

The Wairarapa Diabetes Advisory Group

Locality Diabetes Team (LDT)

ANNUAL REPORT 2008

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1.0 EXECUTIVE SUMMARY

Diabetes is important as a major and increasing cause of disability and premature death. Diabetes management is also a good indicator of the responsiveness of a health service for people in most need. Diabetes is implicated in the increase in the difference in life expectancy between New Zealand Europeans and Maori over the last two decades¹.

In 2005, the Wairarapa District Strategic Plan was revised and a number of Priorities were identified that impact on reducing the incidence and impact of diabetes. These priorities include Long Term Conditions, and focusing on the population groups of Maori and those of low socio-economic status. The continuum of Chronic Illness management includes:

- Prevention and Health Promotion
- Screening and Diagnosis
- Treatment
- Support
- Palliative Care

This report includes and interprets diabetes data for the 2008 calendar year and proposes targets for 2009. During the year, a number of initiatives have taken place and collaborative approaches have been effective (e.g. PHO and Maori health provider following up overdue diabetes checks). Although the results of 2008 may be seen to be disappointing, considerable effort has been expended by a range of agencies and health professionals. Also included in the report are a number of actions the Wairarapa Diabetes Advisory Group has identified that will assist in improving the management of people in the Wairarapa who have diabetes.

The Diabetes report for 2007 included a comprehensive review of diabetes services in Wairarapa. This report therefore only provides additional comment relevant to 2008.

The increase of the annual check rate and its implications for diabetes management will continue to be the focus of the Wairarapa Diabetes Advisory Group.

2.0 INTRODUCTION

Diabetes continues to be a DHB priority, and over recent years much effort has been directed towards diabetes prevention and management.

This report is the primary output for the **Wairarapa Diabetes Advisory Group (WDAG)** which operates as a Locality Diabetes Team (LDT). The main mechanism for the LDT is to provide advice to the DHB.² This report presents the results of the Get Checked programme and achievements for 2008, identifies targets for 2009 and proposes recommendations for further service development.

3.0 WAIRARAPA DIABETES ADVISORY GROUP

The Wairarapa Diabetes Advisory Group identifies what is working well, identifies gaps in service and recommends where quality improvements should be made. The status of the WDAG remains consistent with the national LDT Service Specification. The Planning and

¹ Implementing the New Zealand Health Strategy December 2003

² National Service Specification LOCAL DIABETES TEAM, May 2002

Funding Directorate provide the sponsorship and administrative coordination of WDAG and the chairperson is the Diabetes Lead GP.

The objective of the Wairarapa Diabetes Advisory Group is to create a structure to enable greater involvement of diabetes healthcare providers and consumers in monitoring diabetes services and providing advice to the DHB on quality improvement opportunities. The Advisory Group is not an operational group and has no budget or mandate for managing diabetes expenditure. Lead clinical advisors for diabetes are members of WDAG and include a hospital physician with an interest in Diabetes, two Diabetes Clinical Nurse Specialists and a lead GP.

The advantages of a small District Health Board become apparent when attempting consultation and inclusion in local health planning and developments. WDAG is an example of wide representation and inclusion of relevant interests within the Wairarapa Health District. The terms of reference for this group are reviewed on an annual basis.

This year, the team's membership of the Wairarapa Diabetes Advisory Group has altered slightly, but the range of representation has remained and reflects the recommendations of the Maori Focus Group. Current membership of WDAG is listed below:

Core Wairarapa Diabetes Advisory Group members:

- General practitioner (Chairman)
- Practice Nurse - Masterton
- Practice nurse – South Wairarapa
- General Manager, Community, Public and Mental Health Services
- Podiatrist
- Community Pharmacist
- Dietitian
- Community Nursing
- Diabetes Nurse Educator, Community and Public Health Services
- Diabetes Nurse Educator, Maori and Pacific Island People
- Maori Consumer (and renal patient)
- Consumers, Diabetes NZ Wairarapa and Maori/Renal
- Wairarapa PHO representation
- Wairarapa DHB Portfolio Manager

The Physician and Paediatrician are not members of the core group, but are an integral part of developments in the Wairarapa diabetes service. Although unable to attend regular meetings, they act in an advisory capacity to the team.

The Clinical Nurse Specialists provide a link with the Regional diabetes Paediatric Group. This group meets on a quarterly basis and includes input from Wellington, Hutt Valley and Wairarapa).

The Diabetes Advisory Group would like to acknowledge two valuable members who deceased this year - Dave Morris, Maori Consumer (and renal patient) and Jeff Roberts, Diabetes Wairarapa, who had been a member of this group since its inception.

The WDAG terms of reference have been endorsed for 2008 (See Appendix 4).

4.0 DIABETES SERVICES

Wairarapa diabetes services are provided by a range of providers and the DHB does not fund a single diabetes service provider.

