATUS: Met

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

The review team commended the staff enthusiasm and the high uptake in training courses.

Standard 4: Clinical Review

Standard Statement

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

NHS Western Isles

Essential Criteria

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

Clinical

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

Lifestyle/Well-being

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

STATUS: Met

In 2003, this criterion was graded as 'not met' as there was no single NHS board-wide clinical management system in NHS Western Isles. Consequently, there were difficulties surrounding the recording of figures and the review team had been unable to confirm that data were available to indicate that patients had been offered an annual review of clinical and lifestyle/well-being factors. Where data were available, they were not complete.

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

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

retinal screening which should be assessed at 80% in line with the NHS QIS Clinical Standards for Diabetic Retinopathy Screening (March 2004).

The review team was satisfied that the QOF data submission verified that all clinical indicators noted within this criterion had been recorded in the previous 15 months as part of patients' annual reviews.

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

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

STATUS: Met

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

Desirable Criterion

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

STATUS: Met

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

Standard 5: Clinical Management: Eyes

Standard Statement

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

NHS Western Isles

Essential Criteria

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

STATUS: Met

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

NHS Western Isles has a contractual agreement with NHS Tayside to provide retinal screening and image grading. It was reported that 83% of patients with diabetes were screened in October 2005. At the time of the follow-up review, it was reported that a new local method of retinal screening was under negotiation. The major change to the current system will be where capture of the retinal image is undertaken, which was previously done by the mobile retinal screening unit provided by NHS Tayside. It is proposed that fixed cameras will be available in Stornoway and Benbecula, together with a mobile screening unit. Two local optometrists and an assistant have undergone additional retinal screening training.

Grading of the retinal images will continue to be undertaken by NHS Tayside, with images downloaded and transferred to NHS Tayside overnight. Referral for consultant ophthalmologist review will continue to be provided by NHS Western Isles to visiting consultants from NHS Highland.

An open appointment system is to be introduced. The new system will also include domiciliary screening for housebound patients and long-term patients in residential homes.

It is anticipated that this new system for retinal screening will be operational by December 2006, and phased in over 12 months. As a consequence of implementation of this new system, there is an anticipated dip in initial retinal screening uptake in the first year.

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

STATUS: Met

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

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

STATUS: Met

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

The review team noted the very low number of patients requiring laser treatment as a result of active proliferative diabetic retinopathy.

Standard 6: Clinical Management: Cardiovascular Status

Standard Statement

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

NHS Western Isles

Essential Criteria

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

STATUS: Met

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

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

STATUS: Met

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

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

STATUS: Met

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

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

STATUS: Met

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

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

STATUS: Met

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

Standard 7: Clinical Management: Feet

Standard Statement

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

NHS Western Isles

Essential Criteria

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

STATUS: Met

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

The review team noted the long-term use of patient-held records in podiatry services. It was reported that these are well used by patients and staff alike, as well as proving useful for audit purposes. It was reported that the patient-held record can be used for all patients, not just patients with diabetes.

An update training session was held in September 2006 for tissue viability link nurses in the use of the patient-held record and the referral protocol, which was reported to be well attended. Further comprehensive training is planned for primary care treatment room and practice nurses in basic screening/diabetic assessment, risk stratifications and appropriate referral and use of the patient-held record. The majority of annual foot care is undertaken in primary care.

The review team commended the dual retinal/podiatry screening programme undertaken in 2004. This was a one-off pilot exercise to ensure capture of all patients with diabetes. Annual foot screening was undertaken by a podiatrist within a 6-week timeframe at adjacent GP practices in conjunction with patients undergoing retinal screening with the Tayside mobile retinal screening unit. It was reported that over half the patients were subsequently classed as low risk, with over a further quarter of patients classed as medium risk.

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

STATUS: Met

Please refer to Criterion 3.5. The review team noted the appropriate access to podiatry services.

