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

Report completed by: Mary Scott Report date: 31 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.	With the change over from GPASS and delay in roll-out of back population of SCI-DC to primary care systems, this is unlikely to be achieved by the end of the year				x		
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 have been delays in recruitment, but a process for supporting primary care podiatrists has been identified					x	
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	Joint diabetes and renal clinics are held in all 3 adult acute hospitals					x	
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	Workshops and plenary sessions have been included in the annual professional conference Advice on retinal screening in pregnancy is included in the Lothian diabetes handbook The Lothian diabetes handbook includes advice on screening for GDM Advice on postpartum management of GDM is included in the Lothian diabetes handbook.					x x x x	
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	Work on this has started					x	
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	Adolescent clinics are held in a variety of clinics across Lothian. Advice on management is included in the Lothian diabetes handbook					x	
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.	Still to be established					x	
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)Lothian is one of the PIDPAD adolescent sites b) This will be included in the 2011/12 workplan					x x	

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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.	a) A dietitian and diabetes facilitator currently undertake this b) DAFNE, DESMOND, RECLAIM and conversation maps available across Lothian c) regular assessments of the patient education courses is undertaken and is recorded. d) DAFNE attendance is recorded on SCI-DC Clinical and DESMOND on a customised database e) information for patients is on the patient page of the NHS Lothian website				x x x x	
3.11.2 The local insulin strategy is reviewed	June 2011	The local insulin strategy is published	The strategy is due for revision and will posted on the diabetes webpages				x	
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	The figures are recorded, and can be reported in the annual report				x	
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	This is available in the Scottish Diabetes Survey				x	
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	A subgroup of the MCN has been working with the Scottish Ambulance Service to take this forward				x	
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	A DKA ICP is available in all acute centres and the national DKA checklist is being considered for use				x	
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) This is still to be developed b) Initiatives from the group are awaited.				x x	
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	This will be an outcome of the work of the inpatient audit nurse				x	
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	Staff from institutional settings attend the annual professional conference and the Pan Lothian diabetes programmes				x	
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.	The Lothian Diabetes Handbook has been updated in line with SIGN 116. This will be included in the annual report				x	x

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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.	An annual patient conference is held which includes a stand with MCN information and attendance by the SDRN research nurse. There has been patient input in the development of a variety of resources. These are available at patient conferences.					x x	
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.	There is an individual in place Members of the LDRG are allocated a session in the Management of Diabetes programme and facilitate workshops at the annual professional conference					 x	x
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.	The 2010/11 annual report and updated workplan will be submitted					x	
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	The Lothian Diabetes Representative Group submits a report for the annual report. One iteration of Diabetes Voices has occurred so far and members of the LDRG attended it					x x	
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	Yes at present. The appointment of a new lead clinician has been approved by the Board. The workplan has been endorsed					x x x	
5.1.3.4 **NHS Boards will accredit their diabetes MCNs**	September 2012	Accreditation by the NHS has been granted	The MCN was formally accredited by NHS Lothian in October 2010						x
5.1.4.1 **Telehealth opportunities will be explored and solutions embedded into pathways of care**	January 2013	Telehealth solutions are used where appropriate	A research project is currently assessing the benefits of using telehealth to help people with diabetes manage blood glucose and blood pressure					x	
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	There is a pharmacy subgroup of the MCN with community and primary care pharmacy representation. The group chair sits on the						x

			LDSAG and provides a report for the MCN Annual Report					

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Comments

Progress Report Key

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