Wairarapa DHB's hospital and community health services are provided mainly from Wairarapa Hospital site and Wairarapa Public Health. Services are also delivered from out-reach clinics held at GP practices and on a Marae.

In addition to Wairarapa DHB provider arm, there are a range of other providers who provide a variety of health services and disability services for people in the district. These providers are a mix of private, religious, welfare and other non-governmental organisations. The services they provide include mental health residential and support, rest homes, primary care (GP and nursing services, community workers, pharmacists, laboratories, pharmaceuticals etc), maternity, public health, Well Child, and Kaupapa Maori services. Hutt Valley DHB, in partnership with Wairarapa Public Health Unit, provides Regional Public Health Services for the Wairarapa.

PHOs are a key vehicle in implementing the Primary Care Strategy, achieving improvements in health outcomes and reductions in inequalities. The Wairarapa has one PHO that encompasses the whole district. The DHB has a close working relationship with Wairarapa Community PHO.

Specific Diabetes services include:

Primary Health Nurses and GPs (Annual checks, Care Plus and treatment plans)

Maori Health services – e.g. Whanau Ora and Disease State Management

Secondary Diabetes Clinical Nurse Specialists (education, monitoring, treatment plans, workforce development)

Hospital Specialists – Physician, Paediatrician

Dietetics (education, treatment plans with the Clinical Nurse Specialists)

Primary Mental Health (To Be Heard)

Podiatry

Community Pharmacies

Optometrist (Retinal Screening)

5.0 WAIRARAPA DHB STRATEGIC AND ANNUAL PLAN

Since the establishment of the DHB, Diabetes has been identified as a priority area for Wairarapa and remains relevant today. It is identified within the current Strategic Plan under one of the priority health issues, chronic disease. To achieve the reduction of the incidence and impact of diabetes, the DHB takes both a population health approach and individual treatment approach.

Despite considerable progress against the Strategic Plan, there are increasing numbers of people who develop diabetes with the prevalence of diabetes and serious complications much higher among Maori. A range of DHB strategies are aimed at reducing inequalities in access to health education and promotion and service delivery for people in the lower socio-economic groups.

For the DHB District Annual Plan, 2009-10, the Diabetes continuum, which shares many characteristics of other chronic diseases, is included under the heading of "Reducing the

Incidence and Impact of Chronic Disease”. The focus is on access and early intervention for identified high risk groups of the Wairarapa population and actions include:

- Complete the establishment of a single point of entry for support services for older people
- Implement Maori Outreach Service to assist GP practices reach their Maori population
- Implement the Patient Journey project, with an emphasis on improving points of transfer
- Implement of the Wairarapa Smoke-free Plan
- Work with a range of agencies to promote healthy nutrition and activity
- Continue to increase uptake of the Care Plus programme and improve integration of this programme with other health services.
- Continue implementation of the Long Term Conditions (LTC) project
- Contribute to planning for Regional Renal Services

6.0 2008 RESULTS

The number of people in Wairarapa estimated by the Ministry to have diabetes in 2008 was 1,653. The estimated numbers for each ethnic group are shown in the table below:

Table 1 Estimated number of people with diabetes 2008

Ethnicity	2008 Estimated prevalence	% of estimated total with diabetes	“Actual Diabetes”	
Maori	237	14%	227	13%
Other	1,374	83%	1505	84%
Pacific	43	3%	42	2%
Total	1,653	100%	1794	

The table above shows the Ministry’s estimated number of people with diabetes in 2008 and the number of people with diabetes in Wairarapa who are already identified as having diabetes (e.g. through OPD clinics, hospitalizations, medication).

The three main measures used by the Ministry and the DHB to measure progress for diabetes management are:

- **Diabetes Recognition and Follow up** is measured by the number of annual reviews done
- **Case management** represents the number of people with controlled diabetes as indicated by the number of people with an HbA1C level (blood test) less than or equal to 8.0%. Those people whose annual review blood test shows an HbA1C over 8.0% are considered to have poorly controlled diabetes and therefore considered to be at greater risk of developing the complications of diabetes.
- **Eye screening** data represents the total number of people who have an annual diabetes check, who have had their eyes screened within the past two years.

Wairarapa targets for the above three measures were agreed with the Ministry early in 2008 and results are measured against these targets³.

³ Note: The data does not include children and those people with diabetes being managed by the Paediatrician and Hospital Physicians. Nor do they make any provision for patients who may need their eyes screened more often the every two years, or those who access retinal screening, but not their annual diabetes check.

6.1 Diabetes Annual Reviews

As can be seen from table 2, the Wairarapa target for all ethnicities accessing the annual diabetes checks was not met in 2008. Although these results appear to be rather disappointing, other issues also need to be taken into account. For 2007, the target for Maori was 59% and 51% was achieved. For 2008, the initial DHB target of 65% was increased to 80%. It appears that the initial target for Maori was more realistic and achievable. However, 14% more Maori received diabetes checks in 2008 than in 2007.

