Diabetes Action Plan 2010
NHS Ayrshire and Arran Progress Report March 2011

Report completed by: Dr Iqbal Malik and Mrs Diane Smith Report date: 31/03/2011

Action Point (Summary)	*Month*	*Measured by*	*Comments on Progress*	*R*	*A*	*G*	*
3.3.1 Initiatives will be undertaken to promote prevention of foot problems	December 2011	For people with diabetes a) 80% will have a recorded foot risk score in previous 15 months. b) 80% have documented evidence of having received information relevant to their foot risk.	a) Work in progress to record foot risk score directly into SCI - DC as of the 1st April 2011 by the podiatry service b)as above				
3.3.2 There is an identified individual with a responsibility for educating and supporting primary care podiatrists	April 2011	Individual is in place	Individual is in place – this is a defined part of the role of the Podiatry Diabetes Care Programme Lead				
3.5 Initiatives will be taken to promote optimal kidney function	September 2011	Referral guidelines between diabetes and nephrology services are published and available to all clinicians	As per NHS Ayrshire & Arran's Diabetes Care Guidelines Version 4.0 (care guidelines currently being revised 2011) Guidelines are published and available to all clinicians via Athena website				
3.6.1 Positive pregnancy experiences will be promoted	April 2012	a) Evidence that pregnancy awareness raising sessions for diabetes are available to primary care and secondary care teams b) Systems are in place to ensure appropriate retinal screening during pregnancy in accordance with SIGN 116 c) Evidence that programmes are in place to detect and treat gestational diabetes d) Post-partum lifestyle advice and regular screening is recorded for those who had gestational diabetes	a) Patients of child bearing age are routinely given verbal pregnancy awareness advice when they attend secondary care clinics. We are currently updating a patient information leaflet which will be issued Ayrshire-wide, for use in both primary and secondary care, to be given to women of child bearing age b) Women who attend the antenatal clinic with diabetes are screened by digital retinal imaging at first presentation to the clinic and during each trimester subsequently c) At present, if requested by the lead clinician for that patient, a GTT is performed and if positive the woman is issued with information regarding gestational diabetes and the importance of treating. They are issued with testing equipment and reviewed by a dietician and attend a specialist antenatal clinic for women with gestational diabetes. At present Ayrshire and Arran has not provided the				

			resources required to institute SIGN guideline 116's recommendations with regards to using risk factors for screening and diagnosing women with gestational diabetes. The department of obstetrics has been alerted to the financial constraints and risks inferred and as such a business case is being prepared to address these issues. Until then we will not be able to fully introduce the SIGN recommendations. d) Women with GDM are advised of appropriate lifestyle measures, including the benefits of regular exercise, weight control and dietary advice on reducing the risks of subsequent Type 2 diabetes, throughout their pregnancy. This information is communicated to the GP by letter. Following communication of the result of a post-partum GTT to the GP, the patient and GP are advised to undertake an annual fasting plasma glucose and HbA1c thereafter.					
3.7.2 **Diabetes MCNs will revise and update their needs analysis and review of services for minority ethnic communities**	January 2013	A revised and updated minority ethnic needs assessment is published	Needs analysis and review of services for minority ethnic communities was carried out in 2009. It is estimated a review will be carried out sometime during 2012/13					
3.8.2 **Each NHS board will develop and publish a transitional care plan with measurable outcomes**	April 2012	a) A transitional care plan is published *b) Measurable outcomes to be determined by Paeds Lead*	A meeting is planned in May 2011 to discuss redesigning the transitional clinics, measurable outcomes will be determined within these discussions					
3.9.1 **There will be adequate training of staff in psychological skills**	May 2013	The number of specialist staff in primary and secondary care who have attended a course (minimum duration one half day) on behaviour change over the last 2 years.	The Diabetes Specialist Nursing team and some of the hospital based dieticians have been involved in a ½ day motivational interviewing course. It is hoped that this course will be supported by clinical supervision and additional motivational and interviewing training to improve the specialist team straining in psychological skills					