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

STATUS: Met

In 2003, this criterion was graded as ‘not met’ as, at the time of the review, the local protocol for pressure relief treatment for diabetic foot disease was under development.

At the time of the follow-up review, local protocols for drug and pressure relief treatment for diabetic foot ulceration were in place.

Desirable Criterion

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

STATUS: Met

In 2003, this criterion was graded as ‘not met’ as patients with diabetic foot ulcers were not always reviewed by a diabetes foot specialist. More formal referral criteria were required.

The podiatrist holds a weekly foot ulcer clinic, with a consultant physician contactable, if required. The review team commended the rapid referral protocol used across primary and secondary care to ensure appropriate patient referral to the foot ulcer clinic.

The review team noted the very low ulceration rate, ranging from 0.5–1.5% of all patients with diabetes.

Digital cameras are available for all podiatrists, with cameras used at the initial patient assessment. The image is retained in both the electronic Tynedale podiatry system and the patient-held record. It was reported that it is not possible to upload the image onto SCI-DC.

An additional high risk clinic has been implemented, held every 2 months. Vascular assessment and early intervention assessment is carried out at this clinic. The clinic is also used for newly healed patients, establishing when they are able to be referred back into primary care.

It was reported that work is under way on developing a vascular referral protocol.

Standard 8: Clinical Management: Glycaemia

Standard Statement

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

NHS Western Isles

Essential Criteria

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

STATUS: Met

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

The review team commended the insulin initiation training that has been provided to all practice nurses. Insulin initiation and adjustment is predominantly undertaken in primary care with assistance and support from the diabetes specialist nurse as required. It was reported that small numbers of patients are started on insulin per week, and GPs are satisfied with arrangements.

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

STATUS: Met

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

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

STATUS: Met

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

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

STATUS: Met

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

It was reported that NHS Western Isles has recently purchased two continuous glucose monitoring machines.

Desirable Criterion

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

STATUS: Met

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

Standard 9: Clinical Management: Renal

Standard Statement

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

NHS Western Isles

Essential Criteria

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

STATUS: Met

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

It was reported that discussions are to take place with the renal physician from NHS Highland in relation to new referral criteria for estimated glomerular filtration rate (eGFR).

The review team noted that a renal dialysis unit is being established at the Western Isles Hospital.

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

STATUS: Met

In 2003, this criterion was graded as 'not met (insufficient evidence)' as there was no evidence to support that patients were reviewed more frequently for blood pressure, glycaemic control and serum cholesterol levels where urinary albumin concentration is greater than 300mg/l.

At the time of the follow-up review, the review team noted that a screening strategy and monitoring protocols for microalbuminuria have been established, and it was reported that emphasis is placed on more frequent review.

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

STATUS: Not met (insufficient evidence)

In 2003, this criterion was graded as ‘not met (insufficient evidence)’ as no information was collected on the number of patients with Type 1 diabetes with microalbuminuria or proteinuria who were prescribed an angiotensin converting enzyme (ACE) inhibitor.

Information on the number of people with microalbuminuria or proteinuria who have been prescribed an ACE inhibitor is collected as part of QOF data. The QOF data submission presented to the review team recorded 84% of eligible patients have been prescribed an ACE inhibitor. It was noted that QOF requires exception reporting for patients not prescribed an ACE inhibitor.

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

Data analysis and audit of data in secondary care will take place through SCI-DC Clinical.

Desirable Criterion

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

STATUS: Met

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

Standard 10: Clinical Management: Acute Management

Standard Statement

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

NHS Western Isles

Essential Criteria

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

STATUS: Met

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

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

STATUS: Met

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

The review team highlighted the highly committed, enthusiastic full-time diabetes specialist nurse who is unofficially permanently on call and available to patients. Slight concern was raised by the review team should a sudden leave of absence be required.

It was reported that patients admitted to hospital with diabetic ketoacidosis are predominantly managed via protocols and trained nurses in the high dependency unit (HDU) in the Western Isles Hospital.

