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

Report completed by: Helen Alexander Report date: 19th April, 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<br>a) 80% will have a recorded foot risk score in previous 15 months.<br>b) 80% have documented evidence of having received information relevant to their foot risk. | a) Foot risk score recorded for 53% in January 2011.<br><br>b) Enhanced service includes provision of this information | | | | * | | |
| **3.3.2 There is an identified individual with a responsibility for educating and supporting primary care podiatrists** | April 2011 | Individual is in place | Duncan Stang takes a lead on this locally as well as nationally. | | | | | | * |
| **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 | Guideline being finalised. | | | | | * | |
| **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<br>b) Systems are in place to ensure appropriate retinal screening during pregnancy in accordance with SIGN 116<br>c) Evidence that programmes are in place to detect and treat gestational diabetes<br>d) Post-partum lifestyle advice and regular screening is recorded for those who had gestational diabetes | a) Guideline being finalised, education sessions will be arranged to follow.<br><br>b) Retinal screening service has facility for three month recall during pregnancy.<br><br>c) Working with obstetrics re identification of patients.<br><br>d) Gestational diabetes screens on SCI-DC will be used, lab links to SCI-DC imminent. | | | | | * | |
| **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 | Needs assessment questionnaire being widely distributed across BME communities at present. | | | | | * | |
| **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<br>*b) Measurable outcomes to be determined by Paeds Lead* | Transition service model designed and being implemented, including educational outcomes and patient satisfaction measures | | | | | * | |
| **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. | PID/PAD psychologist undertaking training at present. Evaluation includes process and outcome measures. | | | | | * | |
| **3.9.2 National initiatives are developed and shared** | April 2012 | a) MCNs identify an individual to link with PIDPAD<br>b) An analysis of local resources for emotional support is available and posted on a patient-accessible website | a) MCN Manager and Lead Clinician both link.<br>b) Resources collated by PID/PAD psychologist, being posted on MCN web site. | | | | | * | |

| *Action Point (Summary)* | *Month* | *Measured by* | *Comments on Progress* | | *R* | *A* | *G* | * |
|---|---|---|---|---|---|---|---|---|
| **3.10.3 Education will be improved at local level** | April 2011<br><br>December 2011<br><br>June 2013<br><br>April 2012 | a) There is an identified individual who will oversee the delivery of local patient education programmes<br>b) There is evidence that a range of education solutions, including structured education programmes is available<br>c) A user assessment in relation to patient education has been undertaken as is available<br>d) The proportion of patients attending structured education programmes is recorded<br>e) Support measures for people with diabetes are publicised so they are readily available. | a) Diabetes Service Manager responsible, secretarial support in place.<br>b) X-PERT (Type 2) and DAFNE (Type 1) available throughout Lanarkshire.<br>c) Structured education programmes continuously evaluated.<br>d) Attendance recorded for both structured education programmes.<br>e) Support information available via posters and web site. | | | | * | |
| **3.11.2 The local insulin strategy is reviewed** | June 2011 | The local insulin strategy is published | Insulin strategy will be updated in line with new glycaemic control guideline. | | | | * | |
| **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 | Awaiting facility to record this on SCI-DC | | | | * | |
| **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 | Recorded for ongoing audit. | | | | | * |
| **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 | Awaiting outcome of national work. | | | | * | |
| **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 | Scottish DKA guideline being introduced across Lanarkshire. | | | | * | |
| **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<br>b) Initiatives from the inpatient group as agreed by the SDG will be implemented | MCN Foot group planning to implement SDG-endorsed report, *'Putting Feet First'* Awaiting output from national inpatient group. | | | | * | |
| **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 | Guideline being finalised. Implementation plan to be agreed. | | | | * | |
| **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 | All care settings, including care homes are invited to educational sessions and the number of representatives recorded. | | | | * | |
| **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<br>b) The number of people recruited to the SDRN register is reported. | a) New suite of guidelines being finalised, launch date September 2011.<br>b) Research Nurses record recruitment levels. | | | | * | |

| *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<br>b) There is evidence that MCNs are working with patient representatives to develop and disseminate resources. | a) Link with local support groups, presentations to Community Forums, patient information events planned.<br>b) MCN Patient group critiquing information resources and will advise on dissemination. | | | | * | |
| **4.2.1 An individual to coordinate professional education will be identified** | April 2011 | a) The individual is in place<br>b) There is evidence that there is ongoing patient involvement in the delivery of staff education programmes. | a) Diabetes Service Manager<br>b) Patients involved e.g. in all 'Diabetes Dilemmas' education sessions. | | | | | * |
| **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. | Workplan available, annual report due September 2011. | | | | * | |
| **5.1.2 Diabetes MCNs should ensure that people living with diabetes are fully engaged in the MCN's activities** | June 2011<br><br>April 2011 | a) There is evidence in the annual report that patients are involved in local service development<br>b) The number of people attending a Diabetes voices programme is recorded | a) Patient representatives on MCN groups, Patient Group advises on developments.<br>b) One course completed, course now tailored to groups. | | | | | * |
| **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.<br>b) There is evidence that Boards and operating divisions consult with MCN representatives when planning diabetes service improvements<br>c) The Board endorses the MCN's workplan | a) MCN Lead Clinician and Manager in post.<br><br>b) MCN leads diabetes service developments in conjunction with NHS Board and operating divisions.<br>c) MCN workplan submitted to Clinical Quality and Modernisations Boards for approval. | | | | | * |
| **5.1.3.4 NHS Boards will accredit their diabetes MCNs** | September 2012 | Accreditation by the NHS has been granted | Accreditation process being finalised. | | | | * | |
| **5.1.4.1 Telehealth opportunities will be explored and solutions embedded into pathways of care** | January 2013 | Telehealth solutions are used where appropriate | DRS autograding being considered, SCI-DC patient-held record in use, patients participating in SCI-DC record access project. | | | | * | |
| **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 | Examples - Head of Prescribing involved with all guidelines, has advised on prescription cost savings, locality pharmacists involved in implementation of blood glucose monitoring guideline. | | | | | * |

| | |
|---|---|
| **Diabetes Lead Clinician** | Dr Sue Arnott,<br>St Luke's Medical Practice, Carluke Community Health Centre,<br>40 Chapel Street, Carluke ML8 4BA. |
| *Email* | Susan.Arnott@lanarkshire.scot.nhs.uk |
| *Tel. no.* | 01555-752150 |

| | |
|---|---|
| **Diabetes MCN Manager** | Dr Helen Alexander,<br>Red Deer Centre, Alberta Avenue,<br>Westwood, East Kilbride, G75 8NH |
| *Email* | Helen.Alexander@lanarkshire.scot.nhs.uk |
| *Tel. no.* | 01355-593467 |

| | |
|---|---|
| **Lead Board Representative** | Alan Lawrie,<br>Director, South CHP,<br>Strathclyde Hospital, Airbles Road, Motherwell, ML1 3BW. |
| *Email* | Alan.Lawrie@lanarkshire.scot.nhs.uk |
| *Tel. no.* | 01698-245194 |

| | |
|---|---|
| **Diabetes MCN website URL** | http://www.nhslanarkshire.org.uk/Services/Diabetes/Pages/Default.aspx |
| *Comments* | Web site in the process of being updated. Progress limited by factors unrelated to MCN. |

## Progress Report Key

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