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

Report completed by: David Munro, MCN Manager Report date: 16 March 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/b) QOF achievement data available for 2009/ 10 (DM09 & DM10). Foot Risk Score will not be included in QOF until 2012. Nation-wide issues continue regarding recording in SCI-DC. To be discussed with Duncan Stang and Jim McLaughlan Q2 2011.					
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 post.					
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 guideline in place (based on NHS GG&C guideline)					
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) Previous two diabetes update sessions for primary care clinicians offered workshops on diabetic pregnancy. This is a rolling programme and related topics to be highlighted to primary and secondary care clinicians through Prescriberfile articles. b) System is in place. c) Programme for detecting and screening GDM in place. d) Post partum lifestyle advice is discussed during pregnancy and also by the diabetes team when the patient is seen for follow up and GTT at 3 months post partum (usually the diabetes nurse specialists). Also discussing with nurse managers the possibility of health visitors giving lifestyle advice.					

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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 revised and updated minority ethnic needs assessment is on target to be completed by Jan. 2013.					
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.	Transition clinic in place for last 6 years. Standard process in place.					
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.	Will start recording this in April 2011 for secondary care specialist staff. (KF & HW). Primary care staff have access to training but this is not counted across individual practices.					
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) Link person to be agreed. The first meeting of the PIDPAD group is to be in May 2011 (KF/ AP in attendance). b) QOF depression screening questions backed up by HADS questionnaire. Previous mild to moderate mental health Local Enhanced Service to emphasise the use of HADS screening tool. Use of Moodjuice website and Beating the Blues interactive computer program. Considerable work carried out through LTC Collaborative with development of the Self care Toolkit and "My Support Plan". In FV, print run on order for self care toolkit and support plan for distribution to all primary care practices. LTC eHealth national bid received to develop SID site to improve patient usability and storage of self management materials.					
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) The chair of the Diabetes MCN Education Subgroup oversees the delivery of local patient education programmes. b) A range of solutions available for T2DM (varies across GP Practices). T1DM education is via secondary care. (KF). c) Daily feedback questionnaires completed for NewDEAL. NewDEAL patient stores also available via NES d) Patients attending NewDEAL is recorded. e) Service Information Directory website/ system developed, now with improved patient usability and storage of self management materials.					

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3.11.2 The local insulin strategy is reviewed	June 2011	The local insulin strategy is published	Insulin strategy published.					
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	Information on CHO is added to SCI-DC as free text and is not auditable. Will discuss changes in SCI-DC to automate any audit with Mary Scott.					
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	8 children on CSII pump therapy 32 adults on CSII pump therapy and 7 people who are being considered or have expressed an interest in being considered.					
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	Patients seen in A&E. Weekly list of patients printed for follow-up by DSN by phone. Will consider national findings when available. Will also benchmark local performance with national situation.					
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	DKA pathway published. Will consider national findings when available.					
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) To be discussed with Jim McLaughlin Q2 2011. b) Awaiting feedback from SDG.					
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 inpatient areas have appropriate guidance included with diabetes monitoring sheets/ insulin prescribing sheets.					
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	An initial half day workshop on diabetes for staff from care homes was held in 2007. This was well evaluated and six monthly study sessions for care home staff will be commenced in 2011 led by DSNs.					
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) Process to be led by A. MacKenzie during 2011 and supported by consultant colleagues where necessary. b) The number of people recruited to the SDRN register is recorded. This is also on target.					

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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.	a) FV-wide patient awareness/ education event planned for Q.4. 2011. Diabetes service information now available on internet via FV Service Information Directory. b) MCN will take PFPI input via FV Public Involvement Network. Patient input ongoing via education sub-group (development of patient leaflets etc).					
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) Primary care and secondary care leads identified. b) Patients have been involved in the MCN approving education programmes. We have previously asked patients to outline their thoughts on living with diabetes as part of educational programmes but have not done this recently. We currently have two patient representatives involved with the Diabetes MCN Education Subgroup.					
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.	No MCN annual report produced in 2010/2011. MCN work plan to be endorsed by Medical Director in Q.2 2011. Documents will be submitted when they are published. (DM)					
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) MCN annual report not yet produced in 2010/2011. b) FV patients were invited to attend a Diabetes voices programme but no one wished to participate.					
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) Lead clinician post is currently vacant. MCN Manager remains in post. Future leadership options under consideration by Medical Director. b) Links in place between the MCN and the service. c) MCN work plan to be endorsed by Medical Director in Q.2 2011.					
5.1.3.4 **NHS Boards will accredit their diabetes MCNs**	September 2012	Accreditation by the NHS has been granted	MCN not yet accredited.					

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5.1.4.1 Telehealth opportunities will be explored and solutions embedded into pathways of care	January 2013	Telehealth solutions are used where appropriate	DM to open discussions with Anne Alison in Q2 2011.					
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. Gillian Booth (Acute Services pharmacist) & Fiona Stewart (Lead Pharmacist - Primary & Community Care) on MCN membership. b. Community Pharmacies are utilised to promote/ publicise National and local Diabetes information/ leaflets. In the future, with the recent implementation of the Chronic Medication Service, the final part of the new Pharmacy Contract, we hope to develop & implement local guidance for Community Pharmacists to enable them to help diabetic patients get the best results from their medicines.					

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Comments http://www.nhsforthvalley.com/home/Services/A-Z/Diabetes/MCN/Diabetes_MCN_Main.html

Progress Report Key

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