Desirable Criteria

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

STATUS: Met

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

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

STATUS: Met

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

It was reported that there is a heightened awareness of clinical coding to better enable recording of patients who experience a diabetic emergency. At the time of the follow-up review, the results of an audit were awaited on diabetic ketoacidosis patient admissions.

5 Progress against the national overview recommendations (March 2004)

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

Standard 1: Organisation: IM&T, Clinical Management Systems, Audit and Monitoring	
NHS boards should develop a formal project plan for the local implementation of SCI-DC.	
Progress:	SCI-DC Clinical and SCI-DC Network are in use across NHS Western Isles. A detailed formal roll-out programme for 2005–2006 was presented to the review team.
Standard 2: Organisation: Pathway of Care, Teamworking and Integration of Services	
NHS boards should be engaged in the strategic planning for diabetes services, through the development of MCNs for diabetes. There should be evidence of support from the Board, and incorporation into the Board's local health plan.	
Progress:	The NHS Western Isles diabetes strategy 2005–2010 incorporates plans for the next 5 years. The strategy has been approved and supported by Western Isles NHS Board. This has also been incorporated into the local health plan 2005–2008. The actions detailed within the diabetes strategy are gradually being implemented through the diabetes MCN.
NHS boards should develop methods to routinely record and implement mutually agreed individual care plans for patients.	
Progress:	<p>It was reported that the development of a diabetes patient-held record card has been discussed, although there has been no progress made to date. A diabetes assessment sheet is used across both primary and secondary care. This sheet records all the clinical indicators relevant to diabetes care. Results from this assessment are discussed with the patients at consultation and a verbal plan of care is discussed and agreed. This plan is documented in the patient notes with frequent follow-up with the patient to monitor the agreed plan. There is liaison with other disciplines as necessary.</p> <p>NHS Western Isles recognises that the NHS board-wide implementation of SCI-DC will improve communication between the multidisciplinary diabetes team.</p>

Standard 3: Patient focus**NHS boards should work together to provide a comprehensive range of standardised diabetes patient information materials.**

Progress:	<p>Through the Health Information project, dedicated electronic patient information portals covering all health needs, including diabetes, are available in a number of public places, for example schools, libraries, hospital cafe, transport links and sports centres. This facility has been specifically designed for NHS Western Isles. Information is provided in the form of factsheets, and is reviewed monthly by experts.</p> <p>Standardised risk stratification podiatry leaflets have been developed. Consideration is being given to the Diabetes UK leaflets in relation to what standardised information should be presented to patients.</p> <p>The diabetes MCN has also launched a website which holds a vast amount of information for patients. The website is continuously updated and will also host the NHS Western Isles diabetes handbook, once formalised.</p>
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NHS boards should offer a programme of initial and continuing patient diabetic education, which should detail educational content, provider, and the initial and continuing training requirements for those delivering it.

Progress:	<p>NHS Western Isles holds a diabetes symposium every 2 years. In June 2006, the 4th diabetes symposium was held over 2 days and was attended by medical and nursing staff involved in providing care for the people with diabetes. Lay members from the LDSAG/MCN also attended. The symposium was considered to be highly beneficial from an educational point of view.</p> <p>Due to the geography and size of the patient population, it was acknowledged that there are difficulties in engaging in national education programmes such as Dose Adjustment for Normal Eating (DAFNE) and Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND).</p>
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NHS boards should ensure that all people with diabetes are offered advice about reducing the long-term complications of diabetes and about the purpose and importance of medication.

