Introduction

The Lothian Diabetes Managed Clinical Network

This report reflects the achievements and progress of the Lothian Diabetes Managed Clinical Network (MCN) from 1 April 2013 to 31 March 2016.

This reporting period has seen almost a complete change in Diabetes MCN Staff and Management. Dr Karen Adamson was appointed as MCN Lead Clinician in September 2011 and stood down from this role on 1st January 2016. Dr Nicola Zammitt was appointed as MCN Lead Clinician on 1st January 2016. There are plans to appoint a primary care co-chair, with the job due to be advertised as this annual report is finalised, but as yet this post remains vacant. Manager Mary Scott retired in June 2011 and this full time MCN Manager post was not reappointed. Paul Currie took a secondment to the Scottish Government in November 2012 and Alyson Cumming stepped in as Strategic Programme Manager - Long Term Conditions and Primary Care which included management responsibility for the Diabetes MCN. Paul Currie returned to the MCN in May 2015 but following a review of strategic planning, Paul has stepped down and Alyson has taken over once again as of April 2016. The MCN would like to thank Karen Adamson and Paul Currie for all their hard work over the years. The MCN has also been lacking a coordinator following the departure of Bonnie Thomson in November 2015, although Marie McCallum has been appointed to the post starting in May 2016.

As a result of insufficient administrative support in recent times, the MCN’s activities have slowed down very substantially, such that there have been few recent MCN meetings, several of the subgroups have temporarily ceased to function and this will be the first annual report since 2013. There have been significant changes in MCN staff and management since January 2016, with the expectation that a primary care co-chair will soon be appointed. As this annual report comes at a time when there has been little recent MCN activity, the report will focus on plans for the year ahead and early challenges to be addressed. It will also cover progress made to date against measures on the Diabetes Improvement Plan and previous MCN priorities.

The Diabetes MCN has had to adapt to the challenge of tight financial constraints faced by the National Health Service (NHS) and as such has looked at ways of working more efficiently in the face of rising numbers of patients. The cost of insulin pumps for type 1 diabetes continues to increase as we extend this treatment to appropriate patients, and ensuring continued support for insulin pump therapy from the Integration Joint Boards (IJB’s) will be a future challenge. The MCN will also need to consider the role of continuous glucose monitoring (CGM) for appropriate patients. While this technology can impact significantly on glycaemic control and quality of life, there are significant cost implications and there will be challenges around determining who could best benefit from these therapies. New treatments and earlier diagnoses are having a positive effect on outcomes in diabetes but these inevitably have an impact on primary care prescribing budgets.

The MCN, under Dr Adamson’s lead, previously redesigned the diabetes pathway for Type 2 diabetes to ensure that the right patient is seen at the right time by the right healthcare professional in the right setting. This work culminated in funding for a local enhanced service (LES) for GPs to look after newly diagnosed, uncomplicated type 2 diabetes. Funding for the LES was withdrawn on 31 March 2016 and this has seen an increase in referrals of newly diagnosed patients into secondary care. The MCN is actively working across primary and secondary care to try to resolve this situation to ensure that patients can once again access appropriate care in the right setting.
The last MCN annual report in 2013 reflected the progress of the diabetes multidisciplinary team in working towards the goals of the National Diabetes Action Plan 2010 as well as local priorities as set out by the Lothian Health Board. The current report updates progress on earlier priorities but it mainly reflects the MCN's plans to work towards the goals of the National Diabetes Improvement Plan 2014\(^1\). We continue to strive to improve the service we deliver to those with diabetes, and will use data from the Scottish Diabetes Survey to determine our direction of travel.

Dr Nicola Zammitt
Lead Clinician, Diabetes Managed Clinical Network

Progress against 2011-2013 priorities

Priority 1: Telehealth

• To promote widely the use of the My Diabetes My Way website for all patients with diabetes.

Information on the website, together with a joining form, is available as a link on Ref help as part of standard information disseminated to patients at diagnosis. This information is also provided during DESMOND sessions. All insulin treated patients are given a clinic questionnaire at every diabetes hospital appointment which encourages them to sign up to My Diabetes My Way.

• To consider if there was a place for large scale home self monitoring in our care pathways.

Evidence suggested that the focus should be on the ‘lighter-touch’ and web-based technology. All hospital clinics in Lothian now employ Diasend technology to download readings from blood glucose meters. Patients are encouraged to download meters at home and link their readings to their hospital clinic for tailored advice by Email in between appointments.

