

Progress Report KeyNot Started Red **R**
(at risk)Amber **A**
(some slippage)Green **G**
(on target)Completed **NHS Fife Progress Report – March 2009**

<i>Action Point (Summary)</i>	<i>Month</i>	<i>Comments on Progress</i>		R	A	G	*
1.5.1 Improve collection of data on ethnicity to over 50% of patients.	December 2006	There continues to be improvement in the recording of ethnicity data compared to the previous progress report. Survey data indicates that ethnic data is recorded in 13.3 % (2132) of the diabetes population compared to 7.8% (1230) reported in the previous progress report.					
4.2.1 Monitor first outpatient appointments, routine outpatient waiting times and DNA rates.	December 2006	New GP referrals seen at clinic: Average waiting time 37 days (90 th percentile: 69 days) New to Follow Up split: 141 New to 2491 Follow Up (All Referral Sources) The total of all patients seen was 2632 and 840 DNA's of which 36 were DNA's giving a total DNA rate of 31.9 % and a new DNA rate of 1.37% (All Referral Sources)					
5.1.2 Over 95% of patients with data recorded for CHI, type of diabetes and date of diagnosis.	December 2006	Fife data exceeds the targets set: <ul style="list-style-type: none"> • Use of CHI (100%) • Type of diabetes (99.8%) • Date of diagnosis (99.4%) 					
1.1.2 Work towards reducing incidence of diabetes emergencies in Type 1 diabetes.	March 2007	All DKA admissions continue to be assessed by a DSN or Consultant. The national ICP for DKA is being applied in care settings for people with DKA.					
2.1.1 Implement DRS programme.	March 2007	In Fife we have fully implemented the DRS programme.					
3.1.1 Produce an 'insulin strategy'.	March 2007	An insulin strategy has been produced and approved by the Area Drugs and Therapeutic Committee and available on Fife ADTC website					
5.1.1 Publish expected prevalence and identify gaps in service provision.	March 2007	The current prevalence rate is 4.5 % (16076 people with diabetes). This is an additional 390 people diagnosed with diabetes since the last reporting period.					
8.1.2 Health improvement resources available to frontline staff.	March 2007 *	There continues to be extensive health improvement resources available to front line staff in Fife. This ranges from an array of information resources and services, as well as access to a wide range of health improvement educational programmes.					
6.1.2 Produce a diabetes education strategy informed by a training needs analysis.	April 2007	An educational strategy has been completed and presented to the Diabetes MCN Board. The diabetes scoping exercise undertaken has informed a training needs analysis.					
1.2.2 Staff training courses informed by behaviour change models and the importance of patient empowerment.	April 2007*	15 members of staff have completed the Doing Diabetes Better Course.					
4.1.2 Map current pattern of service delivery and produce a strategy to implement local pathways of care.	June 2007	A clinical strategy has been developed to further shape and deliver improved diabetes services. This work has been complemented by the production of a care pathway. Significant work is ongoing to "shift the balance of care" in support of improved diabetes services in community and primary care settings. Improved diabetes specialist resources					

		have been put in place in each of the CHP's – Diabetes Specialist Nurses; improved dietetic services and enhanced podiatry resource in one CHP.					
4.2.2 Training and support mechanisms in place for lay members of MCNs.	June 2007 *	The Diabetes Voices programme has been implemented in Fife for lay members. Further support for lay members is likely to take place in light of Scottish Government guidance issued re support for volunteers and people involved in patient focus /public involvement activities					
1.1.3 Improve access to out of hours diabetes advice for families with children with diabetes.	September 2007	There is an out of hours advice service in place under the Diabnet MCN.					
1.1.4 Improve patients' experience of transitional care between children's and adult services.	December 2007	Guidance on transitional arrangements have been produced and are currently in draft form. This is being led by Diabnet.					
5.1.3 Over 80% patients to have a recent record of eGFR.	December 2007	Results indicate that 8.8% of patients had eGFR recorded within the last 15 months. However, 91.6% of patients had their serum creatinine results recorded within the last 15 months.					
8.1.1 Improve quality and completeness of BMI and smoking status data to over 80% of patients.	December 2007	Results indicate continuing improvement in reporting from the last reporting period for the following clinical indicators: <ul style="list-style-type: none"> • 89.2 % compared to 86.2% who had their BMI calculated in the last reporting period • 99.1 % compared to 98.1% of patients who had their smoking status recorded in the last reporting period 					
1.5.1 Improve collection of data on ethnicity to over 80% of patients.	December 2007	This question is repeated – see first data entry in this report.					
1.4 Undertake needs analysis of their population to identify disadvantaged groups.	March 2008	The Director of Public Health's Annual report, reports on an annual basis information about the disadvantaged and deprived groups within the local populations within Fife. Each CHP is also provided with a profile of their population from the Scottish Public Health Observatory. This informs decision making in relation to redesigning services which need to be targeted in relation to particular geographically deprived local populations.					
1.5.3 Undertake review of services for people with diabetes from minority ethnic communities.	March 2008	We continue to provide health promotion advice and opportunistic screening to groups by linking with health advocacy workers who have a role in supporting ethnic minority groups We have recently been allocated funding to undertake a review of services for people with diabetes from ethnic minority communities and look forward to taking forward this work.					
8.2.1 Support measures to reduce the risk of people developing diabetes.	March 2008*	There continues to be a comprehensive range of measures in place to improve the health of people within Fife and reduce the risk of people developing diabetes .e.g. Keep Well Programme; Smoking Cessation Services; Targeting of High Risk Groups					
8.2.2 Apply lessons learned from preventive medicine initiatives, such as Prevention 2010.	March 2008*	Lessons learned from Prevention 2010 are taken into account in the delivery of Keep Well programmes.					

