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

Report completed by: Marie O'Sullivan Report date: 30/03/2011

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.	22% of patients have a foot risk score recorded within the previous 15 months.					
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 identified					
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	Diabetes Specialist Nurse to develop pathway in line with current guidelines.					
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	Planning to develop training package which will include powerpoint education available to all staff. All pregnancy patients receive regular DRS screening throughout pregnancy as per local protocol. Programme in place audit tool to be developed to evidence this. As per SIGN 116 GP practices currently do this.					
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	Continued ethnic monitoring is provided via DRS services.					
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*	Diabetes Specialist Nurse to develop transitional care plan with Paediatric and Diabetes Consultant.					
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.						
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						

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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.	Diabetes Specialist Nurse and Dietitian will be responsible for this. CHO counting courses in place. Type 2 education has been developed with courses run last year but is not currently running due to lack of staff. All patients were given questionnaires to complete after attending education courses. All patients who have attended education are recorded. Hand held records have been developed and patients currently receive these via their GP or at education sessions.					
3.11.2 **The local insulin strategy is reviewed**	June 2011	The local insulin strategy is published	DSN is developing this.					
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	Current CHO counting programme is in place.					
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						
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	Ongoing audit of patient admission with hypo which is currently being evaluated.					
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 bundle to be implemented by end of March 2011.					
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						
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 wards given hypo guidelines and information along with hypo packs. Audit tool available.					
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						

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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.	NHS Orkney have adopted NHS Grampian guidelines to ensure standardised equitable care ensuring best practice.					
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.	NHS Staff regularly attend local DUK support groups. Recently DUK have been involved in the consultation process of the diabetes service planning with Senior Management attending DUK session to discuss with patients. Patient representatives are members on the MCN group. All information can then be disseminated to the local DUK support group. DUK have also been involved with producing our Hand held records and materials have been provided from DUK to support this.					
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.	Diabetes Specialist Nurse and Dietitian will co-ordinate professional education along with Learning Department. All education materials are viewed by DUK support group prior to education sessions being available.					
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.	A local action plan will be in place by the end of March 2011 which can be submitted to 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	DUK support group are currently involved with the consultation for diabetes services and have received the report for this which was presented at a recent DUK support group meeting. Patient feedback is also included as part of the consultation. Patient representatives attend the MCN meetings. No members currently attending the Diabetes Voices programme.					

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5.1.3.4 **NHS Boards will accredit their diabetes MCNs**	September 2012	Accreditation by the NHS has been granted						
5.1.4.1 **Telehealth opportunities will be explored and solutions embedded into pathways of care**	January 2013	Telehealth solutions are used where appropriate	All consultant clinics are held via Telemedicine between NHS Orkney and NHS Grampian.					
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 hospital pharmacy representatives on the current MCN group. There are 2 community pharmacies locally and there are local links within the diabetes team with them.					

Diabetes Lead Clinician Dr Sam Philip

Email sam.philip@nhs.net
Tel. no. 01224 552258

Diabetes MCN Manager Marie O'Sullivan
Nickie Milne, MCN Administrator

Email marie.osullivan@nhs.net nichola.milne@nhs.net
Tel. no. 01856 888077 01856 888023

Lead Board Representative
Marthinus Roos

Email marthinus.roos@nhs.net
Tel. no. 01856 888224

Diabetes MCN website URL

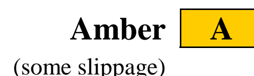
Comments

Progress Report Key

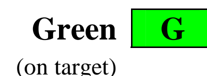
Not Started

Red

(at risk)

Amber 

(some slippage)

Green 

(on target)

Completed