NORTHLAND DISTRICT HEALTH BOARD
Te Poari Hauora Á Rohe O Te Tai Tokerau

The Northland Diabetes Strategy

Implementation Plan

Adopted by the Board December 2006

STAND implementation plan

The strategy

Successfully Taking Action for Northland Diabetes – STAND – the Northland Diabetes Strategy, was developed in 2005. The aim of STAND is

> ***To create an environment that stops people getting diabetes, slows the progression, reduces the impact and improves the quality of life for those diagnosed with diabetes***.

A critical outcome of the implementation of the Strategy will be an improvement in the health of Maori and reduction of health inequalities in the district. To select actions appropriate to this outcome, proposed action areas were screened using the reducing inequalities and HEAT tools[1]. The priority actions will be implemented within the framework of the Treaty of Waitangi to address issues for Maori. Specifically this will mean involving Maori at all levels and stages of health system planning and delivery through processes that reflect the principles of partnership.

STAND is built around **7 action areas**. These, with their major recommendations are:

1 Implement Healthy Eating, Healthy Action and strengthen health promotion activities:

Develop a plan of action for implementation of Healthy Eating, Healthy Action (HEHA) in Northland.

Devise a plan of action for strengthening health promotion coordination and activity by concentrating on the recommendations of the stocktake of Northland health promotion providers undertaken in 2004 by three of the Northland PHOs.

2 Children and diabetes

Develop a consistent, coordinated approach to reducing the prevalence of factors which predispose children to type 2 diabetes by concentrating on:

- breastfeeding
- childhood obesity
- intersectoral approaches

3 A patient-centred clinical care pathway.

Further develop a patient-centred clinical care pathway for Northland.

Continue to support and enhance a structured evidence-based approach to early diagnosis and treatment of diabetes through annual free checks, 'Predict' Diabetes and CVD risk assessment, and Chronic Care Management Programmes.

Carry out regular audits of practice to monitor compliance with the pathway and patient satisfaction.

4 Review existing services for those with diabetes

Carry out a review of all diabetes-related services throughout Northland.

[1] Refer Diabetes Strategy, section 5

5 Develop and support an effective coordinated workforce.

Develop a workforce action plan that is aligned to the needs of people with diabetes in Northland.

6 Information systems that best support STAND

Clarify the impact of the MoH national diabetes database (due to be available by the end of 2005) before embarking on a diabetes information systems strategy in diabetes in Northland.