1.3.2 Foot risk score recorded for at least 75% of people with diabetes.	April 2008	SCI DC survey data indicates incomplete foot risk data on SCI-DC system This is likely to reflect the different clinical systems used by podiatrists and the need for double entry of data into the SCI-DC system. Administrative support recently provided for data entry purposes. Clinical systems used by podiatrists indicate 81% of people have had a foot risk score recorded.					
3.3.1 All newly-diagnosed patients with Type 2 diabetes to be offered structured education within 3 months of diagnosis. Perform annual survey	May 2008	We have undertaken a review of structured education programmes and produced a business case to support the introduction of structured education programmes for both Type 1 and Type 2 diabetes which has been put to the Balance of Care Group. We continue to explore all avenues for funding this development. Group educational sessions continue to progressed and implemented by the DSN's and dietitians in the absence of funding to support implementation of structured education programmes.					

Comments

We continue to progress areas of work which support improved diabetes care, and report on progress in relation to the additional areas of work identified in the previous reporting period.

- Guidelines for Care Homes have been developed and will be launched at the Diabetes MCN Annual Conference to be held on the 28th April 2009. It is hoped that this initiative will be followed up with an educational event for care home staff to discuss the guidelines and how these should be used to improve the care of people with diabetes.
- Byetta Guidelines have been produced and are available on the Fife ADTC website
- The development of a "Sharps" protocol which is being piloted and audited in one CHP
- A short life working group has been established to develop a Fife wide policy on the Disposal of Community Sharps. This group is chaired by the Interim Diabetes MCN Manager.
- A patient leaflet Use of Personal Health Information and SCI-DC has been developed and distributed to make people with diabetes more aware of how and why their personal health information is held on SCI-DC and their rights in relation to this
- A SCI-DC Access protocol has been produced
- The Diabetes MCN have produced their annual report covering the period 2007-08
- We continue to progress the establishment and implementation of nurse led diabetes clinics within community settings as part of our shifting the balance of care work.

Greater Glasgow and Clyde Progress Report

<i>Action Point (Summary)</i>	<i>Month</i>	<i>Comments on Progress</i>		R	A	G	*
1.5.1 Improve collection of data on ethnicity to over 50% of patients.	December 2006	Diabetes LES full payments achieved for over 80% of Type II patients at 31/03/2008. This includes record of patient ethnicity.					X
4.2.1 Monitor first outpatient appointments, routine outpatient waiting times and DNA rates.	December 2006	Work is currently ongoing to collate appropriate data and ensure that this is accurate			X		
5.1.2 Over 95% of patients with data recorded for CHI, type of diabetes and date of diagnosis.	December 2006	All diabetes register patients will have CHI, type of Diabetes and date of diagnosis recorded.					X
1.1.2	March	Brian Kennon, Colin Perry and David McGrane performing			X		

