Diabetes Action Plan 2010
NHS Grampian Progress Report January 2011

Report completed by: Lorraine Urquhart Report date: 06/04/11

Action Point (Summary)	*Month*	*Measured by*	*Responsibility for Action*	*Action Points*		*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) 50% will have documented evidence of having received their foot risk score c) 80% of those who have low risk feet have documented evidence of having received education and literature to support self-management.	Kathleen Spence Kathleen Spence Kathleen Spence	a) Integrated screening (retinal and foot) has been implemented by Aberdeen City and is about to go live in Moray. b) Road shows are about to be commenced through Duncan Stang and local teams to raise awareness and promote foot screening. c) All patients who attended integrated screening receive education and literature at the time of their appointment by a nurse.					
3.3.2 There is an identified individual with a responsibility for educating and supporting primary care podiatrists	June 2011	Individual is in post	Kathleen Spence	There is a an individual in post who is managed by the Diabetes Podiatry Co-ordinator					
3.4.2 The benefits of adopting the approach taken by community optometry pilots will be considered	June 2011	There is evidence of interaction with community optometry services	DRS Management Group	Not applicable in NHS Grampian, although we hope to enable community optometrists to have access to SCI-DC in 2011 as NHS Grampian has been given funding to enable community optometrists to have secure access to the NHS Grampian intranet. This will enable them to see which patients are attending retinal screening and allow them to look at the patient's images if their own clinical examination causes them concern.					
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	Dr Ken McHardy	Guidance on referral to the renal clinic, prepared by our local nephrology team, is included in the Grampian Diabetes Guidelines.					

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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	DRS Management Group Dr Andy Keen Prof Pearson	a) This subject is covered by the Diabetes Annual Professional Conference. b) an agreement is in place with the retinal screening programme that woman with diabetes attend 3 times during pregnancy. The DRS are given details of the dates when the women will be at a particular gestation and the DRS Team arrange the screening for Tuesday afternoon when the women are attending the Combined Clinic. Confirmation required to Dr Gray's Hospital. c) The programme to detect and treat gestational diabetes is under review following the publication of SIGN 116. Discussions are ongoing between the Obstetric and Medical Teams. Meantime we follow the screening and guidelines as per SIGN 55. d) All women with gestational diabetes are seen by the Dietitian who gives advice on lifestyle both during and after pregnancy. A post natal oral glucose tolerance test is organised either in the community or at AMH. The regional guidelines advise that women with GDM should be screened for diabetes on a regular basis.					
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	Lorraine Urquhart	This is to be commenced.					
3.8.2 **Each NHS board will develop and publish a transitional care plan with measurable outcomes**	April 2011	a) A transitional care plan is published *b) Measurable outcomes to be determined by Paeds Lead*	Dr Andy Keen Edna Stewart	Within NHSG we have a dedicated transitional nurse who develops clear plans for transition.					

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3.9.1 **There will be adequate training of staff in psychological skills**	May 2011	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.	Dr Andy Keen	In NHS Grampian, we currently employ a stepped system of training. We aim to provide many health professionals working with young people and adults with diabetes a solid foundation in behaviour change skills and somewhat fewer with advanced skills. Our training is open to all primary and secondary care staff working in diabetes. Over the past two years, 52 health professionals who work with young people who have diabetes have attended a behaviour change course lasting at least half-a-day, and 142 health professionals who work with adults.Currently, advanced training in behaviour change is delivered to 2 paediatric specialist nurses (fortnightly); 3 community dieticians (monthly), and 5 diabetologists in training (6-weekly).					
3.9.2 **National initiatives are developed and shared**	April 2013	a) MCNs acknowledge receipt of the PIDPAD report b) An analysis of local resources for emotional support is available	Dr Andy Keen	The MCN acknowledges receipt of the Pid-Pad report. We are lucky enough to have a paediatric psychologist employed in this project and in fact two of our staff (Dr Andy Keen and Dr Ann Gold) are overseeing it's successful completion on behalf of the SDG. We have begun planning for an analysis of local emotional support for our patients, including wasy in which this is easily accessible to them. In the meantime, we have existing and fruitful professional links with mental health services to facilitate necessary support.					
3.10.3 **Education will be improved at local level**	April 2011 December 2011 June 2012 April 2011	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		The Diabetes Nurse Manager has been appointed to oversee patient education on behalf of the MCN. This is currently being worked upon Not commenced Not commenced but will be part of QOF in the future so a link from this to SCI-DC would be useful.					
3.11.2 **The local insulin strategy is reviewed**	June 2011	The local insulin strategy is published	Dr Ken McHardy	Local guidance on the range and use of insulins, including insulin initiation, is included in the Grampian Diabetes Guidelines (2009) and has been updated in line with SIGN 116 for the revised edition due for launch in 2011.					