Progress:	<p>All healthcare professionals involved in the care of people with diabetes in NHS Western Isles offer ongoing advice to patients during consultations, reinforcing advice on the prevention of long-term complications and emphasising the need for regular medication.</p>
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NHS boards should ensure that provision of dietetic, nursing and psychology services are such that they meet the needs of the local diabetic population.	
Progress:	A multidisciplinary approach is delivered in both primary and secondary care on all aspects of diabetes care. However, there is no access to local psychology services. This has been identified in the diabetes strategy 2005–2010. A needs assessment for psychology services in diabetes is to be undertaken. It is anticipated that a psychology service will be available to people with diabetes by 2010.
NHS boards should ensure that effective staff training is provided to maintain standards of healthcare, and to ensure consistency in care delivery and education.	
Progress:	NHS Western Isles strongly supports continuing, effective staff training in dealing with the reduction of long-term complications of diabetes.

Standard 4:	Clinical review
NHS boards should provide a co-ordinated, structured, formalised annual review process for all people with diabetes. Clinical/lifestyle/well-being indicators may not necessarily need to be reviewed on the same day.	
Progress:	There is a continuing structured and co-ordinated review process in place for all people with diabetes. The majority of the GP practices run their own diabetes clinics, often facilitated by a diabetes specialist nurse, dietitian and podiatrist.
All patients with diabetes should be informed of both normal and abnormal test results in a timely fashion.	
Progress:	<p>Test results are available through SCI Store, enabling early notification of results to all healthcare practitioners.</p> <p>Near patient testing is undertaken in secondary care, with HbA1c results immediately available at the time of the patient consultation. This enables the consultant physician to offer appropriate advice and modifications of treatment.</p> <p>It was reported that patients are informed of their retinal screening results within 6 weeks of their appointment.</p>

Standard 5:	Clinical management: Eyes
NHS boards should implement Health Technology Board for Scotland (HTBS) grading recommendations.	
Progress:	NHS Western Isles has a contractual agreement with NHS Tayside to provide all retinal screening and image grading. NHS Tayside is compliant with the HTBS grading recommendations.

Standard 6: Clinical management: Cardiovascular Status

NHS boards should implement area-wide protocols for identified associated cardiovascular problems in people with diabetes.

Progress:	There are area-wide protocols to manage cardiovascular problems associated with diabetes at both primary and secondary care level. At the time of the follow-up review, all protocols were being updated and reformatted for inclusion within a diabetes handbook. The handbook was out for consultation, with an anticipated implementation date of November 2006.
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Standard 7: Clinical management: Feet

NHS boards should ensure digital photography is available for the monitoring of diabetic foot problems, and photographs are integrated into the patient record.

Progress:	Digital photography is in place as part of the evaluation of diabetic foot problems. A digital photograph is held within the patient-held record which can be accessed by other health professionals when necessary as part of the patient's ongoing treatment.
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Standard 8: Clinical management: Glycaemia

NHS boards should work towards establishing pre-clinic blood testing or near patient testing to allow HbA1c results to be made available to the patient at the time of the clinic appointment.

Progress:	Pre-clinic blood testing is available area-wide in GP practices with results available within 24 hours on SCI Store for when the patient attends the clinic. Near patient testing is undertaken in secondary care, with HbA1c results immediately available at the time of the patient consultation.
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NHS boards should ensure that all patients with diabetes have access to specialist diabetes advice to ensure best possible glycaemic control is achieved.

Progress:	Patients are referred to the diabetes team as clinically indicated to ensure best possible glycaemic control is achieved. Links are also available to mainland specialists if further intervention is required.
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Standard 9: Clinical management: Renal

NHS boards should ensure that mechanisms are in place to identify and best manage people during early, established and late stages of diabetic renal disease.

Progress:	NHS Western Isles has contractual agreements with Raigmore Hospital, Inverness, for referral of patients from Lewis and Harris, and with Glasgow hospitals for patients from Uist and Barra.
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NHS boards should define agreed management guidelines between renal and diabetes services to identify the pathway of care, ensuring consistency of referral.