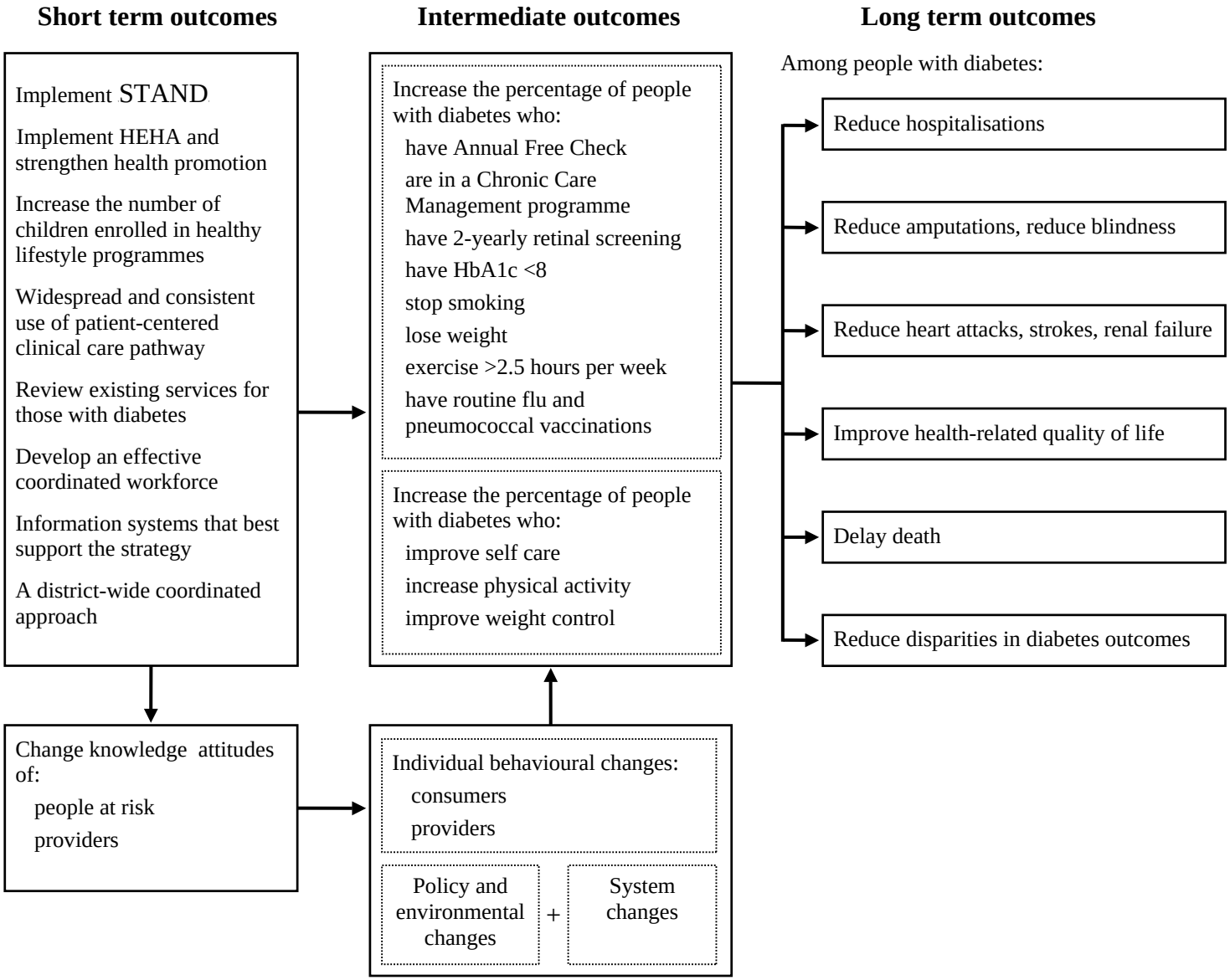
7 Develop a district-wide coordinated approach.

Employ a Diabetes Strategy Coordinator within the Northland DHB's Service Development and Funding team to assist with strategy implementation.

STAND Implementation Plan

The Implementation Plan has been prepared using the information contained in STAND to show what actions need to be taken to address the seven action areas. The review of diabetes services and the HEHA implementation plan need to be funded and completed as a matter of priority, then there should be a formal launch of the strategy, with the aim of engaging all Northlanders in beating diabetes.

This implementation plan aims to achieve the short-term and some of the intermediate outcomes identified in section 7 of the strategy, shown in the "outcome measures" table below.


Short term outcomes
Intermediate outcomes
Long term outcomes
Implement STAND
Implement HEHA and strengthen health promotion
Increase the number of children enrolled in healthy lifestyle programmes
Widespread and consistent use of patient-centered clinical care pathway
Review existing services for those with diabetes
Develop an effective coordinated workforce
Information systems that best support the strategy
A district-wide coordinated approach
Increase the percentage of people with diabetes who:
have Annual Free Check
are in a Chronic Care Management programme
have 2-yearly retinal screening
have HbA1c <8
stop smoking
lose weight
exercise >2.5 hours per week
have routine flu and pneumococcal vaccinations
Increase the percentage of people with diabetes who:
improve self care
increase physical activity
improve weight control
Among people with diabetes:
Reduce hospitalisations
Reduce amputations, reduce blindness
Reduce heart attacks, strokes, renal failure
Improve health-related quality of life
Delay death
Reduce disparities in diabetes outcomes
Change knowledge attitudes of:
people at risk
providers
Individual behavioural changes:
consumers
providers
Policy and environmental changes
+
System changes

Implementing the Priorities for Action

This table shows how the priorities will be turned in to action over the next three years and provides an indication of the agencies involved in accomplishing the actions; the measures of progress; and whether the actions can be achieved using existing, increased or new resources. The plan should be reviewed after 18 months of operation and additional actions added to promote the achievement of the Diabetes Strategy.

