

# Quality standards for Diabetes Care 2020

V6 September 2020

These national standards for diabetes care provide guidance for comprehensive, equitable patient-centred care and service planning in primary and secondary care settings. They should be scaled to local diabetes prevalence and population characteristics. The standards should be read alongside other national or international guidelines highlighting specific clinical recommendations, some of which are identified below.

The standards are specific to people with diabetes and apply equally to type 1, type 2 and other less common causes of diabetes. People identified with **prediabetes** should be monitored and managed in accordance with the latest prediabetes advice provided by the Ministry of Health.

[health.govt.nz/our-work/diseases-and-conditions/diabetes/about-diabetes/pre-diabetes-and-self-management-long-term-conditions](https://health.govt.nz/our-work/diseases-and-conditions/diabetes/about-diabetes/pre-diabetes-and-self-management-long-term-conditions)

## Basic care, self-management and education

All people with diabetes:

1. will receive high quality, culturally relevant, structured self-management education, tailored to their individual needs. Together with their whānau/family, they will be informed of, and provided with, support services and resources that are appropriate and locally available
2. will receive personalised expert advice on lifestyle choices such as good nutrition and regular physical activity together with help with behaviour change, smoking cessation advice and support if required
3. will be offered, as a minimum, an annual assessment for the presence and future risk of cardiovascular disease and diabetes-related complications. They will be provided with the outcome of the risk assessment and should participate in making their own care plans. They should set agreed and documented goals/targets with their health care team, including a specific target for glycaemic control
4. who have other diabetes-related health issues, eg, obesity, sleep apnoea, fatty liver, alcohol use, oral/dental health, will receive personalised advice and support as required
5. will be assessed annually for mental wellbeing and the presence of psychological problems and diabetes distress and provided with timely expert help if required.

# Management of diabetes and cardiovascular risk

[health.govt.nz/our-work/diseases-and-conditions/cardiovascular-disease/cardiovascular-disease-publications](https://www.health.govt.nz/our-work/diseases-and-conditions/cardiovascular-disease/cardiovascular-disease-publications)

All people with diabetes:

6. will have the opportunity to review and discuss their medications with their health care team. This includes starting and stopping medication as appropriate to manage cardiovascular risk, blood glucose and other health issues. They will have access to glucose monitoring devices appropriate to their needs
7. will be screened and offered blood pressure, blood lipid and other specific therapies to lower cardiovascular and renal risk when required, in accordance with current recommendations. Those who do not achieve their agreed targets will have prompt access to appropriate expert help
8. who require insulin will receive the initiation by trained healthcare professionals within a structured programme that, whenever possible, includes education in dose titration by the person with diabetes. People on insulin will know how to access timely expert help and support to manage their condition.

## Management of diabetes complications (extensive guidelines available)

All people with diabetes:

9. will have access to regular retinal photography or an eye examination at nationally recommended intervals, with prompt subsequent specialist ophthalmological treatment if necessary
10. will have regular, at least annual, checks of renal function (eGFR) and proteinuria (ACR) with appropriate management and/or specialist referral if abnormal, especially where progressive renal dysfunction is evident
11. will be regularly assessed, at least annually, for the risk of foot ulceration which will be documented using national guidelines. If required, they will be referred for podiatry review and treatment. Those with active foot problems will be referred to and treated by a specialist multidisciplinary foot care team within recommended timeframes
12. will also be reviewed to identify other complications, eg, peripheral or autonomic neuropathy and provided with appropriate management
13. who have serious or progressive complications of any sort will have timely access to expert/specialist help. Access will be based on clinical need and not on type of diabetes.

# While in hospital

All people with diabetes:

14. who are admitted to hospital for any reason will be cared for by appropriately trained staff and provided access to an expert diabetes team when necessary. The option of self-monitoring will be considered, and they will be encouraged to manage their own insulin whenever clinically safe and appropriate
15. who are admitted as a result of uncontrolled diabetes or diabetic ketoacidosis – and those with newly-diagnosed type 1 diabetes – will receive educational support before discharge and follow-up arranged in liaison with their primary care team and/or a specialist diabetes team, **or** who have experienced severe hypoglycaemia requiring emergency department attendance or admission will be actively followed up and managed in liaison with their primary care team and/or a specialist team to reduce the risk of recurrence and readmission.