Progress:	<p>There are protocols in place for referral of patients to the renal unit.</p> <p>It was noted that a renal dialysis unit is being established at the Western Isles Hospital. This is being led by a renal specialist nurse with support from a renal physician from NHS Highland. This has been a patient-driven initiative in order to avoid the need for excessive travelling by renal patients.</p>
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Standard 10: Clinical management: Acute management

NHS boards should develop mechanisms whereby patients admitted to accident and emergency (A&E) departments with acute diabetic emergencies receive specialist diabetes review.

Progress:	<p>All patients who attend the accident and emergency (A&E) department with an acute diabetic emergency are admitted to hospital as clinically appropriate. Patients receive specialist diabetes review via the referral system.</p> <p>In addition, there is an arrangement in place to inform the diabetes service about patients who attended A&E with an emergency, but who were not admitted to hospital. These patients are subsequently followed up by the diabetes specialist nurses.</p>
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NHS boards should improve the audit and monitoring of diabetic emergencies, both at local and national level.

Progress:	<p>There is a heightened awareness of clinical coding to record patients who experience a diabetic emergency. This will improve the audit and monitoring of diabetic emergencies. At the time of the follow-up review, the results of an audit were awaited on diabetic ketoacidosis patient admissions.</p>
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To develop a link nurse network where diabetes teams of one or two individuals exist. These link nurses, although not expected to be experts in diabetes care, would be able to promote and facilitate the care of patients with diabetes as an additional support to the diabetes specialist nursing team.

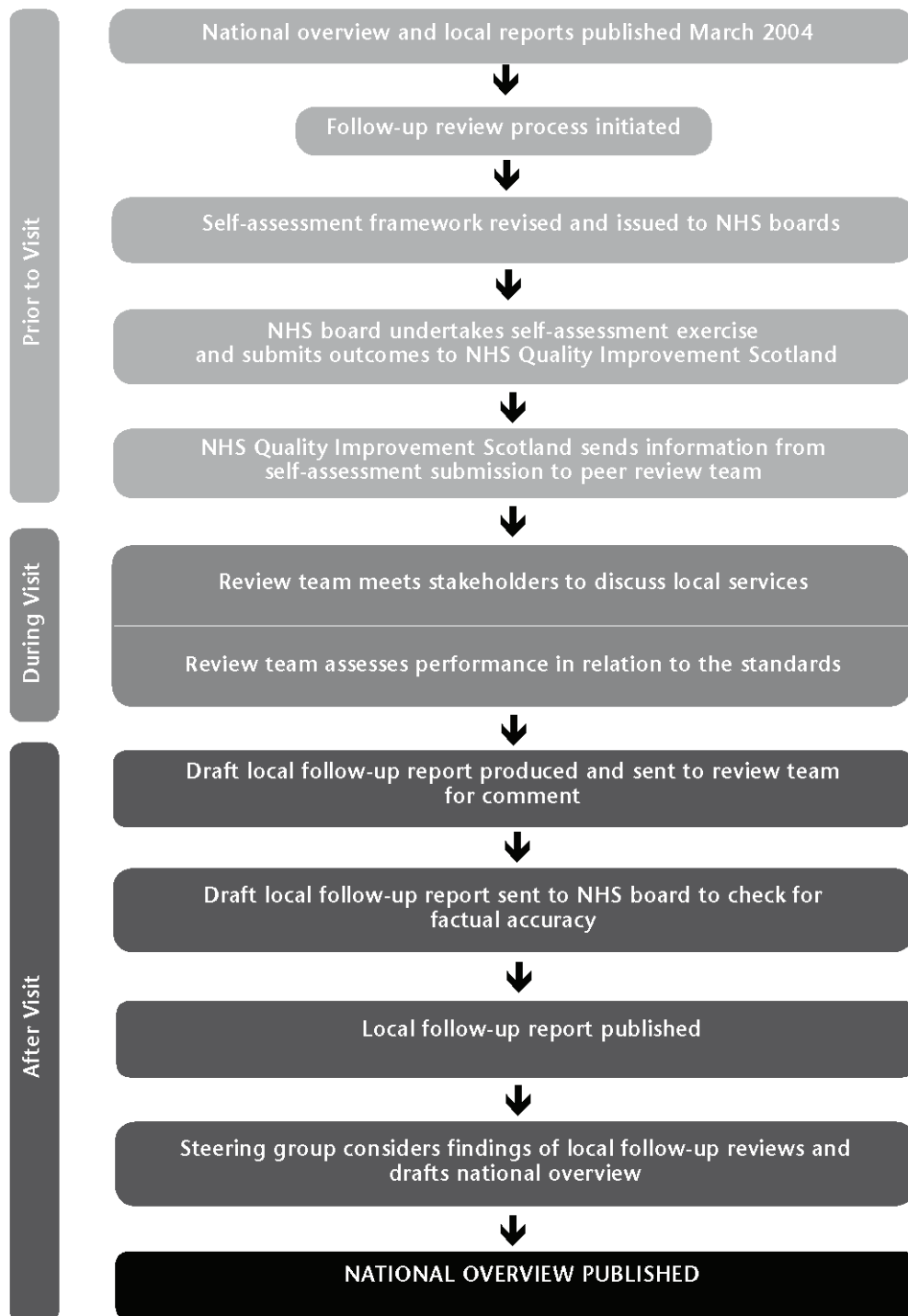
Progress:	<p>The diabetes specialist nurse has trained practice, community and ward nursing staff, including care nursing home staff, to identify and refer patients as appropriate. This has provided staff with the opportunity to increase their own knowledge and skills.</p>
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Appendix 1 – Glossary of abbreviations