Actions	Agencies	Milestones/Progress Measures	Timeframe/ resourcing
Priority for Action 1: Implement Healthy Eating Healthy Action (HEHA) and strengthen health promotion			
1.1 Engage a HEHA project manager to develop a plan of action for implementation of HEHA in Northland and to devise a plan of action for strengthening health promotion coordination and activity[2].	NDHB[3] MAPO Sport Northland NGOs PHOs TAs	Plans developed by May 2006. Reports on activities to strengthen health promotion coordination and activity.	Commence August 2006; use tagged one-off PHU funding for HEHA implementation planning.
1.2 Carry out the HEHA Prescription Project, linking with the HEHA implementation planning process.	NDHB Sport Northland PHOs MAPO	Findings of the HEHA Prescription project incorporated in to HEHA planning and implementation. 100% increase in green prescription uptake on June 2006 baseline by the end of the project in 2008. 150% increase in Maori uptake of green prescriptions on June 2006 baseline by the end of the project in 2008.[4]	Resourced by NDHB, PHOs, Sport Northland and MoH for 2006-08
1.3 Work with all low decile, high Maori population	NDHB	100% of decile 1 schools signed up for	Existing or additional

[2] Using the recommendations of the stocktake of Northland health promotion providers undertaken in 2004 by three of the Northland PHOs.
[3] NDHB refers to the whole organisation with relevant involvement whether from the funder/planner or from the provider arm.
[4] Other measures will be in line with those developed by the HEHA Prescription Project Steering Group.

Actions	Agencies	Milestones/Progress Measures	Timeframe/ resourcing
schools to involve them in the whole school approach to nutrition and exercise.	MAPO Schools Heart Foundation	programmes (Health Promoting Schools; Fruit in Schools and /or Food in Schools) by December 2007.	funding
1.4 Work with food producers and vendors eg supermarkets, to produce and market healthier foods; and work with national food accord initiatives.	NDHB Food industry	Food producers and vendors identified and some initial approaches made, by December 2006. Involvement in rollout or pilots of national Food Industry Project.	Existing
1.5 Make NDHB workplace a healthy lifestyles role model by: • conducting a healthy lifestyles programme for NDHB employees and gathering baseline data on diet and activity levels (this initiative has started but may need additional resources to ensure wider coverage) • evaluating cafeteria food choices and snack and drink vending machines to ensure that the healthy options are promoted above less healthy alternatives • preparing a healthy food policy • providing advice on flexible activity options • encouraging use of stairs, walking and cycling	NDHB Sport Northland	No. of staff healthy lifestyle days held/coverage. Communicate results/best practice models. Only healthy food choices are available in cafeterias, vending machines and volunteer food trolleys – achieved by July 2007. Healthy Food Policy by March 2007. Bike storage facilities and changing rooms/showers provided by end 2007. 10% increase in NDHB staff who are defined as physically active by 2010 i.e. have 30 minutes physical activity per day or at least 2.5 hours physical activity per week..	Existing/new

Actions	Agencies	Milestones/Progress Measures	Timeframe/ resourcing
1.6 Complete the Northland Region Sport and Physical Recreation Strategy and develop a plan to implement the aspects relevant to the NDHB.	NDHB Sport Northland MAPO TAs	Strategy adopted by end June 2006. Implementation plan prepared as phase 2.	Existing ($38,000 already committed) New for implementation
Priority for Action 2: Develop a district-wide coordinated approach			
2. Employ a Diabetes Strategy Coordinator within the NDHB's Service Development and Funding team to co-ordinate implementation of the strategy. Specific responsibilities include: • undertaking, co-ordinating or overseeing the tasks identified in Priorities 3-7 below, commencing with the review. • supporting the development of STAND by working with a diabetes strategy steering group • advocating for resources to be committed to the strategy implementation process • communicating STAND to stakeholders through a variety of forums and processes • monitoring progress in reducing inequalities	NDHB STAND Steering Group	Coordinator position filled and progress made on the specific responsibilities. STAND Steering Group in place.	New funding for a position for an initial 2 year period, with review after that time; plus project resources.
Priority for Action 3: Review existing services for those with diabetes			
3. Review of all diabetes-related services, throughout Northland, including looking at ways to enhance whanau, hapu, iwi and community development and resources for kaupapa maori programmes. The review will include an audit of workforce skills and training needs. It will	NDHB MAPO RDT PHOs NGOs	Review completed within 6 months and reported to the STAND Steering Group and the General Manager Service Development and Funding, NDHB, with recommendations that cover realignment of services to ensure maximum value and elimination of	New funding (Co-ordinator)

