Quality Care for Diabetes in Scotland
Diabetes Action Plan 2010
NHS Fife Progress Report March 2011

Report completed by: M Maillie 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.							
3.3.2 There is an identified individual with a responsibility for educating and supporting primary care podiatrists	April 2011	Individual is in place	*In post 1 x day a week, funding for further year.*						
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	*Referral guidelines will be updated and finalised as part of the handbook this year*						
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	*We plan to include sessions on pregnancy awareness as part of the MCN educational programme.*						
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	*The report will be submitted by April 2011*						
3.8.2 Each NHS board will develop and publish a transitional care plan with measurable outcomes	April 2012	A transitional care plan is published							
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.							
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	*2 Staff representing NHS Fife at upcoming PID PAD Meeting.*						

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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.	*'Range' includes Conversation Maps, X-Pert and Bournemouth Training due in May 2011.* *Patient evaluation is completed for all courses attended.* *Record of training is collated by the MCN.* *Through the Focus Group and 'Living with my condition' website*					
3.11.2 **The local insulin strategy is reviewed**	June 2011	The local insulin strategy is published	*First draft ready for review*					
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						
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						
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						
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						
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						
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						
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						
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.						

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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.						
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.	*Professional Education Group Chair.* *Patient Representation on MCN Board*					
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.	*Annual report will be submitted to Will Scott*					
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	*Patient Focus Group, patient reps attends Board Meetings.* *Voices delivered in 2009 - Plans to deliver Voices Programme*					
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	*Dr Chalmers* *Morag Maillie* *Reports to and links with Redesign, Capacity and Sustainability, CHP PFPI Group* *Work plan is submitted to CHP*					
5.1.3.4 **NHS Boards will accredit their diabetes MCNs**	September 2012	Accreditation by the NHS has been granted	*Communication and stakeholder plan submitted to CHP, accreditation process is being followed.*					
5.1.4.1 **Telehealth opportunities will be explored and solutions embedded into pathways of care**	January 2013	Telehealth solutions are used where appropriate						
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	*Pharmacy Rep on Diabetes Board.* *Diabetes MCN is part of Vascular Prescribing Group.*					

Diabetes Lead Clinician	
	Dr John Chalmers
Email	john.chalmers@nhs.net
Tel. no.	

Diabetes MCN Manager	
	Morag Maillie
Email	moragmaillie@nhs.net
Tel. no.	015920226841

Lead Board Representative	
	Dr Les Bisset
Email	leslie.bisset@nhs.net
Tel. no.	

Diabetes MCN website URL
Comments

Progress Report Key

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