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

Report completed by: Kerry Russell 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.	Joint foot/eye screening programme due to commence end April which is anticipated to further improve foot screening take- up.					
3.3.2 There is an identified individual with a responsibility for educating and supporting primary care podiatrists	April 2011	Individual is in place	Podiatrist with special interest in diabetes is part of MDT diabetes team and MCN member.					
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	Follow NHS Grampian guidelines which are available on NHS Shetland website.					
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	Now have identified midwife lead for diabetes, who is member of MCN. Maternity Department has adopted SIGN 116. Providing training for team on gestational diabetes. Pre-pregnancy planning sessions held. Retinal screening in each trimester of pregnancy. Those who have had gestational diabetes are referred back to ARI and diabetes clinic post-partum.					
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	Due to small numbers individual case conferences are held for specific patients.					
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*	Action added to MCN work plan 2011-12 to write to Consultant Paediatrician regarding transitional care plan.					
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.	Clinical lead, Specialist Nurse and other members of Diabetes MDT undertaking psychological skills training with Clinical Psychologist.					

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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	Clinical lead acts as link for PID PAD There is no local voluntary diabetes group. Action added to MCN workplan 2011-12 to signpost patients to emotional support available e.g primary care counselling service, local LTC self management programmes, Healthcare Chaplain etc					

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.	DSN and Dietitian are overseeing local patient education programme. Attendance and evaluation are recorded. Promoting My Diabetes My Way. Action added to workplan to widely publicise support available through posters and leaflets . Action added to MCN annual work plan to include patient information on Board internet when upgrade complete.					
3.11.2 **The local insulin strategy is reviewed**	June 2011	The local insulin strategy is published	Local protocol currently being consulted on.					
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	Dietitian is devising ½ day structured programme with input from patients. No. of participants will be recorded and reported in MCN annual report.					
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	Patients referred to NHS Grampian but eligibility criteria have been changed. Number of patients on pumps recorded in diabetes survey.					
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	Small numbers tackled on an individual basis. Guidance detailed on discharge sheet of new diabetic inpatient paperwork.					
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	Adopting new Scottish DKA pathway with national audit tools.					

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	Podiatrist with special interest in diabetes is currently working on pathways for foot protection for inpatients. A&E, and Charcot Foot					
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	New diabetic inpatient paperwork which includes specific hypo guidelines is being developed and will be piloted shortly then rolled out to all inpatient wards (4).					
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	A programme of education for social care workers is in place.					
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.	Follow NHS Grampian guidelines, live link on NHS Shetland website. Currently 0 people recruited to SDRN register.					

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.	Local services promoted through education events. Board Communication Strategy in place, due for review Jan 2012.					
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.	DSN co-ordinates professional education with support from staff development department.					
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.	Plans to submit MCN annual report and work plan 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	Patient Representative active in MCN. No of people attending Diabetes Voices is currently 0.					
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	Uncertain future for MCN due to possibility of administrative/co-ordinating function being reduced.					

5.1.3.4 NHS Boards will accredit their diabetes MCNs	September 2012	Accreditation by the NHS has been granted	Collection of evidence for MCN accreditation has begun.					
5.1.4.1 Telehealth opportunities will be explored and solutions embedded into pathways of care	January 2013	Telehealth solutions are used where appropriate	Exploring vc opportunities with consultants in Aberdeen. Remote access is considered as part of the Board's e-health strategy.					
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	The MCN is actively recruiting a local community pharmacist to join its membership.					

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Diabetes MCN website URL http://www.shb.scot.nhs.uk/initiatives/mcn/Minutes190905.asp

Comments NHS Shetland's website is currently being upgraded and the MCN page will be updated once the upgrade is complete.

Progress Report Key

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