Priority 2: Service Redesign

Ensure patients are seen by the appropriate clinician at the appropriate time and place.

The Diabetes Pathway Short Life Working Group redesigned the Type 2 patient pathway so that newly diagnosed patients and those without complications could remain in primary care, thereby freeing up secondary care appointments for more complex cases. The pathway was developed and accepted by the MCN and the GP sub-committee and was followed up by introduction of a Local Enhanced Service (LES) to fund primary care for the initial assessment and management of type 2 diabetes. Uptake of the LES was 95% (118/125 practices signed up). Unfortunately, funding for the LES was withdrawn on 31/3/16, resulting in an increase in referrals of newly diagnosed type 2 diabetes to secondary care. The MCN is currently in discussion with both primary and secondary care to resolve the situation. A short life working group will be convened to rapidly review options for management of patients with newly diagnosed type 2 diabetes, with the aim of re-establishing appropriate community-based care for newly diagnosed type 2 diabetes.

Priority 3: Psychology

Provide patients with access to psychological/psychiatric support to improve self-management which will assist in appropriate use of diabetes services.

The MCN previously obtained funding for a pilot to provide liaison psychiatry time in clinics on all three secondary care sites. This pilot was extended and the diabetes mental health service continues to run, with funding secured till April 2017. Data from this service suggests that it results in annual saving of approximately £96,000 based on reduced diabetes-related A/E use, reduced diabetes-related bed days and reduced diabetes complications as a result of improvements in HbA1c. The MCN will continue to push for ongoing support of this valuable service.

Priority 4: Smoking Cessation

The MCN and Smoking Cessation Services have collaborated to produce a diabetes and smoking leaflet. This leaflet will be introduced to clinics on all three secondary care sites later this year.
New priorities for 2014-2016

The Diabetes Improvement Plan in 2014 sets out the continued ambition to deliver person-centred, clinically effective and safe patient care. The plan identifies key priorities and a range of actions to contribute to improvement. These follow on and build upon actions identified in the 2010 Action Plan. They have been identified as specific challenges for Scotland. The priority areas are:

- Prevention and Early Detection of Diabetes and its Complications
- Type 1 diabetes
- Person-centred care
- Equality of Access
- Supporting and developing staff
- Inpatient diabetes
- Improving information
- Innovation

There is an expectation that NHS Boards, through their diabetes MCNs, will commit themselves to implementing a programme of work to improve the quality of care and outcomes within these identified priority areas. For this reason, the MCN will be focusing on these priority areas.

In addition to the 8 priorities, the Diabetes Improvement Plan outlines how the impact of progress on these priorities will be measured. An initial set of 12 measures are given below.

1. Percentage of people with diabetes who receive all 9 key indicator measurements for diabetes
2. Percentage of persons with an Hba1C <58 mmol/mol within 1 year of diagnosis
3. Percentage of persons with an Hba1C <58 mmol/mol and HbA1c >75 mmol/mol
4. Percentage of current smokers
5. Percentage of people aged 50-80 with a total cholesterol <5 mmol/l AND a systolic BP <140mmHg
6. Percentage of new foot ulcers
7. Percentage of people eligible for diabetic retinopathy screening actually screened within the last 15 months
8. Percentage of people with diabetes reaching end stage renal disease or requiring renal replacement therapy
9. Percentage of people on CSII therapy
10. Percentage of persons with a BMI ≥ 30 who have lost ≥ 5% body weight in the last year
11. Percentage of persons who have attended structured education
12. Percentage disengaged from diabetes care i.e. no HbA1c and retinal screening in the last 15 months

SCI diabetes enables MCNs to generate a quarterly report on these key diabetes measures. Quarterly reporting on these measures started on 29th January 2016. The MCN has reported on 2015 Q4 and 2016 Q1, with the latter report given in appendix 1 to summarise the MCN’s current progress on these 12 measures. Plans to address the 8 priority areas in the improvement plan are covered below.
Priority 1: Prevention and early detection of diabetes and its complications

To establish and implement approaches to support the prevention and early detection of type 2 diabetes, the rapid diagnosis of type 1 and the implementation of measures to promptly detect and prevent the complications of diabetes.

Through appointment of a primary care co-chair and engagement with the IJBs, the MCN will work towards the early detection of type 2 diabetes.

