

**Counties Manukau
District Health Board**

**Diabetes
Health Services Plan**

February 2008

1.0 Current Services

The Diabetes Service provides leadership and clinical care across the continuum of primary and secondary care in both the community and hospital. The focus of the secondary care service is on the management of high risk patients with diabetes, training of primary care providers to effectively manage the low-medium risk patients, and up-skilling of health professionals within the hospital environment.

The Diabetes Service provides the following clinical services:

Inpatient Services

- 2-5 specialty beds for the management of patients admitted to hospital under the specialist diabetes team.
- Medical and nursing diabetes consultation service to other hospital based teams, for diabetic patients admitted to hospital under other specialty teams (e.g. unstable diabetic patients admitted with vascular disease). Approximately 25% of all acute admissions to hospital are people with diabetes.

Outpatient Secondary Care

Outpatient services are provided at Manukau SuperClinic, Botany SuperClinic and at community clinics through a range of clinic types including:

- Diabetes Nurse Specialist clinics
- Diabetes SMO and RMO clinics
- Diabetes Education group clinic
- Diabetic dietetic clinics
- Diabetic podiatry clinics
- Diabetes in Pregnancy clinics
- Health Psychology Clinics (including an intern)
- Young Adult Clinic

Integration Clinics are held in primary care settings and include:

- Dietician
- Diabetes Nurse
- Diabetes SMO

Current Workforce FTE

SMO	2.80
RMO	1.0 (plus two diabetes/endocrinology fellows)
Clinical Nurse Specialists	10.80
Community Liaison	.50
Health Psychologist	.40
Podiatrist	Contracted external resource
Clerical	1.20
Allied Health	Support service provided by Acute Allied Health Services

Diabetes	2006/07	2007	2008	2009	2010	2011	2016	2021	2026	Increase 2006-26	% Increase 2006-26	PA Increase
New Patient	536	552	568	585	601	617	700	800	900	324	60	2.4
Follow Up Patient	480	494	509	524	538	552	600	700	700	269	56	2.2

Outpatient Volume Projections

SWOT Analysis - Diabetes

<p>Strengths:</p> <ul style="list-style-type: none"> • Multi-disciplinary team • Well established team with consistent membership • Continuity and integration with primary care • Alignment with national guidelines • Building capacity and support of primary care • Mentoring, upskilling and training within service and wider secondary care • Annual planning days – service, education and audit • Annual regional meetings • Quarterly regional meetings • National society (NZSSD) • Contribute to technical advisory groups to the DHB 	<p>Weaknesses:</p> <ul style="list-style-type: none"> • Lack of outpatient resource • Inadequate IT support at some venues • No auditable clinical record • Service not growing in line with population growth and increasing prevalence of diabetes • Limited clinical oversight • No census or 'real time' reporting of diabetes in secondary care environment
<p>Opportunities:</p> <ul style="list-style-type: none"> • Maximizing educational opportunities • Increasing oversight and peer review for nursing team • Increasing audit within the service • Increasing training opportunities; <ul style="list-style-type: none"> – In primary care – Utilising inpatient cases e.g. Grand round – Increase auditable clinical data • Multifactorial risk management (including increasing scope for management for hypertension) • Building relationships within secondary care • Trialling database CVDIS 	<p>Threats:</p> <ul style="list-style-type: none"> • Devolvement of skilled workforce and funding to primary care • Service resource lagging behind increasing prevalence and speciality need of people with diabetes • Hospital and GP referral demand • Supporting other services – Maternal Medicine, Acute Services • Growth in obesity

2.0 Key Issues

Increased prevalence of Diabetes

An increase in the number of people with diabetes is being addressed in CMDHB through the “Lets Beat Diabetes” programme. This is a comprehensive strategy across all components of the continuum of care for people with Diabetes.

Workforce Development

Growth in the number of people with diabetes will challenge both the primary and secondary care workforce. Secondary care needs to have a well trained medical, nursing and allied health workforce to support the current continuum of care and allow for associated growth in service volumes.

Health professionals working in primary and secondary care settings need to have ongoing education, skill acquisition, in-house training and peer supervision.

Facilities

Ensuring adequate multidisciplinary consultation and group education facilities for expanding outpatient services both at Manukau SuperClinic and in community clinics (e.g. PCHC). Facilities with adequate infrastructure (e.g. IT and clerical support) need to be available in high need communities for the provision of secondary care clinics.

Integration between primary and secondary care

Integration of care for people with diabetes involves working across all aspects of the care continuum and this requires ongoing attention. The Specialist Diabetes services will continue to show leadership across all aspects of the strategy and ongoing support and training of primary care in the long term management of people with diabetes.

Integration at CMDHB is driven through the "Lets Beat Diabetes" strategy and in February 2007, PHOs reinforced the value of Specialist Diabetes Services supporting primary care in the management of people with diabetes. The Let's Beat Diabetes (LBD) strategy is a well coordinated approach to achieving the action areas where secondary care has a role, principally in supporting Primary Care based Prevention and Early Intervention and in Improving Service Integration and Care for Advanced Disease.

The concept of Integrated Clinics between secondary and primary care is beneficial to both the health professionals involved and the patients, however the ability of primary care to meet the requirements of the agreed entry strategy can be problematic.

3.0 Trends and Future Directions

The Diabetes Service has a well established model of care developed in 1999-2000 as part of a formal review and then updated in 2005. The Diabetes Service has extensive interaction with the DHB's clinical advising and planning forums and is aligned to the Diabetes and Cardiovascular advisory group, Lets Beat Diabetes and Chronic Care Management Advisory Group. A national quality improvement plan for diabetes care was released in 2007, and the 2003 national guidelines for Management of Type 2 diabetes is entering a review phase with expected publication mid-2008.

CMDHB Diabetes Services will continue to work across the continuum of care, building strong relationships with all health care providers to support the prevention of diabetes and the management of patients with diabetes. Services will continue to strive to identify opportunities in the acute setting to support patients with diabetes on return to their primary care provider, to ensure they are enrolled in appropriate programs and to ensure that their disease is appropriately managed.

The CMDHB Diabetes Service will continue to provide a strong nursing outpatient service that runs clinics at CMDHB sites as well as in key local areas such as Otara and Mangere. The service will also focus on supporting Primary Care both in seeing patients and in providing education to General Practitioners and practice nurses.

4.0 Key Directions

- ✓ *Continued implementation of the Lets Beat Diabetes Strategy with specialist Diabetes Services supporting Primary Care providers with training and long term management of people with Diabetes.*

- ✓ *Continuing the development of community-based secondary care clinics in high need areas. e.g. Otara and Mangere.*
- ✓ *Continued support of secondary care specialist services in the provision of care for patients with diabetes experiencing other health episodic or chronic care.*
- ✓ *Continued roll out of 'Lets Beat Diabetes' strategies and initiatives.*