**Manukau Group – Modified DCIP**

Present – representatives from:

Manukau Medical Associates (MMA)

Manurewa Family Doctors (MFD)

Papakura Marae Clinic (PMC)

PHO – NHC & Procare

Pharmacy

Allied healthAlliance

Whitiora Diabetes Service

MMA & MFD happy to be identified with data and PMC will come back once discussed with Medical Director NHC.

**PMC**

Links with Caran Barrett-Boyes, Imelda (DNS), SMO – Pui Ling Chan

SMO role to create a relationship with patients and PMC staff, this has been a huge step forward and much appreciated. Both MDT and clinics.

3 principles – **Manaakitanga**, **Whanaungatanga, Rangatiratanga**

**MMA**

Links with SMO – Carl Eagleton and MDT’s only. Looking to link with DNS once available.

Allocated a nurse within the practice to be the diabetes champion for diabetes initiatives.

Utilising ARI as well.

Utilising text to reminds for diabetes testing

Suggested video for diabetes in Pacific Languages (? To be played in the waiting room).

**MFD**

They have just taken over this practice of ~4,000.

Wishing to bring some of the lessons and ideas from their Henderson practice.

Intensifying diabetes care and making it personal

* Nurse specialist in the practice
* DSME nurse
* Personalised plans – budgeting, social, follow up phone calls, home visits where necessary, quality improvement programme (these are not all running yet at MFD).

Extended diabetes care.

Found the use of the **“Healthy conversations workshop” run by the Liggin’s institute** very useful for their practice nurses – healthy babies, healthy futures. This sounds very useful to consider running with the modified DCIP practice nurses.

Found in Henderson that they focussed on an initial 15 patients and the lessons spilled over to the other 800 + patients in the practice.

Currently have MDT with SMO – Dr Griffiths.

DNS contact – Elham

**Allied Health**

PMC – monthly podiatrist, weekly psychologist, no dietician

MMA – weekly podiatry and utilise ARI and POAC, fortnightly dietician, psych via proextra but not on site.

MFD – all accessible through proextra but nil onsite.

**Pharmacy**

Each practice has a community pharmacy associated with it and a high percentage of scripts are dispensed from them.

Opportunties to link more closely, issues of $ identified for patients and scripts.

Question raised why pharmacy and GPs don’t let each other know if a patient doesn’t pick up a repeat or regular script. E-prescribing will help but not immediately on the horizon.

**DHB**

Reinforced the usefulness of the MIT course as foundation. However it is a 5 day course and small practices have trouble releasing their staff for this. Sideline discussion with PHOs needed to consider a rotator or backfilling role for the practice nurses to attend. Important also in the relationships developed with the DNS’s running the course.

**MDT frequency**

Varies from fortnightly to every 3 months and currently every practice happy with current arrangements but there is variation amongst the 3 practices in this huddle.

**PHO’s**

Support and empower nurses to lead diabetes

Support for the MIT course needed

Back filling role for practices needs to be centralised

Group dietician sessions need to be facilitated.