The MCN has been working with the PLIG (Primary Care and Laboratory Interface Group) to develop guidance on the use of HbA1c for diagnosis of type 2 diabetes. This has been piloted in a sector of Edinburgh city and there are plans to roll-out HbA1c as a diagnostic tool across Lothian during this calendar year.

There are pathways in place at all 3 secondary care sites in Lothian for assessment of people with newly diagnosed type 1 diabetes within 24 hours of referral.

Through engagement with quarterly reports to the Scottish Diabetes Group (SDG), the MCN will work on improving the screening for complications across Lothian.

In summer 2014, the then Edinburgh Community Health Partnership recruited two Community Diabetes Specialist Nurses (CDSMNs). The nurses are focussing on targeting patients who frequently attend the Emergency Department, hard to reach groups and are following up those who do not attend clinic appointments, including Type 1 diabetes non-attenders. An evaluation of the benefit of the CDSNs role will consider the post’s impact on: admission prevention; reduction in occupied bed days; and on improved patient engagement with services.

Priority 2: Type 1 diabetes

To improve the care and outcomes of all people living with type 1 diabetes

The Royal Infirmary of Edinburgh has a dedicated type 1 diabetes clinic and there are plans to establish a similar service at the Western General Hospital.

All 3 secondary care sites in Lothian participated in structured education for type 1 diabetes (DAFNE) and support provision of insulin pump therapy.

Member of the Lothian multi-disciplinary team are actively engaged with the SDG’s national meetings to improve outcomes in type 1 diabetes and one of the NHS Lothian consultants, Dr Fraser Gibb, sits on the SDG’s type 1 group. RIE is involved in piloting a pathway for the early intensification of glycaemic control in newly diagnosed type 1 diabetes. This is part of an evolving national strategy to develop a structured education package for use within 6 months of diagnosis.
Priority 3: Person-centred care

To ensure people with diabetes are enabled and empowered to safely and effectively self-manage their condition by accessing consistent, high quality education and by creating mutually agreed individualised care plans

For care to be person centred, improvements must cover social care as well as health issues. Integration of health and social care has resulted in the formation of the Integration Joint Boards of the Health and Social Care Partnerships to deliver joined-up care provision across Scotland. Over the coming year, the MCN will engage with the 4 IJBs in Lothian to deliver patient-centred care and with team who are taking forward the House of Care approach.

The MCN will build on earlier work done on the diabetes mental health care pathway to ensure ongoing provision of this service, which takes a holistic look at patients’ psychological and emotional needs as well as their physical health.

As an urgent priority, the MCN will work towards restoring community-based care for people with newly diagnosed type 2 diabetes. Delivery of care had been supported by the LES and cessation of funding has precipitated an increase in secondary care referrals for patients whose care would be best delivered in the community. The MCN will participate in a short life working group to urgently review how community-based care can be restored for this patient group. The MCN is also establishing links with the GameChanger initiative between NHS Lothian with Hibernian Football Club to consider opportunities for community diabetes clinics hosted at Hibernian’s Easter Road Stadium for individuals with diabetes residing in North East Edinburgh.

The MCN will also review the provision of DESMOND, which is the current structured education package employed in NHS Lothian for type 2 diabetes. Capacity is barely sufficient to meet demand for newly diagnosed patients, with no capacity for people with established type 2 diabetes.

The MCN has an active patient sub-group (Lothian Diabetes Representative Group) to ensure ongoing involvement of people living with diabetes in improving diabetes services. The LDRG held their bi-annual Lothian Diabetes Patient Conference in 2015 attended by 78 patients and carers. The group also undertook an audit of the experiences of parents and young people of the support provided in Lothian schools for children and young people with diabetes. The LDRG circulated the audit report to Local Authority Heads of Education in May 2016. The group has been tasked to undertake a scoping exercise during 2016 to consider a range of options to support and deliver patient education.

The multi-disciplinary team has recently revised and streamlined the pathway for the diagnosis and care of women with gestational diabetes to ensure prompt and consistent access to high quality care.

Priority 4: Equality of Access

To reduce the impact of deprivation, ethnicity and disadvantage on diabetes care and outcomes.

The Scottish Government is committed to reducing health inequalities and supports the targeting of anticipatory care approaches to those most at risk of poor health. The MCN will continue to work with the Diabetes Mental Health Service to put in place anticipatory care plans for patients who attend Accident and Emergency most frequently to try to reduce their hospital admissions
whilst ensuring they have the mechanisms in place to access support for their diabetes management through other routes.

