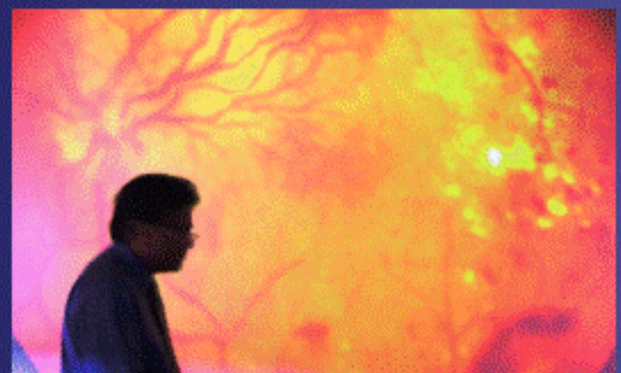


Local Diabetes Services Advisory Group and
Managed Clinical Network

Annual Report 2004 - 05



Western Isles NHS Board
Board Headquarters
37 South Beach Street
Stornoway
Isle of Lewis
HS1 2BB

Phone
(01851) 702997

Fax
(01851) 704405

www.wihb.org.uk

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Contact

Phil Tilley
Planning & Development Manager

phil.tilley@wihb.scot.nhs.uk

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Chairman's Foreword

The number of patients with diabetes in the Western Isles has quadrupled over the past 12 years and is set to pass through the 1000 barrier this coming year. This means that 4 persons in every 100 Western Isles residents will have diabetes and this will touch on the lives of thousands more. The islands also have the highest incidence of childhood diabetes in Scotland.

These are the challenges facing professionals providing care for patients with diabetes and this is being addressed by the development of the Diabetes Managed Clinical Network in the Western Isles. All of the disciplines providing care are represented on the MCN, for example medical, diabetes specialist nursing, podiatry and dietetics, but most importantly patients are being placed in the centre of the process and will have a say in the health issues which affect their day to day lives and contribute to the delivery of modern, high quality services.



This is exemplified by the two conferences that were held last year in Stornoway and Benbecula where the users of the service were able to air their views on service development to the professionals and many of these ideas will dictate the future strategy for diabetes services.

The Diabetes Managed Clinical Network will be dedicated to reducing inequalities in service provision and ensuring that all people with diabetes have access to the relevant screening and monitoring of health through partnership between professional groups, in education and through achievement of clinical outcomes as relevant for each individual.

I would like to especially thank Phil Tilley for his work in producing this annual report and Marina Sinclair for her efforts in arranging the conferences but I would also like to thank all of the individuals who have contributed to the MCN since its inception at the beginning of 2004. There are too many to mention but you all know who you are!

There is much work still to be done but I hope you will agree on reading this report that a good start has been made.

"Coming together is the beginning. Keeping together is progress. Working together is success."

Henry Ford (1863-1947),

A handwritten signature in black ink, appearing to be 'AS' with a large loop at the bottom.

Andrew Senior
General Practitioner, Benbecula Medical Practice
Chairperson LDSAG and Diabetes MCN

2. Introduction

The Scottish Diabetes Framework published in 2002, required Boards to have Diabetes Managed Clinical Networks in place by September 2004 and a key requirement for MCN's is to produce their annual reports at the end of each financial year.

The Western Isles Diabetes Managed Clinical Network was inaugurated in January 2004 and over the course of the past year has made considerable progress in developing the infrastructure and systems that are required to allow the network to effectively plan and manage diabetes care. There is still significant work ahead of the MCN in terms of assuring that the services it delivers across all sectors in the Western Isles, meet national recommendations and standards.

In March 2004, Quality Assurance Scotland published the report on their review of diabetes services in Scotland. Reports were published on the performance of each Board in relation to compliance with national standards. Western Isles NHS compared very favourably with like Boards but the report indicated that there were areas where progress could be made.

There are a number of national programmes namely, the development of a national software for the electronic management of registers, patient records and quality assurance of diabetes care and the development of national standards for diabetes retinal screening. Implementing these programmes along with the ambitious agenda before the MCN has seen considerable progress being made during the past year. These changes and the changing needs of the local community will continue to set a challenging work programme for the coming years.

During 2004 a local diabetes conference, "Have Your Say", was held in Lewis and a second conference day in Benbecula. This provided the opportunity for lay delegates and local professionals to hear key note speeches on policy direction and to discuss the future of diabetes services in the Western Isles. Since then a Lay Representatives Group with seventeen members has been established who continue to contribute towards developing diabetes services. Thus members of the public have been involved with professionals before planning and redesign of services was taking place.

A revised Accountability and Governance Framework for the LDSAG / MCN was drafted and approved by the group early in 2005 and is being consulted on at this time. It is hoped that this will receive final Board approval in May. This will establish the MCN within the Board's corporate structure, define the roles and responsibilities of diabetes groups and individuals within the diabetes community. It also clearly identifies the role of the LDSAG / MCN in planning and delivering services within the Western Isles and for monitoring performance through the Board's clinical governance mechanisms.

The ring-fenced money made available by the Scottish Diabetes Group facilitated the development of the MCN and funded the conference, training for staff, participation in national groups, SCI-DC developments and part funded staff posts. It is anticipated that this sum will be available after 2004-05 for diabetes development from the Board's general allocation.

