Te Wāhi Tiaki Tātou

Te Wāhi Tiaki Tātou – Reimagining Sessions

Long Term Conditions - Diabetes

31 October – 1 & 2 November 2023

Contents

Executive Summary

The purpose of Te Wāhi Tiaki Tātou is to share the aspirations and priorities of whānau and individuals in the Porirua community, enabling their voices to inform the transformation of hauora in our rohe. Te Wāhi Tiaki Tātou represents a unique opportunity to define and determine how the local health and disability system operates to better meet the needs of the Porirua community.

The community have shared what is important to them, and now the focus is on working together through Reimagining Sessions to create change. The goal of the Reimagining Sessions is to facilitate **community/whānau-driven change** to redesign how health and well-being services are delivered **to achieve equitable outcomes in Porirua.**

Individuals with lived experience and passion for the topics are invited to participate in the Reimagining Sessions and be part of the journey to transform hauora in Porirua.

This slide pack is a record of the Reimagining the community and provider have done on diabetes services in Porirua with a focus on prevention. It is important to note that our community participants shared a lack of understanding about the fundamentals and intricacies of diabetes and their disappointment in not receiving adequate support to cope with the confronting lifestyle changes that are required for living well with diabetes.

Recommendations:

We have recommended four initiatives to progress now and be funded as 'quick wins'. These have been estimated to have the largest impact on whānau, alongside low to medium estimated timeframes and cost to implement. Most of them relate to themes linked to prevention, access to services/hauora services and education, and information provision.

Additional initiatives that carry increased cost, complexity, risk and timeframes have been documented for further scoping analysis. Many of these initiatives will require strategic change at a national level, significant investment and have an increased complexity to implement. These opportunities will be analysed and will inform the medium to long term ambitions for Te Wāhi Tiaki Tātou.

Now is the time to implement community-led solutions!

Background

Reimagining Sessions for Diabetes were held across three days from Tuesday 31st October to Thursday 2nd November 2023. The first two days were for community members with lived experience, with the final day with service providers. These sessions were held at Te Wānanga o Aotearoa.

Over the course of the reimagining sessions we heard strongly from community and providers the need for both systemic level change at a national level, and locally driven initiatives that would create tangible impact for whānau in the immediate/short term.

This document sets out a record of what we heard in the Reimagining Sessions, in addition to our key recommendations of initiatives that will be undertaken and driven by Te Wāhi Tiaki Tātou.

"When I was diagnosed, I was disappointed with myself...it's lifelong now"
- Focus Group Participant

"Tired, thirsty, just told to lose weight – but no support for this"
- Focus Group Participant

"When the Dr. shows you a graph with lots of info it can be overwhelming, there has to be a better way"
- Focus Group Participant

"Not much support as pre diabetic, which has led to type 2, that could have been avoided"
- Focus Group Participant

"Health professionals don't have enough time"
- Focus Group Participant

"Don't like taking the prick all the time. Can we find another way. Sometimes I don't do it. I get lots of needles. I only do it if I've got an appt coming up"
- Focus Group Participant

"Lifestyle changes are hard with no support"
- Focus Group Participant

"Dr. didn't even offer free support that's available"
- Focus Group Participant

"Age restriction for soft drinks would be good, some places have done it already for energy drinks"
- Focus Group Participant

"More support for staff. Doesn't matter who provides that support as long as they're qualified and working together"
- Focus Group Participant

"It's not always price of the food sometimes we want an easy option"
- Focus Group Participant

Recommendations

Key recommendations from the Reimagining Sessions are themed into five core areas; funding, workforce, prevention, access to services/hauora services, and education and information provision. These groups and interrelated and fit into broader groups of core enabling functions for diabetes services, prevention and service delivery.

Four key initiatives are proposed to be further developed, funded and delivered. Details of these are provided on the following page. Appendix B summarises the priority opportunities identified by both the community and providers in more detail. This summary enabled us to understand which opportunities were supported across different groups and allowed us to identify our recommendations.

A wide range of other opportunities were identified during the Reimagining Sessions, these are recorded in the appendices. Many of these opportunities will require strategic change at a national level, significant investment and have an increased complexity to implement. These opportunities will be analysed and will inform the medium to long term ambitions for Te Wāhi Tiaki Tātou.