It should also be noted that these results are for the Wairarapa in total and mask variations between practices. The Diabetes Advisory Group notes that GP practices vary considerably in the attention they give to diabetes and their clinical management of people with diabetes. Referrals to and engagement with the Diabetes Specialist Nurses also varies considerably. There is scope for improving the links between GP practices and the specialist nurses when a person is diagnosed.

Most practices now have diabetes reviews linked effectively with Care Plus. It is anticipated that, with recall systems being established in GP practices, the number of people with diabetes who receive their annual reviews will continue to rise.

In 2008, the Maori Health Whanau Ora contract was amended to more clearly describe expected links with GP practices in terms of Diabetes annual reviews and management. For example GP practices can now identify non-attenders for review and refer to the Whanau Ora provider for follow-up access to services and assistance in managing the person's diabetes.

Table 2 *Number of Diabetes Annual Reviews 2008*

	Target % for 2008	Target # People for 2008	Actual Free Annual Checks for 2008 %	Actual Free Annual Checks for 2008 # People	Target Met
Maori	80%	190	65%	155	x
Pacific*	%		67%	29	x
Other	80%	1099	73%	1003	x
Total	78%	1289	72%	1187	x

Because of the low number of Pacific Island People with diabetes, setting of targets for the numbers of annual reviews becomes meaningless. However, this does not mean that the DHB focuses less on diagnosing and managing diabetes for Pacific Island people. 29 Pacific Island people accessed the free Diabetes Annual Check in 2008.

6.2 Diabetes Management

As can be seen in Table 3, Wairarapa targets were not met for the 2008 calendar year. The PHO has had a significant drive to ensure annual reviews for their more difficult diabetes patients (with less well controlled HbA1c) and that this will skew results. In addition CVD risk screening and the PHO's Long Term Condition project has resulted in a number of first time reviews for Maori with high HbA1C. It is expected that now that these people are in the system their diabetes will be better managed. Unfortunately the 'snapshot' data that is reported on a

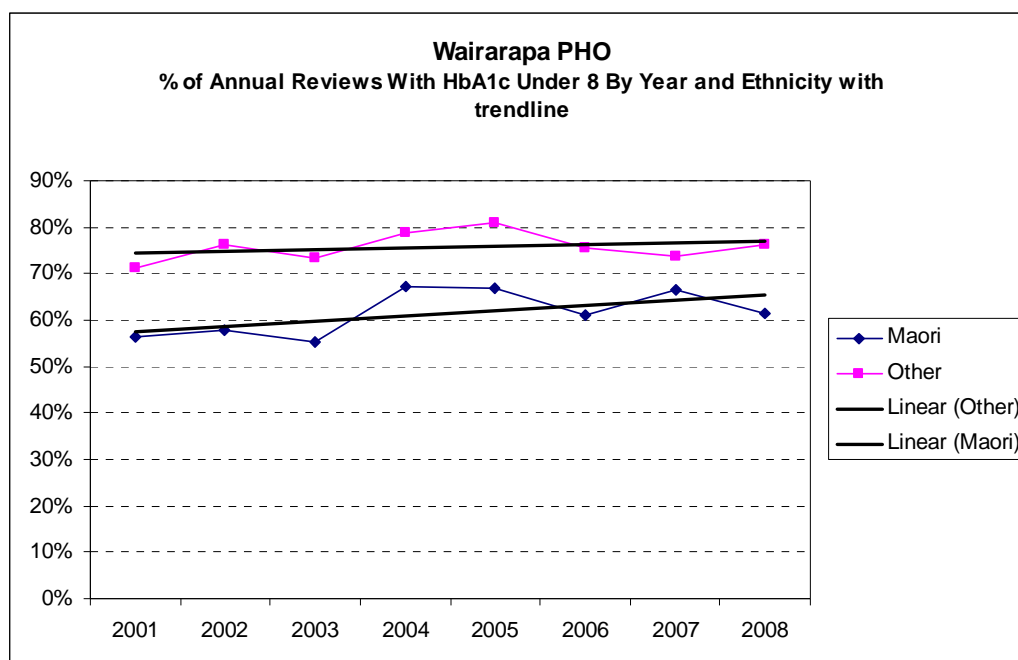
quarterly or annual basis does not capture the whole story in terms of improvement over time for either individuals or cohorts as the population that are having reviews keeps changing.

Suggested additional measures for assisting people to better control their diabetes could include routine referral to the specialist diabetes nurses for anyone with an HbA1c over 8. It would be useful for the specialist nurses to draft referral guidelines for GP practices. An appropriate referral system to the nurses then has to become a standard part of GP practice protocols.