This report sets out the detail of the work and progress that has been made in the past year.

Phil Tilley
Planning & Development Manager

3. Structure

3.1 Model

The Western Isles NHS Diabetes Manage Clinical Network was inaugurated in February 2004 whose membership emerged out of the steering group that was established by the Local Diabetes Advisory Group for its implementation. The logical morphosis for these two groups, which had a considerable over-lap of membership, was to unify the groups with a single shared remit. The benefit in doing this, apart from saving on the duplication of meetings, was to empower the MCN element of the group's purpose with direct links to the Board and its planning and advisory responsibilities. Although this model deviated slightly from the structures being implemented in other Boards it was supported by the Scottish Diabetes Group and Deputy CMO for Scotland. Indeed it was the intention of the CMO that all managed clinical networks would eventually evolve to assume this position in all Boards.

The amalgamation of LDSAG and Diabetes MCN created the opportunity for a single corporate structure that would have responsibility for identifying priorities, planning, implementing decisions and for service delivery. This cuts out significant bureaucracy, time delays and duplication making the structure more responsive and action orientated. Results at the delivery end of the development pathway are immediate. It empowers clinical staff and affords them the opportunity to inform and influence policy. It should not be under-estimated how powerful an influence this simple measure has had on staff moral, their ability to bring issues to the attention of planners and to see quick and effective responses from decision-makers. This measure has proven so successful that we would recommend it to other Boards.

Critical to the success of this model is the membership of the LDSAG / MCN the main cohort of which should be made up of clinical staff, patients and lay members. There also has to be a clear understanding within the corporate structure that within the resources allocated to the group, the group will determine what the priorities are and allocate resources to where they are needed. Support from professional planners and managers should be to act as a support mechanism guiding, rather than determining, the activities of the group. The level of enthusiasm this approach encourages is considerable. Resources are better allocated and more effectively deployed. In turn the level and quality of information that is returned to the planning process at Board level is far superior and pertinent to achieving targets than it previously has been.

This model is in no small way responsible for the progress that has been made over the past twelve months and is being highly regarded within the local health community as an example and model for other projects.

3.2 Links with the Board

The Director of Public Health is the Board lead officer for Diabetes and a member of the planning team, the Planning and Development Manager, was tasked with developing the Diabetes Managed Clinical Network. Both are members of the LDSAG / MCN. Thus affording the group direct links into the board's management and planning structures. The role of key staff, principally the Diabetes Centre Co-ordinator was enhanced to take account of the structural and management changes necessary to develop an MCN. Additional administrative support was provided and this along with the links described above reinforced the structures supporting diabetes services and contributed to the changes that occurred.

3.3 Lay Representation

Leading on from the local diabetes conference hosted by the LDSAG / MCN in June 2004, seventeen lay members were recruited to compliment the two lay members of the group that worked with the steering group from the outset. There is representation from Diabetes UK, Type 1 Diabetics, Parents of Children with diabetes and teenagers. Some of the lay representatives also have other roles within the health care community. One is a Non-Executive Board Member. There is representation on this panel from the islands of Lewis & Harris (in the north) and the Uists and Barra (in the south).

Because of the interest expressed by the public, an annex meeting for lay members was established. This group meet quarterly, two meetings by video link and two 'face to face' meetings (one in Lewis and one in the Uists) annually. Funding for these meetings including travel and over-night accommodation for members is provided by the Board's Patient and Public Involvement Group (PFPI).

3.4 Clinical Leads

Three lead clinicians provide the MCN's clinical lead. The Consultant Physician with responsibility for diabetes management, Dr. Achar is the MCN's designated lead clinician. This role is shared with Dr. Senior, Primary Care Lead Clinician (Uists and Barra) and Dr. Louise Scott, Primary Care Lead Clinician (Lewis and Harris).

Both Diabetes Nurse Specialists are members and there is representation from Podiatry, Dietetics, Health Promotion, Quality Assurance, Community Services Division, IT Computer Services, Paediatric Services and the Director of Nursing and Allied Health Professionals.

3.5 Working Groups and Subgroups

Due to the size of the organisation and the limited resources in terms of personnel the main group have agreed to keep subgroups to a minimum. Groups are formed from time to time as requirement dictates but these are not standing groups. The two standing groups are; the Lay Members Group and the Policy and Protocol Group. All other matters are referred to the main MCN meeting.

3.6 Organisation, Accountability and Clinical Governance Framework

This document, approved in January 2005, sets out the remit of the LDSAG / MCN and describes where the group sits in relation to the Board's corporate structure. It also sets out arrangements for clinical governance and describes the roles of individuals within the diabetes structure. (Copy available from phil.tilley@wihb.scot.nhs.uk).

3.7 Diabetes Strategy

During 2004 – 05 work began on revising diabetes care in the Western Isles beginning with a local diabetes conference held in June 2004. A draft strategy is being consulted on as the year ends and it is anticipated will be published in May 2005.

