Effectiveness of the Get Checked diabetes programme

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Auditor-General's overview

My staff have prepared this document to help district health boards (DHBs) further improve the effectiveness of the Get Checked diabetes programme.

This document follows a report my Office produced in 2007, entitled *Ministry of Health and district health boards: Effectiveness of the "Get Checked" diabetes programme*. That report had 17 recommendations for DHBs.

This document clearly sets out the intent behind those recommendations. It also includes examples of actions that some DHBs reported to us in 2009, which they were carrying out to meet the intent of our recommendations. I encourage all DHBs to share their experiences of improving the effectiveness of the Get Checked programme.

DHBs can use the contents of this document, and the questions posed in it, to consider their progress and identify how the Get Checked programme could be improved.

This document is a new approach for my Office, so I am also interested in feedback from DHBs, and any other organisations involved in the Get Checked programme, on this document's usefulness. I would be grateful if you could send your feedback to diabetesguidefeedback@oag.govt.nz by 1 December 2010. We will use your feedback to inform our future approach to sharing our findings with public entities.

I thank all the DHBs for providing my staff with information about their progress with the recommendations made in our 2007 report.

I would like to acknowledge the expert assistance and advice that the late Professor Sir Donald Beaven provided to my staff while we were preparing our original report on the Get Checked diabetes programme. He was always very conscious of the need for effective public health initiatives to improve the health outcomes of people with diabetes. Sir Donald Beaven showed tireless enthusiasm and energy in holding public health entities accountable for the resources allocated to improving diabetes management and treatment.

Lyn Provost
Controller and Auditor-General

24 September 2010

Part 1
Introduction

1.1 In June 2007, we presented a performance audit report to Parliament on the effectiveness of the Get Checked diabetes programme, *Ministry of Health and district health boards: Effectiveness of the "Get Checked" diabetes programme* (the Get Checked report). In 2008, we followed up on the actions that the Ministry of Health (the Ministry) had taken in response to the recommendations we made in the Get Checked report. We included the results from this follow-up in *Performance audits from 2007: Follow-up report*, which we published in March 2009.

1.2 In *Performance audits from 2007*, we said that we would follow up on the responses to our recommendations for district health boards (DHBs). Accordingly, in 2009, we asked DHBs to report to us on their progress with the recommendations. This document is the result of our follow-up work with DHBs.

About our 2007 Get Checked report

1.3 In the Get Checked report, we reported that the Get Checked programme (the programme) had, in general, improved certain aspects of diabetes management. These improvements included:

- an increase in the number of people taking part in the programme;
- a heightened awareness of diabetes;
- improved monitoring of patients;
- better guidance provided to general practitioners (GPs) on diabetes treatment and referrals to specialist diabetes services; and
- the use, in some areas, of innovative programmes to remove barriers for people accessing diabetes care, particularly Māori and Pacific Island peoples.

1.4 We made 18 recommendations[1] to improve the quality of the programme data and the effectiveness of the programme. We consulted with diabetes expert Professor Sir Donald Beaven when drafting the report and forming our recommendations.

Structure of this document

1.5 The information presented in this document is based on the DHBs' representation of the actions, as reported to us in 2009, that they had taken in response to our recommendations.

1.6 We have grouped the recommendations into five parts. In Part 2, we discuss our recommendations about DHBs identifying who has been diagnosed with diabetes and whether they are getting checked.

1 One of the recommendations was aimed only at the Ministry and we do not deal with that recommendation in this document.

1.7 In Part 3, we discuss our recommendations about DHBs analysing, reporting, and using information from their diabetes services.

1.8 In Part 4, we discuss our recommendations about DHBs checking the quality of diabetes services provided to patients diagnosed with diabetes.

1.9 In Part 5, we discuss our recommendations about DHBs making it easier for patients diagnosed with diabetes to take part in the programme.

1.10 In Part 6, we discuss our recommendations about DHBs working more effectively with their local diabetes teams (LDTs).

1.11 Appendix 1 sets out how the recommendations from the Get Checked report correspond to the sections of this document.

1.12 In each Part, we pose questions that DHBs can use to consider how effectively they are implementing the programme. Appendix 2 lists all the questions we pose.

Part 2
Knowing who has been diagnosed with diabetes and whether they are getting checked

Identifying people who have been diagnosed with diabetes

2.1 In our Get Checked report, we considered that all DHBs should be able to identify the actual number of people who have been diagnosed with diabetes in their district.

2.2 The programme has now been running for more than nine years. It is important that DHBs know the actual number of people diagnosed with diabetes in their districts so they can accurately assess the coverage of the programme.

2.3 Without this information, DHBs cannot be certain that all people diagnosed with diabetes have been offered the opportunity to take part in the programme. Equally, DHBs might be overestimating the programme's coverage. It is also important that DHBs know the actual number of people with diabetes so they can plan for the likely future demand for services, especially for treating complications from diabetes.