Abbreviation

A&E	accident and emergency
ACE	angiotensin converting enzyme
DAFNE	Dose Adjustment for Normal Eating
DCCT	Diabetes Control & Complications Trial
DESMOND	Diabetes Education and Self-Management for Ongoing and Newly Diagnosed
DKA	diabetic ketoacidosis
eGFR	estimated glomerular filtration rate
GENIE	generic importer exporter
GP	general practitioner
GPASS	General Practice Administration System for Scotland
HbA1c	glycated haemoglobin
HDU	high dependency unit
HTBS	Health Technology Board for Scotland
LDSAG	local diabetes service advisory group
MCN	managed clinical network
MODY	maturity onset diabetes of youth
nGMS	new General Medical Services
NHS QIS	NHS Quality Improvement Scotland
QOF	Quality and Outcomes Framework
SCI-DC	Scottish Care Information - Diabetes Collaboration

Appendix 2 – The follow-up review process



Appendix 3 – Details of review visit

The follow-up review visit to NHS Western Isles was conducted on 2 November 2006.

Review team members

Dr Mike Small (Team Leader)

Consultant Physician, NHS Greater Glasgow and Clyde

Dr Helen Alexander

Network Manager, Vascular Services and Diabetes MCNs, NHS Lanarkshire

Mrs Kaye McIntyre

Acute Podiatry Team Leader, NHS Lanarkshire

Ms Philomena McKenzie

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Mr Robert Stewart

Public Partner, Ayrshire

NHS Quality Improvement Scotland Personnel

Miss Jan Nicolson

Project Officer

Mrs Fiona Russell

Senior Project Officer

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

Appendix 4 – NHS QIS diabetes steering group members

Chair

Dr Mike Small

Consultant Physician, NHS Greater Glasgow and Clyde

Steering Group Members

Mr David Cline

Programme Manager – Diabetes, Scottish Executive Health Department

Mrs Alison Crooks

MCN Diabetes Project Manager, NHS Dumfries & Galloway

Ms Margaret Doyle

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Dr Malcolm Kerr

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Miss Mary Scott

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

Ms Anna Thomson

Public Partner, Forth Valley

Mrs Debbie Voigt

Diabetes Specialist Nurse, NHS Tayside

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

Appendix 5 – Timetable of review visits

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

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

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