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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	Leanne Gardner	Teaching of CHO counting to patients with type 1 diabetes as a group session commenced in March 2006 and approx 10 courses are run per year. CHO counting is not delivered to patients with type 2 diabetes. Since we started we have trained 327 patients in the group sessions although there is an unidentified number who have been taught on an individual basis in the community. The Community Dietetic Department is actively involved in providing training (based on training needs assessments and identified areas of poor practice) and resources in all aspects of nutrition to care home staff in collaboration with other HCP where appropriate					
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	Lorraine Urquhart	Currently there are 63 patients on insulin pump within NHSG. Proposals for putting 12 new patients on a pump per year are is in the process of being agreed.					
3.12.3.1 The incidence of hypoglycaemia that results in emergency admissions will be reduced	December 2010	A care pathway of people who experience severe hypoglycaemia will be published	Dr Ann Gold	A national protocol is being developed and will soon be rolled out. We plan to wait until this is available before updating the guidelines.					
3.12.3.2 The incidence and care of DKA will be improved	December 2010	A care pathway of people for the presentation and management of DKA will be published	Dr Ken McHardy	As the DKA care pathway has just been published then ways of implementing are being explored. Contact has been made with the Unscheduled Care MCN to ensure implementation.					
3.13.1.1 There will be initiatives to improve care for inpatients	June 2012	A foot protection programme for patients with diabetes on general wards will be published	Kathleen Spence	This requires development but work has commenced					

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3.13.1.2 Mechanisms to record the number of inpatient wards with specific hypo guidelines are developed	June 2012	The number of wards is reported	Louise Black/Linda Caie	There are hypo boxes in each ward within NHS which have guidelines in them. Currently an audit is taking place to identify usage.					
3.13.2.1 Local provision of education to the staff working in institutional settings is improved	December 2010	There is evidence that staff from institutional settings, including care homes, have access to educational events	Education Group	A number of education sessions have been held in conjunction with local authority carers. Further work for those staff within institutional setting requires completion.					
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.	Dr Mark Houliston Dr Prakash Abraham	The revised Diabetes guidelines within NHSG are at a final draft and are to be completed by May 2011.					
4.1.2 Organisations are able to communicate effectively through the development of a communications strategy	August 2011	a) There is evidence that an 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.	Lorraine Urquhart	We hold an annual Diabetes Professional Conference. The Diabetes MCN is currently working with the Scottish Health Council to further develop and explore patient involvement in order that we get more people interested.					
4.2.1 An individual to coordinate professional education will be identified	January 2011	a) The individual is in post b) There is evidence that patients have been involved in the provision of staff education programmes	Dr Kcn McHardy	Dr Ken McHardy leads on the education group which is part of the MCN. Dr McHardy is the Asst Clinical Lead of the MCN. We are exploring the involvement of patients through use of a questionnaire to deliver improvements in service delivery. Patient Forum					
4.2.2 SDG and Diabetes MCNs will consider how to share best practice	January 2013	Best practice in delivering person-centred consultations is shared with SDG	Dr Mark Houliston	Ongoing					

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5.1.2 **Diabetes MCNs should ensure that people living with diabetes are fully engaged in the MCN's activities**	April 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 Forum Lorraine Urquhart	The Diabetes MCN has a very active patient forum of which two representatives are on the Diabetes MCN Board. Diabetes voices is currently being revamped and it will be explored once this is completed. This will be taken forward by the patient forum.					
5.1.3.1 **NHS Boards maintain the effectiveness of MCNs**	April 2011	a) There is evidence that Boards consult with MCN representatives when planning diabetes service improvements b) The Board endorses the MCN's workplan	Lorraine Urquhart	Diabetes MCN in NHSG are regarded as the expert group within Diabetes. The Diabetes MCN is integral and embedded into the planning process of NHS Grampian. This is submitted annually to the Board through the Head of Service Development.					
5.1.3.4 **NHS Boards will accredit their diabetes MCNs**	September 2012	Accreditation by the NHS has been granted	Lorraine Urquhart	In progress and will be complete by March 2012.					
5.1.4.1 **Telehealth opportunities will be explored and solutions embedded into pathways of care**	January 2013	Telehealth solutions are used where appropriate	Dr Sam Philip	NHS Grampian operate a telehealth service to Orkney patients which is extremely successful on a weekly basis.					
5.1.4.2 **Effective links will be developed with community pharmacy**	December 2010	a) There is community pharmacy representation on MCNs or other evidence of engagement with colleagues in community pharmacy b) Support measures for people with diabetes are publicised so they are readily available.	David Pfleger	This requires development, however, David Pfleger, Director of Pharmacy at NHS Grampian has been asked to be part of the MCN. This will require further development and would be interested to hear how other MCNs have developed this aspect with community pharmacy.					