Table 3 Percentage of People having checks with controlled diabetes (HbA1C = or < 8%)

	Target % for 2008	Actual #People checked 2008	Actual # people with HbA1C <8	Actual Result % for 2008	Target Met
Māori	72%	155	92	59%	x
Pacific		29	19	66%	x
Other	75%	1003	743	74%	x
Total	75%	1187	854	72%	x

Although Table 3 indicates that 2008 targets were not met, the trends shown in the graph below show not only continued improvement, but also a narrowing of the difference between Maori and Non-Maori.



6.3 Retinal Screening

The reporting measure of the percentage of people having retinal screening within 2 years of their annual check has now been replaced by the ministry with CVD risk screening. Although targets are therefore no longer set for this measure, it is still useful to identify retinal screening results. Table 4 shows a marked improvement from 2007. It is highly likely that part of this improvement could reflect more accurate data collection through improved data management of long term conditions by the PHO.

Table 4 Percentage of People having retinal (eye) screening within 2 years of their annual check

	Actual Result % for 2007	Actual Result % for 2008
Māori	70%	84%
Pacific*	90%	97%
Other	77%	85%
Total	76%	85%

6.4 CVD Risk Screening

From 1 July 2008, the focus on chronic disease within the national health target has been broadened to include an indicator for cardiovascular disease (CVD). The target indicator is: "Proportion of priority groups who have had their five-year absolute CVD risk recorded in the last five years". This new indicator replaces one of the three diabetes target indicators previously included in the target set ("percentage of people in all population groups who have had retinal screening in the past two years"). Early detection of those at risk and early intervention through primary care are two of the key approaches to controlling CVD and diabetes.

The priority groups for this indicator are:

1. Māori/Pacific & Indian subcontinent men >35 years of age
2. Māori/Pacific & Indian subcontinent women >45 years of age
3. NZ European & other men >45 years of age
4. NZ European & other women >55 years of age.

Considerable effort has been made by the PHO to reach Maori, especially through links with Maori Health providers. The PHO Long Term Conditions project is resulting in an improved focus on identifying CVD risk of people in priority groups. Table 5 presents Wairarapa baseline data, 2008-09 targets and data for July to September 2008, provided by the Ministry.

Table 5 Percentage of Priority Groups who have had their CVD Risk recorded in the last 5 years

	Baseline Jan- March 2008	2008 – 09 Targets		% July – Sept 2008 data
Māori	67.3%	69.3%	Māori	68.2%
Pacific	61.5%	N/A	Pacific	59%
Other	73.8%	75.8%	Other	76.1%
Total	73%	75%	Total	75%

6.5 National Minimum Data Set

The table in appendix 1 is the Ministry's national data set, which is used to monitor progress for each DHB and give national benchmarking information. It includes not only the data for the above measures, but also contains details of factors such as smoking and high cholesterol which increase risk of complications. Pharmaceutical information contained in the data set indicates active control of risk factors such as high blood pressure and high cholesterol (see Appendix 1). Data is provided by GPs and collection of this data is linked with the GP system for claiming payment for the diabetes annual reviews. As the National Minimum Data Set does not extend to paediatrics, data collected only relates to adults with diabetes.

The tables in appendix 1 present a comparison of Wairarapa diabetes data for 2007 and 2008. These results are based on the National Minimum Data Set for Diabetes and include the measures of:

- How many people with diabetes have had an annual review during 2006 and 2007
- The number of annual reviews being accessed by different ethnic groups
- How many of these people have accessed retinal (eye) screening within the past 2 years
- The number of people who have had an annual review in 2006 and 2007 who are at risk of developing complications (those with poorly controlled diabetes, high cholesterol or smokers)
- The number of people who have had an annual review during 2006 and 2007 who are on medication to reduce the risk of complications.

From comparison of tables 9 (2007) and 10 (2008), a number of points are worth noting:

- 92 more checks were achieved in 2008 than in 2007. This was a larger increase than for previous years
- The number of people identified as having had their eyes screened within 2 years of their annual check increased by 8.9%
- A smaller percentage of people with diabetes had their diabetes satisfactorily controlled and a higher percentage of those getting checked smoked (13% in 2007 and 15% in 2008)

7.0 ACHIEVEMENTS IN THE PAST YEAR

The Diabetes report for 2007 included a comprehensive review of diabetes services in Wairarapa and this report provides additional comment, relevant to 2008.

