Rotherham High Impact Diabetes Programme

What we achieved and what happens next

June 2026

What the programme set out to do

Improving diabetes care in Rotherham

- Improve prevention and support for people at risk of diabetes
- Improve the quality and consistency of care
- Better join up services across GP practices, community and hospitals
- Provide more targeted support for people with complex needs

OUTCOMES AND IMPACT

What has been achieved

- Over 7,000 people referred into diabetes prevention support, with strong uptake of programmes
- Increased access to weight management and early intervention support
- Reduction in hospital length of stay, showing improved management and earlier intervention
- Improved delivery of routine diabetes care, with more people receiving the right checks and treatment
- More consistent care across GP practices and services, reducing variation
- Increased use of technology and specialist support for people with complex diabetes needs

OUTCOMES AND IMPACT

30%
Prevention uptake
(Target 17%)

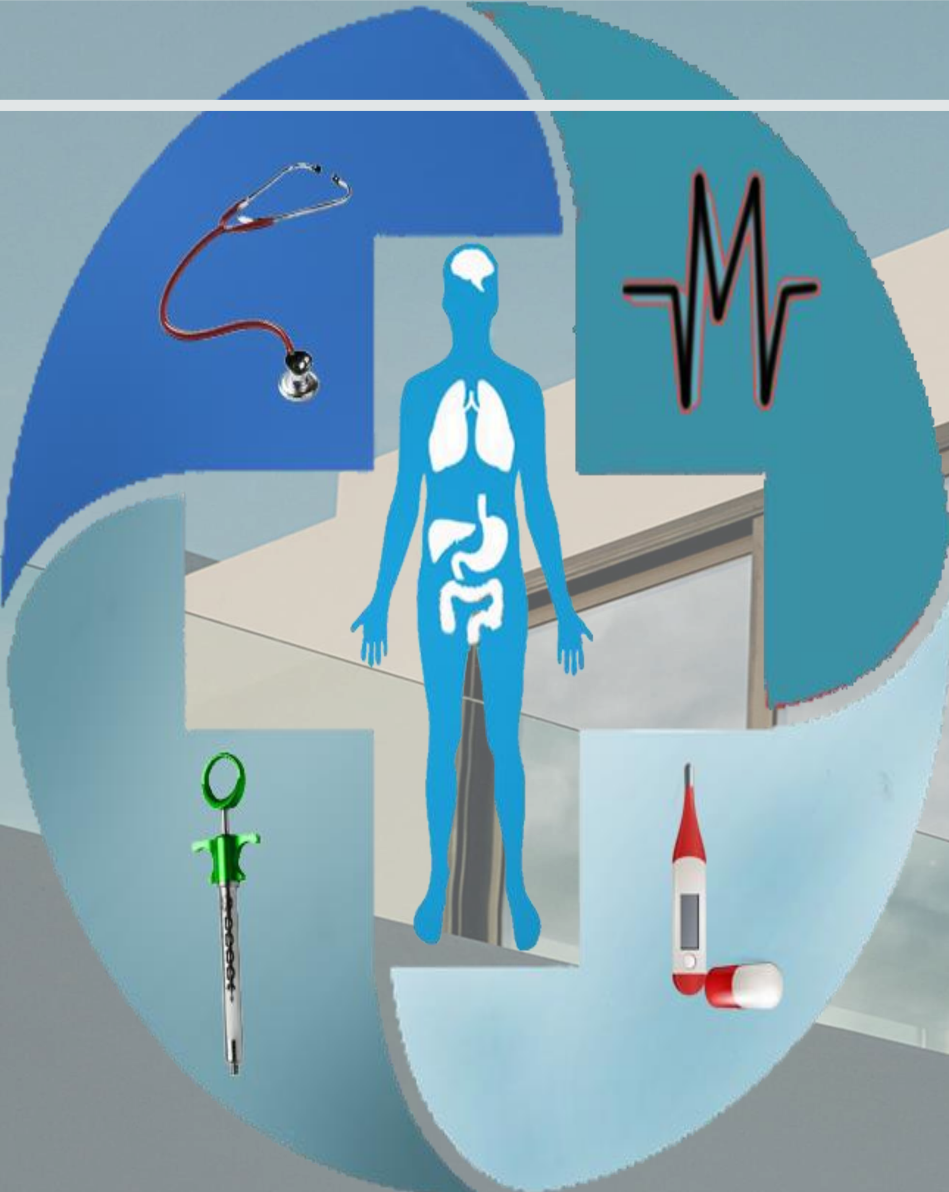
~90%
Children using
technology

52%
Care processes
(Up from 42%)

7,016
NDPP referrals

5.9 days
Avg stay
(Down from 7.1)

WIDER BENEFITS



What this means for people and services

- Earlier support helping people stay well for longer
- Better experience with more joined-up services
- Care delivered closer to home where appropriate
- Reduced pressure on hospitals through proactive care
- Stronger workforce with integrated diabetes nursing team
- Greater focus on reducing inequalities across communities

WHAT HAPPENS NEXT

Moving into neighbourhood working

- The programme has now achieved its core objectives
- Improvements are embedded into everyday services
- Work will continue through neighbourhood teams
- Strong governance will remain in place

👉 Decision requested: Approve closure of the programme and support transition