Diabetes Action Plan 2010
NHS Borders Progress Report March 2011

Report completed by: <MCN Manager> Report date:

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.	Diabetes SES 2010/11 will be further developed for 2011/12 to include collection of foot risk score and to make practices aware of the information already available on SCI DC Network which should be given to each patient as they are screened.				*		
3.3.2 There is an identified individual with a responsibility for educating and supporting primary care podiatrists	April 2011	Individual is in place	Specialist Podiatrist at BGH has undertaken a secondment to provide this and has provided sessions of specific education which will be delivered as a rolling programme.					*	
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	Clear guidelines for the management of renal disease in diabetes is on the internet and intranet -available to all clinicians. The Diabetologists work closely with the Nephrologist and clinics are run concurrently on the 3rd Monday of every month. This allows patients to be seen by both services simultaneously.					*	
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)NHS Borders have recently undertaken a TiME session (protected learning time for primary care) on SIGN guidelines and a specific session on SIGN guidelines for the management of diabetes in pregnancy. All patients with gestational diabetes, type 1 or type 2 diabetes in pregnancy are referred to and managed within secondary care by the MD team including the Obstetrician in a combined clinic. b) As all patients with diabetes are seen in secondary care, they are automatically referred for retinal screening at the beginning of each trimester of pregnancy. c) see above d) All patients with GDM have a six week post partum OGTT in primary care. The GP will refer accordingly depending on the GTT.					*	

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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	A needs assessment was undertaken two years ago. The majority of our patients from ethnic communities are Polish and Chinese. Numbers are small and patient's needs are met individually. A further needs assessment will be undertaken 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 joint paediatric / adult diabetes transitional clinic has been established and is held twice a year, however this is under review as attendance has been problematic.				*		
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.	All secondary care specialist diabetes nurses have attended specific training as part of eKSF requirements and in line with the national guidance. Currently there are no specialist staff in primary care other than those who outreach from secondary care.				*		
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	Lack of capacity within the MCN and within Psychological Services has meant that to date this has not been possible. This will be reviewed and addressed over 2011/12.			*			
3.10.3 **Education will be improved at local level**	April 2011 Decembe r 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)The MCN provides modules on diabetes care as part of a rolling LTC training & education programme in primary care as part of TiME sessions. b)We are also in the process of instructing practice nurses in the provision of structured patient education. The development of the forthcoming Diabetes SES if successful will incorporate this. c) As part of the SES, GP practices will be asked to distribute patient feedback questionnaires to all those undertaking structured education programmes. d) see above e) Information is already available on the Diabetes website and on Borders Health in Hand and is updated when appropriate				*		
3.11.2 **The local insulin strategy is reviewed**	June 2011	The local insulin strategy is published	The local insulin strategy has been reviewed. Data is currently being extracted from SCI DC on insulin usage. The document will be updated with this information and published accordingly.					*	

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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	All type 1 patients currently receive structured education and carbohydrate counting. Type 2 patients currently receive education on a 1:1 basis by the Dietician and DSN. This will form part of the SES for 2011/12				*	
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	NHS Borders provides a pump service					*
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 the management of inpatient diabetes is being reviewed through the appointment of a DSN and will incorporate this aspect of care.			*		
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	The guidelines for the management of DKA are followed and are available on the intranet. All junior staff are trained in this protocol through teaching and induction programmes. An audit of DKA was undertaken in 2009 and it is planned to repeat this in 2011 following the release of the latest national guidelines.				*	
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	Currently underway			*		
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	This is currently underway			*		
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	DSNs attend care homes to deliver on-site education to staff. Care home staff are invited to attend the rolling training & education programme at TIME				*	
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.	All guidelines updated Dec 2010					*
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 There is evidence that MCNs are working with patient representatives to develop and disseminate resources.	a) A programme is planned for 2011 b) Patient representatives are full members of the MCN and participate in decision making			*	*	

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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)The education programme is run by the Lead Clinician with involvement of all members of the team.				*	
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.					*	
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					*	
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	The position and support of MCNs within the organisation is currently under discussion.				*	
5.1.3.4 **NHS Boards will accredit their diabetes MCNs**	September 2012	Accreditation by the NHS has been granted	Under discussion				*	
5.1.4.1 **Telehealth opportunities will be explored and solutions embedded into pathways of care**	January 2013	Telehealth solutions are used where appropriate	Currently being explored				*	
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	In progress				*	

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Diabetes MCN website URL

Comments

Progress Report Key

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