Recommendations

#	Initiative	Impact for Whānau	Impact for Providers	Estimated Timeframe	Estimated Cost	Complexity to implement	Detail	Theme
1	'Porirua diabetes pathway' and community support network. Community and providers acknowledged a low level of health literacy and a poor referral process.	High Community said there is a lack of support, guidance and information and education. 'changing my whole lifestyle is hard'	High Providers said there is a huge lost opportunity to support people to possibly reverse T2 diabetes.	Short-term	Low-medium	Low-medium	A collaboration of providers to take the best current delivery services to develop a shared pathway for people (and their whānau) with pre/diabetes.	
2	Increase access and information and education via Pharmacy.	High Community said that getting information about their medications and having regular checks is challenging.	Medium Providers said that there are workforce issues and going to the doctors isn't always the best option.	Short-term	Low-medium	Low-medium	Trial increasing the service offering from pharmacies and promote in the community. Similar concept to the winter wellness initiative.	
3	Water only in schools and 'fizz free' Porirua events. Examples of this already exist in Porirua and this aligns with ideas for the dental reimagining.	High Community raised a similar idea to have age restriction on fizzy drinks similar the energy drink initiative.	Medium	Short-term	Low-medium	Low-medium	Te Wāhi Tiaki Tātou project team to work with Hauora network and develop promotion package for schools.	
4	Trial a workplace health & wellbeing initiative (large employer, like a supermarket).	High	Medium	Short-term	Low-medium	Low-medium	Work with medium sized employer in Porirua to trial a health & wellbeing program – with a strong emphasis on healthy kai and exercise for their kaimahi.	

Four initiatives from the Reimagining sessions have been identified as 'quick wins'. These have been estimated to have the largest impact for whānau, alongside with low-medium estimated timeframes and costs to implement. Most relate to themes of prevention, access to services/hauora services and education and information provision.

Additional initiatives that carry increased cost, complexity, risk and timeframes have been documented for further scoping analysis. Many of these initiatives relate to population health determinants and have also come up in previous reimagining sessions including; access to healthy kai, and access. These will inform the medium to long term ambitions for Te Wāhi Tiaki Tātou.

Key

Funding	
Workforce	
Prevention	
Access to services / hauora services	
Education and information provision	

Appendices

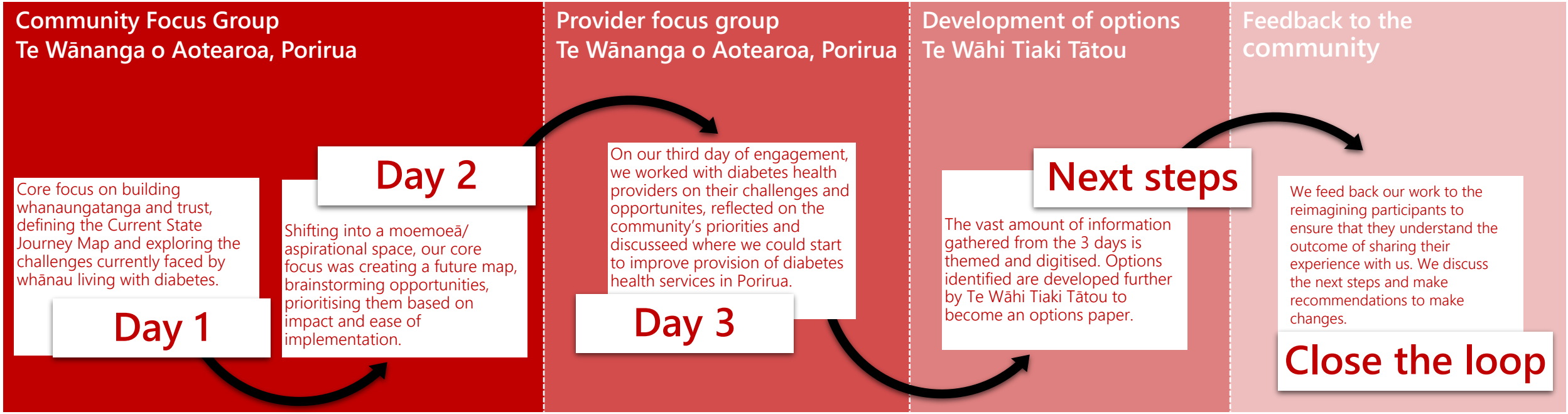
Appendix A: Overview of Reimagining Hui
Appendix B: Opportunities – Priority Overview
Appendix C & D: Current State Journey Map
Appendix E & F: Moemoeā Map
Appendix G, H & I: Challenges - Providers
Appendix J & K: Opportunities - Providers

The appendices in this document serve as a record of the kōrero received from the community and providers throughout the Reimagining Sessions. Ensuring we accurately document the voices of community is part of our commitment to be kaitiaki of the mauri of this mahi and the kōrero gifted to us from our whānau, which is a taonga.