4. Geography and Population

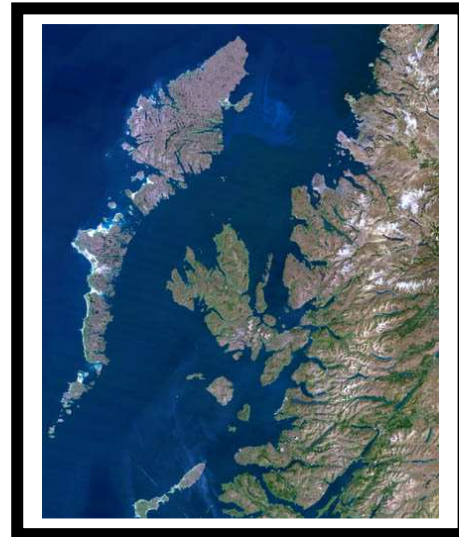
4.1 Geography & Demographics

The Western Isles is an archipelago of islands off the west coast of Scotland that stretch 160 miles from the Butt of Lewis in the north to Barra in the South. The islands, according to the 2001 census, have a declining population of 26,502.

The rate of decline in the population is predicted to accelerate with a fall of 17.4% for the Western Isles against a predicted fall of 2% for Scotland.

Of this ages >45 are predicted to fall by 36-41%. The main accelerators are migration and fewer births than deaths.

The main island populations are: Lewis 18,489, Harris 1,984, the Uists 4,857 and Barra 1,172.



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.

4.2 Diabetes Population

Diabetes Incidence and Trend

The diabetes population in the Western Isles has multiplied four-fold since 1992 when there were 230 people registered with diabetes. In line with the national incidence of diabetes this number has risen steadily over the past eleven years and is currently 980.

The Western Isles has the highest incidence of childhood diabetes in the UK

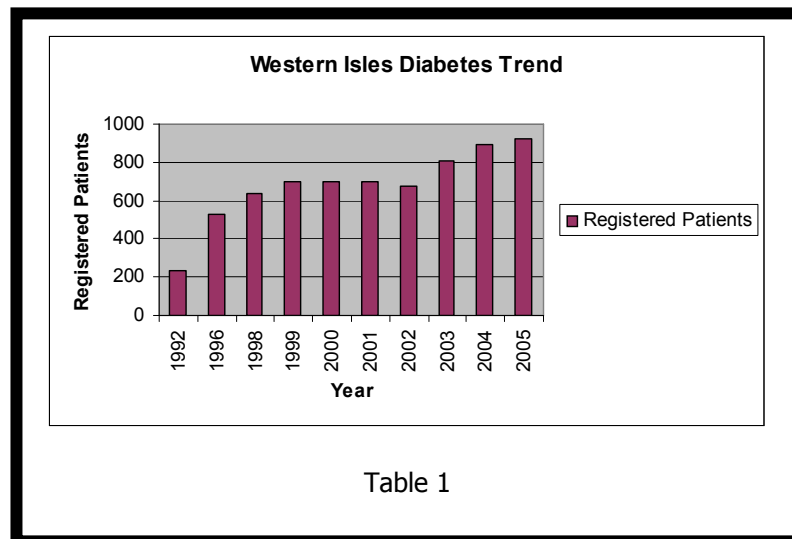


Table 1

The World Health Organisation and Public Health Institute for Scotland predict that the incidence of diabetes will double in the next five to ten years. For a small community with limited resources any increase can place significant pressures on services. There is a need to adopt a flexible policy on service provision so that there is a timely response to changing needs and patterns.

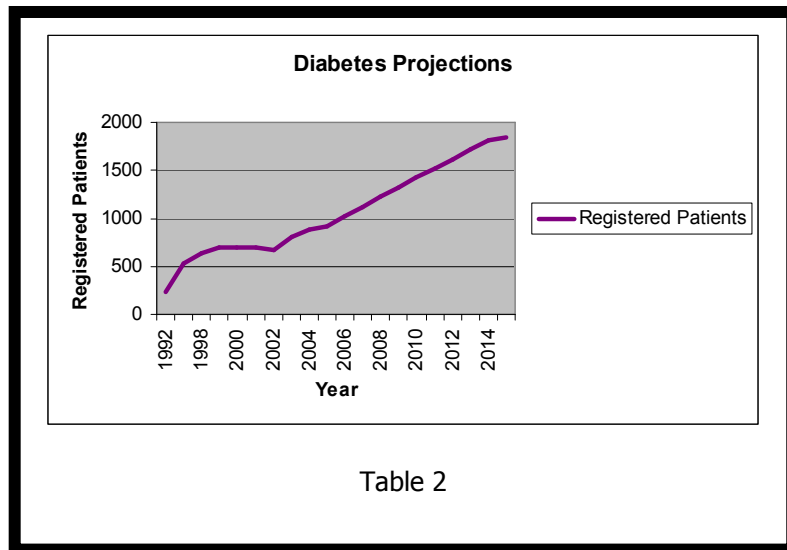


Table 2

National analysis indicates that there are a similar number of people with undiagnosed diabetes in the community. This identifies a significant unmet need and some 900 people, if taken in line with national incidence figures, who are untreated. It is critical therefore that screening strategies are developed to detect and treat these people and avoid the health risks of untreated diabetes.

