Thalamus Type 2 Diabetes Audit
1. Introduction and References

Thalamus Type 2 Diabetes Audit Package

Improving Type 2 Diabetes Care and Equity

WellSouth Primary Health Network

INTRODUCTION

1. Background

Type 2 diabetes (T2D) is a chronic, progressive condition presenting a significant and growing challenge to New Zealand's health system. An estimated 348,500 people were affected in 2024, with prevalence projected to increase substantially over the next two decades. Diagnoses are occurring at younger ages, compounding the future burden on healthcare resources [1,2]. In the Southern district (Otago and Southland), prevalence is 34.7 per 1,000 population [1].

From 1 July 2026, the HbA1c diagnostic threshold for diabetes has been lowered from >= 50 to >= 48 mmol/mol, aligning New Zealand with WHO and international standards. At a national level, around 34,500 New Zealanders previously classified as having prediabetes will now meet the criteria for diabetes. This equates to approximately 9 newly diagnosable patients per practice across New Zealand [Health NZ, March 2026].

Why Early Identification Matters

The initial clinical focus is on people aged under 60 years, where early intervention makes the greatest long-term difference. In this group, diabetes can reduce life expectancy by more than 10 years, and is the leading cause of vision loss, chronic kidney disease, dialysis, amputations, and increases the risk of heart attack, stroke, and some cancers [Health NZ, March 2026].

There is clear evidence that early, aggressive management of T2D leads to lifelong legacy benefits. Clinical inertia — where action is delayed despite meeting treatment thresholds — is a recognised barrier to optimal outcomes.

Marked Inequities Exist

Pacific peoples have the highest prevalence at 137.2 per 1,000 population, followed by Indian (103.6 per 1,000), Māori (82.4 per 1,000), and European/other (33.3 per 1,000) [2,3,4]. Indo-Asian communities and young people under 25 are also disproportionately affected. Urgent, targeted action is needed.

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2. Change in Diagnostic Threshold: Effective 1 July 2026

Category	Old Threshold	New Threshold (from 1 July 2026)
Normal	HbA1c < 41 mmol/mol	HbA1c < 42 mmol/mol
Pre-diabetes	HbA1c 41–49 mmol/mol	HbA1c 42–47 mmol/mol
Diabetes	HbA1c >= 50 mmol/mol	HbA1c >= 48 mmol/mol

Confirmatory testing rules:

- HbA1c >= 53 mmol/mol: No confirmatory test required. A single reading confirms diabetes.
- HbA1c 48–52 mmol/mol with 2 or more readings >= 48: Confirmed. No repeat needed.
- HbA1c 48–52 mmol/mol with only 1 reading >= 48: A repeat HbA1c, fasting glucose, or random glucose (if symptomatic) is required as soon as practical.

Important notes from Health NZ:

- All those aged under 25 diagnosed with diabetes should be referred to specialist diabetes services.
- HbA1c 42–47 mmol/mol is not normal in children or pregnancy — refer to Specialist Diabetes Services.
- Retinal photoscreening can be deferred for 3 years in people newly meeting the diagnostic threshold.
- Consider additional glucose-lowering therapy at diagnosis if HbA1c > 64 mmol/mol.
- Consider insulin at diagnosis if HbA1c > 90 mmol/mol and/or concerns about type 1 or pancreatogenic diabetes.
- There is no change in glucose diagnostic criteria.

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3. Priority Populations

When identifying and contacting newly diagnosable patients, practices are strongly encouraged to prioritise the following groups, as they carry a disproportionate burden of diabetes and its complications:

1. **Māori**
2. **Pacific peoples (Pasifika)**
3. **Indo-Asian communities**
4. **People aged under 25 years (require specialist referral if diagnosed)**
5. **People aged under 60 years (primary national focus for early intervention)**
6. **People with severe and enduring mental illness (SEMI)**
7. **NZDep quintile 5 (most deprived)**

All audit tables in this package include columns for these seven priority groups.

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4. How to Use This Audit Package

Link to thalamus Diabetes audit page:

https://wellsouth.thalamus.nz/?report-key=713

This package contains three mini audits. Practices can choose to complete one, two, or all three, depending on local priorities and capacity. There is no expectation that all three are completed at once.

- Mini Audit 1: New diagnoses, classifications and recalls
- Mini Audit 2: Diabetes Annual Review (DAR) and components
- Mini Audit 3: Medication eligibility

Recommended order if completing more than one: Complete Mini Audit 1 first, as identifying newly diagnosable patients must happen before verifying or correcting other classifications, and all other audits rely on having an accurate register of your patients with diabetes. This is itself a key baseline finding.

Choosing your focus — where are the biggest gains? Before deciding which mini audit to prioritise, look at the Thalamus overview dashboard to identify which indicators have the largest gaps or the most patients affected. With the threshold change, identifying unclassified patients with HbA1c >= 48 is a natural first priority for most practices. However, if your dashboard shows a large number of overdue DARs or significant medication prescribing gaps, these may warrant equal or greater focus. Use the data to guide your decision. You may also wish to align your audit focus with your practice's Māori Health Plan or other existing quality improvement initiatives, as this will reinforce efforts already underway. Consider what your practice team can realistically act on within the audit timeframe — there is no expectation that all measures are addressed at once.

Each mini audit contains its own:

- Background and rationale

- Step-by-step guide using Thalamus
- Practical intervention examples
- Data tables to complete
- Quality improvement planning section

This audit package is suitable for RNZCGP Cornerstone CQI activity. A separate CQI Submission Form is available, with a shared introduction and individual sections for each mini audit.

We would really appreciate it if you could send your completed audit submission to WellSouth at [WellSouth contact email] so we can learn from your experience and share successful strategies across the network (with your consent). Please also indicate if you are happy for other practices to reach out to you to share your processes. Your feedback will also help us optimize this audit package.

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5. References

1. Ministry of Health. New Zealand Health Survey: Annual Data Explorer.
2. Te Whatu Ora. Virtual Diabetes Register.
3. Yu D, et al. Ethnic differences in mortality and hospital admission rates among people with type 2 diabetes in New Zealand. Lancet Global Health, 2020.
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5. bpacnz. Weight loss for the prevention and treatment of type 2 diabetes. 2022.
6. American Diabetes Association. Standards of Medical Care in Diabetes. 2021.
7. Rawshani A, et al. Risk factors, mortality, and cardiovascular outcomes in patients with type 2 diabetes. NEJM, 2018.
8. NZSSD and Ministry of Health. Type 2 diabetes management guidance. 2021.
9. bpacnz. The annual diabetes review. 2022.
10. Health NZ | Te Whatu Ora. Notice of Updated HbA1c Diagnostic Thresholds from 1 July 2026. March 2026.
11. bpacnz. New diabetes medicines funded: empagliflozin, dulaglutide, liraglutide. Diabetes Toolbox, updated 2025.
12. Pharmac. Schedule updates: liraglutide Special Authority SA2510, February 2026.
13. NZSSD. Special Authority updates for GLP-1 receptor agonists.