Appendix A:
Overview of Reimagining Sessions

Reimagining Sessions for diabetes were held over three days in Porirua. The Appendices in this document provide detail of the exercises which the community and providers undertook. We focused on understanding the Challenges and Opportunities that the community and providers experience, mapped the opportunities on a priority matrix based on 'impact for whānau' and 'ease of implementation', created a current state map and a future state moemoeā map for diabetes care and prevention in our rohe.

The diagram below sets out the process we went through to get to the recommendations in this report and the content set out in the appendices.



Appendix B - Opportunities

Community and Provider Priority Overview

Key: Community-identified priority | Provider-identified priority

★ = community opportunities that community voted as the most important to them

This slide summarises the priorities identified across community and providers. This summary allowed us to understand which opportunities were supported across different groups and allowed us to identify our key recommendations.

Provider initiatives

- Diabetes free goal by 2050
- More opportunities for health providers to connect and learn
- Simpler referral system
- Health Care Professionals upskilled in how to help people into remission for T2

Access

- All diabetes CGM and medications free
- More support from health professionals eg. nurses, pharmacy, kaiawhina
- CGM for all with no barriers = FREE + Free CGM/Pumps for diabetics

Other

- Free Social Supermarket
- Dental support ★

Support for Diabetics

- Cooking classes
- Free gym and support on how to exercise ★
- Access to personal trainers and hospital gyms
- Whānau inclusive programmes ★
- Support groups for pre-diabetes & diabetes ★
- Diabetes induction pack / education programme
- Porirua diabetes clinic ★
- Green prescriptions for all diabetics
- Education providers collaborating with health delivery services

Prevention initiatives

- Better prevention for high-risk patients e.g. PCOS = Don't wait till they get diabetes
- School based education in all Porirua Schools e.g.Ka Ora, Ka Ako programme ★
- Age restriction on sugary drinks, similar to the energy drinks initiative ★
- Workplace clinics
- Free bikes in schools
- Free sports at school, and more people to run them
- Workplace initiatives like Monday yoga etc ★
- Funding for health promotion programmes e.g.: Well-fed
- Identify pre-diabetics and educate at that stage to delay onset

KEY

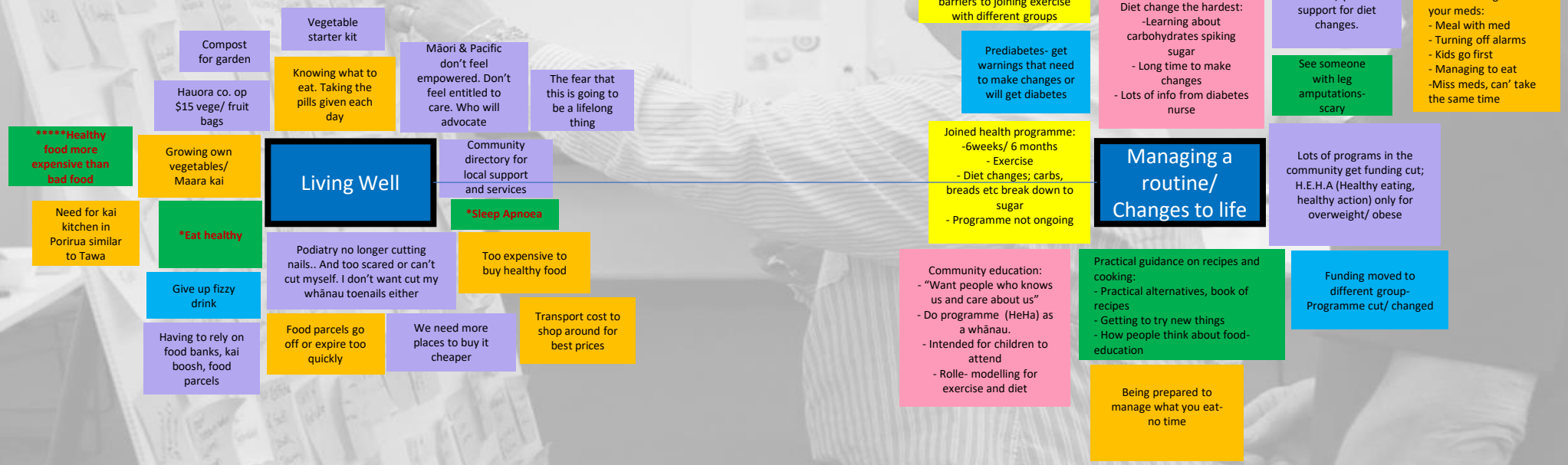
★ = community opportunities that community voted as the most important to them