Work towards reducing incidence of diabetes emergencies in Type 1 diabetes.	2007	audit of DKA management – keen to use this to implement the introduction of a ICP.					
2.1.1 Implement DRS programme.	March 2007	Fully implemented. Local pathways developed to encourage uptake. All people with diabetes have had the opportunity to be screened during the year. Work is ongoing to smoothly implement the merger with Clyde.					X
3.1.1 Produce an ‘insulin strategy’.	March 2007	An Insulin Strategy has been produced. Work is in progress to review and ensure it meets requirements across Glasgow & Clyde.			X		
5.1.1 Publish expected prevalence and identify gaps in service provision.	March 2007	Work is ongoing as part of implementing the LTC Strategy.				X	
8.1.2 Health improvement resources available to frontline staff.	March 2007 *	Health Improvement pathways for healthy eating, physical activity, weight management, smoking and alcohol have been developed. HI team will link with MCN to identify staff groups for dissemination. These pathways will complement the HI service training programme.				X	
6.1.2 Produce a diabetes education strategy informed by a training needs analysis.	April 2007	A training needs questionnaire has been developed in order to inform the strategy This has been circulated for opinion and is currently under discussion by the Staff Education subgroup of the MCN. In addition the group plan to consider the national Scottish Education Strategy.				X	
1.2.2 Staff training courses informed by behaviour change models and the importance of patient empowerment.	April 2007*	<u>Practice Nurse training</u> Two further Half-day Health Improvement Services Training for Practices delivering enhanced services will be delivered in autumn 2009. Two additional one day courses: “Challenge of Changing Behaviour” (for developing health behaviour change skills) will also be delivered autumn/winter 2009. dates will be confirmed and circulated directly to practices via GMS contract manager / practice Nurse advisor. <u>Health Improvement training for wider staff</u> Four ½ day Health Improvement services training will be delivered during 2009-10. This training is open to all NHSGGC staff and will cover all core HI services. Dates will be circulated via the MCN.				X	
4.1.2 Map current pattern of service delivery and produce a strategy to implement local pathways of care.	June 2007	CH(C)P areas are in process of reviewing their local pathway of care as part of the LTC implementation.				X	
4.2.2 Training and support mechanisms in place for lay members of MCNs.	June 2007 *	Diabetes voices training delivered to lay members. Heart, Stroke and Diabetes Patient Forum supporting lay members. The Health Improvement Senior PFPI has put together Top Tips for lay members. Diabetes voices update planned for Saturday 9 th May. A report to answer the various issues raised at Diabetes Voices training is in progress. It is hoped that this will be ratified by the MCN in mid May.					X
1.1.3 Improve access to out of hours diabetes advice for families with children with diabetes.	September 2007	There is a review of out of hours arrangements currently ongoing, which will include appropriate signposting of services and provision of appropriate information..			X		
1.1.4 Improve patients’ experience of transitional care between children’s and adult services.	December 2007	Each of the sites now has transfer clinics and most are appropriately age banded. . The Transitional Care in Adolescent Diabetes MCN Working Group is currently working towards the implementation of future transitional clinics.				X	
5.1.3 Over 80% patients to have a recent record of eGFR.	December 2007	As of 31/3/2008, e-GFR was recorded for 96.82% patients in board practices in the past 15 months.					X
8.1.1 Improve quality and completeness of	December 2007	As of 31/3/2008, BMI was recorded for 97.05% of patients and smoking status for 96.59% of patients in the last 15					X

BMI and smoking status data to over 80% of patients.		months.					
1.5.1 Improve collection of data on ethnicity to over 80% of patients.	December 2007	Diabetes LES full payments achieved for over 80% of Type II patients at 31/03/2008. This includes record of patient ethnicity. Recording for Type I unknown – this will be followed up.					X
1.4 Undertake needs analysis of their population to identify disadvantaged groups.	March 2008	The Diabetes MCN Ethnicity Group has identified a number of communities living in Glasgow to target based on prevalence, risk factors etc and on populations living in Glasgow. In particular the group has carried out a review of the demographics, definitions, prevalence of the BME population of Glasgow and Clyde. Other disadvantaged groups to be looked at include: the disabled and those with mental health issues or learning disabilities.					X
1.5.3 Undertake review of services for people with diabetes from minority ethnic communities.	March 2008	The Diabetes MCN Ethnicity Group is working to ensure that all people from minority ethnic communities are able to access diabetes services which are culturally competent. Meetings were held with the Muslim, Hindu, Sikh and Chinese Communities.					X
8.2.1 Support measures to reduce the risk of people developing diabetes.	March 2008*	Core Health Improvement services are operational across NHS GGC area, including Live Active, Shape-up, weight Management and smoke free services. Training and HI service pathways will encourage NHS staff to sign – post / refer patients who would benefit from these interventions. The Keep Well programme operates within 5 CH(C)P areas in NHSGGC. North, SW & East Glasgow are currently delivering GP led primary prevention approach, targeting individuals between 45-64 years of age in the most deprived data zones. Plans are progressing to further expand the primary prevention approach in west Dunbartonshire & Inverclyde.					X
8.2.2 Apply lessons learned from preventive medicine initiatives, such as Keep Well	March 2008*	Governance arrangements have been reviewed and implemented with closer integration with key planning structures, including MCNs. An evaluation framework has been developed and key learning will be disseminated when it emerges.					X
1.3.2 Foot risk score recorded for at least 75% of people with diabetes.	April 2008	Foot risk score is now recorded in Glasgow and some parts of Clyde. This will be monitored by analysis of the LES data. Currently data is well recorded for peripheral pulses (76.6% in Glasgow). Foot risk score will be available after the implementation of the new system.					X
3.3.1 All newly-diagnosed patients with Type 2 diabetes to be offered structured education within 3 months of diagnosis. Perform annual survey	May 2008	All newly diagnosed patients with Type II Diabetes across Glasgow and Clyde will now be offered the opportunity to take part in DESMOND structured education. This has recently been added as part of the LES. This will be monitored by analysis of the LES data.					X