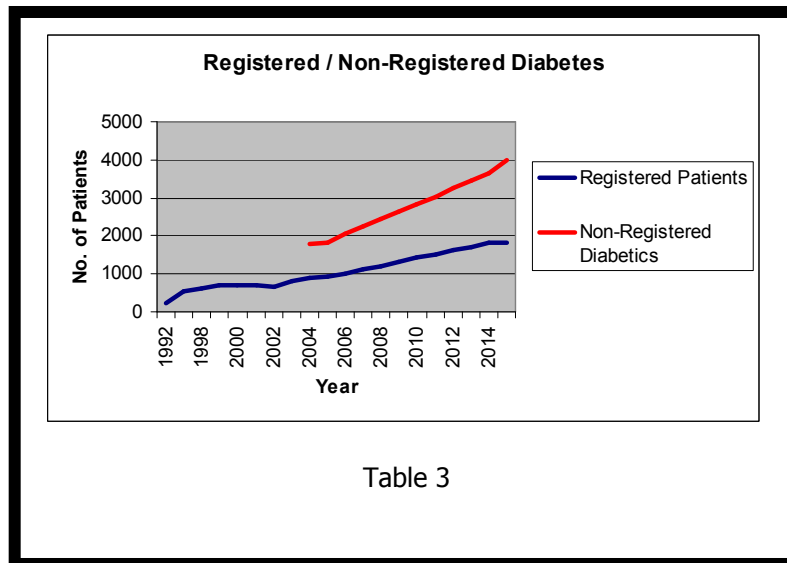


Table 3

The significance of this phenomenon will only increase over time placing ever increasing burdens on NHS costs and upon the personal lives of those affected.

4.3 Diabetes Services

Diabetes Care is co-ordinated through the Diabetes Resource Centre based at Western Isles Hospital. The centre provides a service to primary and secondary care and is the base for the Lewis and Harris Diabetes Nurse Specialist. Specialist clinics are held in the centre and it provides a local drop-in service. The centre also acts as the control for the retinal screening programme and manages the local diabetes register and SCI-DC programme.

The majority of diabetes care is delivered by local clinics in general practices across the islands. All practices have a dedicated staff member, in most cases the Practice Nurse, who manages diabetes clinics. These clinics are supported by diabetes specialist nurses, one nurse in Lewis and Harris and one nurse based in the Uists and who also covers Barra. A Consultant Physician, based at the Western Isles Hospital in Lewis provides part time diabetes specialist cover for all the islands. A visiting Consultant Paediatrician from Raigmore provides clinics for children and adolescents every three months.

Adults in the Western Isles do not currently have access to a Consultant Diabetologist. Historically this service was provided by a visiting consultant from the Royal Infirmary in Glasgow but the service was stopped when the previous visiting consultant retired.

People with diabetes access dietetics and podiatry through general service referral routes. Specialist clinics are held at secondary care clinics and two GP practices in Stornoway.

Diabetes retinal screening is contracted from Ninewells Hospital, Dundee who provide a mobile screening unit once per year.

4.4 Service Delivery

The diabetes centre has a key role in the delivery and co-ordination of care across the islands and is critical to the management of diabetes care. However no clear lines of management and accountability are in place. The centre co-ordinator reports to the General Manager of Hospital Services, medical accountability occurs through the hospital medical structure to the Medical Director and the Specialist Nurses report through the Community Nurse Manager to the General Manager for Community Services. This anomalous situation has given rise to no one manager identified as responsible for the delivery of services or the quality and governance of care. There is also no clear route through which general management issues relating to diabetes services can be processed.

General Practices across the islands vary in the way that diabetes services are delivered to patients and in the level of support their clinics require from diabetes nurse specialists. Not only does this create inconsistencies in practice but because some practices exercise an over-dependence on diabetes nurses specialist, this places an unnecessary burden on that service and is not the most efficient use of limited specialist time. It also implies that dedicated diabetes personnel have to adjust working practice to suit the variable working practice of different practitioners. This places an unrealistic burden upon staff to continually adjust their methods and level of support dependent upon the level of local commitment to the provision of diabetes clinics.

Some patients have exercised their choice and elected to be referred to mainland Diabetology services in Inverness or Glasgow rather than attend local clinics.

5. Retinal Screening Report 2004

5.1 Eye Store 2004 Data

Overall Appointed Patients	846
Did Not Attend	144
No Diabetic Retinopathy	456
Mild BDR	135
Moderate BDR	7
Severe BDR	2
Proliferative Retinopathy	4
Observable Maculopathy	9
Referrable Maculopathy	35
Other Non-Diabetic Lesion (includes laser photocoagulation scars and enucleated)	4
Not Adequately Visualised	16
No Image Recorded	178

5.2 Overview

This report summarises the Diabetic Retinal Screening Programme for 2004. The Tayside Mobile Eye Screening unit visits the Western Isles NHS Board area in September each year. Preparation for the visit begins in July when accurate numbers of patients to be screened, are collated and a detailed schedule for the visit is made. Individual appointment letters are prepared in the Diabetes Centre and sent to the GPs for distribution to their patients. From the 4th September 2004, the van travelled to 13 different locations throughout the Western and Southern isles with a final destination in Stornoway where it continued screening until Friday 8th of October.