2.4 In 2009, most DHBs reported examples of work that they, their Get Checked programme administrators (programme administrators), or primary health organisations (PHOs) were carrying out to improve GPs' coding and recording of patients diagnosed with diabetes. Figure 1 sets out the different ways that DHBs were doing this. See also the case studies in Figures 2 and 3.

Figure 1
Examples of work to improve GPs' coding and recording of patients diagnosed with diabetes

Common action DHBs had taken included:

- increasing the funding to general practices for annual checks to improve the recording of those checks;
- funding information technology positions to support general practices;
- assisting general practices to build their electronic patient management systems;
- providing regular reports to general practices that benchmark their performance against other general practices;
- introducing software into patient management systems to prompt GPs to code patients as having been diagnosed with diabetes; and
- putting in place a local quality indicator programme, which includes diabetes coding as a quality indicator.

2.5 Some DHBs reported that the national PHO Performance Programme provides an incentive for their PHOs to identify people diagnosed with diabetes in their GPs' patient management systems.

2.6 The PHO Performance Programme, which started in 2006, was designed to improve the health of people enrolled with a PHO and reduce inequalities in health outcomes. If PHOs improve their performance against nationally consistent indicators, including two diabetes indicators, they receive incentive payments.

2.7 All but one PHOs participate in the diabetes part of the PHO Performance Programme.

2.8 Some DHBs told us that they check how complete their diabetes register is by comparing it to the Ministry's register. The Ministry's register includes a list of people who have had:

- diabetes-specific medications dispensed;
- a hospital discharge recorded;
- four or more HbA1c tests[2] in a two-year period; or
- a diabetes-specific outpatient appointment.

2.9 We consider it good practice for DHBs to use this information to ensure that they have identified all those diagnosed with diabetes in their district.

Ensuring that diabetes registers are accurate and up to date

2.10 In our Get Checked report, we recommended that DHBs work to ensure that their diabetes registers are accurate and up to date, which is essential to identify patients who have been diagnosed with diabetes.

2.11 In 2009, many DHBs reported examples of work that they were carrying out to ensure that their diabetes registers were accurate and up to date. Much of this work was aimed at helping GPs correctly code those diagnosed with diabetes in their patient management system (see Figure 1).

Question to consider:

1. Have you identified all of the people in your district who have been diagnosed with diabetes by ensuring your diabetes register is accurate and up to date?

2 An HbA1c test is a blood test to measure a person's glycosylated haemoglobin level. The test indicates how well a person has been managing their blood glucose levels, and the results are given as a percentage.

Identifying people diagnosed with diabetes who are not getting checked

2.12 In our Get Checked report, we considered that DHBs, their programme administrators, and PHOs should be able to identify those people diagnosed with diabetes who were not taking part in the programme. This would allow DHBs to know the real coverage of the programme in their district, rather than the coverage of the number of people estimated to have diabetes. Patients not taking part in the programme could then be asked to join, if they had not been asked already.

2.13 In 2009, some DHBs reported examples of work to identify those diagnosed with diabetes who were not attending the free annual health check that the programme offers. The case studies in Figures 2 and 3 show how two DHBs were carrying out this work.

Figure 2
Counties Manukau District Health Board – Known Diabetes project

Counties Manukau DHB set up the Known Diabetes project to identify the number of patients in its district diagnosed with diabetes. The DHB used several local databases to identify diabetes patients, including Counties Manukau DHB inpatients, diabetes and ophthalmology diabetes outpatients, diabetes waitlist and referrals, enrolees in the diabetes Chronic Care Management programme, enrolees in the Get Checked programme, and retinal screening patients.

The results from the project were then triangulated with other surveys, databases, and data sets, such as the Let's Beat Diabetes baseline survey that interviewed 2500 adults living in the Counties Manukau DHB district. Counties Manukau DHB told us that this triangulation showed that the data from the Known Diabetes project aligned closely with the other data sets.

The results of the Known Diabetes project identified that there were about 25,000 people diagnosed with diabetes living in the Counties Manukau DHB district. The data also showed a very high prevalence of diabetes for the Pacific and Indian populations (at 11% and 9% respectively of those aged over 15). Overall, of the Counties Manukau DHB population over the age of 60, around 20% have been diagnosed with diabetes.

Because of the Known Diabetes project, Counties Manukau DHB was able to provide all its PHOs with lists of patients (by National Health Index number* at general practice level) who were on its "known diabetes" list but who were not enrolled in the Get Checked programme. PHOs have used these lists to update their registers and to contact individual patients and encourage them to have the free annual health check. Counties Manukau DHB told us that it employed two medical students to update registers for its largest PHO and contact these patients to offer them the free annual health check.

* The National Health Index number is an alphanumeric unique identifier used in the New Zealand health system.

Figure 3
Otago District Health Board – Data matching project

Otago DHB reported that its LDT was carrying out a data matching project that included the PHOs, general practices, and the DHB. The data matching project compares the Ministry's 2008 diabetes data for Otago against the programme data for the same period to identify people with diabetes who have not accessed the programme during 2008.