NHS Lanarkshire Progress Report – March 2009

<i>Action Point (Summary)</i>	<i>Month</i>	<i>Comments on Progress</i>		R	A	G	*
1.5.1 Improve collection of data on ethnicity to over 50% of patients.	December 2006	The 2008 Scottish Diabetes Survey indicates that ethnicity was recorded for 34.8% of those with diabetes. A request for more recent data has been submitted as we think the figure considerably higher now that ethnicity is recorded for everyone with diabetes as part of the new enhanced service.			*		
4.2.1 Monitor first outpatient appointments, routine outpatient waiting times and DNA rates.	December 2006	Data is tabled every six months at Diabetes MCN Clinical Governance meetings.					*

5.1.2 Over 95% of patients with data recorded for CHI, type of diabetes and date of diagnosis.	December 2006	100% CHI recorded. Type of diabetes known for 99.8% of people and date of diagnosis recorded for 97.9%. (Scottish Diabetes Survey 2007).					*
1.1.2 Work towards reducing incidence of diabetes emergencies in Type 1 diabetes.	March 2007	Exploring how to more accurately record baseline level (currently reporting SMR1 data). Actions include DKA awareness in all patient education programmes and section in Type 1 chapter of patient education strategy.					*
2.1.1 Implement DRS programme.	March 2007	DRS programme continues to operate in all three community locations. Implementing local DRS arrangements following regional agreement changes. Mobile van commenced during 2008, but currently experiencing technical difficulties.					*
3.1.1 Produce an 'insulin strategy'.	March 2007	Insulin strategy had been finalised and signed off. Awaiting completion of NHS Lanarkshire web site upgrade to publish strategy.					*
5.1.1 Publish expected prevalence and identify gaps in service provision.	March 2007	Prevalence data has been published on PHO web site. Gaps highlighted by workforce mapping survey and Diabetes Service Development meetings currently being addressed via enhanced service and new community diabetes posts.					*
8.1.2 Health improvement resources available to frontline staff.	March 2007 *	Information has been posted to Diabetes MCN web site which is an evolving resource.					*
6.1.2 Produce a diabetes education strategy informed by a training needs analysis.	April 2007	Workforce survey completed, results being used to inform Education strategy (currently being drafted). New MCN Lead Clinician taking this forward.			*		
1.2.2 Staff training courses informed by behaviour change models and the importance of patient empowerment.	April 2007*	Motivational Interviewing training available to all NHS Lanarkshire staff via Health Promotion Dept. This will be further promoted within the suite of provision being developed by the MCN Education sub-group. 'Doing Diabetes Better' course held in March 2009.					*
4.1.2 Map current pattern of service delivery and produce a strategy to implement local pathways of care.	June 2007	Overall pattern of current service delivery has been mapped at two diabetes service development meetings. This was combined with the workforce survey results to secure funding for enhanced service and other major changes to pathways of care.					*
4.2.2 Training and support mechanisms in place for lay members of MCNs.	June 2007 *	Individual input and access to Diabetes UK lay training provision. Ongoing collaboration with other MCNs across Scotland.					*
1.1.3 Improve access to out of hours diabetes advice for families with children with diabetes.	September 2007	Currently via NHS 24. Need update on work that was planned via Scottish Diabetes Group.			*		
1.1.4 Improve patients' experience of transitional care between children's and adult services.	December 2007	Initial meeting held in June 2008 and currently arranging a service redesign meeting. Children and Young People's information/activities event held 25 th October, 2008.			*		
5.1.3 Over 80% patients to have a recent record of eGFR.	December 2007	eGFR introduced 2 nd October 2006. We currently appear to have a recording error since the % eGFR recorded in the Scottish Diabetes Survey does not reflect the expected level. The biochemistry department are looking into this.					*
8.1.1 Improve quality and completeness of BMI and smoking status data to over 80% of patients.	December 2007	This is a GMS target. Ongoing work to include non-GPASS practices in Lanarkshire. QOF data shows 93.1% of patients with BMI recorded, 98.7% with smoking status recorded and 97.3% smoking cessation advice given.					*