In total the Eye Screening Van visited 13 different sites and screened for a total of 23.5 days, allowing only 1 half day in Uist and 1 half day in Stornoway for patients from any practice to attend. The Retinal Screener felt that more "free" days were need in Lewis and some practices needed more time to screen all their patients. Overall 23.5 days is not adequate time to screen the allocated patients. With the expected annual increase in diabetes, this is something we need to take into consideration when planning the 2005 visit.

Every GP Practice sent an up to date list of all their diabetic patients over the age of 12 years who were fit to be screened, to the Diabetes Centre. Appointment letters are prepared at the Centre and sent to each Practice, who then allocate times and send them out to the patients. Advertising prior to the van visiting an area took place. Local papers including Guth Bharraidh (Barra), Am Paipear (Uist) and De Tha Dol (Harris) printed the schedule relevant to their area. The Stornoway Gazette also prints the schedule the week before and the week during the screening to remind patients of the service.

2004 saw the introduction of eye drops for a minority of patients, where the image capture was not of a gradable quality. We informed all patients in writing of the possibility of this being carried out and the necessary precautions required for example, "your vision may be blurred and you will not be able to drive for approximately 2 hours." Out of 702 patients screened, 102 of them required eye drops; 97 of them had taken the necessary precautions and were able to have them done on the day, but 5 had to come to the Diabetes Centre at a later date to have drops instilled.

The results come back to the Diabetes Centre around November, at which point they are sent to each GP practice for distribution to their patients

5.3 Results of the Screening Programme

Treatment Information

Patients with Small Pupils	144
Dilated Drops used	97
Already attends Eye Clinic	93
Re-Screen in Diabetes Clinic (eye drops)	5
Re-Screen with Slit Lamp(eye clinic)	12
Referred to Eye Clinic	20

5.4 IT and the Diabetic Register

Ideally we should be able to run accurate figures from the Diabetes Register, but for two reasons this has not yet been possible and GP cooperation is vital for acquiring patient data. Firstly the system we use for the Diabetes Register is old and there is very limited IT support available to help resolve problems when they occur. Secondly we have a number of patients who did not consent to placing their names on the Register, so relying exclusively on the electronic register would miss out that group. Due to our relatively small numbers it has been possible to collate numbers manually, however we are aware that as the incidence of diabetes increases we can't and shouldn't continue to work in this way. We hope to resolve this problem by the implementation of the SCI-DC (Scottish Care Information - Diabetes Collaboration) system. SCI-DC aims to deliver effective IT solutions to Diabetes Services in NHS Scotland. Many other health boards in Scotland are already using this and we hope to start using it here within the next few months.

During 2004-05 investment was made to upgrade the IT resource for the retinal screening programme. The local ICT team have been working with SCI-DC Scottish Implementation Team to upgrade equipment and software. We are currently using the 'Tayside Eye Store' software provided by Ninewells Hospital. A national software development programme is underway co-ordinated by the Scottish DRS Planning Group. New hardware was purchased and hold our eye screening records. A new server meeting national specifications was purchased and installed.

Images are required to be kept for a period of 6 years and therefore new equipment was purchased to hold the Western Isles Eye Store files. It was bought to a particular specification as recommended by The Retinal Screening Programme Manager in Tayside. The new PC is held in the Diabetes Centre and allows the Retinal Screener to perform the first stage of grading the results before sending the images to Tayside for the next 2 stages of grading. Although the equipment was not here in time for us to benefit during 2004, it will be used for this purpose in 2005, which will speed up the results process.

5.5 Administration

The screening programme requires a considerable level of administrative support to prepare for the screening visits and appointments, to act as a central control while the programme is underway and to record and notify of results, update medical records and liaise with Tayside on any difficulties or problems. This requires handling in excess of 5000 individual records and appointments. There are prescribed standards to be met set down by QIS Retinal screening Standards and during 2004 these were met. This would not have been possible without additional investment in administrative support.

Extra admin support was provided again this year, 20 hrs per week from September 04 to March 05. This enabled efficient co-ordination of the Screening Programme without too much disruption to the daily activities of the Diabetes Centre. Using the Eye Store, individual results were produced and posted to patients within 11 working days of them being delivered to the Diabetes Centre. Prior to this, copies were sent to each Practice and a further copy is currently being filed in hospital notes. The screening finished on the 8th of October and the results arrived at the centre on 27th October. By the 11th of November all 702 patients who attended for screening had been sent their result.

5.6 Changes in 2004

It was highlighted in the previous year that there was a lot of confusion over whose responsibility it was to inform the patient of their result, with the effect of long delays in patients receiving them, if even at all. The Retinal Screening Group looked at these problems and put systems in place to improve reporting. It was agreed to model other screening programmes such as cervical and breast, where the results are sent out centrally and not via the GPs. It was felt that the Diabetes Centre was the obvious control point for the Screening Programme. This system which was fully implemented before the beginning of the programme in 2004 demonstrated that the anticipated improvements were achieved with clearer communications between patients, GPs, screening unit and the Resource Centre. The service improved on reporting times from the previous year. All reports were posted within 4 weeks therefore meeting the national standard.

