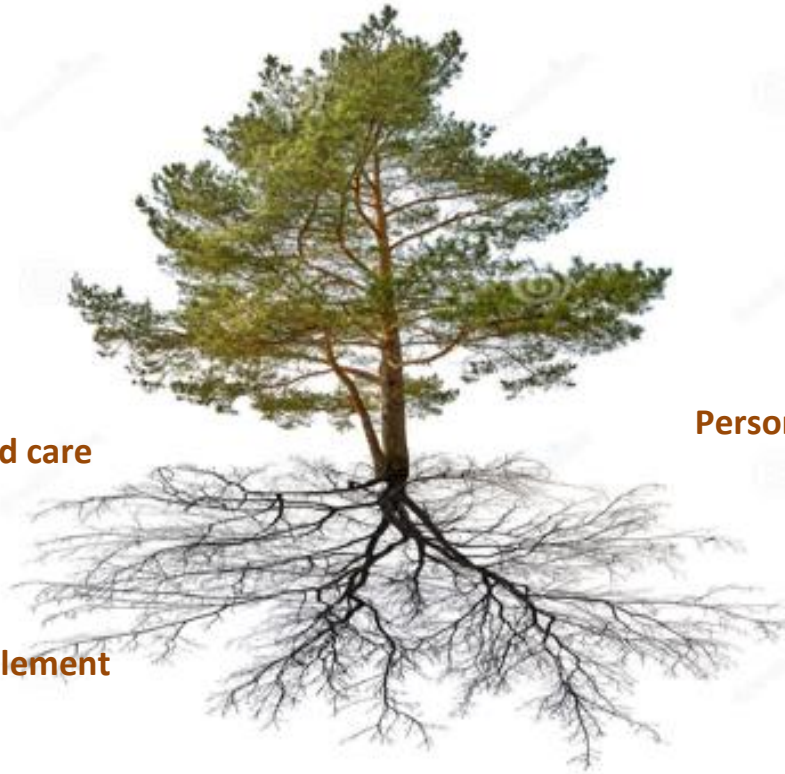
Hawke's Bay DHB
Long Term Conditions (LTCs) Framework

Person- family - whānau centred care

Person centred systems and processes



Workforce development and enablement

Risk identification and mitigation

The Kahikatea[1]

[1] The Kahikatea – or white pine is native to New Zealand. Significant for its extensive and intertwining root system indicating interdependencies support.

Content

Executive Summary:

Why do we need a Hawke's Bay Framework - Long Term Conditions have become the most significant cause of death and disease contributing to; to 80% of deaths and 80% of the health budget spend. Hawke's Bay is above the national prevalence level in 6 out of 11 chronic disease risk factors for adults aged 15 years and over2. This has a significant impact on individuals, whanau and the wider community.

The structure of the framework is - Based on the Four Aka (roots); Person-Family-Whanau Centred Care, Person centred systems and processes, Workforce development and enablement and Risk identification and mitigation. Each of the Four Aka have four contributing dimensions (see pages 8-11 below). Where appropriate the outcome attached to each of the dimensions is linked to both System Level Measures and the outcomes (currently draft) of Transform and Sustain. The methodology for change on which the framework is based is IHI Improvement Methodology. This is an outcomes based methodology that works through setting up manageable (small) change environments that lead to system wide improvements.

System wide improvement – implementation tool. The Long Term Conditions **Service Review Matrix (LTC-SRM - Appendix One)** is a self-review tool, against which services can evaluate their achievement against the four Aka. The SRM is structured around a continuum of excellence
With the support of QIPS facilitators et.al, services will;

- be invited to work within a multi-disciplinary approach to addressing Long Term Conditions
- assess where they sit on the LTC-SRM using agreed sources of evidence
- utilise service planning and reporting mechanisms to work towards shifting performance within the continuum towards excellence.

The LTC-SRM serves also as a global assessment tool - for where services across the sector (both primary and secondary) sit in relation to performance against LTC outcomes. *(See page 11 of Appendix One).* This will provide a helicopter view of where additional resources and support need to be placed within the sectors to move performance from entry level to excellence.

The framework is NOT disease specific – People often experience more than one chronic condition and associated mental health challenges. We need to promote holistic care of the person and their whānau in a stay well – get well – be well model.

Prevention vs intervention – the framework is focused on prevention, early intervention and management as a strategy for reducing the increasing demand on acute hospital based services. Self-care and self-management underpins the framework so that people choose well in relation to addressing their own health needs. Based on business intelligence modelling of population trends coupled with a shift of emphasis to early intervention, it is anticipated that a reduction of up to 4% demand on acute services can be achieved. This will be evidenced through; reduced ED presentations, reduced ED admission rates and reduced length of stay. Over a 5 year period that will equate to resource economies of 20%.