## Special groups

16. Young people with type 1 or type 2 diabetes will have access to an experienced multidisciplinary team including developmental expertise, youth health, health psychology, social work and dietetics. During the transition from paediatric/youth services to adult services people with diabetes and their whānau/families be well supported and receive integrated care. Young adults with either type 1 or type 2 diabetes will receive structured care.
17. All patients with type 1 and other insulin-dependent diabetes will have access to an experienced multidisciplinary team, including expertise in insulin pumps, continuous glucose monitoring systems (CGMS) and up-to-date technology when required.
18. Vulnerable persons with diabetes, including those in residential facilities and those with mental health, intellectual disability or cognitive problems, will have access to all aspects of care, tailored to their individual needs.
19. Those with uncommon causes of diabetes (eg, cystic fibrosis, monogenic, post-pancreatectomy) will have access to specialist expertise with experience in these conditions.
20.
  - A. Pregnant women with established diabetes, either type 1 or type 2, and those developing gestational diabetes (GDM) will have access to prompt expert advice and management, with follow-up after pregnancy.
  - B. Women of child bearing age with diagnosed diabetes will be offered pre-conception care including the benefits of improved glycaemic control and optimal planning of pregnancy.
  - C. Women not wishing to become pregnant will be offered appropriate contraceptive advice.

## Delivery of systematic high-quality diabetes care

21. Equity is a central focus of diabetes care improvement. Māori and Pacific people have a higher prevalence of diabetes and a substantially reduced life expectancy. Service planning will take full account of relevant documents including the 2019 Wai 2575 report<sup>1</sup> and subsequent updates, and He Korowai Oranga<sup>2</sup>. Services will be co-designed and culturally appropriate to improve care delivery in line with Whakamaua and Ola Manuia, the Māori Health Action Plan and Pacific Health and Wellbeing Action Plans 2020–2025.  
**[health.govt.nz/publication/whakamaua-maori-health-action-plan-2020-2025](https://health.govt.nz/publication/whakamaua-maori-health-action-plan-2020-2025)**  
**[health.govt.nz/publication/ola-manuia-pacific-health-and-wellbeing-action-plan-2020-2025](https://health.govt.nz/publication/ola-manuia-pacific-health-and-wellbeing-action-plan-2020-2025)**
22. Each district health board (DHB) will have a functioning diabetes governance group (local diabetes team, service level alliance or similar) overseeing the delivery of diabetes care and services across their district and primary health organisations (PHOs). The group will include clinical representatives of all PHOs and secondary care specialist services, consumers, Māori, Pacific people and other ethnic groups as appropriate, DHB and PHO management and other providers as required.
23. Each DHB diabetes governance group will have full and timely access to PHO and DHB performance and activity data and use this to improve equity and quality of patient care throughout the PHO/DHB. This will include analyses by ethnicity, by deprivation and, where appropriate, by rurality.
24. The governance group will, at appropriate intervals, undertake a stocktake of its performance against these standards whose agreed results will be reported to the Ministry of Health. This will include analyses by ethnicity and by deprivation.
25. Care should be offered where possible close to an individual's home by their primary care or community team, ensuring access to financial subsidies such as Care Plus, High User Health Card (HUHC), prescription subsidy schemes, Community Service Card (CSC), etc. as well as non-governmental organisation (NGO) support services, eg, Diabetes New Zealand.
26. Where smaller DHBs are unable to provide aspects of specific specialist expertise, they will arrange with neighbouring or convenient larger DHBs to provide any services that are lacking locally.

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1 **[health.govt.nz/our-work/populations/maori-health/wai-2575-health-services-and-outcomes-kaupapa-inquiry](https://health.govt.nz/our-work/populations/maori-health/wai-2575-health-services-and-outcomes-kaupapa-inquiry)**

2 **[health.govt.nz/our-work/populations/maori-health/he-korowai-oranga](https://health.govt.nz/our-work/populations/maori-health/he-korowai-oranga)**