In previous years those patients whose results indicated that a second opinion was required were normally referred to Dr. Macrae, Consultant Ophthalmologist. It was agreed with Dr. Macrae that the Tayside Eye Screening Centre would provide second opinions therefore negating the need to refer to the local ophthalmology clinic. This amendment achieved a number of benefits:

- Second opinions were given much faster than was previously achievable
- It reduced Dr. Macrae's workload
- Only patients who require further treatment were referred to ophthalmology
- Reports were available weeks and in some cases months earlier than previous years
- Patients were referred for treatment much sooner as a consequence.
- The system is now more cost effective

Discussions have taken place with Mr. R Doig, Optometrist, Stornoway, about providing a local service for those patients who DNA on their programmed appointments, are away from the islands during that time or otherwise are unable to attend the screening van. Training has been provided for Mr. Doig at Ninewells Hospital Dundee who attended a screening course in January 2005. To provide this service investment will be required in digital imaging equipment and a case is being prepared. Further discussion is required before formal proposals are drafted but it is hoped to have this service established during 2005 – 06

5.7 Performance

The screening programme performed slightly better in 2004 than it did in 2003. Of those people on the register > 12years of age 82.98% attended a retinal screening appointment (a percentage increase of 2.98 %). There is opportunity to improve performance through the development of a local screening service provided by the optometrist in Stornoway. Discussion has taken place between the Board and Mr. Doig and training provided in preparation that this service might be available in 2005. It is intended that this is complimentary to the service currently provided and aimed at capturing those patients who have not attended their appointments and to close gaps in the service for patients who are unavailable when the mobile unit is here.

5.8 RETINAL SCREENING ATTENDANCE FIGURES 2004

Attendance Figures by Area							
Practice		Number of days	Patients Appointed	Patients Attended	% Patients Attended	Patients DNA	% Patients DNA
W90007	Borve	1	29	26	89.66	3	10.34
W90026	Carloway	1	26	24	92.31	2	7.69
W90031B	Group	3.5	157	130	82.80	27	17.20
W90031S	Habost	1	28	27	96.43	1	3.57
W90172S	Springfield	2.5	93	70	75.27	23	24.73
W90172A	Archway	2.5	106	83	78.30	23	21.70
W90064	Uig	1	20	18	90.00	2	10.00
W90079	North Lochs	1.5	63	53	84.13	10	15.87
W90083	South Lochs	1	15	13	86.67	2	13.33
W90098	North Harris	1.5	61	48	78.69	13	21.31
W90101	Leverburgh	1	35	32	91.43	3	8.57
W90115	North Uist	1.5	62	55	88.71	7	11.29
W90120M	Griminish	1.5	59	47	79.66	12	20.34
W90120B	Branch Surgery	0.5	10	8	80.00	2	20.00
W90134	South Uist	1	41	33	80.49	8	19.51
W90149	Barra	1	41	35	85.37	6	14.63
TOTALS		23.5	846	702	82.98%	144	17.02
National Target					60%		

Annual Attendance Figures

YEAR	Patients Booked	Patients Attended	ATTENDANCE %
1998	536	497	93%
1999	394	349	89%
2001	698	573	82%
2002	729	580	86%
2003	755	605	80%
2004	846	702	83%

6. Foot Screening

A pilot project investigating the effectiveness of using a new model to screen the feet of people with diabetes in the Western Isles was run in September 2004.

The project, thought to be the first of its kind in Scotland, is now set to be a vital tool in the early detection of diabetes-related foot disease and hopes are high that it will be developed locally. There is potential for the system to be developed nationally.

The checks were offered in September 2004 at five GP surgeries on Lewis to patients as they attended their annual retinal screenings.

Funding was earmarked by the Board's Diabetes Managed Clinical Network for the project to investigate the feasibility of concentrating annual foot screening into a six-week period and the benefits of running a foot screening programme along side the Board's retinal screening programme. This project was regarded as an opportunity to gather evidence to examine different and better ways of providing podiatry foot screening for diabetics. If successful the potential benefits could be significant.

The podiatry department based at Western Isles Hospital in Stornoway had previously carried out annual foot screening clinics but appointments were often not kept with a Did Not Attend (DNA) rate of 27.5 per cent, proving that an appointment system is not the most effective way of providing foot screening.

Of the 121 patients screened, 48 of them needed podiatric follow-up. Of these, 25 needed foot care, four were referred for possible limb surgery, one needed nail surgery and two needed intensive treatment.

Options on offer included education for patients and carers to be referred for training on foot care, intensive treatments for those who needed podiatry intervention to reduce the risks of future foot problems and assessment of limb and foot function to reduce problems with altered foot functions and pressures. An ulcer clinic is also offered to those who need specialist interventions as well as nail surgery where appropriate.

Diabetic foot problems are recognised as one of the most expensive of diabetes-related admissions and there is good evidence that people at high risk of developing lower limb complications can be identified and offered effective treatment. The benefit to patient quality of life in avoiding foot disease associated with diabetes is considerable. Prevention is far more effective in saving costs to the patient and to the NHS than treatment.

The reported results recommend that the Health Board invest resources available for podiatry services to meet the increasing demands of a growing population of patients with diabetes. Two years ago, we screened 291 of the 809 known patients which represented 35.9 per cent of the population. Last year, excluding those patients screened in the pilot project, this had increased to 359 of 890, which represents 40.3 per cent. These figures are unacceptably low and alternative approaches to achieving higher screening figures need to be explored.