The MCN will continue to work with members of the multidisciplinary team to provide culturally-appropriate support for ethnic minorities.

**Priority 5: Supporting and developing staff**

To ensure healthcare professionals caring for people living with diabetes have access to consistent, high quality diabetes education to equip them with the knowledge, skills and confidence to deliver safe and effective diabetes care

The MCN’s professional education sub-group is led by Jill Little, Diabetes Specialist Nurse. Plans for the bi-annual professional conference in September 2016 have been deferred till February 2017, as the recent lack of administrative support made it impossible for the sub-group to continue its activities. With the recent appointment of the MCN coordinator, we anticipate that the professional education sub-group will resume its activities. In the meantime, Jill Little has continued to lead on the training modules for registered and unregistered staff that run several time a year.

**Priority 6: Inpatient diabetes**

To improve the quality of care for people living with diabetes admitted to hospital by improving glucose management and reducing the risk of complications during admission

The diabetes team at the Royal Infirmary of Edinburgh (RIE) RIE team has also advertised for a new consultant with dedicated time for in-patient diabetes. This will bring the compliment of consultants on the RIE in-patient diabetes team up to five.

At the Western General Hospital, Dr Stuart Ritchie has been rolling out elements of the “Think, Check, Act” project in his capacity as national clinical lead for this programme. Extension of this programme will be discussed at a consultants’ meeting in early June 2016 and at the Acute Diabetes Senior Management Team to seek support for further roll out of the project across NHS Lothian acute hospital sites.

**Priority 7: Improving information**

To ensure appropriate and accurate information is available in a suitable format and effectively and reliably used by all those involved in diabetes care

One of the aims of the Diabetes Improvement Plan is to better use data to inform discussions on improving care. The MCN is already engaging with the new quarterly reports to the SG to understand the local data from SCI Diabetes and use that information to drive improvements in the quality of care offered to people with diabetes.

The Diabetes Improvement Plan also calls for better patient access to their own data to support self management. The MCN is working with the DESMOND team to raise awareness of the “My Diabetes
My Way” (MDMW) website amongst individuals with recently diagnosed type 2 diabetes. All three secondary care sites currently use SCI Diabetes to sign patients up to MDMW at hospital clinic visits.

Priority 8: Innovation

To accelerate the development and diffusion and innovative solutions to improve treatment, care and quality of life of people living with diabetes.

The Scottish Government has recently re-stated its commitment to increasing provision of insulin pumps. The MCN will continue to work with the IJBs and across the multidisciplinary team to extend the provision of this technology. At present, Lothian performs well against other Scottish Health Boards on insulin pump use (34% of children and 9.4% of adults with type 1 diabetes currently use an insulin pump). However these figures still fall short of pump use in England and other parts of Europe. The 2016 SNP manifesto included a commitment to offer insulin pumps to 20% of people with type 1 diabetes.

The MCN will examine how the use of other technologies, such as continuous glucose monitoring, can be embedded in our current models of care given the financial pressures under which all health boards are currently operating.
Diabetes Multidisciplinary Service Reports

As a result of the recent hiatus in administrative support for the MCN, most of the MCN sub-groups have not met recently. There are therefore no formal multidisciplinary reports to include in this year’s annual report. As a matter of priority, the MCN clinical lead will re-establish the MCN sub-groups. The following is a short update on the current state of the MSN sub-groups:

1. **Diabetic Retinopathy Screening (DRS) Steering Group (Chair Dr Sarah Wild)**
   This sub-group is chaired by the Public Health Representative on the MCN. This was formerly Dr Joy Tomlinson but she has moved out of NHS Lothian and was replaced in 2016 by Dr Sarah Wild. The DRS sub-group has recently been involved in commenting on the new proposed DRS standards.

   When the last MCN annual report was produced in 2013, 78.7% of the eligible population had been screened, which was slightly lower than the Scottish average of 79.4%. On the 2015 Scottish Diabetes Survey, NHS Lothian had screened 29284 patients out of an eligible 35,042 over the preceding 15 months, representing 83.6% of eligible patients screened. This is a significant improvement on our 2013 data and is above the 80% national target for screening.

2. **Dietetic Diabetes Network (Chair: Emma Shaw)**
   The dietetic network has continued to meet 2-3 times a year. Current challenges include:
   a. Available capacity and timetabling of commitments to DAFNE, DESMOND and insulin pumps
   b. Variance of service provision across the sites, especially with regard to the diabetes antenatal service.