Action Point (Summary)	*Month*	*Measured by*	*Comments on Progress*		*R*	*A*	*G*	*
3.9.2 **National initiatives are developed and shared**	April 2012	a) MCNs identify an individual to link with PIDPAD b) An analysis of local resources for emotional support is available and posted on a patient-accessible website	a) National PIDPAD meeting arranged for the 18th May 2011. A Consultant Diabetologist will be attending as our representative as with the Lead Diabetes Nurse b) Staff has had introductory training on CBT. Psychological and emotional support is available on an ad hoc basis. Information is not currently available on a patient accessible website. An information leaflet on availability of support is planned and will be implemented by April 2012					
3.10.3 **Education will be improved at local level**	April 2011 December 2011 June 2013 April 2012	a) There is an identified individual who will oversee the delivery of local patient education programmes b) There is evidence that a range of education solutions, including structured education programmes is available c) A user assessment in relation to patient education has been undertaken as is available d) The proportion of patients attending structured education programmes is recorded e) Support measures for people with diabetes are publicised so they are readily available.	a) Individual is in place b) Current education – Information sessions for people with type 2 diabetes, challenging your condition, BRUCIE, conversation maps for dietetics (newly diagnosed and Annual Review). Currently reviewing information sessions, involved in the development of a generic self management programme with a condition specific element which may allow us to meet the requirements of structured education c) A patient needs assessment is being planned at present d) Education Group reviewing the consultation document with regards to the changes to Quality Outcome Framework (QOF) e) Support information is sent out to the patient mailing list – 550 patients and a press release is issued before each information session. Posters are sent to all General Practices, Community Pharmacists, Libraries, Optometrists, Diabetes Clinics etc. Patient Conference is advertised in the same way. Advertised on PPF websites across Ayrshire					

Action Point (Summary)	*Month*	*Measured by*	*Comments on Progress*		*R*	*A*	*G*	*
3.11.2 The local insulin strategy is reviewed	June 2011	The local insulin strategy is published	Currently in progress					
3.11.1.1 People with diabetes who could benefit from intensive insulin therapy should have access to structured education programmes	June 2012	The number of people with diabetes who receive instruction in CHO counting is recorded and reported	The BRUCIE (Better Regulation Using Carbohydrate and Insulin Education) structured education programme for Type 1 Diabetes has been audited and data is available. Currently BRUCIE 2 (Better Regulation Using Carbohydrate and Insulin Education for individuals with Type 2 Diabetes) is currently being developed					
3.11.1.2 Insulin pump therapy is available for those patients who would benefit from it	June 2011	The number of people on insulin pumps is reported	As at January 2011 – 18 people are reported as being on insulin pumps (Figures submitted to the Scottish Diabetes Survey 2010)					
3.12.3.1 The incidence of hypoglycaemia that results in emergency admissions will be reduced	December 2012	A care pathway of people who experience severe hypoglycaemia will take account of national work and implement when appropriate	Currently in development. Local guidelines are in place					
3.12.3.2 The incidence and care of DKA will be improved	December 2011	A care pathway of people for the presentation and management of DKA will take account of national work and implement as appropriate	Local DKA guidelines have been updated and implemented recently. The national care pathway has been approved by D & T and will be rolled out shortly					
3.13.1.1 There will be initiatives to improve care for inpatients	June 2012	a) A foot protection programme for patients with diabetes on general wards will be published b) Initiatives from the inpatient group as agreed by the SDG will be implemented	a) An objective for Podiatry Services 2011/12 b) Awaiting further info from the inpatient group					
3.13.1.2 Mechanisms to record the number of inpatient wards with specific hypo guidelines are developed	June 2012	The number and proportion of wards is reported	All wards within NHS Ayrshire and Arran have access to specific hypo guidelines via the insulin and blood glucose monitoring chart					
3.13.2.1 Local provision of education to the staff working in institutional settings is improved	December 2011	There is evidence that staff from institutional settings, including care homes, have access to educational events	The Education Group is currently reviewing this group of staff and is supporting the Practice Development Units Specialist Care Home sessions. It is hoped that further events can be established that will be open to these staff					

