Integrated Diabetes Service Development Group Work Plan 2020-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. Improve health outcomes for high risk populations with diabetes by increased engagement in health services by: ▪ Māori, ▪ Pasifika Peoples, ▪ Indian ▪ Adolescents/Young Adults, ▪ People with mental illness	Gather information and apply this to advance service delivery to high risk populations (EOA): ▪ Access and analyse PHO and practice level data for population health outcomes to enable prioritisation of community service delivery. ▪ Analyse Canterbury wide data to identify population groups, including where they reside and attend general practice by: ▪ Identify national diabetes programmes that have demonstrated positive outcomes for priority groups and disseminate successful models of care and innovation. ▪ Support and enable Marae based diabetes outreach services to Māori & whānau, including diabetes education, testing, and retinal screening. ▪ Plan a community outreach for Pacific people with diabetes.	▪ Q2-Q4: ▪ Increased access to services for priority populations. ▪ Improved Hba1c results in all population (HBA1c. Baseline 78.3% (2017, Atlas of Healthcare Variation) for Māori). ▪ Reduced ethnic variation. ▪ Narrow gap between European and priority population. (HBA1c. Baseline 78.3% (2017, Atlas of Healthcare Variation) for Māori).	▪ Delayed/avoided burden of disease & long-term conditions ▪ 'At risk' population identified
2. Increased service delivery for people with diabetes in the community and alignment of the dietetic and nutritionist workforce to the location of service delivery	Align dietetic and nutritionist workforce: ▪ Complete a stock take of the current access to and location of dietetic and nutritional services to establish baseline and unmet need. ▪ Develop recommendations for changes in workforce and location.	Q1 Dietetic/nutritionist services stocktake completed and baseline and unmet need established. Workforce proposal developed.	▪ Delayed/avoided burden of disease & long- term conditions ▪ Access to care improved
3. Increased system level Integration and access to clinical notes E.g. Documentation , I.T, and clinical oversight	Improve integration and access to clinical information by: ▪ Complete a stock take of the current access of key providers and identify any gaps. ▪ Develop recommendations for changes.	Year 2021/22 Q4: Key stakeholders have access to the same level of information to provide best outcomes and a system level approach to care and treatment.	▪ Delayed/avoided burden of disease & long-term conditions ▪ Access to care improved
4. Reduce people with diabetes hospital admissions and length of stay in secondary care in-patient service	Develop an inpatient in-reach service to actively identify and engage with people with diabetes while in hospital.	▪ Year 2021/22 Q4 ▪ Reduced length of stay of people in hospital. ▪ Continuity of care provided for people to remain well and out of hospital.	

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Actions towards monitoring progress			
5. Monitor engagement with high risk groups such as: ▪ Māori ▪ Pasifika Peoples ▪ Indian ▪ Adolescents/ Young adults ▪ People with ▪ mental illness	Monitor integrated diabetes (specialist and community) services, general practice, retinal screening, and high-risk diabetic foot) activity for priority populations.	▪ Q2/Q4 ▪ Number of Māori and Pasifika people with diabetes. ▪ Six-monthly reporting to IDSDG on activity, including ethnicity.	▪ Delayed/avoided burden of disease & long-term conditions
6. Enhance self-management and health literacy for people with diabetes including for priority populations	Monitor progress with implementation of redesigned patient education in a range of community settings to support improved access for priority populations.	Q1-Q4: Education is accessible and increased attendance is evident.	
7. Enable people with diabetes to better manage their condition	Monitor integration of diabetes nursing workforce to allow: ▪ Increased community service delivery. ▪ Consistent clinical oversight ▪ Equity of access for patients regardless of complexity of diabetes.	Q1: Work plan for integrated nursing services project completed.	▪ Reduced clinic cancellations ▪ No wasted resource ▪ Right care, in the right place, at the right time, delivered by the right person
8. MoH reporting	Monitor delivery against the Ministry of Health Quality Standards for Diabetes Care.	Annual review completed. Service delivery reflects the National Quality Standards for Diabetes Care.	
Key metrics to indicate progress delivering work plan actions, impact on health outcomes and/or monitor performance			

Description of metric	Data Source
1. Number of people with diabetes and their HbA1C results by age and ethnicity at PHO and Practice level.	PHOs/DHB
2. Volume and wait times for retinal screening by ethnicity.	Decision Support
3. Volume of participants receiving diabetes foot care – community.	PHOs/DHB
4. Volume of participants receiving diabetes foot care – MDT podiatry/vascular/ID clinics.	Decision Support

The 2020-21/22 CCN Work Plan for all alliance groups can be viewed on the CCN website here.