Diabetes statewide health service strategy 2013

Service direction	**Diabetes services are provided in the most appropriate setting by the most appropriate service delivery model for local health needs, especially in rural or remote communities, according to the stage of disease.**	**Diabetes services are networked and coordinated for greater collaboration across and within public and primary care sectors to minimise duplication of effort and improve the patient journey.**	**Diabetes services are comprised of sustainable service models supported by high quality clinical care across the state.**
Objectives	1. **Increase access** to services (such as specialist, multidisciplinary paediatric and/or adult diabetes teams) where there are identified service gaps. 2. **Improve research opportunities** that will provide information for future diabetes planning in determining the most care appropriate setting 3. **Improve the clinical ability and resources** of diabetes services to manage different types of care at clinically appropriate intervals. 4. **Improve the coordination, communication and clinical handover** of inter-hospital patient transfers and retrievals. 5. **Improve access to culturally appropriate services** for people from Aboriginal and Torres Strait Islander and CALD populations, particularly pregnant women. 6. **Promote use of telehealth technology** as a coordinated service package. 7. **Promote use of information technology** that promotes and enables greater self-management.	1. **Improve service coordination and integration** between acute and primary healthcare settings. 2. **Improve the integration of public and private sector services** to increase service efficiencies by reducing duplicate service provision. 3. **Expand service networks** that will allow patients with to seamlessly move between varying types and levels of service delivery. 4. **Increase the availability and use of online information technology based solutions that capture diabetes service clinical information and allows information sharing when patients are referred between providers.** 5. **Improve representation** of diabetes services at executive level and clinical forums to influence greater collaboration in improving services for patients with diabetes. 6. **Increase the use of patient-focussed care plans** that incorporate self-management, and promotion of lifestyle-changing behaviours. 7. **Improve patient awareness** of the importance of formulating their annual cycle of care with their GP.	1. **Adoption of best practice models of care and published best practice treatment guidelines.** 2. **Improve the recruitment and retention of the diabetes workforce.** 3. **Establish flexible staffing arrangements to support efficient service delivery encompassing role delineation and scope of practice (e.g. working across settings, services and sectors).**
Actions	**Short-term (1–2 years)** • Undertake planning to inform local service requirements and allocation of resources to support service delivery. • Develop options to improve access to programs that teach adjustment of insulin according to carbohydrate intake for type 1 diabetes, pre-conception counselling and intensive self-management of continuous subcutaneous insulin infusion (CSII) pumps. • Increase the capacity of GPs to manage diabetes by building cohesive multidisciplinary diabetes teams around identified community need and promoting principles of patient self-management. • Build service activity around known service gaps particularly CSII pump management, paediatric care and high risk foot clinics. • Identify opportunities to improve clinical ability and resources to meet demand of the local catchment population. • Use case management and targeted interventions for complex high risk patients. **Medium-term (3–5 years)** • Implement programs that teach adjustment of insulin according to carbohydrate intake for type 1 diabetes, pre-conception counselling, and intensive self-management of CSII pumps. • Improve access to specialist diabetes services for pregnant women with type 1 and 2 diabetes through enhanced use of Telehealth, electronic referral arrangements, and more education for local healthcare providers in rural and remote areas.	**Short-term (1–2 years)** • Develop protocols that allow for type 1 adults to have at least an annual specialist multidisciplinary team review and ensure all children have access to specialist multidisciplinary team management of their diabetes. • Assess feasibility of creating a patient coordination/case management system to oversee coordination of diabetes care. • Work with MLs to pursue opportunities to improve service integration and reduce referrals for non-complex cases. • Work with MLs to identify opportunities to improve efficiencies and reduce duplication of effort. • Partner with MLs to map and plan better integration and coordination across acute, higher level specialist services, and primary health settings. • Undertake a national and international review for examples of best practice shared clinical care record systems. • Explore the feasibility of adopting ADIPS guidelines. **Medium-term (3–5 years)** • Implement protocols that allow the opportunity for type 1 adults to have at least annual specialist review and ensure all children have access to specialist management of their diabetes. • Work with the primary care sector to develop processes and pathways that will result in greater uptake of type 2 patients. • Improve transition programs for patients with type 1 diabetes progressing from childhood to adulthood. • Examine opportunities to improve the coordination of patient transfers from hospital to home or community based care **Long-term (6–10 years)** • Examine options for a statewide data collection system to monitor and manage performance, quality and safety, provide data for research opportunities, and track patient outcomes.	**Short-term (1–2 years)** • Development of a policy position for bariatric surgery as an option in the management of type 2 diabetes. • Examine options to implement emerging and best practice diabetes models, guidelines and/or frameworks such as the Chronic Disease Initiative or the Department of Health, State of Western Australia Diabetes Model of Care (2008) within local planning activities. • Provide opportunities for staff to update and maintain their clinical competency in diabetes care to ensure multidisciplinary teams are suitably skilled. **Medium-term (3–5 years)** • Develop a statewide framework, strategy or plan to support diabetes workforce recruitment, retention and/or access to training. • Provide staff with opportunities to undertake credentialed diabetes educator (CDE) training and/or other relevant training. • Work in partnership with the private sector for greater use of Telehealth to deliver diabetes services. **Long-term (6–10 years)** • Implement a multidisciplinary diabetes team model of care and ensure all members maintain their clinical competence and that succession planning is considered.