1.5.1 Improve collection of data on ethnicity to over 80% of patients.	December 2007	See 1.5.1			*		
1.4 Undertake needs analysis of their population to identify disadvantaged groups.	March 2008	Need more formal data gathering to build on existing knowledge. An information request has been sent to our Public Health department and the MCN Lead Clinician is scoping this work.			*		
1.5.3 Undertake review of services for people with diabetes from minority ethnic communities.	March 2008	Data gathering tool has been translated into the six main languages represented in Lanarkshire and advice is being sought from key stakeholders in relation to data gathering. Working in collaboration with the Equalities Officer locally.			*		
8.2.1 Support measures to reduce the risk of people developing diabetes.	March 2008*	MCN actively contributes to ongoing work of Long Term Conditions Collaborative Group. Health Promotion representatives attend MCN meetings. Childhood obesity strategy in preparation.					*
8.2.2 Apply lessons learned from preventive medicine initiatives, such as Prevention 2010.	March 2008*	Lanarkshire pilot of 'Keep Well' continues to identify people at risk of developing diabetes and refer them on appropriately. Interim evaluation report with recommendations now available.					*
1.3.2 Foot risk score recorded for at least 75% of people with diabetes.	April 2008	Currently working to combine foot screening with eye screening in fixed DRS locations. Some delay re Podiatry staffing, but hope to begin pilot in one fixed location in near future. Scottish Diabetes Survey indicates 31.2% had score recorded in 2008.			*		
3.3.1 All newly-diagnosed patients with Type 2 diabetes to be offered structured education within 3 months of diagnosis. Perform annual survey	May 2008	Proposal to roll out X-PERT programme across Lanarkshire has been fully funded. Further staff training held September 2008. New Service Manager and three Team Leaders appointed, recruitment of other staff in hand. Areas where X-PERT delivered are offering to all newly diagnosed and the programme is fully audited.			*		

NHS Lothian Progress Report - March 2009

<i>Action Point (Summary)</i>	<i>Month</i>	<i>Comments on Progress</i>		R	A	G	*
1.5.1 Improve collection of data on ethnicity to over 50% of patients.	December 2006	Ethnicity is collected on 62% of the Lothian diabetes population in SCI-DC and over 80% on Soarian.					X
4.2.1 Monitor first outpatient appointments, routine outpatient waiting times and DNA rates.	December 2006	First outpatient appointments and routine waiting times are available from TRAK. DNA rates for diabetes are routinely recorded in SCI-DC Clinical				X	
5.1.2 Over 95% of patients with data recorded for CHI, type of diabetes and date of diagnosis.	December 2006	This has been achieved					X
1.1.2 Work towards reducing incidence of diabetes emergencies in Type 1 diabetes.	March 2007	DKA and HONK ICPs in use. Training sessions for staff, patients and carers all include diabetes emergency sessions. CHO classes include managing diabetes emergencies. Information sheets are available for patients					X
2.1.1 Implement DRS programme.	March 2007	DRS programme is implemented					X

8.2.2 Apply lessons learned from preventive medicine initiatives, such as Prevention 2010.	March 2008*	Work is due to start on Anticipatory Care through Well North Programme although this will initially focus on CHD and COPD/respiratory disease.	✓				
1.3.2 Foot risk score recorded for at least 75% of people with diabetes.	April 2008	93.6% peripheral pulses recorded in SCI-DC. 92.4% neurological assessment in SCI-DC 56% foot risk score in SCI-DC Unfortunately, as a large percentage of the population have their foot screening assessed within primary care and recorded in their GP systems and the foot risk score does not transfer to SCI-DC. The only patients we have foot risk scores are patients seen by Podiatry services and entered into SCI-DC although the percentage of patients with peripheral pulses recorded indicate that many more have had full foot risk scores assessed.			✓		
3.3.1 All newly-diagnosed patients with Type 2 diabetes to be offered structured education within 3 months of diagnosis. Perform annual survey	May 2008	Home grown education sessions started in November 2008. and mothly sessions are ongoing.			✓		

Comments

- Consultant Services now commenced via Telelinking
- Budgetary constraints are affecting some of the outcomes.
- Clinical lead now appointed for 2 sessions per week