3. **Pharmacy Services (Chair Alison Cockburn)**
   The MCN will need to re-establish contact with members of this sub-group.

4. **SCI-Diabetes user Group (Former chair Dr Ian Dickson)**
   The previous chair of this group has retired so the MCN will need to identify a new chair and re-establish activity of this sub-group.

5. **Diabetes Patient Education Group (Former chair Anne Morrison)**
   Anne Morrison has recently retired and a new chair for this sub-group has not yet been established. Lack of capacity on DESMOND courses for newly diagnosed patients and the lack of structured education for the majority of patients with type 2 diabetes of more than one year’s duration will be a priority for this sub-group over the coming year. There is also a lack of structured education for people who do not meet DESMOND criteria, for example people who don’t speak English as their first language and people with learning difficulties. Equality of access is one of the priorities under the 2014 Diabetes Improvement Plan so the patient education sub-group will also need to consider education for currently overlooked patient subgroups.

6. **Professional Education subgroup (Chair Jill Little)**
   This subgroup has not met for some time due to lack of administrative support. However, the subgroup will be re-established as a matter of urgency now that an MCN coordinator has been appointed. In the interim, Jill Little has continued to coordinate and deliver professional education for registered and non-registered staff in Lothian. The professional conference which
had been planned for September 2016 has had to be postponed and we anticipate it will go ahead in February 2017.

7. **Paediatric and Adolescent Diabetes (Chair Dr Louise Bath)**
   The Adolescent subgroup meets three times a year. Recent improvements to the adolescent diabetes services has included a training day for the whole multidisciplinary team from the Making Connections Team from Diabetes Scotland. It was encouraging to find that the Lothian multidisciplinary team is already delivering care in the way recommended by Making Connections but since the training day, work has begun on a patient leaflet for children transitioning to the adolescent clinic in keeping with the principles of Making Connections.

8. **Foot subgroup (Chair Dr Matthew Young)**
   This subgroup has not met for some time so the MCN will re-establish contact with the sub-group over the coming months.

9. **Insulin pump subgroup (Chair Liz Mackay)**
   The main challenge faced by this sub-group has been the restricted funding for insulin pump therapy. Originally, it looked like the NHS Lothian funding allocation was going to leave the pump budget with a shortfall of approximately £500,000 for the financial year 2016/2017. Once all current insulin pumps due for upgrade had been replaced and consumables for the year purchased for all current pump users, it would have meant that no adults could be commenced on insulin pumps in this financial year after April 2016 and no children could be commenced on pump therapy after July 2016.

   Working with the diabetes Senior Management Team and Procurement, the pump group has managed to negotiate an improved price on insulin pumps and changed our mechanism of delivery of pump consumables to allow VAT to be recouped. This should mean that we are able to offer the planned number of pump starts within the current financial envelope.

   The pump sub-group will certainly face ongoing financial challenges, especially as the SNP manifesto included a commitment to ensure that 20% of patients with type 1 diabetes receive insulin pump therapy. There will also be a need to the sub-group to address the use of other technologies such as Continuous Glucose Monitoring (CGM) systems, as there is increasing demand for these from patients with no allocated funding at present.
Clinical Processes and Outcomes

The data reported below are taken directly from the Scottish Diabetes Survey extract that Lothian submits to the Scottish Diabetes Survey Monitoring Group each year. The data outlined below was extracted on 1 January 2016 relating the period January to December 2015. Scottish Diabetes Survey data accurately reflects the changing priorities of diabetes services based on national targets. The Scottish Diabetes Survey 2015 has not yet been published. Once the 2015 SDS has been published, the MCN will compare results from the 2014 survey and develop an action plan to support improvements in recording and management.

Type of Diabetes

![Bar Chart showing Type 1, Type 2, Other Types of Diabetes, Total (all FRANK Types), Total Type 1 and Type 2 with counts ranging from 0 to 45000]
Age of People (years) on Diabetes Register (FRANK diabetes only)
Number of People with Diabetes by Age (years)
Incidence of Type 1 and Type 2 Diabetes in the Prior Year by Age (years)
Body Mass Index (BMI) in Type 1 and Type 2

<table>
<thead>
<tr>
<th>Population</th>
<th>Type 1</th>
<th>Type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calculated within the last 15 months</td>
<td>3,753</td>
<td>28,421</td>
</tr>
<tr>
<td>Not Recorded</td>
<td>495</td>
<td>5,151</td>
</tr>
<tr>
<td>Excluded*</td>
<td>357</td>
<td>8</td>
</tr>
</tbody>
</table>

