Quality Care for Diabetes in Scotland
Diabetes Action Plan 2010
NHS Highland Progress Report January 2011

Report completed by: G Sell Report date: 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.	Currently 70% with risk score. Argyll and Bute CHP action plan needed. Other CHPs to emphasise with GP practices use of SCI-DC tool. Escro link to tool is in use..			***A***		
3.3.2 There is an identified individual with a responsibility for educating and supporting primary care podiatrists	April 2011	Individual is in place	There is a Podiatry Diabetes Coordinator for NHSH supported by CHP placed Diabetes Specialist Podiatrists					***B***
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	Pathways in place in North. Argyll and Bute to confirm links with Glasgow.				***G***	
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) Continuous education programme underway for secondary care teams. Primary care education through diabetes symposium and PLT sessions b) In place c) In place. Initial review of SIGN 116 guidance complete. Work commencing on business case for implementation d) Needs addressed			***A***		
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	Requirement for current position to be checked.					
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) Transition clinics in place. Care plans to be agreed b) To be agreed			***A***		
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.	Training underway			***A***		
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	Dr W Van-Reit To be addressed			***A***		

Action Point (Summary)	*Month*	*Measured by*	*Comments on Progress*			*R*	*A*	*G*	*
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) Local education coordinator in post b) In progress c) Not started d) Not started e) Not started				*A*		
3.11.2 **The local insulin strategy is reviewed**	June 2011	The local insulin strategy is published	Complete						***B***
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	Not started; pending further staff training	[redacted]					
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	Currently 22 people – reported in January with Scottish Diabetes Survey. No paediatric pumps.						***B***
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	Initial audit of individuals attending A&E with severe hypoglycaemia underway.				***A***		
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	National DKA guideline implemented. OP sick day rules guidance provided					***G***	
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) No in-patient podiatry b) Await guidance from national Inpatient group				***A***		
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	Audit of in patient hypoglycaemia complete. Work ongoing on professional education and provision of hypoglycaemia guidelines.				***A***		
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	Await outcome of DEAG survey	[redacted]					
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.	Guidelines updated but yet to be published. Target May 2011 900					***G***	

Action Point (Summary)	*Month*	*Measured by*	*Comments on Progress*		*R*	*A*	*G*	*
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) Web site being implemented. Should be available during May 2011.		***R***			
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) Local coordinator in place b) Patient representative on DET group				***G***	
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	a) Patient representatives on Network group b) No annual report			***A***		
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	Lead Clinician to be appointed.					
5.1.3.4 **NHS Boards will accredit their diabetes MCNs**	September 2012	Accreditation by the NHS has been granted	No plans for accreditation					
5.1.4.1 **Telehealth opportunities will be explored and solutions embedded into pathways of care**	January 2013	Telehealth solutions are used where appropriate	Possibility of joining in with NHS Lothian on the research project 'Telescot'. Raigmore exploring opportunities to use telecare for clinics in Caithness			***A***		
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	Community Pharmacy manager is included in Diabetes planning and reviews					B

Diabetes Network Chair

Dr Ian Scott, Clincal Lead SE Highland CHP

Email Ian.scott3@nhs.net
Tel. no. 01463 706956

Diabetes MCN Manager

Gavin Sell, LTC Manager SE Highland CHP
Email Gavin.sell@nhs.net
Tel. no. 01463 704600

Lead Board Representative

Dr Ian Bashford, Board Medical Director
Email Ian.bashford@nhs.net
Tel. no. 01463 704936

Diabetes MCN website URL

Comments Website is currently being re-developed – new URL not yet provided.

Progress Report Key

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