NHS Shetland Report – March 2009

Action Point (Summary)	Target Date	Comments on Progress		R	A	G	*
1.5.1 Improve collection of data on ethnicity to over 50% of patients.	December 2006	Data collection for ethnicity status commenced through Diabetic Retinal Screening service has been in place since 2007/08. Processes for data capture and input to SOARIAN system now in place so we can calculate exact uptake rate.		X			
4.2.1 Monitor first outpatient appointments, routine outpatient waiting times and DNA rates.	December 2006	Have reviewed monitoring arrangements for OPD waiting times (in light of work with 18 weeks).					X
5.1.2 Over 95% of patients with data recorded for CHI, type of diabetes and date of diagnosis.	December 2006	100% CHI recording in place.					X
4.2.2 Training and support mechanisms in place for lay members of MCNs.	February 2007 *	Training and orientation sessions in place for lay reps through PFPI group. Will look to enhancing this for MCNs and specific programme for diabetes group from June 2009. Will build national support/resources into local plans.					X
1.1.2 Work towards reducing incidence of diabetes emergencies in Type 1 diabetes.	March 2007	Participated in national audit in 2007/08. Local guidelines for children in partnership with Paediatric Department in NHS Grampian were introduced in 2007. Adult DKA guidelines in line with Scottish Diabetic Group protocols. Audit of emergency admissions also takes place following each admission.					X

1.1.3 Improve access to out of hours diabetes advice for families with children with diabetes.	March 2007	Good links/systems in place for liaison with community nursing teams, local diabetes team and NHS Grampian.						X
2.1.1 Implement DRS programme.	March 2007	Service fully operational.						X
3.1.1 Produce an 'insulin strategy'.	March 2007	Work in progress to agree the local strategy.				X		
5.1.1 Publish expected prevalence and identify gaps in service provision.	March 2007	Service strategy agreed and in place to 2009.						X
8.1.2 Health improvement resources available to frontline staff.	March 2007*	Work in progress to ensure consistency of health improvement resources with local health promotion team.						X
6.1.2 Produce a diabetes education strategy informed by training needs analysis.	April 2007	Training needs analysis project planned as part of overall strategy.				X		
1.2.2 Staff training courses informed by behaviour change models and the importance of patient empowerment.	April 2007*	Training courses on behaviour change models run by national team in September 2007.						X
4.1.2 Map current pattern of service delivery and produce a strategy to implement local pathways of care.	June 2007	Process mapping work undertaken to put into place an integrated Diabetes Clinic in 2009.						X
1.1.4 Improve patients' experience of transitional care between children's and adult services.	December 2007	Work already being undertaken locally to build on joint clinic arrangements with visiting paediatrician.						X
5.1.3 Over 80% patients to have a recent record of eGFR.	December 2007	Local figures pulled off from SCI-DC system show 94% of patients have had recent record of eGFR.						X
8.1.1 Improve quality and completeness of BMI and smoking status data to over 80% of patients.	December 2007	Work already being undertaken by local Practices as part of GMS contract, quality outcomes framework.						X
1.5.1 Improve collection of data on ethnicity to over 80% of patients.	December 2007	Data collection through DRS service – predicted to be on target by September 2009.				X		
1.4 Undertake needs analysis of their population to identify disadvantaged groups.	March 2008	Local public health team has undertaken significant body of work reviewing community/population needs (which includes the needs of people with diabetes).						X
1.5.3 Undertake review of services for people with diabetes from minority ethnic communities.	March 2008	Local public health team has undertaken significant body of work reviewing community/population needs (which includes the needs of people with diabetes).						X
8.2.1 Support measures to reduce the risk of people developing diabetes.	March 2008*	Already built into the local health improvement strategy for NHS Shetland. Obesity management strategy in place. Healthy schools programme in place. Anticipatory, health-screening clinics for men and women have been implemented across Shetland.						X
8.2.2	March	Local initiatives have been put in place to support						X

Apply lessons learned from preventive medicine initiatives, such as Prevention 2010.	2008*	anticipatory care model (e.g. well men/women clinics, CHD review nurse role for six months etc).						
1.3.2 Foot risk score recorded for at least 75% of people with diabetes.	April 2008	This is being collected via SCI-DC and monitored by the Diabetes MCN.					X	
3.3.1 All newly diagnosed patients with Type 2 diabetes to be offered structured education within 3 months of diagnosis. Perform annual survey	May 2008	Local structured education programme in place since April 2007.					X	