[2] Chronic Disease: Current Situation Analysis-Prevalence, Morbidity and Mortality. Lisa Jones HBDHB Business Intelligence Team.

Vision

Your Health in Your Hands with Our Help and Support

Kei a koe te tikanga [3]

Mission statements[4]

Our people and systems respect and support self-management

Ka whakamiha, ka tautoko hoki ō tātou tāngata, ā tātou pūnaha i te whakahaere whaiaro a te tangata.

people powered – people and whānau centred care[5]

We are a connected collaborative team involved in your care

He tira tūhono, he tira mahi tahi mātou ka tiaki i a koe.

one team – whole public sector delivery

We value quality, effectiveness and innovation

Ka matapopore mātou ki te kounga, te whaihua, te auaha hoki

value and high performance - smart system – information system connectivity

We strive to be responsive and flexible

Ka whakarīrā mātou kia rarata ai, kia urutau ai hoki

closer to home – health and social care networks

[3] Kahungungu Hikoi Whenua

[4] The mission statements connect with the **NZ Health Strategy priorities** and **Transform and Sustain refresh priorities**. Te Reo translation provided by HBDHB translation team.

[5] These statements align with the NZ Health Strategy and the Refresh Transform and Sustain Program

The Four Aka

Person - Family - Whānau Centred Care

- Consumer voice
- Health Literacy
- Self-Care
- Understanding the determinants of health

Person Centred Systems and Processes

- Care Coordination
- Transition of care
- Collaborative clinical pathways
- Integrated IT systems and enablement

Your Health in Your Hands with Our Help and Support

Kei a koe te tikanga

Workforce Development and Enablement

- Clinical Leadership
- Clinical expertise
- Workforce capacity and capability
- Inter-sectoral development

Risk Identification and Mitigation

- Population health
- Equity
- Continuous quality improvement
- Governance and advisory support

Section One: Why do we need a strategy?

What do we know?

Context and definition: Long term chronic conditions are defined by the **World Health Organisation** as having one or more of the following characteristics: they are permanent, leave residual disability, are caused by non-reversible pathological alteration, require special training of the person for rehabilitation, or may be expected to require a long period of supervision and care (WHO. 2005. Preventing Chronic Disease) refer: https://www.rnzcgp.org.nz/assets/documents/Training-and-Beyond/Curriculum-Documents-2014/Long-term-Conditions-CS.pdf . Not all LTCs are precipitated by lifestyle factors, some are genetic, such as cystic fibrosis. LTCs can originate at birth or in childhood and persist into adulthood.[6] Minimising the impact of Long Term Conditions on our populations' health requires of us attention to what can be prevented and or minimised through mitigation of risk, minimisation of harm and early and effective intervention and management strategies.

The effects of LTCs for the Individual: Long term conditions impact greatly on quality of life, independence and economic wellbeing. The psychological aspects of dealing with long term conditions can be considerable, varying from dealing with personal response to the disease; coping with treatment; feeling of lack of personal control and handling the responses of others. People with multiple morbidities risk experiencing poor coordination of treatments primarily designed to address single conditions.

For the health and care system: It is predicted by the World Health Organisation that chronic conditions will be the leading cause of disability by 2020 and that if not successfully managed will become the most expensive problem for health care systems.

Chronic disease is a major contributor to the life expectancy gap between Māori and Pasifika and Non Māori and Pasifika peoples[7]

15% of the population of Hawke's Bay have one or more Long Term Condition[8]

An estimated **80%** of health care funds are spent on chronic disease[9]

80% of all deaths in NZ result from chronic conditions.[10]

Getting serious about eliminating health inequity: Māori and Pasifika should not be disproportionately represented within this population group[11]. They should not expect to have much higher levels of chronic disease at a much earlier stage in life [12] than Non Māori. Māori and Pasifika have the right to expect the same life expectancy, morbidity and mortality rates as Non Māori.

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[6] Referenced to the developing draft Long Term Conditions Service Specifications – Ministry of Health.

[7] Ajwani S, Blakely T, Robson B, Tobias M, Bonne M. 2003. *Decades of Disparity: Ethnic mortality trends in New Zealand 1980-1999*. Wellington: Ministry of Health and University of Otago.

[8] Chronic Disease: Current Situation Analysis-Prevalence, Morbidity and Mortality. Lisa Jones HBDHB Business Intelligence Team.

[9] New Zealand Guidelines Group. 2001. *Chronic Care Management: Policy and Planning Guide*. Compiled by the Disease Management Working Group

[10] Ministry of Health. 1999. *Our Health Our Future: Hauora Pakari, Koiora Roa*. Wellington: Ministry of Health

[11] This population group refers to those with a long term condition.