Appendix C - Current State Journey Map

KEY

★ = community opportunities that community voted as the most important to them

Appendix D- Current State Journey Map (Contd)

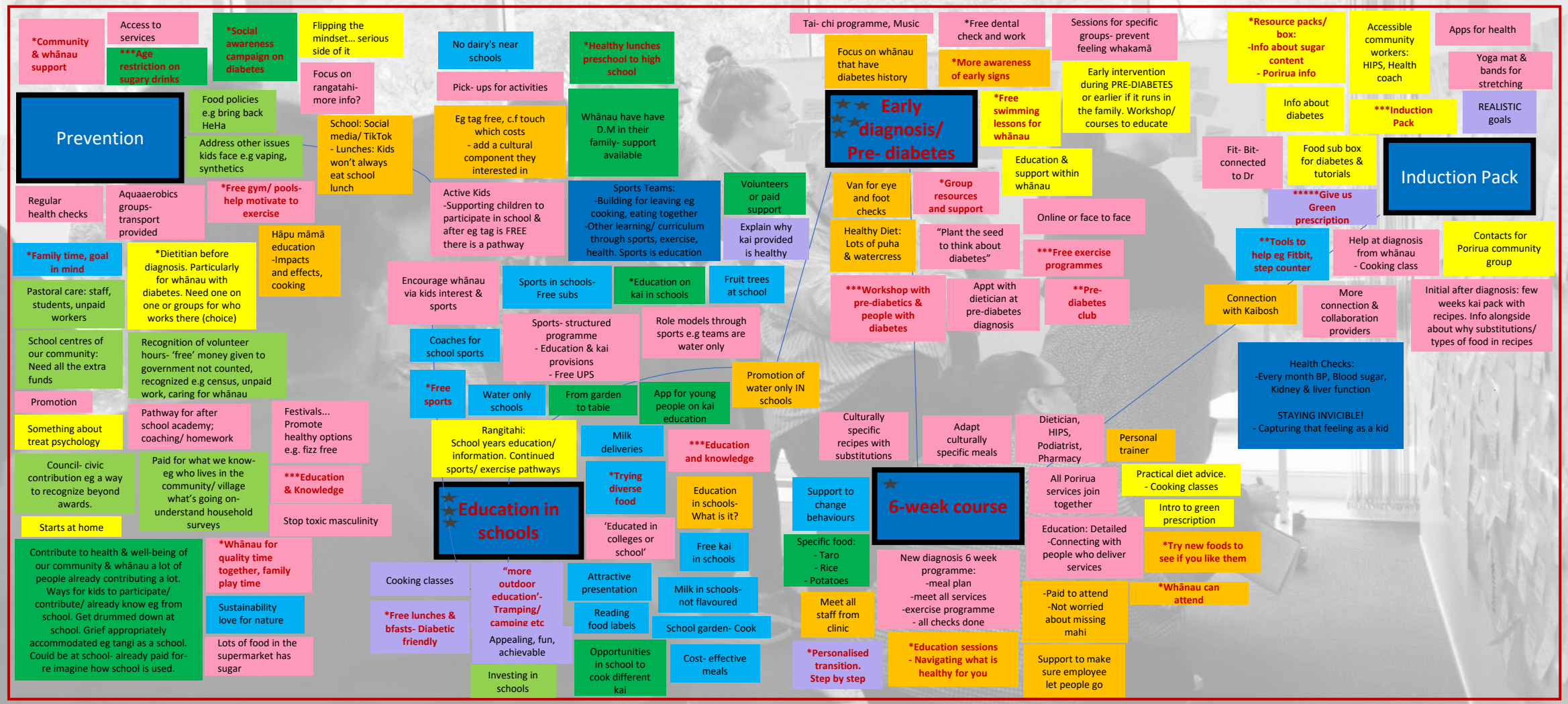


KEY

★ = community opportunities that community voted as the most important to them

★ = community opportunities that providers voted as the most important to them

Appendix E – Moemoeā Map

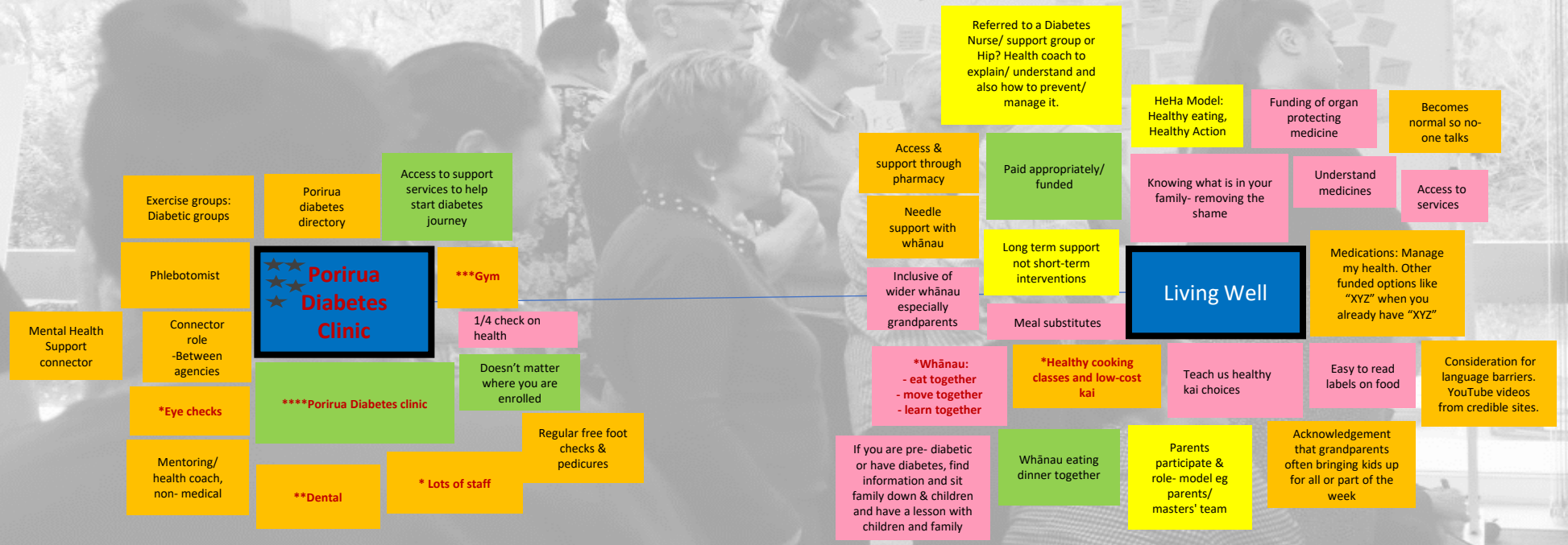


Appendix F - Moemoeā Map (Contd)

KEY

★ = community opportunities that community voted as the most important to them

★ = community opportunities that providers voted as the most important to them



Appendix G - Provider Challenges

KEY

★ = providers challenges that providers voted as the most important to them

Theme	Detail
Whānau / logistics	•The legacy effect of coming from a family with poor diabetes outcomes – people need hope •Healthy food 'deserts' •Isolation (no whanau support) •Not spoken of openly in whanau settings •**Time poor – clients** ★★ •Family commitments •People don't have the time/options for leave to attend appointments •Patient doesn't have time and confidence to ask questions •Number of diabetics •Not taking their medicines •Going above and beyond for patients and they don't also make an effort •People do not take medications as prescribed – give them a lifestyle option •**Pt and whānau not fully informed and able to make decisions when major decisions need to be made** •**Time (mahi, whānau – no time to go to the GP)** ★ ★
Pūtea	• Cost • **Costs of medication** ★ • **Cost of living** ★★★★ • **Living in poverty** ★★★ • **Lack of funded podiatry services** ★ • **Access to healthy and affordable kai** ★ • The cost to society and cost of expensive medications • Lack of employment opportunities for diabetes patients • Cost of GP visits • Time and money a huge challenge. We have the relationships with the community • Finding – CGM funding/technology i.e. pumps • Funding for our service is a big challenge