NHS Tayside Progress Report March 2009

<i>Action Point (Summary)</i>	<i>Month</i>	<i>Comments on Progress</i>						
			R	A	G	*		
1.5.1 Improve collection of data on ethnicity to over 50% of patients.	December 2006	There continues to be progress in collecting ethnicity data by the retinopathy screening service. The percentage of patients with diabetes with ethnicity recorded increased from 57% in the last report to 64.2%. This information is being recorded in Sorian, however, there are mapping issues with data transferring from Sorian to SCI-DC. This is due to be fixed with the next Sorian interface release.						✓
4.2.1 Monitor first outpatient appointments, routine outpatient waiting times and DNA rates.	December 2006	Processes are in place to monitor these. Waiting times for new outpatient appointments and DNA rates for diabetes clinics are produced monthly. Audits undertaken to monitor waiting times for return/review appointments.						✓
5.1.2 Over 95% of patients with data recorded for CHI, type of diabetes and date of diagnosis.	December 2006	The target for these indicators has been met with 100% attainment for all of these. Data is supplied annually as part of the Scottish Diabetes Survey.						✓
1.1.2 Work towards reducing incidence of diabetes emergencies in Type 1 diabetes.	March 2007	All patients with Type 1 diabetes receive individualised education and have access to the specialist diabetes team. Insulin pump and carbohydrate counting education is available. A Tayside protocol for the treatment of DKA is in place. Patients admitted to Acute Medical Admissions Unit are referred to the specialist diabetes team. Information leaflets with the contact details of the specialist diabetes team are available in all A&E departments across NHS Tayside. A range of work has been undertaken to improve inpatient care of people with diabetes including dedicated Diabetes Specialist Nurse, education for ward staff, insulin charts, hypo boxes in wards areas, blood ketone monitoring.						✓
2.1.1 Implement DRS programme.	March 2007	The Diabetic Retinopathy Screening programme is in place and eligible patients are offered screening at the static sites in Dundee and Perth or at the two mobile units. Implementation of the national software to replace local software was completed in October 2007, although issues remain with the national software and SCI-DC. A new interface to address these issues is expected in summer 2009. The screening grading processes are formally quality assured in line with National Clinical Standards.						✓
3.1.1 Produce an 'insulin strategy'.	March 2007	Insulin Strategy completed and available on Tayside Diabetes MCN website. Insulin pump criteria have been reviewed in light of updated NICE Guidance.						✓

5.1.1 Publish expected prevalence and identify gaps in service provision.	March 2007	Expected prevalence data is published on the Public Health Observatory web site. Prevalence information for Tayside is published annually in the Tayside Diabetes Annual Report which is available on the Tayside Diabetes MCN website. This information and any gaps are reviewed on an ongoing basis as part of the implementation of our local strategy and annual work planning cycle.					✓
8.1.2 Health improvement resources available to frontline staff.	March 2007 *	Tayside Diabetes MCN website has information for staff and patients on diet, smoking, exercise and lifestyle advice. There is also information on a range of local activities across Tayside which support health improvement, for example, walking groups, cooking classes. Health promotion activities such as weight management, smoking cessation and exercise on referral are also promoted to staff by NHS Tayside Public Health so staff know how to refer.					✓
6.1.2 Produce a diabetes education strategy informed by a training needs analysis.	April 2007	The MCN continues to provide a wide range of education programmes on an ongoing basis for healthcare professional and patients, including: <ul style="list-style-type: none"> • University of Dundee Multiprofessional Module in Diabetes run annually. • 12 education forums each year for healthcare professionals covering a range of topics • Training sessions on foot screening. • Biennial MCN Professional conference • Adhoc training events for care home staff, community nursing staff. • Group education for people newly diagnosed with Type 2 diabetes • Group education for people with Type 1 diabetes on intensive insulin management • Annual patient event A formal education strategy will be developed based on a needs assessment.			✓		
1.2.2 Staff training courses informed by behaviour change models and the importance of patient empowerment.	April 2007*	The joint Tayside Diabetes MCN and University of Dundee Professional Learning Module “Caring for people with diabetes” uses a range of teaching methods in such a way that they can be applied by practitioners within their own practice context. It also includes the patient’s perspective. Generic behaviour change courses are available to all staff in NHS Tayside as part of the Long Term Conditions Programme. The “Doing Diabetes Better” course is arranged for May 2009.					✓
4.1.2 Map current pattern of service delivery and produce a strategy to implement local pathways of care.	June 2007	This was undertaken as part of the local strategy published in 2002 which set out an Integrated Care Pathway for diabetes care. The strategy was reviewed in collaboration with Community Health Partnerships and Acute Services Division. Priorities from the strategy are being taken forward within the Collaborative Commissioning Model in Tayside which was presented to and approved by NHS Tayside Board in December 2007. Work is ongoing to deliver the Diabetes Collaborative Commissioning Plan.					✓
4.2.2 Training and support mechanisms in place for lay members of MCNs.	June 2007 *	A local Patient Involvement Induction Pack is available and used. Chest, Heart & Stroke Scotland’s “Hearty Voices” programme was run for CHS and diabetes patients in March and June 2007. Ongoing support is provided to					✓