Specific Achievements in 2008 include:

A focus on diabetes prevention through a range of intersectoral health promotion and Healthy Eating, Healthy Action (HEHA) programmes, enabling access for people with low socio-economic status

- Appointment of another FTE dietitian working in Public Health, HEHA and general outpatients.
- Progressed the PHO Long Term Conditions project which involves all Wairarapa GP practices. Software installed and being used to extract population health data. The value of this project has been demonstrated by achieving CVD risk assessments, targeted at specific population risk groups.
- Commenced pilot for improving systems and processes for generic treatment and management of LTCs at primary health care level, which includes three strands
 - System design and change management at individual practice level
 - Improved prescribing and medication management – for patients in the community and Wairarapa hospital
 - Targeted multi-disciplinary case management for 'frequent flyers' and support for them to better self-manage.
- Implemented single point of entry for all Community Health and Support Services. This provides Universal access to support services and community nursing (regardless of age, diagnosis or disability status) through a single agency. It has enhanced the continuum of care through providing seamless transition between funding streams and has enabled equitable access to support for people with long term conditions.

- Appointment of Clinical Nurse Specialist – Gerontology and Rehabilitation to assist in establishing organised stroke services and developing pathways across the primary-secondary interface.
- Successful tender for a new podiatry service for people with at risk/high risk feet Workforce development (see appendix 2)

8.0 2009 TARGETS

Table 5 Estimated number of people with diabetes 2009 - 10

Ethnicity	2009 Estimated prevalence	% of estimated total with diabetes	"Actual Diabetes"	
Maori	275	14%	227	13%
Other	1738	83%	1505	85%
Pacific	44	3%	42	2%
Total	2053	100%	1774	

The following targets have been derived from Ministry guidelines and actual prevalence of diabetes in Wairarapa, for all ethnicities. No targets are set for some ethnicities with low numbers in Wairarapa, e.g. Pacific Island People and Asian (Indian). However, actual results are reported and monitored.

The following two tables show the proposed Wairarapa targets (2009) for annual diabetes checks and diabetes management. No targets are required by the Ministry for Retinal Screening in 2009, but results for this indicator will continue to be reported.

Table 6 2008 Target Number of Diabetes Annual Reviews

	Actual Free Annual Checks for 2008	Actual Free Annual Checks for 2008	Actual # People with diagnosed Diabetes	Target # People for 2009	Target % for 2009 (Based on Actual Diabetes population)
Māori	65%	155	227	182	80%
Pacific	67%	29	42	N/A	N/A
Other	73%	1003	1505	1204	80%
Total	72%	1187	1773	1383	78%

Revised May 09	Actual Free Annual Checks for 2008	Actual Free Annual Checks for 2008	Actual # People with diagnosed Diabetes	Target # People for 2009	Target % for 2009 (Based on Actual Diabetes population)
Māori	65%	155	227	163	72%
Pacific	67%	29	42	N/A	N/A
Other	73%	1003	1505	1159	77%
Total	72%	1187	1773	1330	75%

Table 7 2008 Target Percentage of People having checks with controlled diabetes (HbA1C = or < 8%)

	Actual Result % for 2008	Target % for 2009	Revised Targets May 2009
Māori	65%	72%	72%
Pacific	67%	N/A	N/A
Other	73%	75%	77%
Total	72%	75%	75%

Table 8 Cardiovascular Risk Targets

	2008 -09 Targets	2009-10 Targets
Māori	69.3%	71%
Pacific	N/A	N/A
Other	75.8%	76%
Total	75%	75%

9.0 ACTIONS AND RECOMMENDATIONS FOR 2009

In line with the DHB Strategic Plan, activity related to long term conditions will focus on healthier lifestyles (reducing smoking, improving nutrition and exercise), increased access to primary care, increased early intervention and improved disease management. Further developments in these areas will be within a multi-sectoral approach and will build on the achievements of the past year.

The 2009-10 District Annual Plan includes the following actions which are intended to contribute towards reducing the incidence and impact of diabetes:

- Focus on high needs populations and population health priority areas in order to reduce health inequalities, support the development of healthy communities and reduce the health impact of chronic illness
- Implementation of both the “Keeping Well” plan and the Healthy Lifestyles Strategy
- Increase access and opportunities for physical activity in the community
- Implementation of the Wairarapa Smokefree Plan (WSFP) by smokefree co-ordinator appointed in 2007/2008.
- Support the implementation of the Healthy Lifestyle and Whanau Ora Initiatives delivered by Whaiora Whanui
- Support proposal for improved Obesity Services (increased access to comprehensive service)
- Support the promotion of healthy eating and activity in Outreach health clinics for Maori, Pacific and low-income people

The Diabetes Advisory Group recommends that:

1. That Diabetes continues to be a high priority for the PHO Long Term Conditions Management project. Also, that the PHO links with Dr Jeremy Krebs’ Patient Self management project.

