Integrated Diabetes Service Development Group Work Plan 2021-22

Objectives	Actions	Measures of Success / Targets / Milestones	System Outcomes
Priority actions towards transformational change, improved system outcomes and/or enhanced integration			
1. Increased engagement of high-risk populations in health services including: ▪ Māori, ▪ Pasifika Peoples ▪ Indian ▪ Adolescents/ young Adults ▪ People with mental illness	▪ 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. ▪ 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, retinal screening. ▪ Plan a community outreach for Pacific people with diabetes. ▪ Explore access for people with Mental Health conditions. (EOA)	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 Narrower gap between European and priority population.	▪ Delayed/avoided burden of disease & long-term conditions ▪ 'At risk' population identified
2. Increased service delivery in the community and alignment of the dietetic and nutritionist workforce to the location of service delivery	Build on the stocktake of the current access to and location of dietetic and nutritional services to: ▪ Establish baseline and unmet need. ▪ Consider the Pae Ora ki Waitaha Principles for designing Health Lifestyles - being led by the Population Health and Access SLA ▪ Develop recommendations for changes in workforce and location. (EOA)	Q4: ▪ 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. System wide access to clinical notes e.g. Documentation, I.T, and clinical oversight	▪ Complete a stock take of the current access of key providers and identify any gaps. ▪ Develop recommendations for changes.	Q4: Key stakeholders have access to the same level of information to provide best outcomes and a system level approach to care & treatment.	
4. Reduce hospital admissions and length of stay in secondary care in-patient services	▪ Develop an inpatient in-reach service to actively identify and engage with people while in hospital. ▪ Identify gaps in service delivery ▪ Identify pathways / processes on discharge back to general practice	Q4: ▪ Reduced length of stay of people in hospital ▪ Continuity of care provided for people to remain well and out of hospital.	

*EOA – Equity Outcome Action / *SLM – System Level Measures

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.	Q1-Q4: ▪ Number of Māori and Pasifika people with diabetes. ▪ Six-monthly reporting to IDSDG on activity, including ethnicity.	▪ Delayed/avoided burden of disease and 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-Q4: Work plan 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.	Q2: 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 current CCN Work Plan for all alliance groups can be viewed on the CCN website here.