		lay members of Committees by the MCN Manager as required. It is planned to run Diabetes Voices by Diabetes UK for new patient representatives in Autumn 2009.					
1.1.3 Improve access to out of hours diabetes advice for families with children with diabetes.	September 2007	The Paediatric Team are part of Diabnet which provides out of hours advice across Tayside, Fife and Forth Valley.					✓
1.1.4 Improve patients' experience of transitional care between children's and adult services.	December 2007	There is a young adult clinic in Dundee and Perth & Kinross with input from the adult and paediatric team. Revised transition arrangements have been agreed and implemented to improve the process for patients. A patient satisfaction survey is being undertaken to review the effect of the revised process. Tayside adult and paediatric teams are involved in the Diabnet work to improve transition arrangements.					✓
5.1.3 Over 80% patients to have a recent record of eGFR.	December 2007	This target is met. Current position: 92% of patients have a record of eGFR within previous 15 months.					✓
8.1.1 Improve quality and completeness of BMI and smoking status data to over 80% of patients.	December 2007	These targets are met. BMI: 88% recorded within previous 15 months (98% recorded ever). Smoking Status: 89% recorded within previous 15 months (98% recorded ever)					✓
1.5.1 Improve collection of data on ethnicity to over 80% of patients.	December 2007	There continues to be progress in collecting ethnicity data by the retinopathy screening service. The percentage of patients with diabetes with ethnicity recorded increased from 57% in the last report to 64.2%. This information is being recorded in Sorian, however, there are mapping issues with data transferring from Sorian to SCI-DC. This is due to be fixed with the next Sorian interface release.				✓	
1.4 Undertake needs analysis of their population to identify disadvantaged groups.	March 2008	MCN has reviewed data available on prevalence of diabetes, access to services and clinical indicators in relation to disadvantaged groups (where available). This identified areas for improvement in the diabetes care of people in nursing homes and a proposal has been developed to address this. Links have been made with the Public Health Team in relation to the work being undertaken on health profiles at Scottish Index of Multiple Deprivation (SIMD) datazone level.					✓
1.5.3 Undertake review of services for people with diabetes from minority ethnic communities.	March 2008	The Diabetes MCN participated in the national review on diabetes service provision for minority ethnic groups. This report was published in September 2006. Information on ethnic groups accessing services has been undertaken as part of 1.4, however, accurate information will not be possible until more complete ethnicity data (1.5.1) is available. A recent study published by the Universities of Edinburgh and Dundee showed that of 10,500 people with Type 2 diabetes in Tayside, 176 were South Asian. The study found evidence of equity in many aspects of diabetes care for South Asians in Tayside. Information leaflets in different languages are available as well as translation services.					✓
8.2.1 Support measures to reduce the risk of	March 2008*	Generic health improvement services are in place across NHS Tayside. The Diabetes MCN works with other Long					✓

people developing diabetes.		<p>Term Condition MCNs and Health Improvement colleagues in NHS Tayside. The MCN contributed to the development of NHS Tayside's strategy for the primary prevention of CHD which includes a section on diabetes. There is Public Health representation on the MCN Network Board.</p> <p>There is a huge amount of work at a local level towards health improvement including Dundee Health Living Initiative, Keep Well. The MCN will continue to work with these colleagues to reduce risk of people developing diabetes.</p>					
8.2.2 Apply lessons learned from preventive medicine initiatives, such as Prevention 2010.	March 2008*	The MCN Network Board receives updates on such initiatives through its Public Health representation and will cognizance of recommendations.					✓
1.3.2 Foot risk score recorded for at least 75% of people with diabetes.	April 2008	Significant progress has been made in this area with the inclusion of foot risk screening within a Local Enhanced Service for Diabetes. 84% of people have had a foot risk score recorded ever. Since last report the % that have had a score recorded in the past 15 months has increased from 58% to 74%					✓
3.3.1 All newly-diagnosed patients with Type 2 diabetes to be offered structured education within 3 months of diagnosis. Perform annual survey	May 2008	<p>Tayside Diabetes Education Programme has been in place since October 2004 and work is underway to ensure it is available to all newly diagnosed patients across Tayside. This is being taken forward as part implementation of the diabetes strategy – see 4.1.2. It has also been included within a Local Enhanced Service for Diabetes.</p> <p>An additional TDEP session commenced in Montrose in August 2008 resulting in all practices in Angus having access to book patients into TDEP. A Diabetes Patient Educator took up post in October 2008 for 15 months to support roll out and Expansion of TDEP in Dundee and Perth & Kinross. Plans are underway to ensure it is made available to all patients in Perth & Kinross area.</p> <p>The percentage of people newly diagnosed with Type 2 diabetes accessing TDEP increased from 68% in 2007 to 83% in 2008. The waiting time for access to the programme has been maintained within one month.</p>				✓	