Actions	Agencies	Milestones/Progress Measures	Timeframe/ resourcing
also review the NDHB Diabetes service, annual free checks and retinal screening.		duplication and fragmentation; with equity of access to culturally appropriate services.	
Priority for Action 4: Reduce the number of children at risk of diabetes			
4. Develop a consistent, coordinated approach to reducing the prevalence of factors that predispose children to type 2 diabetes by concentrating on breastfeeding; childhood obesity; and intersectoral approaches. 4.1 Actions for breastfeeding include:	NDHB MSD NGOs Sport Northland		
• Working closely with all lead maternity carers to ensure all hospital maternity/obstetric facilities meet Baby Friendly Hospital Initiative standards and provide ongoing resources to maintain the standard.		Facilities meet Baby Friendly Hospital Initiative standards.	Existing/increased.
• Demonstrating leadership as an employer by having an effective breastfeeding policy and facilities to support staff and contractors who are breastfeeding their own children.		Breastfeeding policy maintained.	Existing
• Participating in and/or promoting intersectoral initiatives that support breastfeeding friendly environments		Reports on intersectoral initiatives	Existing
• Enhancing existing and/or prioritising new services that focus on improving breastfeeding rates among vulnerable		Maori breastfeeding rates reach at least the national 2005 targets of 74% (exclusive/ fully) at 6 weeks; 57% at 3 months and 21% at 6 months, by 2008.	Increased/new

Actions	Agencies	Milestones/Progress Measures	Timeframe/ resourcing
populations throughout Northland.			
4.2 Actions on childhood obesity include: • extending the Lifestyle Clinic model in Whangarei and delivering a similar culturally competent service throughout the region. (Refer also implementation of the HEHA strategy.)	NDHB MAPO PHOs NGOs Sport Northland	Extension of culturally competent lifestyle clinic concept in the region, implemented by June 2007. Increased number of Maori children accessing the service throughout the district (at least at the rate at which they are represented in the obesity statistics for the district).	Increased/new
• ensure early identification and optimal management of gestational diabetes, pre-conception counselling and optimal management of young women with diabetes	NDHB PHOs NGOs	Develop and implement guidelines by June 2007	
▪ strengthen the capabilities of well child services, general practice and Maori providers to assess children with developing obesity risks and ensure early and appropriate referral. (Refer action 1 above)		Support provided to well child services, general practice and Maori providers to identify and refer children at risk of obesity, by providing referral guidelines. Increased availability throughout Northland of primary care dietician services. Increased no. HEHA prescriptions.	PHO funding
4.3 Actions to improve intersectoral collaboration include:			

Actions	Agencies	Milestones/Progress Measures	Timeframe/ resourcing
• Form partnerships with MSD to ensure maternity and well child providers better identify at risk children and families, and provide intensive support or referral where necessary • Strengthen the partnership with Sport Northland through Lifestyle Clinic model providers.	NDHB MSD Sport Northland	Partnerships formed with MSD and Sport Northland. Lifestyle clinic model extended.	Existing
Priority for Action 5: Use a patient-centred clinical care pathway			
5.1 Continue development, implementation and monitoring of clinical pathways and guidelines based on best practice; set up a clinical advisory group to develop pathways; ensure that pathways/guidelines are specific for Maori and other at risk groups and ensure a seamless transfer of patients and information between services and providers.	NDHB PHOs RDT MAPO	Clinical Advisory Group complete pathways and guidelines by Dec 2006 ready for implementation. Pathways specific to the needs of Maori developed.	Mix of new funding (for Co-ordinator) and existing (unless otherwise stated)
5.2 Involve PHO clinical committees and DHB clinicians in reviewing criteria for access to secondary and tertiary services and shared arrangements; disseminate these criteria to ensure the pathway is implemented in primary and secondary care.		Joint primary/secondary clinical governance structure in place.	
5.3 Carry out opportunistic screening of high risk groups in hospital and in the community.		Promote guideline for in hospital and community opportunistic screening by Dec 2006.	