Otago DHB told us that it intended to review the results of the matching process, and that each PHO would discuss the findings with the relevant general practice and determine how each general practice would investigate those who had not accessed the programme.

Otago DHB hoped that, once this was completed, the PHOs and general practices would have a much better understanding of who was not accessing the programme and how they might increase the number of eligible people accessing the programme.

Question to consider:

2. Have you identified those patients diagnosed with diabetes who are not taking part in the programme and made sure they have been asked if they would like to take part?

2.14 In paragraphs 5.1-5.5, we discuss identifying why people diagnosed with diabetes are not taking part in the Get Checked programme.

Encouraging people to participate in the programme

2.15 In our Get Checked report, we identified that some GPs were not encouraging patients to take part in the programme. The main reason for their reluctance was that the GPs believed that the fee paid for carrying out the free annual health check was not enough to cover the costs of the check or the costs of completing the documentation that accompanied it. Other issues reported to us included:

- some GPs saw the reviews as an information-collecting exercise;
- technology problems sometimes meant that data from the free annual health check was not submitted to the PHO or DHB and the fee was not paid to the general practice; and
- a higher proportion of people failed to attend the pre-arranged appointment for the free annual health check than failed to attend appointments made for existing conditions.

2.16 In our view, all people diagnosed with diabetes should be offered a chance to take part in the programme. DHBs and their programme administrators or PHOs need to work with general practices to address concerns about the programme, where possible.

2.17 In our 2009 survey, one DHB told us that low participation in the programme by general practices was still an issue. This DHB reported to us that its GPs view the checks as an administrative data collection exercise and the wrong driver for better diabetes management. Although the GPs see the individual measures in the review as valid, they do not support the concept of an annual review about a single disease when people with diabetes may have other conditions, and need ongoing management of all of them.

2.18 Some DHBs reported that they had taken some steps to encourage GPs to promote and support the programme. Several DHBs reported to us that they have increased the funding to general practices for each free annual health check to better reflect the work involved. Waikato DHB told us that it has encouraged its PHOs to ensure that patients diagnosed with diabetes, especially Māori and Pacific Island patients, are encouraged to join the programme by way of its local quality indicator programme.

Question to consider:

3. Where GPs may not be promoting and supporting those diagnosed with diabetes to take part in the programme, have you (or your programme administrator or PHOs) considered whether you need to address concerns that GPs in your district might have about the Get Checked programme?

Part 3
Analysing, reporting, and using information from diabetes services

Regular reporting of programme data to general practitioners

3.1 In our Get Checked report, we recommended that programme administrators (or PHOs) regularly analyse and report information from the programme to GPs to enable them to benchmark their performance.

3.2 In 2009, most DHBs reported to us that programme administrators (or PHOs) are regularly analysing and reporting data from the programme to GPs. Most DHBs told us that the frequency of reporting to general practices was either monthly or quarterly. In our view, this frequency is appropriate.

3.3 Only one DHB told us that its programme administrator was not regularly reporting information from the programme to GPs. We encourage this DHB, and any others where programme administrators or PHOs are not reporting to GPs, to work with programme administrators or PHOs to achieve regular reporting to GPs.

Question to consider:

4. If the GPs in your district are not receiving regular reports on the Get Checked programme, have you identified what needs to be done to achieve regular reporting and are you addressing the problem?

Identifying improvements to the programme

3.4 In our Get Checked report, we recommended that the Ministry and DHBs analyse data from the programme to better understand how the programme and other factors contributing to diabetes care are linked, and to identify how diabetes care can be improved further (including how the programme can be improved).

3.5 We suggested that cohort analysis[3] might be helpful in showing whether the programme was leading to more effective management of diabetes.

3.6 Since our Get Checked report, the Health Research Council[4] commissioned a national study of a group of people in the programme who have Type 2 diabetes. The study examined changes in the health status and management of the group over two years. The results of the study were published in September 2008. The study concluded that participating in the free annual health check may have contributed to improving the clinical management of the group and reduced

3 A cohort analysis follows a defined population, in this case defined by the year the people started participating in the programme, to establish whether there is any change in the recorded results over time.

4 The Health Research Council is the Crown agency responsible for managing investment in public good health research. The Minister of Health is responsible for the Health Research Council, with most of its funding coming from Vote Research, Science and Technology.

disparities. The study acknowledged that removing restrictions on the use of statin in 2002, and introducing diabetes management guidelines in 2003, may also have improved the management standards.

3.7 In 2009, some DHBs reported to us that they had analysed the treatment and outcomes of patients taking part in the programme. For example, Waitemata DHB told us that it had compared data about patients who were taking part in the programme with those who were not. It found that those taking part in the programme had better process measures of care (for example, retinal screening rates) but that differences in intermediate outcomes (such as HbA1c levels) were small or non-existent. The DHB noted in its study that it was difficult to determine what caused the differences because these two patient groups may have been different for reasons other than participating in the programme.