Action Point (Summary)	*Month*	*Measured by*	*Comments on Progress*		*R*	*A*	*G*	*
4.1.1 **Implementation of research-based high quality clinical practice will be supported**	December 2011	a) There is evidence that local diabetes guidelines are updated in line with SIGN 116 b) The number of people recruited to the SDRN register is reported.	a) Ayrshire and Arran's Diabetes Care Guidelines Version 4.0 are currently being reviewed in line with SIGN 116 b) The number of people from Ayrshire and Arran who are currently recruited to the SDRN register is 2					
4.1.2 **Organisations are able to communicate effectively through the development of a communications strategy**	August 2011	a) There is evidence that a patient event has been hosted to raise awareness of local services and research b) There is evidence that MCNs are working with patient representatives to develop and disseminate resources.	a) Patient Conference – September 2010, arrangements being considered for another in September 2011. Arrangements currently in place for further Support Groups (family and adult - peer groups) for 2011. Diabetes Service Options Stakeholder event due to take place June 2011 b) A meeting has already taken place with Diabetes UK March 2011. Diabetes UK invited to attend MCN Steering Group 27th April to discuss Diabetes Voices					
4.2.1 **An individual to coordinate professional education will be identified**	April 2011	a) The individual is in place b) There is evidence that there is ongoing patient involvement in the delivery of staff education programmes.	a) Individual is in place b) Not at present – previously in Warwick Courses however it is anticipated that this can be introduced to the new Diabetes Module for the West of Scotland					
4.2.1 **An individual to coordinate professional education will be identified**	April 2011	a) The individual is in place b) There is evidence that there is ongoing patient involvement in the delivery of staff education programmes.	a) Individual is in place b) Not at present – previously in Warwick Courses however it is anticipated that this can be introduced to the new Diabetes Module for the West of Scotland					
4.2.2 **SDG and Diabetes MCNs will consider how to share best practice**	December 2011	MCNs submit workplan and annual report to the SDG.	The 2011/12 workplan is currently being circulated with the Executive Group for agreement, once agreed it will be sent to the SDG The 2009/10 Annual Report is currently being written, it will be sent to the SDG once completed					

Action Point (Summary)	*Month*	*Measured by*	*Comments on Progress*		*R*	*A*	*G*	*
5.1.2 **Diabetes MCNs should ensure that people living with diabetes are fully engaged in the MCN's activities**	June 2011 April 2011	a) There is evidence in the annual report that patients are involved in local service development b) The number of people attending a Diabetes voices programme is recorded	a) Patient representatives sit on various MCN groups. Diabetes Service Options Stakeholder event planned for June 2011. Mailing list of 550 patients who are contacted regularly b) A meeting has already taken place with Diabetes UK March 2011. Diabetes UK invited to attend MCN Steering Group 27th April to discuss Diabetes Voices					
5.1.3.1 **NHS Boards maintain the effectiveness of MCNs**	April 2011	a) There is a lead clinician in each board working with and supported by a manager. b) There is evidence that Boards and operating divisions consult with MCN representatives when planning diabetes service improvements c) The Board endorses the MCN's workplan	a) A Lead Clinician and an MCN Manager are in place and meet every 3 weeks to discuss relevant issues b) Diabetes Services are currently under review in Ayrshire and Arran – Diabetes Service Options Group which is made up people from Primary/Secondary Care, Head of Primary Care Development, Heads of Services, Health Care Managers and includes Patient Representation c) The Diabetes MCN Workplan 2011/12 once agreed by the Executive Group will be passed to the Board to be endorsed					
5.1.3.4 **NHS Boards will accredit their diabetes MCNs**	September 2012	Accreditation by the NHS has been granted	Some local work being carried out with other MCN's within the health board					
5.1.4.1 **Telehealth opportunities will be explored and solutions embedded into pathways of care**	January 2013	Telehealth solutions are used where appropriate	Not yet used however opportunities will be explored to see if and or where telehealth can be used appropriately within Diabetes					
5.1.4.2 **Effective links will be developed with community pharmacy**	June 2011	There is community pharmacy representation on MCNs or other evidence of engagement with colleagues in community pharmacy	A Community Development Pharmacist is a member the Diabetes MCN Steering Group who meets quarterly.					

Diabetes Lead Clinician

Dr Iqbal Malik

Email iqbal.malik@aaaht.scot.nhs.uk
Tel. no. 01292 614017

Diabetes MCN Manager

Diane Smith

Email Diane.smith@aapct.scot.nhs.uk
Tel. no. 01294 323470

Lead Board Representative

Liz Moore

Email Liz.Moore@aapct.scot.nhs.uk
Tel. no. 01292 614629

Diabetes MCN website URL

Comments

Progress Report Key

Not Started | **Red** R (at risk) | **Amber** A (some slippage) | **Green** G (on target) | **Completed**