Welcome!
The “Working Together for Better Diabetes Care” Partnership formed in 2011 as outcome of the Peninsula Health “Care In Your Community” initiative which identified the need for greater collaboration to improve and address identified gaps & issues across the diabetes care continuum.

Our Partners

⇒ Clients
⇒ Royal District Nursing Service
⇒ Peninsula Health
⇒ Peninsula General Practice Network
⇒ Frankston Mornington Peninsula
⇒ Primary Care Partnership
⇒ Allied Health
⇒ Endocrinologist
⇒ Frankston City Council/ Mornington Peninsula Shire

Achievements So Far!!

♦ A committed partnership across the Frankston Mornington Peninsula to “Work Together for Better Diabetes Care”
♦ FMP Best Care & Support Diabetes Model & interactive diagram for Health Professional’s to support appropriate referral.
♦ Developing a client focussed interactive Diabetes Support Model that identifies resource’s to support self management
♦ An Agreed Quality Referral & Feedback Minimum Data set—Audit
♦ Hospital Admissions and Diabetes
  ♦ Task Team - PART A - Consumer Perspective - Capturing planned/unplanned admissions & inpatient experience
  ♦ Task Team - PART B - System supports/Protocols and Policies

Our Focus-

The focus of our partnership is:
1. To work with our community to improve health outcomes, wellbeing and quality of life for people with Diabetes or at risk of developing Diabetes.
2. To explore opportunities for improved service integration that links and consolidates care treatment and referrals.

Our partnership places the client at the centre of all interactions; we take into account the client’s personal preferences, cultural beliefs and values, their family and lifestyles situations. Clients are an integral member of the “Working Together for Better Diabetes Care “ partnership and will be consulted and involved in all planning initiatives.

Planning

Our planning uses most recent local demographic and service related information to provide an evidence based approach to local population health needs and the identification of issues pertinent to the needs of the Frankston Mornington Peninsula.

Outcome Focus

♦ We will develop a suite of indicators that measure outcomes or impacts for people with diabetes
♦ We will develop a suite of outcome indicators that support a continuous quality improvement cycle to monitor the performance of our integration and planning initiatives

We aim to expand the provision of high quality diabetes care in the Frankston Mornington Peninsula
Frankston Mornington Peninsula—Best Care & Support for Diabetes

In consultation the “Working Together for Better Diabetes Care” Steering Committee has developed an interactive Best Care and Support Model to enable appropriate referral practice for clients with diabetes. The Diagram describes Diabetes levels and intensity of care with links to services and service information in the Frankston Mornington Peninsula. The Best Care and Support Model is being placed on the DAV website and will be interactive allowing service providers to link to a range of diabetes support & wellbeing programs, service providers, hospitals, etc. in the Frankston Mornington Peninsula catchment.

**Contact Us**
If you would like more information about any of the articles in this issue of the "Working Together for Better Diabetes Care" Newsletter please contact:

Julie White  
“Working Together for Better Diabetes Care” - Integrated Chronic Disease Management Peninsula Health  
Tel: 9784-7764  
Email jwhite@phcn.vic.gov.au