Theme	Detail
Workforce	• No dietitians • Lack of nurses and doctors • **Lack of staff** ★ • **Personalities of health providers** ★ • Clinical supervision – needing to look after ourselves too! • How to get our kaimahi knowledgeable enough to provide holistic care • **Lack of specialist staff in regions** ★ • Lack of workforce and workforce of cultures affected • Lack of employment opportunities for diabetes podiatrist • Getting staff… shortage • Staff wages – not paid enough – look at other job offers • Not having enough staff i.e. appropriate staff e.g. SW, psychologist
Cultural	• **Obesiogenic society** ★★★★ • Lack of role models • **Cultural beliefs** ★★ • People/HCP see medication as an easy option • Judgement • Lack of cultural views • **Social acceptance** ★★ • **They just hear the word diabetes and think that's their lot – that they can't change it or prevent it** ★★ • Often no symptoms so not taken seriously • People's lives are stressful, this impacts ability to self-manage diseases like diabetes • No restrictions of foods (schools, takeaways)

Appendix H- Provider Challenges (Contd)

KEY

★ = providers challenges that providers voted as the most important to them

Theme	Detail
Information & Education	• Minimal education opportunities to upskill practitioners in diabetic foot • **Lack of prevention strategies** ★ • Knowledge • Poor medication adherence • **Patient's understanding of health issues** ★ • Lack of public awareness of diabetes and complications and challenges • **Health literacy** ★★★★★★ • Mixed messaged all the time • Diabetes education for our healthy lifestyle's coaches • People not aware that eating healthy also decreases risk of cancer – another reason to eat well • Health literacy • Funding limits the amount of time that can be spent on education • **No T2 diabetes education for gps nationally or locally** ★ • Health promotion approach -> provide knowledge to existing people working in the community • Marketing by NZ super stars e.g. All Blacks drinking Powerade – is this ethical? • When someone gets diagnosed they're not given the resources that are out there to help them • Central component of social connection in true health promotion – requires long term relationships • Conflicting advice – diet, exercise • There is not enough knowledge in at risk groups about ability to prevent T2DM • We need strong, empowered consumer advocates for the diabetes clinical network
Technology	Use of new technology Cost of technology Limits of technology use – self referral etc

Theme	Detail
System	• Poor communication systems between primary and secondary care • Business models of care • No dietitian support • Limited national guidelines – different interpretations of managing diabetes • **Funding impact's ability to plan projects – sustainability. Need long term funding to embed change.** ★ • **Siloed services** ★ • Not easy to refer to dietitians and other complementary services • Funding i.e. CGM funding • **Not having a coordinated approach** ★★★★ • We need to counter media, big pharma and big food • Services not geared up for holistic approach • One size doesn't fit all • Pharmac rules • Patch protection • No system to record diabetes assessments collectively Complex cases – finding appropriate support e.g. WINZ support • Lack of communication from surgical team, no time to debrief • Settings/Environment • Difficult to find where to refer people even at an organisational level • **Independent PHOs not joining up** ★ • Collaboration with other services is difficult including social services • No time for case discussions with MDT team • Business first not whanau first • **Links to mental health is high** ★ • **No proper mental health service or support** ★ • Housing

Appendix I - Provider Challenges (Contd)

KEY

★ = providers challenges that providers voted as the most important to them

Theme	Detail
Workforce	• No dietitians • Lack of nurses and doctors • **Lack of staff** ★ • **Personalities of health providers** ★ • Clinical supervision – needing to look after ourselves too! • How to get our kaimahi knowledgeable enough to provide holistic care • **Lack of specialist staff in regions** ★ • Lack of workforce and workforce of cultures affected • Lack of employment opportunities for diabetes podiatrist • Getting staff… shortage • Staff wages – not paid enough – look at other job offers • Not having enough staff i.e. appropriate staff e.g. SW, psychologist
Access	•Barriers – transport, funding •Complicated referral pathway for diabetic foot management •**Accessibility 9-5** ★ •Access to service only through GPs •Access to medication – not available •We've lost generosity of time •Medicine supply issues e.g. Trulicity Medication availability •**We need to offer different hours** ★