[12] Ajwani S, Blakely T, Robson B, Tobias M, Bonne M. Decades of disparity: Ethnic mortality trends in New Zealand 1980-1999. Wellington: *Ministry of Health and University of Otago; 2003.*

My Challenge - Your Challenge - Our Challenge

The health of our population changes dramatically when we approach 35yrs of age.
To make a difference we need to begin at birth, working with our partners across all sectors, all disciplines

Starting now

Our way of working will be sustainable.
Our focus will shift from curative to preventative practices in all aspect of our work and care.

Focusing on Māori and Pasifika

Getting it right for Māori and Pasifika will mean everyone benefits.
Find the gap and take action to reduce it.

Not just one but multiple conditions present challenges for the individual and the health system: Increasing numbers of people present with more than one LTC. The rise in the incidence of long term conditions can be attributed to an increase in lifestyle risk factors (refer snap shot one – page 5) an ageing population with associated increased levels of frailty, and the socioeconomic determinants of health. People with multiple long-term conditions have markedly poorer quality of life, poorer clinical outcomes and longer hospital stays, causing them to be the most costly group of patients.[13]

Mental health and well-being is a challenge faced by all with a long term condition. It is a long term condition that will impact significantly on the health outcomes of our population.

Prevention and early intervention need to be the focus of the Long Term Condition Framework; the majority of long term conditions are preventable or could be better managed. Elimination of modifiable risk factors would prevent 80 percent of premature heart disease, 80 percent of premature stroke, 80 percent of type 2 diabetes and 40 percent of cancer.[14]

Prevention should be the focus of all aspects of Long Term Condition Management; prevention of expectation of occurrence, prevention of occurrence, prevention of exacerbation of risk factors, prevention of deterioration in health and wellbeing, prevention of increasing levels of acuity.

Prevention is about the individual and the health system working in partnership to fund and provide appropriate access to resources, activities and expectations that promote self-care – self management from a cradle to the grave. It is supporting a system that "empowers the patient to take a lead role in managing their health and ensuring access to the range of services and resources required to achieve optimal outcomes (WHO, 2002)

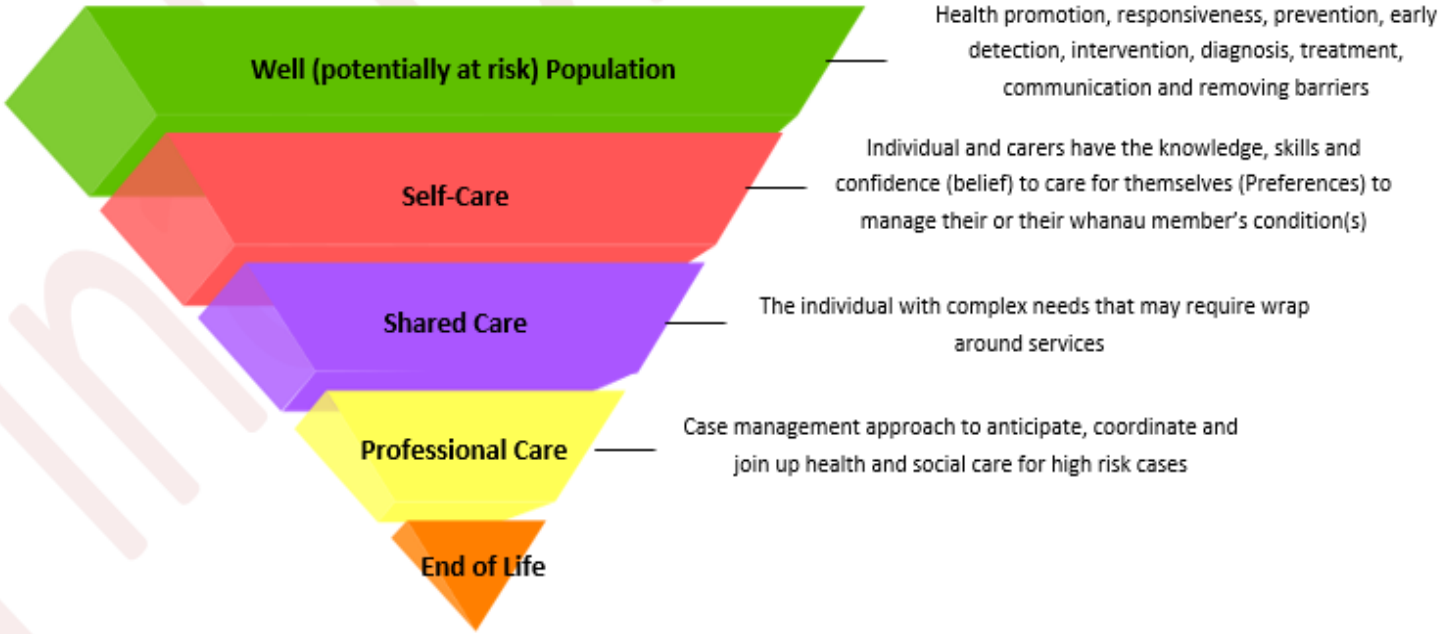
[13] Goodwin, N., Curry, N., Naylor, C., Ross, S., Dulig, W., Managing People with Long Term Conditions (2010), *The King's Fund*.
[14] World Health Organization, 2009. Interventions on Diet and Physical Activity: What Works: Summary Report