3.8 No DHB reported to us that they had carried out cohort analysis using the data from the programme.

Question to consider:

5. Have you considered (either individually or with other DHBs or organisations) carrying out further analysis (for example, cohort analysis) using the data from the Get Checked programme to identify improvements that could be made to diabetes care?

Managing service demand

Current demand

3.9 In our Get Checked report, we said that DHBs should collect information from their specialist diabetes services about:

- the number of patients attending the service;
- the complexity of patients' conditions; and
- waiting times.

3.10 This would allow DHBs to identify whether there is a need for more services and, if necessary, to take action to provide more services.

3.11 In 2009, most DHBs reported that they were working towards collecting this information. For example, Capital and Coast DHB reported that its specialist diabetes team records information about its patients, including the reason for referral and waiting time. This information can be accessed when needed. The DHB's specialist diabetes team was also working on creating a program that will automatically analyse the information.

Question to consider:

6. Are you collecting enough information to identify any shortages in your specialist diabetes services and taking action to provide more services where they are needed?

Future demand

3.12 In our Get Checked report, we said that DHBs should be using information from the programme about the number of people who are likely to suffer certain complications from diabetes. For example, the programme was collecting information on the number of people who may develop diabetic kidney disease. It is important that DHBs collect and use this type of information when planning services to treat patients with certain diabetes complications.

3.13 We recognise that some DHBs may be using this information already but did not report it to us in 2009.

Question to consider:

7. Are you using information about the potential incidence of complications from diabetes to inform your service planning?

Part 4
Checking the quality of the service

Clinical audit of diabetes care

4.1 In our Get Checked report, we recommended that DHBs (or their programme administrators or PHOs) use information in diabetes registers to identify general practices that may need extra support to manage patients diagnosed with diabetes. We then expected DHBs to carry out a more focused audit of the diabetes care that these general practices provide, to discover what the issue was and what support the DHB needed to provide.

4.2 In 2009, some DHBs told us that they carry out audits like this. For example, Counties Manukau DHB reported that it was working with its local provider, the Diabetes Project Trust,[5] to focus its audits of GPs on general practices that PHOs had highlighted as needing clinical assistance. The Diabetes Project Trust had initially identified those general practices with case management rates under 55% and those with retinal screening rates under 60% as needing clinical assistance.

4.3 We also understand that all PHOs are required to carry out clinical audits of their general practices under the DHB-PHO agreement. In our view, DHBs should use the information from these audits to identify general practices that need extra support to manage patients diagnosed with diabetes.

4.4 Many DHBs reported that they tend to provide support and education to general practices rather than auditing their clinical care to ensure that it is of an acceptable quality. Figure 4 sets out examples of this support and education.

Figure 4
Examples of quality improvement support that district health boards provided to general practices

DHBs have told us that they have:

- resourced providers of local diabetes education to educate primary and secondary care clinicians;
- increased resourcing of PHO diabetes nurse educators who work with general practices to improve their management of diabetes patients;
- worked with the sector to prepare standardised assessment and care planning templates;
- employed diabetes co-ordinators to work with general practices on diabetes planning and management;
- funded software in general practices that supports diabetes assessment;
- diabetes specialists working with primary health care practitioners to promote, educate, and support best practice care in line with the guidelines;
- the LDT actively working with general practices and acting as a resource on effectively managing their diabetic population; and
- provided national-guidelines-based education to primary and secondary health care nurses.

5 The Diabetes Project Trust is a non-governmental organisation that runs and manages the Diabetes Care Support Audit (see page 37 in the Get Checked report).

4.5 We consider this work appropriate, but note that it is also important to ensure that patients receive diabetes care in line with the evidence-based best practice guidelines and national referral guidelines. In our view, an audit component would strengthen this work.

4.6 An audit component would also allow DHBs to identify where general practices need support and education in their diabetes care. Providing support and education will be more effective if it addresses identified issues of quality.

Question to consider:

8. Have you considered whether you or your PHO(s) should inform and complement the support and education for general practices with more in-depth audits of their diabetes care?

Checking diabetes treatment plans

4.7 In our Get Checked report, we recommended that DHBs, their programme administrators, or their PHOs check that patients taking part in the programme were getting treatment plans and that the treatment plans were of an acceptable quality. Treatment plans can make a considerable contribution to the success of the programme. They encourage patients to effectively manage their diabetes and control their blood glucose levels.

4.8 Few DHBs reported to us in 2009 that they checked this. The ones that did told us that they have checked that patients were getting treatment plans, but have not checked the quality of those plans.

Question to consider:

9. Are you, your programme administrator, or your PHO(s) checking that diabetes treatment plans are of an acceptable quality?

Establishing the effectiveness of treatment plans

4.9 In our Get Checked report, we recommended that DHBs (or their programme administrators or PHOs) monitor the effectiveness of the treatment plans in improving self-management of diabetes through lifestyle changes. Indicators of improved self-management may include reducing body mass indexes, reducing the number of people smoking, and improving HbA1c levels.