Appendix J - Provider Opportunities

KEY

★ = providers opportunities that providers voted as the most important to them

Funding for health promotion programmes e.g.: Wellfed ★★

Identify pre-diabetics & educate at that stage to delay onset ★★★★★★

Easy access to healthcare + appointments

More after hours clinics: DR/Hospital/Allied health services

Use schools as healthy hub – run education groups with dinner home for whānau

Better prevention for high-risk patients. E.g. PCOS = don't wait till they get diabetes ★★★

Flow on effect = pay a lot more to our health workers = love their job/spread the good work ★

Add to school curriculum – healthy eating, use professionals, locals to relate to

Free transport

Community cooking sessions with help from health professionals

24 hr access either phone or visit c

CGM for all with no barriers = FREE + Free CGM/Pumps for diabetics ★★★★★

Access to free Libre devices to all diabetics to see the BGL changes

Free childcare available for patients to attend appts

Education providers collaborating with delivery ★★★★

Apps that send prompts each day =positive reinforcement

★ **HCPs are not up to speed.** ★ **Remission possible of T2 Diabetes**

Regulate to control fast food advertising and positioning

Starting/funding school lunches to establish healthy habits/eating

24 hr interpreters

24 hr dietitians

Diabetes clinics in pharmacies

Do more for pre-diabetes i.e.: Prescribe metformin

Funding medicine reviews and educate in pharmacy

Education of practitioner

More staff to support mahi

Free or koha movement facilities

Free bikes in school/ access to personal trainers and hospital gyms ★

GP knowledgeable and confident

Refer to dietician/podiatry/optometrists etc at point of diagnosis

Free artificial intelligence (AI)

Workplace clinics ★

24 hr councillors

Free social supermarket ★

All diabetes CGM and medications free ★

Out of hours clinics

Social media campaign – consistent messaging

Bakeries next to schools and fish/chip shops and alcohol stores

National push on advertising – equal to smoking

Access to healthy kai

Outpatient appointment in the community

Community health services with funded services to make appointment free for low income

Funding for both meds. Trulicity and empagliflozin

Subsidised weight loss meds for pre-diabetics + diabetics

More opportunities for health providers to connect and learn ★★★

We all talk of uncontrolled diabetes being the problem not just diabetes

Limit size of fizzy drinks for sale

Diabetes free goal by 2050 ★★

Free prescriptions

24 hr podiatrists

Funding BSL kits

Local access to cheap fruit & veges

Simpler referral system ★★

Diagnosis in community – not providing care

Appendix K - Provider Opportunities (Contd)

KEY

★ = providers opportunities that providers voted as the most important to them

- Swap meds for food – ask me how?
- Make sure everyone knows T2 DM is potentially reversable within 4-6 years
- Pick up Gestational diabetes and effective follow up with education linking to healthy food availability
- More people in the health work force that reflects population
- Kai sessions more kitchens open
- 3D imagining diabetic foot
- Hire staff appropriate for staff-in clinics i.e.: social workers and psychologists
- Free Childcare for women with gestational diabetes. 6-12 months after birth.
- Education on healthy eating and with health improvement practitioners
- Research with high-risk families who are on dialysis to change the narrative and outcomes
- Community movement equipment trailers
- More updates on radio access and in printed newsletters /churches – not everyone listens to radio NZ or reads the listener
- Yearly review be shared – refer to pod/dietician/optom etrist – fully funded for every diabetic
- More clinical space/gyms and trainers/transport
- Offer clinics out of 9-5 hrs
- More healthcare staff
- Staff present to local community groups (church)- educate
- More clinical space/gyms and trainers/transport
- Get rid of PHARMAC
- Subsidised total diet replacement for weight loss / for PW T2 DM or Post GDM for 12 weeks
- Reinforcement of GP info/ Their follow up, clarification, pharmacists across the region
- Intervention at all levels – gout/community/ health/council

Ngā Mihi

Mā te rongo, ka mohio; mā te mohio, ka marama;
mā te mārama ka mātau.

Through listening comes awareness; with awareness comes understanding; through understanding comes knowledge and the ability to effect change.

He mihi nui ki ngā tāngata katoa i whai wāhi ki tēnei mahi

Ngā mihi nui and acknowledgement for the time and energy, the community and providers have dedicated to supporting Te Wāhi Tiaki Tātou Localities Programme, without whom this work would be unable to happen. The Project delivery team and Rūnanga are deeply grateful.

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