Performance indicators

Service direction 1

- HHSs local health service planning inclusive of diabetes service providers to improve ability of diabetes services to meet patient needs.
- Hospital admissions standardised rate per 100 000 population for diabetes is at or below the Australian rate as an indicator of most appropriate setting (in the community) by the most appropriate service model.
- Reduction in average inpatient length of stay for patients with diabetes.
- Increasing uptake of Telehealth delivered as a coordinated service package including some face-to-face time in rural and remote health services in accessing different types and levels of diabetes services.

Service direction 2

- Documented agreements between different public sector diabetes services to coordinate treatment and management of patients with diabetes.
- Increasing inter-sectoral and cross policy sector membership of SDCN.
- Documented referral pathways available for use by each diabetes service.

Service direction 3

- Sustainable workforce to support diabetes services (by endocrinology positions available, retention and/or access to training).
- Core multidisciplinary teams established in chronic disease management services (including diabetes services).
- Published best practice treatment guidelines accessible by all diabetes care services.

For more information contact

Policy and Planning Branch
System Policy and Performance Division
Department of Health
GPO Box 48, Brisbane QLD 4001
Statewide_Planning@health.qld.gov.au

Diabetes

statewide health service strategy 2013

Diabetes is described as Australia's fastest-growing chronic condition. Diabetes has become one of the leading threats to the health of Australians and is one of the top 10 causes of death in Australia. Trends suggest by 2025, up to 3 000 000 Australians over the age of 25 years will have diabetes. By 2017, type 2 diabetes—the most common type of diabetes and described as the epidemic of the 21st century—is set to become the leading burden of disease in Australia. Presently diabetes affects the health of nearly 178 900 Queenslanders.

The service directions proposed in this strategy outline a 10-year approach to future diabetes services delivery for Health and Hospital Boards and Health Service Chief Executives, as well as clinicians. The directions relate to diabetes services in general and the identified service issues were largely consistent between type 1, type 2 and diabetes in pregnancy services. The major themes focused around service access and coordination, service capability and capacity, workforce, best practice models, patient flows, technology and equipment and research

The *Diabetes services statewide health service strategy 2013* provides public sector services with a vision for diabetes services across Queensland over the next ten years.

The strategy embraces the themes of the *Blueprint for better health care in Queensland* and focuses on:

- improving care services for people with cancer
- empowering the health workforce to drive the strategy
- improving the efficiency of services, and
- planning for the future.

The vision for Queensland public sector diabetes services in 2023 involves efficient and responsive services continuing to strive for further improvements.