Demands on podiatry services are high and funding to provide screening specifically for patients with diabetes is necessary. There is inherent risk in not continuing with a successful screening programme and hopefully the report from this project will provide a convincing argument for the funding of an annual foot screening programme.

The Western Isles Board is due to publish their diabetes strategy for 2005 to 2010. The findings of the project will be referred to in the strategy and a case made for the provision of diabetes foot screening across the Islands. To make the new system work will require the support of general practitioners, podiatrists and especially the people who will ultimately benefit, those with diabetes. A full copy of the project report is available from phil.tilley@wihb.scot.nhs.uk or by contacting Western Isles NHS

7. SCI-DC

Target dates set for the implementation of SCI-DC at the beginning of the year were not achieved. It had been anticipated that SCI-DC Clinical would be available in September 2004 and that the first practices, the Group Practice in Stornoway and Benbecula Medical Practice, would have SCI-DC Network by November 2004. There was investment in IT including the purchase of the server and terminals that were achieved within their target dates but difficulties arose in configuring the server and in the transfer of data from the 'Lanarkshire' register that had previously been in operation. There was also a considerable back-log of 18 months data on hard copy to be transferred to populate the system.

Difficulties arose in unlocking the files prepared for the system from the SCI-DC team and that new versions of SCI-DC clinical were becoming available thus out-dating the versions that the local IT managers were working with.

A revised time-table for the implementation of SCI-DC clinical is May 2005 with a roll-out programme for SCI-DC Network to follow.

The introduction of this system was well supported by local GPs. The delays have led to a degree of frustration though hopefully the good will expressed early in the project can be redeemed.

8. Public Involvement: 2004 Diabetes Conference

The MCN hosted a local diabetes conference in June 2004 aimed at involving the public and professionals in determining the priorities for the future design of diabetes care in the Western Isles. Although our numbers in the Western Isles are small the representation at the conference was 10% of the diabetes community.

The conference was held over two days with key note speeches from Audry Birt, Director of Diabetes UK, Mary Scott, Scottish MCN Managers Co-ordinator, Angela Ellingford, Manager Retinal Screening Service, Tayside, Dr. Andrew Senior Chair, LDSAG/MCN, Dr. Achar, Lead Clinician and Dr. Louise Scott, Primary Care Lead Clinician for Lewis and Harris. The conference was chaired by Dr. Michie, Medical Director, Community Services Division.

As a consequence of the conference some seventeen members of the public have become directly involved with the work of the MCN. A copy of the conference report is available from phil.tilley@wihb.scot.nhs.uk or by contacting Western Isles NHS

9. Ethnic Minorities

The MCN has debated how best to involve people from ethnic minorities in the work of the MCN and to plan for their particular needs. Members of the MCN are concerned that there is a very small number of people from ethnic minorities in the Western Isles and an even smaller number of people with diabetes (10). The concern is over issues of confidentiality and whether any of

this group would want to put themselves forward for involvement in the MCN. The strategy is to deal sensitively with the issue. Each person will be individually asked by clinical staff with whom they have contact.

Information for patients is provided in the language of their choice and when required, interpreters are made available.

10 Training and Education

Funding was made available for 32 local professionals who complete the Bradford Diploma in Diabetes Management during 2004. These were:

10.1 Bradford Diploma in Diabetes Management

This is a distance learning course in Diabetes Management credited by University of Huddersfield which is managed by Diabetes Primary Care Training Centre in Bradford. Course work for this diploma consists of five separate sections each containing reading course work, activities and appendices.

Funding for the course was requested and secured from Primary Care for staff to undertake this course locally. Cost per student was £430 + VAT.

Details regarding this course were circulated to primary and secondary care within the NHS Western Isles. Thirty one members of staff started the course in November 2003. This included a cross section of staff within the health board area –

Practice Nurses	11
General Practitioners	5
Dieticians	2
Podiatrists	2
Community Nursing staff	3
Hospital Nursing staff	8

Training staff and course facilitators from Bradford travelled to Stornoway in November 2003, when course work packs were issued and "students" were advised on the course content and the aims of the course. Subsequent training days in February 2004 and May 2004 included workshops and a final written examination.

All aspects of diabetic management are included in this diploma course with emphasis on Type 2 diabetes management in Primary Care.

Feedback from staff on completion of the course was extremely encouraging. More importantly repeated referral was made to the fact that this course was made available "on our door step".

Having successfully completed this diploma course, measures have to be put in place so that staff can consolidate the theory into practise. Staff working in primary care, dietetics and podiatry who manage diabetic patients regularly will be able to do this relatively easily, however it will be more difficult for staff in secondary care to do so. In dialogue with the Senior Nurse Community Lewis & Harris, Senior Nurse Hospital and the hospital staff who completed the diploma course, the following plan was discussed:-

- Allocate each hospital based nurse a specific GP Practice
- Hospital based nurses to attend diabetic clinic in practice area, working alongside practice nurse experienced in diabetic care.
- Hospital based nurses provide support for patients with diabetes from their allocated practice area should they require to be hospitalised.

The proposed plan has gone to practice managers and practice nurses in Lewis & Harris. If practices are in agreement, this will be implemented shortly and the Diabetes Specialist Nurse will co-ordinate.