38,185 4,605 33,580

BMI Range in Type 1 and Type 2 Diabetes

*Excluded = Number under 18 years of age or had no date of birth
HbA1c Recorded in Type 1 and Type 2 Diabetes

<table>
<thead>
<tr>
<th></th>
<th>Population</th>
<th>Type 1</th>
<th>Type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calculated within the last 15 months</td>
<td>4,252</td>
<td>31,353</td>
<td></td>
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<tr>
<td>Not Recorded</td>
<td>353</td>
<td>2,045</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>38,185</td>
<td>4,605</td>
<td>33,580</td>
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Most Recent HbA1c Measurement in Type 1 and Type 2 Diabetes
Blood Pressure Recorded in Type 1 and Type 2 Diabetes

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<thead>
<tr>
<th>Population</th>
<th>Type 1</th>
<th>Type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recorded within the last 15 months</td>
<td>3,969</td>
<td>31,569</td>
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<tr>
<td>Not Recorded</td>
<td>636</td>
<td>2,011</td>
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<tr>
<td>Total</td>
<td>38,185</td>
<td>4,605</td>
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</table>

Most Recent Blood Pressure Measurement within a Specified Value Range in Type 1 and Type 2
### Cholesterol Recorded in Type 1 and Type 2 Diabetes

<table>
<thead>
<tr>
<th>Population</th>
<th>Type 1</th>
<th>Type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recorded within the last 15 months</td>
<td>3503</td>
<td>30405</td>
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<tr>
<td>Not Recorded</td>
<td>745</td>
<td>3167</td>
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<tr>
<td>Excluded*</td>
<td>357</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>38,185</td>
<td>4,605</td>
</tr>
</tbody>
</table>

### Most Recent Total Cholesterol Measurement in Type 1 and Type 2 Diabetes

*Excluded = Number under 18 years of age or had no date of birth*
HbA1c, Cholesterol and Blood Pressure Targets in Type 1 and Type 2

Targets are:
- HbA1c of less than 53mmol/mol (7%)
- Systolic BP of >130 and Diastolic BP of 80mmHg
- Cholesterol of 5 mmol/L or less

Note: All age exclusions are ignored for this question
Smoking Status in Type 1 and Type 2 Diabetes (recorded within the last 15 months)

Diabetic Retinopathy Screening (DRS) in Type 1 and Type 2

Excluded = Number under 12 years of age or had no date of birth
Diabetic Retinopathy – Left of Right Eye in Type 1 or Type 2 Diabetes

Excluded = Number under 12 years of age or had no date of birth recorded
Recorded as Having: Myocardial Infarct, Undergone Cardiac Revascularisation, Stroke, Foot Ulcer, Lower Limb Amputation and End Stage Renal Failure

Foot Risk Calculation in Type 1 and Type 2 Diabetes
Deprivation Quintile – Type 1 and Type 2 Diabetes Population

Care Processes Done in the Prior 15 Months – All Age Exclusions are Ignored
Appendix 1

<table>
<thead>
<tr>
<th>Quality improvement and outcome measure</th>
<th>Baseline RAG Status</th>
<th>Self-assessment (please indicate which areas you have identified for improvement against the relevant measures and rationale. Any areas/measures not included please provide rationale to explain RAG rating and if there is future planned activity)</th>
<th>Identify target for improvement by the end of the year</th>
</tr>
</thead>
</table>
| 1. % people with diabetes who receive all 9 key indicator measurements for diabetes | Baseline data for the 0-11 year old type 1 group is excellent and well above the Scottish average. Other age groups are only just above the national average. Data collection for the 0-11 year old group has remained at a stable high level (94.4%) while data collection for all other age groups has increased by 0.5-1% since 2015 Q4. Although we are performing above the Scottish average, only 49% of patients overall are getting all 9 key indicator measurements of diabetes care. | 1a. Aim for 60% of people to receive all 9 key indicators by the end of 2016.  
1b. Improve documentation of smoking status from 75% to at least 80% by end of 2016. Currently exploring why documentation of smoking status is so low. Possibly a data entry issue as QOF pages suggest that smoking data are 95% complete for people diabetes. Source of SCI smoking data for patients seen in primary care is currently being explored with SCI Diabetes Team |
Scottish Diabetes Survey 2015 data suggests that documentation of smoking status is the measurement that is most frequently missed.

