Improving West Coast access to care and the journey for ~~individuals and families~~ Māori and whānau with ~~pre-diabetes and~~ diabetes

Whakakotahi
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Adjusted Buller Medical Project Team:

- DNS
- EN
- Kaupapa Māori Nurse
- Kaiarataki
- Clinical Manager WCPHO
- GP
- Consumer

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Implementation Plan - Amended

- Project team – meeting fortnightly
- Consumer co-design (HQSC workshops, project team, patient survey)
- Teamwork using key provider groups – Poutini Waiora, health navigators
- Include pharmacy delayed, re-explore
- Baseline data/identified project measures established (DAR, HbA1c, referrals)
- PDSAs:
  - lifestyle programme referrals (completed)
  - Outreach Māori (in progress) proposed ‘New’ model
  - Retinal screening processes (completed) ongoing though
  - Patient survey about the service and patient’s needs (completed)
  - Patient medication leaflets (in progress) continue
  - Pre-commencing medication audit (delayed)
- Sustainability: need to reconsider
  - Project in workstream plan (to get wider support) (done, still needs progress)
  - Communications plan:
    - regular feedback to practice team / sponsor / CGC / LDT / PHO Board (ongoing)
    - Monthly data reporting to practice team (ongoing, still needs progress)
    - Monitoring/tracking (continue)

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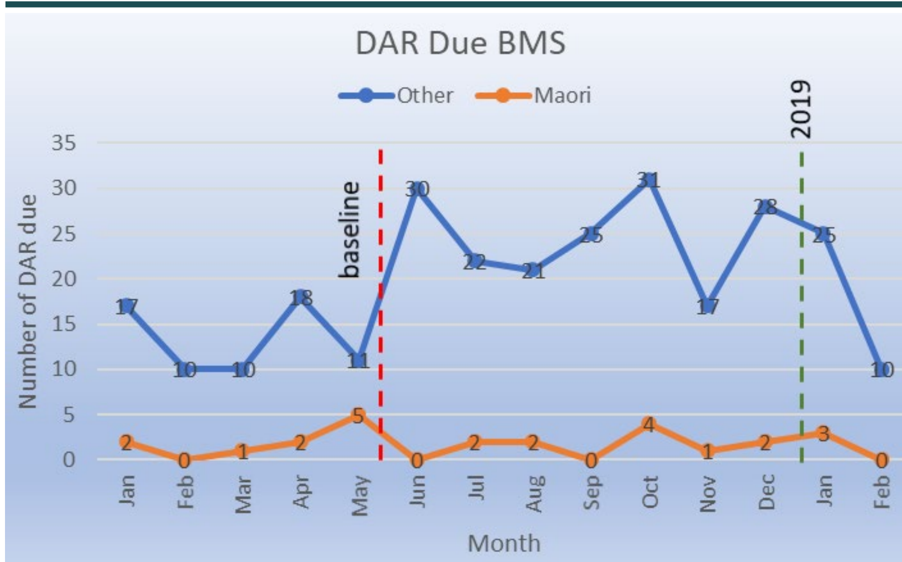
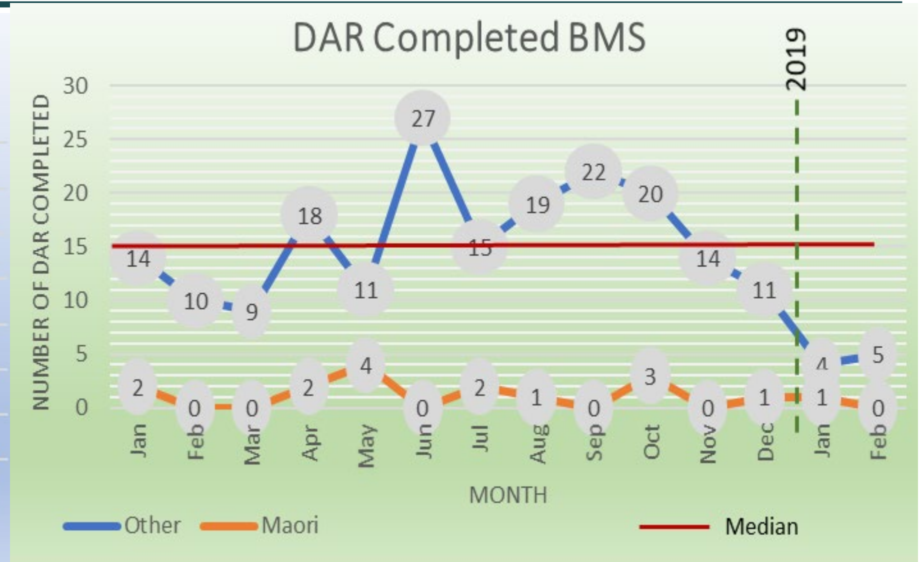
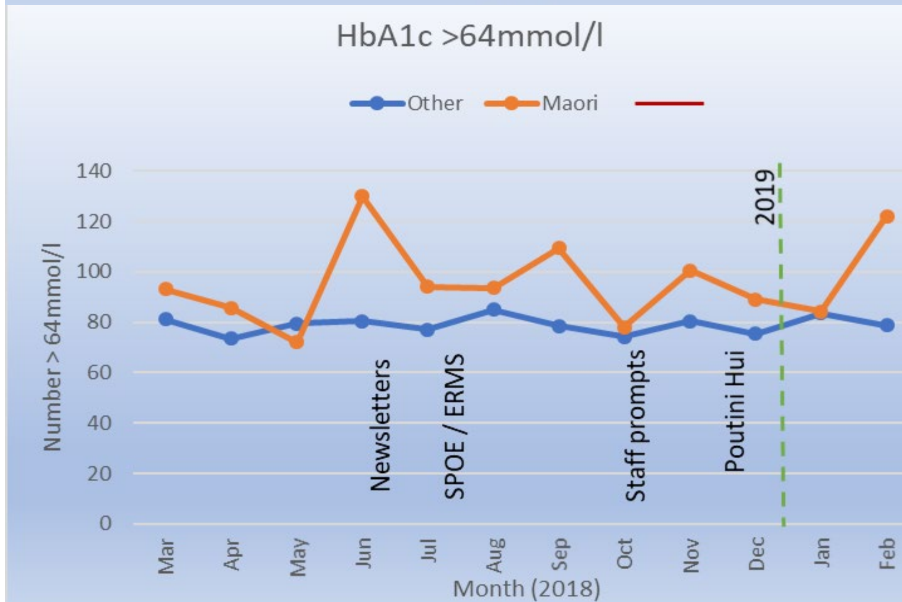
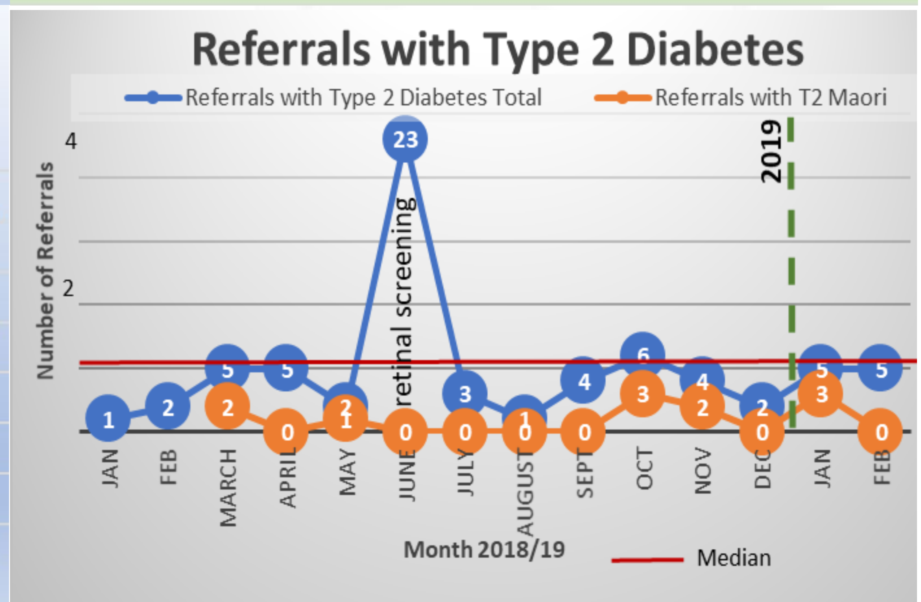
Outcome Measures: DAR, HbA1c, lifestyle referrals