4.10 After we published the Get Checked report, the Government introduced Health Targets for diabetes care. All DHBs must now record and report each year the

proportion of people who have had a free annual health check with satisfactory or better diabetes control (as indicated by HbA1c levels).

4.11 A few DHBs reported using other indicators to monitor the effectiveness of treatment plans, such as lifestyle changes. For example, West Coast DHB told us that its PHO monitors the effectiveness of treatment plans by analysing information collected through the programme, such as smoking rates, medication rates, lipid levels, HbA1c levels, and blood pressure levels. This analysis is fed back to general practices with peer comparisons on a quarterly basis.

4.12 Auckland DHB also analyses information collected by its PHOs, such as smoking cessation rates, medication prescription rates, and HbA1c levels. The DHB shares this information with its PHOs and LDT annually.

4.13 Where the evidence indicates a lack of progress in improving self-management, DHBs (and their programme administrators or PHOs) need to work to improve it. In the Get Checked report, we reported examples of work to improve HbA1c levels. Figure 5 sets out these examples.

Figure 5
Examples of work to try to improve self-management of diabetes

Counties Manukau DHB had offered a payment to general practices as an incentive to reduce HbA1c levels for a trial period. The incentive covered patients who had been enrolled in the Chronic Care Management programme because they had an HbA1c level greater than 9% and who had been in the Chronic Care Management programme for at least one year. For each general practice, the DHB planned to calculate the average HbA1c level for the group of qualifying patients at the time of their enrolment and pay $20 for each patient in the group whose HbA1c level decreased by at least 1.5%.

South Link Health Incorporated introduced an Enhanced Diabetes Programme on 1 April 2005. The Enhanced Diabetes Programme provided an additional subsidised visit for patients who had an HbA1c level greater than 8% for two consecutive free annual health checks. The main purpose of this extra visit was to focus on lifestyle and medication changes.

Question to consider:

10. Are you, your programme administrator, or your PHO(s) working to improve the effectiveness of the treatment plans in improving self-management of diabetes where there is evidence of a lack of progress?

Part 5
Making it easier to take part in the programme

Recording why people decline the free annual health check

5.1 In our Get Checked report, we recommended that DHBs record the reasons patients give for turning down the free annual health check. Having this information would allow DHBs to recognise any common barriers to people accessing that check and to take action to remove these barriers, if possible.

5.2 We recognise that people diagnosed with diabetes have the right to decide whether they take part in the programme. However, some people may not take part in the programme because of reasons outside of their control. For example, a patient may decline a free annual health check because they cannot easily attend an appointment during their GP's normal opening hours because of work or family commitments.

5.3 In our 2009 survey, few DHBs provided us with information about whether GPs in their district were recording the reasons why patients declined to take part in the programme. One DHB told us that its PHO collects the general reasons for patients declining to take part in the programme.

5.4 Some DHBs reported that they carry out other activities to discover why people were not getting checked. These activities were often targeted at particular groups with low uptake of the programme, such as Māori and Pacific Island groups. For example, Canterbury DHB told us that it had contracted a market research company to survey patients diagnosed with diabetes. The survey's aim was to examine the lack of uptake of programmes for primary care diabetes management, such as the Get Checked programme. Capital and Coast DHB told us that it supports an annual Pacific Diabetes Fono, during which issues about accessing diabetes care are discussed.

5.5 We support the use of these methods and consider that they may be effective and efficient in discovering why people are not taking part in the programme.

Question to consider:

11. Are you working to identify why patients are not taking part in the Get Checked programme?

Removing barriers for Māori and Pacific Island peoples to diabetes care

5.6 In our Get Checked report, we said that DHBs should have initiatives to remove barriers to Māori and Pacific Island peoples accessing diabetes care. It is important that Māori and Pacific Island peoples have access to diabetes care because they have significantly worse health outcomes than other people with diabetes.

5.7 In our 2009 survey, most DHBs told us that they had initiatives to reduce barriers to accessing diabetes care for their Māori and Pacific Island populations. They had different approaches to this, although several had a focus on providing diabetes care through services other than general practices. Figure 6 sets out some examples of DHBs' initiatives to improve access to diabetes care for Māori and Pacific Island peoples.

Figure 6
Examples of initiatives to remove barriers for Māori and Pacific Island peoples diagnosed with diabetes

Auckland DHB told us that it had adopted strategies to optimise access for high-needs groups (including Māori and Pacific Island peoples). These strategies included access to interpreting services in primary health care, increasing the capacity of general practices in high-needs areas with large Māori and Pacific populations to provide appointments outside of traditional opening hours, and providing courses on diabetes self-management.

Bay of Plenty DHB reported that its transportation scheme for patients in a low socio-economic area of its district was proving very successful.

Capital and Coast DHB told us that, among other initiatives, it had established Diabetes Nurse Educator roles to provide clinical and general-practice-based support for Māori and Pacific peoples to improve diabetes management.