### 2. % persons with an HbA1c <58mmol/mol at 1 year post diagnosis

Performing above the national average overall with the exception of the 12-17 year old type 1 group which has dipped below the average. Performance for the type 1 >18 year old and the 6-11 year old groups are particularly good (15-20% above national average). Performance for type 2 patients is similar to the national average.

2a. Approximately 70% of type 2’s achieve HbA1c <58 mmol/mol at 1 year post diagnosis. Aim to increase this to 75% by the end of the year

2b. Maintain performance above the national average for type 1 diabetes.

### 3. % persons with an HbA1c <58 mmol/mol and >75 mmol/mol

Performance is similar to the Scottish average but there is room for improvement. In the type 1 18+ age group there has been a small reduction in the % achieving HbA1c <58 mmol/mol and a slight increase in the % achieving >75mmol/mol over the last 4 quarters. However, for all age groups in type 1 diabetes, Lothian generally performs better than the national average for both parameters. Figures for type 2 are steady over the last 3 quarters and much better, with 60% achieving HbA1c <58 mmol/mol 1 year after diagnosis and only 13% having HbA1c >75 mmol/mol 1 year after diagnosis.

3. Reverse the trend in type 1 18+ age group so that the proportion with hba1c <58mmol/mol 1 year after diagnosis increases and the % with HbA1c >75mmol/mol falls over the next year. Planned changes to structured education at diagnosis should help address this.

### 4. % current smokers

Percentage of smokers in Lothian is no different to the Scottish Average, but there is room for improvement. Currently 25% of people with diabetes in Lothian do not have smoking status recorded.

4a. Provide targeted information on smoking cessation for people with diabetes by end of 2016

4b. Increase percentage of people with a recorded smoking status from 75% to 80% by the end of 2016

### 5. % of people aged 50 to 80 with a total cholesterol <5mmol/l AND a systolic BP <140 mm Hg

Percentage of people aged 50-80 with cholesterol and SBP within target is similar to the Scottish average, but there is room for improvement.

5a. reduce proportion of people aged 50-70 with no recorded SBP and cholesterol to <10%

5b. Increase percentage of people aged 50-80 with cholesterol and SBP within target to >55% by the end of 2016

### 6. % of new foot ulcers

The figures for new foot ulcers are very low, not just in Lothian but across Scotland. This almost certainly

Involve foot subgroup of MCN to increase reporting of ulcers using ulcer management
<table>
<thead>
<tr>
<th>Indicators</th>
<th>Scottish Diabetes Survey 2015 Data</th>
<th>Lothian’s Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. % of people eligible for diabetic retinopathy screening actually screened within last 15 months</td>
<td>DRS standards require a minimum of 80% of eligible people to receive retinopathy screening in the last 15 months. Lothian is meeting this target.</td>
<td>7. Maintain current level of retinopathy screening</td>
</tr>
<tr>
<td>8. % of people with diabetes reaching end stage renal disease or requiring renal replacement therapy</td>
<td>Only 1.2% of patients with type 1 diabetes and 0.7% patients with type 2 diabetes reached end stage renal failure, in line with the rest of Scotland.</td>
<td>8. Maintain current low levels of patients progressing to ESRF or RRT</td>
</tr>
<tr>
<td>9. % of people on CSII therapy</td>
<td>NHS Lothian performs well against the rest of Scotland on this measure, but % of people on CSII still falls well short of UK-wide, European and international figures. The proportion of patients on CSII has grown each quarter across 2015</td>
<td>9. continue to increase pump provision to appropriate patients with type 1 diabetes</td>
</tr>
<tr>
<td>10. % of persons with a BMI ≥ 30 who have lost ≥ 5% body weight in the last year</td>
<td>Figures similar to the Scottish average but there is room for improvement, with just 14% of obese individuals with type 2 diabetes losing at least 5% body weight over 12 months. Figures are steady over the last 3 quarters. Following a dip in performance for type 1 patients aged 17 or under in the last quarter, Lothian’s performance is back up to the national average in this quarter.</td>
<td>10. Changes to referral criteria into Lothian Weight Management Service should help increase the % of people with BMI &gt;30 who have lost at least 5% body weight over 12 months.</td>
</tr>
<tr>
<td>11. % persons who have attended structured education</td>
<td>NHS Lothian performs at similar levels to the Scottish average but there is significant room for improvement. Participation in DESMOND is not currently systematically recorded on SCI so the data for type 2 diabetes is not reliable.</td>
<td>11. Establish systems for accurately recording how many people have been offered structured education – by end of 2016</td>
</tr>
<tr>
<td>12. % disengaged from diabetes care i.e. no HbA1c and retinal screening in the preceding 15 months</td>
<td>&lt;5% of patients are disengaged from care over the last 15 months</td>
<td>12. Maintain % of disengaged patients at &lt;5%</td>
</tr>
</tbody>
</table>
Section 2  Please complete the table below to provide identified, measurable actions to be taken forward throughout the year to improve diabetes services, under the relevant outcome measure.

