Summary of achievements and outcomes of the Diabetes Strategy and three year plan

Diabetes Strategy Plan	Achievement / Outcomes
Year One:	
Establish our expectations of Acute Care Providers (predominantly UHSFT) by clearly defining what services they are expected to deliver particularly with regard pre-conception advice, foot care and general ward care. This must be evidence based and robust outcomes monitoring must be established, so we must determine what we expect the outcomes to be. (i.e. reduction in hospital stay, fewer hospital follow ups etc.)	• New Acute Hospital Diabetes Care service spec implemented with clearly defined service objectives, KPIs and reporting requirements (from April 14) • Quarterly service review meetings established (from April 14) • Enhanced pathway for pre-conception care (May 16) • Implementation of new combined foot care clinics with access to MDT (From April 2016) • Reduction in the number of admissions and the cost of these admissions since 2013/14. • No reduction in Follow-up appointments (13/14 466, 14/15 451, 15/16 486)
Review the current contract for Solent podiatry and community diabetes education and support services. Clarify contractual requirements and ensure they are delivering what is currently expected. This will require specific measurable outcomes to be defined and monitored.	• New Community service specification implemented to reflect change in service delivery. It clearly defines scope of service and service objectives (April 2016)
Develop and implement a local insulin pump service	• New IPT service started April 14
Set up a city wide Diabetic network to coordinate communication, education and review of services	• Stakeholder Workshop held 2nd October 2013 to give an up-date on progress to date on the Diabetes Improvement Programme and to also determine 'What would a good Diabetes Network look like' • Options explored on establishing a Network but lacked support, local stakeholders concluded that the facilitation of a Network should not be through the CCG – no further action was taken.
Specific locality based projects (CEPA) looking at a. Accessible structured patient education and opportunities to maximise self-care b. A Multidisciplinary foot care service that fully supports practices c. Improving primary care professional education d. A practice based stocktake to clarify the current situation	• A Self-management summary report and a IT resources for Self-Management were produced to support Primary Care and the aims of the DAS • Foot Care pathway development and commissioned from April 2016 • DAS supported the access to professional education • Stocktake was completed
Development of a model for a primary care led integrated service model based on the above work which clearly defines the roles of each organisation and the emphasis is on primary care coordination of community based care. This will be foundational in determining the commissioning of services for 2014/15.	New model of diabetes integrated care developed and implemented June 14 this included the implementation of the Diabetes Accreditation Scheme for Primary Care which started 1st October 2015

Year Two:	
Robust and active monitoring of Acute/Community Contracts – this will require Primary Care to be monitoring outcomes referrals and admissions to secondary care	• CCG Service review meetings established • Diabetes Development Group established June 14 • Clinical Reference Group established January 15
Establish a process / network which can monitor outcomes and cost of the services.	As above
Mobilisation of Insulin Pump service	Service was quick to mobilise from April 14
Delivery of new arrangements for out of hospital care with clear roles and responsibilities and mechanisms for integrative care established	• New model of diabetes integrated care provides specialist support in primary care
Year Three:	
Delivery of new integrated service • 80% of patients managed via practice based co-ordinated care • 90% of patients availed themselves of educational opportunities • 100% of healthcare staff with responsibility for diabetes care demonstrated improved knowledge and confidence	• The focus on primary care led care continues and the PC Stock Take in 2013 found that a large proportion of patients were being managed solely in PC. • 2014-15 NDA reported 33% of those with Type 1 'offered and attended' structured education programme and 74.8% with Type 2. Whist the Type 1 percentage is the same as the average for England, the Type 2 achievement is less than the England average of 78.9%. Further work needs to be undertaken to ensure that GP system records the attendance of structured education. • This has not been measured however the Diabetes Accreditation Scheme which aimed improve practice based knowledge and skills provided evidence that between Oct 14 to Oct 15 674 hours of training had been undertaken, the target was 198 hours.