Nelson Marlborough DHB reported that both of its PHOs had established good links with Māori health providers and local marae for delivering diabetes services to Māori diagnosed with diabetes in an appropriate setting. In Marlborough, the Tane Ora conference and the Vascular Risk Assessment service (delivered through practices and community venues) have identified Māori with diabetes, or at risk of developing diabetes, and supported them to enter the care of a general practice. Kimi Hauora Wairau (Marlborough PHO) provides funding, training, and professional development for the nurses of two Māori health providers working in diabetes care, supporting the provision of diabetes care in a kaupapa Māori environment.

Waikato DHB told us that it had given PHOs an incentive, through a local quality indicator programme, to target Māori and Pacific Island peoples to have an annual review.

5.8 However, it is not always clear how effective these initiatives have been in removing barriers for Māori and Pacific Island peoples accessing diabetes care. We discuss the evaluation of such initiatives in paragraphs 5.15-5.18.

Question to consider:

12. Do you have initiatives in place to remove barriers to diabetes care for Māori and Pacific Island peoples?

Removing barriers for other groups to diabetes care

5.9 In our Get Checked report, we recommended that DHBs consider whether any other groups had trouble accessing the programme and create initiatives to improve access for those groups, if possible. In particular, we noted that some Asian ethnic groups had a high prevalence of diabetes.

5.10 In 2009, Auckland DHB told us that it had identified a need for additional support for the Asian ethnic group to access diabetes care. Auckland DHB reported that it had employed a diabetes nurse specialist since 2008 specifically to work with this ethnic group, and with providers with a high proportion of people from this ethnic group in their general practices. This DHB has the highest proportion of Asian people in its population. In our view, this is a positive step towards supporting this ethnic group to access diabetes care.

5.11 Some other DHBs reported that they did not have initiatives to support other population groups to access diabetes care. This was because they had high numbers of Māori and Pacific Island peoples or small numbers of other groups, or both. However, only one of these DHBs told us that it had information that the Asian community in its district was satisfactorily accessing primary health care. DHBs need to provide additional support to groups where there is evidence that these groups are not satisfactorily accessing diabetes care.

5.12 Some DHBs reported to us that they had identified other groups needing extra support to access annual checks, such as:

- those living in low income areas;
- refugees and migrants;
- children and adolescents;
- seasonal workers; and
- those living in rural areas.

5.13 Figure 7 sets out the groups some DHBs had identified and the support they reported having in place.

Figure 7
Other groups identified as needing support to access diabetes care and initiatives to support access

Capital and Coast DHB reported that its other high-needs populations, including those in low income areas and refugees, are able to access some additional support. A high number of this population live in one of the targeted areas for the diabetes nurse specialists that is also provided with a PHO diabetes nurse.

Hutt DHB reported that it has created specific services for children and adolescents with diabetes. It reported that "Paediatric clinics are clustered around age-banded cohorts with joint child and parent sessions run prior to Outpatient clinics, which increases practical day to day supports within this vulnerable group". It also had services to send text messages to adolescents. Its LDT had identified that the DHB needs to consider the needs of migrants and refugees in the future.

Nelson Marlborough DHB reported that the needs of its other low-income populations are served by existing Māori health providers and, in rural areas, by the DHB's rural services. In rural Marlborough, people receive care from satellite medical clinics in Havelock and Seddon. Eligible seasonal workers in Marlborough receive care from the range of general practices in Marlborough.

5.14 Other DHBs should consider whether other groups within their district need additional support to access diabetes care.

Question to consider:

13. Have you established whether groups other than Māori and Pacific Island peoples in your district are satisfactorily accessing diabetes care, and do you have arrangements to support access by these groups where it is needed?

Evaluating and sharing successful initiatives to remove barriers to diabetes care

5.15 In our Get Checked report, we recommended that initiatives to help certain groups to access diabetes care be evaluated to test whether they are achieving their goal. Such evaluation would also identify any improvements that could be made to the programme. Without knowing how effective initiatives are, DHBs and PHOs may be wasting their resources.

5.16 Few DHBs reported to us in 2009 that they had measures to evaluate initiatives for removing barriers to accessing diabetes care. No DHBs provided detailed information on their work.

5.17 In our view, any initiatives evaluated as successful should be shared with other DHBs and PHOs to see whether they could be successful in other districts.

5.18 Some DHBs told us that they were sharing successful initiatives. Figure 8 sets out some examples of the ways DHBs reported sharing successful initiatives.

Figure 8
Examples of sharing successful initiatives for removing barriers to accessing diabetes care

Auckland DHB reported that it had set up an information network and various forums where PHOs and other organisations can share their experiences and highlight what is working for them.

Capital and Coast DHB told us that it supported discussion about existing initiatives at various forums within its district, including LDT meetings, the PHO Advisory Group, and the Primary/Secondary Clinical Governance Group.

MidCentral DHB reported that it and its PHO had been sharing with other DHBs its successes with the programme and with the Diabetes Service Plan.