10.2 Insulin Initiation

Following the Bradford Course staff requested training in insulin initiation. Training by an accredited trainer with Warwick Diabetes Centre, training for intensive management in type 2 diabetes was arranged.

First Insulin Training Workshop was held locally in August 2004 when GPs and Practice Nurses from 4 practices were instructed on the different aspects of insulin initiation. A further training day will take place at the end of this month when 18 members of staff will be trained. Two trainers from Warwick Diabetes Centre will be assisting the lead DSN in this training which will also be rolled out to other areas in coming months. This training will enable staff to initiate insulin therapy, provide education and support to patients who require insulin and to their families.

As the incidence of Type 2 diabetes continues to rise, the requirement for insulin therapy will increase requiring staff to have the skills and the knowledge to deal with this in their own practice area. Following this training staff will be expected to initiate insulin to patients with type 2 diabetes with support and guidance from local and Warwick course trainees.

A certificate of extended practice will be issued from Warwick University to staff who initiates ten insulin starts.

To enable people with diabetes to manage this chronic condition requires health care professional who can provide support

To provide support and empowerment for patients requires health professionals who have skills and training

To gain skills and knowledge require training and motivation

10.3 Retinal Screening Training

Funding was provided for the local optometrist to complete graders training at Ninewells Hospital Dundee.

Two members of staff were provided with IT training for retinal screening report and image management.

10.4 IT & SCI-DC

The diabetes Centre Co-ordinator attended trainers training in Inverness with the SCI-DC team to support the implementation programme for SCI-DC.

10.5 Secondment Opportunities

During 2004 two staff nurse from general hospital services were provided with in-service training and given the opportunity of secondment to work with the diabetes team. Discussions have taken place with the Directors of the service divisions on strategies for maintaining the skills base of those who completed the Bradford diploma and to improve the skills base within the general workforce. While no formal decision has yet been made key targets will be agreed in the diabetes strategy and developed during 2005 – 06.

10.6 Diabetes Team In service Training

Paediatric Consultant: Attended the British Society for Endocrinology "Diabetes Strand" Day and the Scottish Study Group for the Care of Diabetes in the Young, autumn and spring meetings. Six members of the MCN, 1 GP, 1 Consultant, 1 Podiatrist, 2 Nurse Specialist attended Diabetes in Scotland Conference 2004

10.7 Lay Members Training

Lay members were offered training to prepare them for their role and involvement with Western Isles NHS. The training was provided through the Patient and Public Training Officer, Diabetes UK (Scotland).

Public Involvement Training Report

In response to the Scottish Diabetes Framework (2002), the Scottish Executive provided funding for a Patient and Carer Involvement project, whose role is to support and facilitate this process. Georgina Milliken is the Project Manager and is based in the Diabetes UK Glasgow office. She provided training to prepare lay people and professionals identify their role and build up confidence to be an active member of their LDSAG/MCN group. Georgina agreed to facilitate training for us in Lewis on 22nd & 23rd of November and in the Southern Isles on 23rd & 24th November 2004. The total cost of the training was funded by the Patient & Carer Involvement Project budget. For various reasons the training was reduced to 1 ½ days. Eight delegates, consisting of patients and professionals, attended the training which was held in the Lews Castle College and 5 delegates attended the training in the Southern Isles which was held in Tagasa Uibhist. Both venues provided excellent facilities.

Course content consisted of:

- Involvement- Opportunity or Threat
- Assertiveness
- Listening Skills
- Dealing with Conflict
- Team Roles
- Representation (individual & collective)
- Meeting Skills
- Negotiation

The training was very relaxed and allowed for discussion and questions. Participants were given worksheets to complete which were then used for further debate. The training enabled the participant to be more aware of issues from "both sides of the fence". It encouraged them to think about their own skills and talents and identify where they could fit into the group. Amongst other issues, intimidation within groups and how to handle difficult situations was addressed.

Positive feedback was received including the comment "A very informative and enlightening agenda delivered by a very experienced congenial person" Overall, it is hoped that the training event has encouraged and empowered the group to take an active role and contribute more effectively in the design and delivery of Diabetes Services locally.

11. Professional Register

To comply with recommendation in the Scottish Diabetes Framework and guidance on the structure of MCNs, a register of all staff in the Western Isles who have any involvement in the delivery of diabetes care was compiled during 2004. This register is available from Phil Tilley, Planning and Development Manager, Western Isles NHS, 37 South Beach Street, Stornoway, Isle of Lewis. HS21 2BB. This register will be updated annually.

12. Finance

During 2004 -05 ring-fenced funding for MCN development was made available from the Scottish Diabetes Group SEHD. The disbursement of this fund was;

	£
Salaries	32788.00
Travel and Expenses	4447.38
Subsistence	569.60
Training and Education	246.53
Diabetes Conference	5200.00
IT and Communication	3488.00
Catering	556.00
Total	47295.51

NOTES

Western Isles NHS Board

**Local Diabetes Services Advisory Group and
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Western Isles NHS
Headquarters
37 South Beach Street
Stornoway
Isle of Lewis HS1 2BB

Tel: (01851) 702997

www.wihb.org.uk