Actions	Agencies	Milestones/Progress Measures	Timeframe/ resourcing
5.4 Provide a patient-held agreed plan of care to each person with diabetes.		Each individual has a patient-held agreed plan of care by end 2007.	
5.5 Give timely access to retinal screening programmes to all patients as part of their care pathway and improve uptake of retinal screening.		80% of Maori receive screening at least bi-annually	
5.6 Encourage use of structured patient education programmes.		Structured education programmes available and accessible to all with a diabetes diagnosis through the PREDICT software, by 2008.	Increased
5.7 Investigate and implement the provision of Northland-specific culturally competent information on services for people with diabetes and how to access them (eg booklet, web-based resource eg Healthpoint).		Culturally competent information on services available by December 2007.	New
5.8 Continue to support and enhance a structured evidence-based approach to early diagnosis and treatment of diabetes through annual free checks, 'Predict' Diabetes and CVD risk assessment, and Chronic Care Management Programmes.		Achievement of regional targets[5] for 2006 and 2007 for uptake of annual free checks; control; and retinal screening, in particular for Maori with diabetes. AFC targets reached; new community outreach services or community health workers.	DHB funding of AFCs. PHO SIA funding of community outreach services.
5.9 Improve case detection and case management through incentives (PHO funding) or other measures for Maori.			

[5] Refer Northland Regional Diabetes Team Report of 2005 Annual Free Check Data, Feb. 2006

Actions	Agencies	Milestones/Progress Measures	Timeframe/ resourcing
5.10 Put in place an auditing system to monitor compliance with the pathway and patient satisfaction		Auditing system in place by early 2007. Annual satisfaction surveys conducted to gauge patient perceptions of care.	
Priority for Action 6: Develop an effective coordinated workforce			
6.1 Develop a workforce action plan that is aligned to the needs of people with diabetes in Northland[6].	NDHB RDT MAPO	Workforce action plan prepared by December 2007, including specific actions to support enhancement of Maori workforce	New funding – Co-ordinator
6.2 Make available accredited courses specific to the management of diabetes, which emphasise the patient experience and respond to gaps in skills and knowledge, with culturally competent content and delivery.		Courses available by December 2008.	Existing/increased
6.3 Collaborate with other organisations involved in research; and maintaining and forming linkages with universities where appropriate		Involvement in research and innovative care models.	Existing
6.4 Ensure all workforce development initiatives aim to achieve a culturally responsive service.		All NDHB staff attend cultural competence training annually. Maori workforce recruited/developed.	Existing
Priority for Action 7: Implement information systems that best support STAND			
7.1 Prepare a diabetes information systems strategy to achieve the goal of an integrated diabetes IT	NDHB MoH	Strategy and implementation plan prepared by June 2008.	Start Jan '08[7]

[6] Refer action 3, review of services.
[7] To coincide with MoH Primary Care database being fully operational for the 2006 calendar year.

Actions	Agencies	Milestones/Progress Measures	Timeframe/ resourcing
system fully operational by 2010.	PHOs	Implementation commenced July 2008.	New funding
7.2 Work with the MoH and providers to roll out a primary care database to prevent duplication		Rollout completed January 2007	Existing
7.3 Link retinal screening database with other information systems / primary care data base		Appropriate links made with primary care	New
7.4 Funder continues to set and monitor ethnic-specific targets; ensuring that information on ethnicity is an integral part of all data systems, recorded consistently by all staff.		Ethnicity data available.	Existing