Question to consider:

14. Do you know whether initiatives you and your PHOs have to remove barriers to accessing diabetes care are effective, and are you sharing successful initiatives within your district and with other DHBs?

Part 6
Working with local diabetes teams

Improving the effectiveness of local diabetes teams

6.1 In our Get Checked report, we found that none of the LDTs we visited were as effective as they could have been. For example, none of the LDTs were fully meeting the requirements set out in the LDT service specification. We recommended that DHBs ensure that their LDT was as effective as possible.

6.2 Many DHBs told us in 2009 that they were working to review or improve the effectiveness of their LDTs. For example, Southland DHB told us that the management of its LDT moved from the DHB's Planning and Funding team to the PHO in January 2009 to provide greater independence for the LDT. Waitemata DHB reported that it had reviewed its LDT in 2008 and created a new group called the Diabetes Clinical Advisory Group that includes all the roles of the LDT. This group includes representatives of all stakeholders and has an increased strategic role.

Question to consider:

15. If your LDT is not working as effectively as it should be, what are you doing to help it be more effective?

Analysis by local diabetes teams of secondary diabetes service gaps

6.3 In our Get Checked report, we considered that LDTs should meet the service specification requirement to include analysis of primary care data and other clinical information in their annual report. For "other clinical information", LDTs are required to collect and analyse information from specialist diabetes services. Analysing this information would enable shortages in services provided at a secondary care level to be identified. This would also allow a picture of patients diagnosed with diabetes treated in secondary care to be established and enable comparisons between secondary care units throughout the country.

6.4 In 2009, 18 out of 21 DHBs had LDTs. Only a few of the 18 DHBs reported that their LDTs were identifying shortages at both the primary and secondary care levels. However, we have reviewed the annual reports from these few LDTs for the 2008/09 year, and they do not indicate that they have analysed the demand and supply for secondary diabetes services.

Question to consider:

16. Are you helping your LDT to analyse information from secondary care to identify service shortages?

Listening to your local diabetes team

6.5 In our Get Checked report, we reported that most of the LDTs we talked to found it hard to get DHBs to listen to their recommendations. We recommended that DHBs give due consideration to recommendations that their LDTs make so that the resources that are dedicated to LDTs are not going to waste. We consider that DHBs responding to their LDT's reports in a timely manner is good practice.

6.6 In 2009, many DHBs told us that they were working with their LDTs to include their advice when planning diabetes services. Several DHBs told us that their LDTs' recommendations were put into effect through the direct involvement of the DHB's planning and funding staff in the LDT, or through the annual planning process. For example, Canterbury DHB has a dedicated staff member within its Planning and Funding division who liaises with the LDT. Also, the DHB's planned diabetes outputs for 2009/10 were aligned with working towards the LDT's recommendations.

6.7 Waitemata DHB told us that there was an agreed expectation that the DHB will provide a response to the LDT's recommendations but that the recommendations cannot be binding. Waikato DHB reported that, when its LDT submitted its next report to the DHB Community and Public Health Advisory Committee, the DHB would submit an action plan detailing the DHB's response to the recommendations made.

Question to consider:

17. Are you giving your LDT's reports, including any recommendations, due consideration and responding to them in a timely manner?

Appendix 1
How our recommendations correspond to sections in this document

Original recommendations		Sections in this document
1	We recommend that district health boards work with programme administrators to identify those patients in patient management systems who have been diagnosed with diabetes.	Identifying people who have been diagnosed with diabetes (Part 2)
2	We recommend that district health boards work with programme administrators to identify those people in the population diagnosed with diabetes who are not taking part in the programme, ensure that they have been invited to join the Get Checked programme, and (if possible) note and address their reasons for declining.	Identifying people diagnosed with diabetes who are not getting checked (Part 2) Encouraging people to participate in the programme (Part 2) Recording why people decline the free annual health check (Part 5)
3	We recommend that district health boards work with primary health organisations to monitor the preparation and audit the quality of treatment plans, and establish the effectiveness of these plans over time.	Checking diabetes treatment plans (Part 4) Establishing the effectiveness of treatment plans (Part 4)
4	We recommend that the Ministry of Health review and, if necessary, update the national referral guidelines.	Not discussed in this document because the recommendation is for the Ministry of Health.
5	We recommend that district health board specialist diabetes services maintain enough data on the numbers of patients attending their clinics, the complexity of patients' conditions, and waiting times to enable the district health board to identify and plan for the funding and resources needed to provide adequate diabetes services at this level.	Managing service demand (Part 3)
6	We recommend that those district health boards where there are shortfalls in specialist diabetes services investigate the shortfalls and provide additional services as considered necessary.	Managing service demand (Part 3)
7	We recommend that district health boards ensure that the information in their diabetes registers is accurate and updated, and work with programme administrators to identify, clarify, and resolve current problems affecting data quality.	Ensuring that diabetes registers are accurate and up to date (Part 2)
8	We recommend that district health boards ensure that enough audit processes are in place to verify that payments are being made for genuine annual checks, and that they work with their programme administrators to achieve this.	Not discussed in this document because our focus here is on improving the effectiveness of the programme.