2. The PHO increases its effort to contact Maori not accessing their annual reviews
 - a) Active assistance to attend for annual review – Maori health provider to assist GPs connect with Maori with diabetes
 - b) Specialist Nurses to actively promote reviews
 - c) PHO to encourage GP practices to use OPD data to contribute to reviews.
3. Clarify protocols across primary and secondary health for people with poorly managed diabetes
 - a) All people with HbA1C over 8 to be referred to the diabetes specialist nurses by the GP practice.
 - b) Care plus personal health goals and care plans are completed and linked to the work of other agencies/health professionals.
 - d) Ensure Out Patient clinic laboratory data (sent to GPs) is included in Get Checked system
 - e) Improved linkages between health professionals involved with people with diabetes (e.g. Practice Nurses, Specialist Diabetes Nurse Educators, Dietitian, Maori Health Providers, District Nurses).
 - f) Those who smoke are all offered nicotine therapy. Any cost or cultural barriers for accessing smoking cessation programmes be identified and addressed.
4. Contribute to Regional Renal Network.
5. Minimum of 2 education sessions specifically aimed at management of diabetes in residential care.

10.0 CONCLUSION

The Wairarapa Diabetes Services span all health settings and include a wide variety of health providers. A number of initiatives have resulted in improved services for people with diabetes. It is envisaged that current and future developments will continue to address issues for people with diabetes (or at risk of diabetes) in an effective and efficient way, in order to achieve real health gains.

During 2008, the emphasis has been on reducing the incidence and impact of long term health conditions, including diabetes. Many of the impacts of these changes are likely to become more apparent in years to follow. It is encouraging to note there is still a strong direction of improvement (as illustrated in Appendix 1). Recommendations contained in this document arise from the gap between where Diabetes management in the Wairarapa is currently and where it should be in terms of best practice.

With the continuing development of the Wairarapa Community PHO and Wairarapa Hospital, 2009 promises some exciting developments in diabetes. The Wairarapa Diabetes Advisory Group believes that the targets set for 2009 are realistic and provide clear direction for the year.

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APPENDIX 1

DIABETES DATA SET 2007 AND 2008

Below is a summary of results for Wairarapa DHB for both 2007 and 2008 to enable a comparison between the years.

Table 9 Data Set for Wairarapa 2007 – Annual checks:

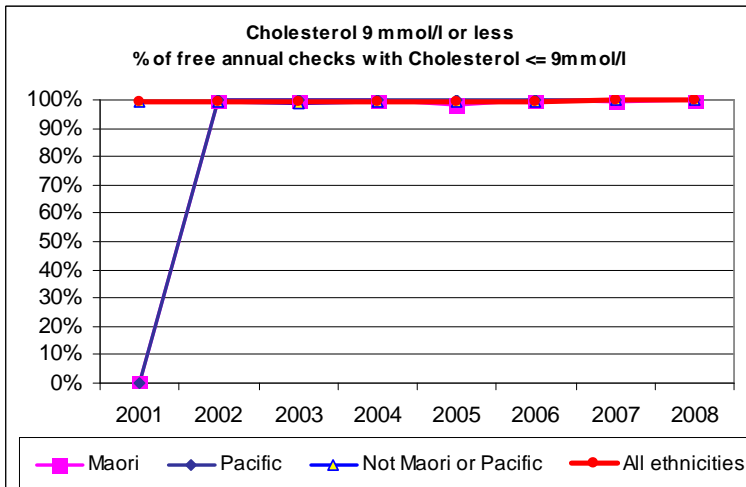
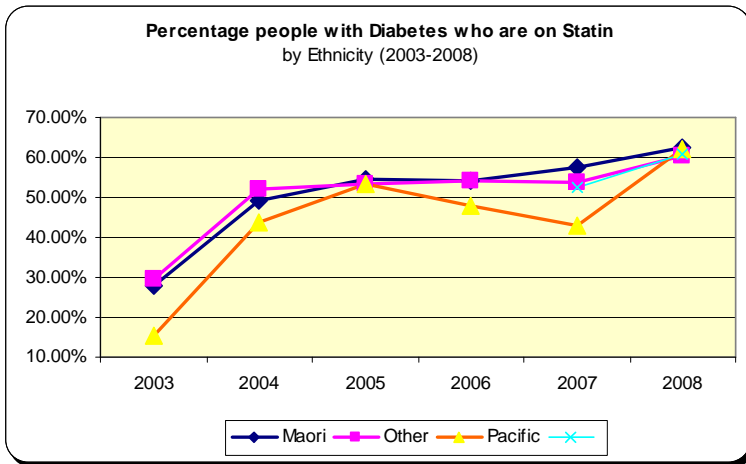
	# Type 1 Diabetes	# Type 2 Diabetes	Other Diabetes	Total Diabetes	As % of Total Annual Reviews	Retinal exam within the last 2 Years	% Annual Reviews receiving Retinal Exams	# HBA1c > 7.0 and < or = 8.0	# HBA1c > 8.0	# Smokers	# On ACE Inhibitor	# With Cholesterol reported	# With Cholesterol > 9.0	# on Statin
Maori	8	145		153	14%	107	70%	81	48	47	99	153	1	88
Pacific NZ	1	20		21	2%	19	90%	13	5	2	14	21	0	9
Caucasian	73	823		896	82%	683	76%	444	231	93	518	896	3	495
Other	0	25		25	2%	22	88%	8	3	2	12	25	0	10
Not Stated	0	0		0	0%	0	0%	0	0	0	0	0	0	0
TOTALS	82	1013	0	1095	1	831	76%	546	287	144	643	1095	4	602