Where we are at
problems / successes / challenges

- Engaged key nurse champions, pharmacist / GP – *need to re-engage as key staff have left*
- Teaching the project team to **fish** – *staffing/resource constraints / capacity and leadership issues*
- Increasing visibility through workstream – *QI team established & trained – capacity and leadership issues hindering progress*
- Resources / capacity: no funding or time allocated for the project (*protected time*); getting buy in; support from the sponsor / manager / GP Practice; IT - *if facilitator doesn't drive it the project stalls, so not sustainable*
- Hba1c and DAR data has to be obtained manually from the PMS
- PMS data is prone to flaws – through user error & *creative use of system/s*

- Team want to implement their own ideas and do the work – *limited progress due to capacity issues*
- **Patient survey feedback positive ☺**
- **Plan B:**
  Adapt project to Poutini Waiora & focus on Māori with diabetes.
  - *modelled / documented consultations & processes*
  - *whānau ora clinic commenced & outreach prn*
  - *DNS working with PW team*
  - *training and support from DNS & PHO*
  - *consumer on project team*
  - *measures: DAR, HbA1c, lifestyle referrals, patient feedback*

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Lessons Learned

- Keep it simple
- Go *very* slow (while maintaining progress)
- Need most influential people involved – key Practice Nurse / Diabetes Nurse Specialist / GP now / Manager
- Learn to approach change methodically
- Flexibility / adaptability – change, but don't give up
- Staff and patient co-design – staff learn to listen to the voice of the consumer and develop change from their perspective
- Involve project in workstream plan to help drive progress (*though hindered by capacity issues*)