Original recommendations		Sections in this document
9	We recommend that district health boards work with programme administrators to ensure that the data from the Get Checked programme is thoroughly analysed and the results regularly reported back to general practices to improve diabetes care.	Regular reporting of programme data to general practitioners (Part 3)
10	We recommend that district health boards work with primary health organisations and programme administrators to ensure that adequate clinical audit is carried out to provide assurance that general practices are providing diabetes care in line with the evidence-based best practice guidelines and national referral guidelines.	Clinical audit of diabetes care (Part 4)
11	We recommend that district health boards work with local diabetes teams to carry out a more robust analysis of supply and demand for diabetes services at both the primary and secondary care levels, so that any shortages in services provided at both the primary and secondary care levels can be identified.	Analysis by local diabetes teams of secondary diabetes service gaps (Part 6)
12	We recommend that the Ministry of Health and district health boards review the role of the local diabetes teams to establish how these teams are best able to adequately fulfil the role of providing advice on the effectiveness of healthcare services for people with diabetes.	Improving the effectiveness of local diabetes teams (Part 6)
13	We recommend that the Ministry of Health and district health boards consider how to improve the adoption of the local diabetes teams' recommendations.	Listening to your local diabetes teams (Part 6)
14	We recommend that district health boards work with primary health organisations to continue to focus on removing the barriers to Māori and Pacific Island peoples accessing the Get Checked programme.	Removing barriers for Māori and Pacific Island peoples to diabetes care (Part 5)
15	We recommend that the Ministry of Health and district health boards work with primary health organisations to evaluate existing initiatives for removing barriers to accessing diabetes care, and ensure that there is a mechanism in place to disseminate successful initiatives throughout district health boards and primary health organisations.	Evaluating and sharing successful initiatives to remove barriers to diabetes care (Part 5)

Original recommendations		Sections in this document
16	We recommend that district health boards consider whether initiatives need to be put in place for populations within their districts other than Māori and Pacific Island peoples who also experience barriers to accessing diabetes care.	Removing barriers for other groups to diabetes care (Part 5)
17	We recommend that district health boards and the Ministry of Health carry out further analysis (for example, cohort analysis) of the effect that the Get Checked programme has had on diabetes care and management, to better understand how the programme and other factors contributing to diabetes care are linked and to identify what further improvements can be made in diabetes care and management.	Identifying improvements to the programme (Part 3)
18	We recommend that district health boards work with local diabetes teams and programme administrators to make more use of the data available from the Get Checked programme to plan their diabetes services.	Managing service demand (Part 3)

Appendix 2
Index of questions to consider

Knowing who has been diagnosed with diabetes and whether they are getting checked	
1	Have you identified all of the people in your district who have been diagnosed with diabetes by ensuring your diabetes register is accurate and up to date?
2	Have you identified those patients diagnosed with diabetes who are not taking part in the programme and made sure they have been asked if they would like to take part?
3	Where GPs may not be promoting and supporting those diagnosed with diabetes to take part in the programme, have you (or your programme administrator or PHOs) considered whether you need to address concerns that GPs in your district might have about the Get Checked programme?
Analysing, reporting, and using information from diabetes services	
4	If the GPs in your district are not receiving regular reports on the Get Checked programme, have you identified what needs to be done to achieve regular reporting and are you addressing the problem?
5	Have you considered (either individually or with other DHBs or organisations) carrying out further analysis (for example, cohort analysis) using the data from the Get Checked programme to identify improvements that could be made to diabetes care?
6	Are you collecting enough information to identify any shortages in your specialist diabetes services and taking action to provide more services where they are needed?
7	Are you using information about the potential incidence of complications from diabetes to inform your service planning?
Checking the quality of the service	
8	Have you considered whether you or your PHO(s) should inform and complement the support and education for general practices with more in-depth audits of their diabetes care?
9	Are you, your programme administrator, or your PHO(s) checking that diabetes treatment plans are of an acceptable quality?
10	Are you, your programme administrator, or your PHO(s) working to improve the effectiveness of the treatment plans in improving self-management of diabetes where there is evidence of a lack of progress?
Making it easier to take part in the programme	
11	Are you working to identify why patients are not taking part in the Get Checked programme?
12	Do you have initiatives in place to remove barriers to diabetes care for Māori and Pacific Island peoples?
13	Have you established whether groups other than Māori and Pacific Island peoples in your district are satisfactorily accessing diabetes care, and do you have arrangements to support access by these groups where it is needed?
14	Do you know whether initiatives you and your PHOs have to remove barriers to accessing diabetes care are effective, and are you sharing successful initiatives within your district and with other DHBs?
Working with local diabetes teams	
15	If your LDT is not working as effectively as it should be, what are you doing to help it be more effective?
16	Are you helping your LDT to analyse information from secondary care to identify service shortages?
17	Are you giving your LDT's reports, including any recommendations, due consideration and responding to them in a timely manner?