Table 10 Data Set for Wairarapa 2008 – Annual checks:

	Number with Type 1 Diabetes	Number with Type 2 Diabetes	Number with Other Diabetes	Number with Total Diabetes	As % of Total Annual Reviews	Retinal exam within the last 2 Years	% Annual Reviews with Retinal exam within the last 2 Years	Number of people with HBA1c > 7.0 and < or = 8.0	Number of people with HBA1c > 8.0*	Number of current Smokers	# On ACE Inhibitor	Number of people with Cholesterol reported	Number of people with Cholesterol > 9.0	Number of people on Statin
Maori	8	147	0	155	13%	130	83.9%	42	63	51	109	155	0	97
Pacific NZ	2	27	0	29	2.4%	28	96.6%	9	10	5	17	29	0	18
Caucasian	77	899	0	976	82.2%	831	85.14%	270	260	115	556	978	2	594
Asian (Indian)	0	0	0	0	0%	0	0%	0	0	0	0	0	0	0
Other	0	25	0	25	2.1%	18	72%	6	4	1	10	25	0	10
Not Stated	0	2	0	2	0.7%	1	50%	0	1	1	2	2	0	2
TOTALS	87	1100	0	1187		1008	84.9%	327	338	173	694	1189	2	721

Percentage of People Receiving Checks Who Are On Statin medication

	Maori	Other	Pacific
2003	27.78%	29.71%	15.38%
2004	49.04%	52.13%	43.75%
2005	54.69%	53.14%	53.33%
2006	54.25%	54.26%	48.00%
2007	57.52%	53.75%	42.86%
2008	62.60%	60.40%	62.00%



APPENDIX 2

HOSPITAL RELATED DIABETES SERVICES 2007

	2005 Calendar Year		2006 Calendar Year		2007 Calendar Year	
	Contacts	Patients	Contacts	Patients	Contacts	Patients
Outpatients						
M20004 - Diabetes - 1st attendance	24	24	36	34	33	33
M20005 - Diabetes - Subsequent attendance	410	197	288	178	271	160
	434	221	324	212	304	193
<i>* Provided by C&C Outreach Clinics</i>						
M20002 - Endocrinology - 1st attendance	63	61	62	61	67	67
M20003 - Endocrinology - Subsequent attendance	115	82	105	70	91	67
	178	143	167	131	158	134
M55002 - Paediatrics - 1st attendance for diabetes*	0	0	1	1	1	1
M55003 - Paediatrics - Subsequent for diabetes	17	6	11	4	12	6
<i>*(based on referral reason, where description contains "diab")</i>	17	6	12	5	13	7
M20006 - Diabetes Education and Management	2323	784	1847	710	1905	694

Admissions to Hospital - with diabetes as primary reason**	2005 Calendar Year				2006 Calendar Year				2007 Calendar Year			
	Admissions	Patients	LOS	ALOS	Admissions	Patients	LOS	ALOS	Admissions	Patients	LOS	ALOS
Age 0-15 yrs	5	4	7	1.4	7	7	13	1.9	11	9	14	1.3
16-45 yrs	7	7	14	2.0	10	9	23	2.3	12	12	32	2.7
46-64 yrs	11	10	21	1.9	4	4	11	2.8	6	6	7	1.2
65yrs+	10	9	24	2.4	13	11	55	4.2	13	12	49	3.8
Total	33	30	66	2.0	34	31	102	3.0	42	39	102	2.4

** Based on principle diagnosis, where description contains "diab"

LOS = Length of Stay
ALOS = Average Length of Stay

APPENDIX 3

DIABETES WORKFORCE DEVELOPMENT 2008

DIABETES WORKFORCE DEVELOPMENT - 2008									
DATE	COURSE TITLE	No.	DESIGNATION				ETHNICITY		
			R.N.	E.N.	CARER	OTHER	Maori	PI	Other
8/02/2008	Diabetes 101	3	3						3
9/05/08	Diabetes 101	13	12			1		4	9
21/05/2008	Rest Home	4	1		3			1	3
22/05/2008	Practice Nurses	11	9			2			11
27/06/2008	Practice Nurses	11	9			1			10
22/08/2008	Practice Nurses	10	8			2		1	9
5/09/2008	Diabetes 101	5	4			1		1	4
10/10/08	Practice Nurses	8	7			1		2	6
8 SESSIONS									