<table>
<thead>
<tr>
<th>Improvement aim number (as identified in the table above)</th>
<th>Actions to achieve aim (Please insert as many actions as required to achieve identified improvement target)</th>
<th>Summary of Progress (what progress has been made on actions since the previous quarter?)</th>
<th>Date for completion</th>
<th>On trajectory to achieve improvement aim by end of year? (Please indicate either; &quot;on trajectory - green, 'at risk' – amber or 'achieved green' Please use the table below for exception reporting any 'at risk'actions.)</th>
<th>MCN Lead Contact (insert named local contact who is leading this work.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a &amp; 1b</td>
<td>Write to GPs and clinicians to ensure improved documentation of smoking status in order for 70% of people to receive all 9 key indicators.</td>
<td>Action to be taken once primary care co-chair appointed to MCN (post being advertised in May 2016)</td>
<td>End of 2016</td>
<td></td>
<td>Nicola Zammitt</td>
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<tr>
<td>2.</td>
<td>Review type 1 early education structured education at diagnosis. Improve access to information for newly diagnosed type 2's (sign-post Living it Up and My Diabetes My Way)</td>
<td>New pathway for type 1 education being piloted at RIE NNZ met DESMOND coordinator 25/4/16: information leaflet has been developed to send to individuals referred for DESMOND to sign-post patients to MDMW, Living it Up and Council leisure facilities.</td>
<td>End of 2016</td>
<td></td>
<td>Nicola Zammitt</td>
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<tr>
<td>3</td>
<td>As for 2</td>
<td>As for 2</td>
<td>End of 2016</td>
<td></td>
<td>Nicola Zammitt</td>
</tr>
<tr>
<td>4a.</td>
<td>Provide leaflet on smoking cessation for people with diabetes by the end of 2016</td>
<td>Leaflet being finalised before distribution</td>
<td>End of 2016</td>
<td></td>
<td>Nicola Zammitt</td>
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<td><strong>4b</strong></td>
<td>Write to GP’s and consultants to increase percentage of people with a recorded smoking status from 75% to 80%</td>
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<tr>
<td><strong>5</strong></td>
<td>Write to GPs to improve documentation of SBP and cholesterol</td>
<td>Action to be taken once primary care co-chair appointed to MCN (post being advertised in May 2016)</td>
<td>End of 2016</td>
<td>Nicola Zammitt</td>
<td></td>
</tr>
<tr>
<td><strong>6</strong></td>
<td>Involve foot subgroup of MCN to increase reporting of ulcers using ulcer management screens</td>
<td>Initial meeting taken place with Matthew Young</td>
<td>End of 2016</td>
<td>Nicola Zammitt, Matthew Young</td>
<td></td>
</tr>
<tr>
<td><strong>9.</strong></td>
<td>Liaise with Integration Joint Boards via Health Board to continue to increase pump provision to appropriate patients with type 1 diabetes</td>
<td>Funding being finalised for pumps for 2016/17 financial year</td>
<td>End of 2016</td>
<td>Nicola Zammitt</td>
<td></td>
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<tr>
<td><strong>10</strong></td>
<td>Remind consultants of change of referral criteria to Lothian Weight Management Service.</td>
<td>Email sent Feb 2016</td>
<td>End of 2016</td>
<td>Nicola Zammitt</td>
<td></td>
</tr>
<tr>
<td><strong>11</strong></td>
<td>Contact DESMOND and DAFNE coordinators to obtain up to date information on structured education provision</td>
<td>Have had meeting with DESMOND coordinator. Not yet met with local DAFNE leads</td>
<td>End of 2016</td>
<td>Nicola Zammitt</td>
<td></td>
</tr>
</tbody>
</table>