Notes:

1. "Other Ethnicity" includes all ethnicities not Maori or Pacific Island people
2. Data collection needs to continue recording workplace, designation of staff and ethnicity as a minimum data set for workforce development
3. This data does not include the many and varied informal workforce education opportunities that have occurred through the Diabetes Nurse Educators presence in various workplaces

APPENDIX 4

LDT TERMS OF REFERENCE

WAIRARAPA DIABETES ADVISORY GROUP

(Reviewed: November 2008)

1. INTRODUCTION / BACKGROUND

Diabetes has been identified as a major burden on the health of people throughout New Zealand. Type 2 Diabetes is of particular concern and is recognised as having preventable determinants (e.g. obesity). National concern about Diabetes and its impact on health has resulted in this condition being a major focus in the New Zealand Health strategy and the Wairarapa District Health Board Strategic Plan.

The Wairarapa Locality Diabetes Team (LDT) – “Wairarapa Diabetes Advisory Group” has been established as part of the National Diabetes Framework in an attempt to reduce the incidence and impact of diabetes. The Local Diabetes Team (LDT) is considered to be a major stakeholder in the Wairarapa Diabetes service.

2. PURPOSE / SCOPE

To act in an advisory capacity to the Wairarapa District Health Board on matters relating to diabetes (it is an advisory role rather than an operational one).

3. OBJECTIVES

These objectives are specifically related to diabetes, its prevention and effective management:

- To identify local services that are working well
- To identify gaps in local services
- To make recommendations to the Wairarapa District Health Board that highlight prevention and reduce impacts of diabetes
- To provide an annual report (Feb) to the Wairarapa District Health Board and the Ministry of Health which includes the above.

4. SPONSOR

Joy Cooper, Director, Planning and Funding.

5. SELECTION AND COMPOSITION

All indications of interest by individuals or groups who wish to be represented on this group will be considered. Maori representation on this group will be recommended by the Te Iwi Kainga. A group of key representatives from the primary and secondary health sectors and relevant interest groups will be selected by the DHB sponsor according to:

- Their recognised interest and expertise in diabetes
- The perspective(s) they offer which adds value to the group's composition.
- Their willingness to give time and energy to helping progress planning and service development for diabetes.

Representation will reflect the major contributors to diabetes care in the Wairarapa:

- Maori consumers and providers
- Diabetes Wairarapa
- PHO Representation - GPs/Practice nurses
- Diabetes Clinical Nurse Specialists
- Podiatrist, Dietician, Pharmacist – clinical representation
- Physician, Paediatrician – medical advisors
- Public Health
- DHB Planning and Funding representation

6. MEETINGS

Three monthly, with provision to meet more frequently as needed.

The Fees and Expenses Policy for Advisory Groups (WH/POL/GOV/005) will apply

7. MEMBERSHIP

Gael Binns, District Nurse

Annette Castle, Practice Nurse, South Wairarapa

Joy Cooper, Director, Planning and Funding

Anne Davies, Chapel Street Family Doctors, Masterton

Joanne Edwards, Portfolio Manager, Planning and Funding

Mollie Kainuku, Diabetes Clinical Nurse Specialist

Trevor Kauika, Consumer (diabetes and renal)

John Miller, Podiatry, Foot Mechanics

Maggie Morgan, General Manager, Community, Public Health and Mental Health

Dr David Nixon, The Doctors Masterton (Chairman)

Sheila Roberts, Consumer, Diabetes Wairarapa

Jenny Skeet, Diabetes Clinical Nurse Specialist

Stuart Stubbs, Community Pharmacist

Additional Diabetes Advisors

Michelle Dowman, Clare Davies, Dietitians

Dr Niels Dugan, Physician

Joe Howells, WIPA Manager, Parent of children with Type 1 Diabetes

8. DELEGATIONS

- The authority to elect its chairperson and other office holders on an annual basis.

9. RELATIONSHIPS (EXTERNAL / INTERNAL).

- Through its membership, the Team relates to Diabetes Wairarapa (consumer group), Primary, Secondary and Maori Health Providers and Public Health.
- Information is given to and input sought from a wider diabetes reference group (individuals with an interest in diabetes, and related issues).
- Receives and analyses data from the annual diabetes reviews
- Seeks guidance from the Te Iwi Kainga in relation to Maori Health needs and service provision for Maori.
- Is provided with advisory support and assistance by the National Diabetes Working Group (NDWG).
- Is provided with support and assistance by the Wairarapa Primary Health Organisation (PHO)
- Is provided with support and assistance by the Wairarapa District Health Board

10. REPORTING

The Team produces an annual report that makes recommendations to the Wairarapa District Health Board and is provided to the Ministry of Health