A non-disease person centred framework - The need to reduce health inequalities is a priority. Considerable health inequalities occur between population groups due to many factors including; historical, cultural, socio-economic status, geographical place of residence, ethnic identity, and gender. Long term chronic conditions account for a higher proportion of illness and deaths among Māori, people on low incomes and Pacific peoples than among the general population. New Zealand studies have identified organisational, human resource, and person-community issues in access to health care as barriers for care[15].

Less focus on disease (medical diagnosis) and greater focus on the person as a whole: Current service provision, is still weighted towards disease diagnostics but there needs to be a shift from reactive to managed care within a social, cultural and economic context. There needs to be a greater emphases on prevention, early intervention, self-management and improved cross sector integration (inclusive of social services, education, housing and justice) and relationships. The emphasis needs to be on the person and their families/whānau being partners in their care.

Model of care delivery is now gearing up to meet the needs of the population by stratifying it by risk rather than by disease. This predicates the requirements for care and will determine the design of workforce capacity and capability.

Figure 1.1 – Population Care Stratification



[15] *Discussion paper, Improving Responsiveness to Māori with Chronic Conditions May 2010*

Section Three: The Four Aka

Key: SLM – System Level measures | c-SLM – Contributing Measure

	Components of each aka	Objectives	Process measures	Outcomes Transform and Sustain
Person - Family - Whānau centred Care	**Consumer voice**	Consumers are integral to the design and evaluation of services	**Consumer input is demonstrated in service level planning and reporting** • Consumer feedback mechanisms in place *(number + variety)* • Complaints trends analysis *(utilising the WHO[16] taxonomy of categories)* • Service level plans demonstrate response to consumer voice	**Power balance shifted more in favour of consumers**
	Health Literacy	Health literacy improvements enhance access and navigation to health services by the consumer	**Health information is consumer / user focused** • Utilisation of consumer experience surveys (c-SLM) • GP practices offering an e-portal • Consumers engaged in self-management/rehabilitation programs • DNA rates-Outpatients / GP LTC consults	**Consumers access understandable information & enabled to take action**
	Self-Care	Consumers are supported to self-manage to their highest level of confidence	**Proactive Utilisation of Health services** • *+7 ED presentations (acute)* • Referral rates to accredited self-management programs • **Reduction in ASH rates** (SLM) • **Reduction in admission and readmission rates** (SLM)	**Consumers equal partners in their health care and engaged in their own treatment** *(management)*
	Understanding the determinants of health	Health professionals implement clinical and cultural competence[17] health strategies based on an understanding of the determinants of health	**Completion rates of Mandatory training** • Treaty of Waitangi Responsiveness • Cultural competency • ACE assessment • Health Literacy modules (Primary) • Relationship Centred care training • Utilisation of Patient and clinical activation measures[18]	**Services are aligned to community need**

[16] http://www.who.int/patientsafety/taxonomy/icps_full_report.pdf

[17] Cultural competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations. Refer: Cross T, Bazron B, Dennis K, Isaacs M. Towards a Culturally Competent System of Care, Volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center, 1989. Ewen S. Cultural Literacy: An Educational Approach for Health Professionals to Help Address Disparities in Health Care Outcomes. Journal of Australian Indigenous Issues 2010; 13(3); 84-94.

[18] Reference Andy's documents / Relationship Centred Care.

	Components of each Aka	Objectives	Process measures	Outcomes Transform and Sustain
Person centred clinical systems and processes	**Care Co-ordination**	Shared care collaboration between health and social care providers support the needs of the consumer to achieve optimal health outcomes	**Utilisation of health resources effectively** • HBDHB Workforce framework completed • Individual workforce strategies align to population health needs[19] • Contracting supports collaborative approaches to service provision through multi agency performance reporting. • Decreased ASH rates 45-64 (c-SLM)	**Consumers experience quality connected support for all their health (and social) needs**
	Transition of care	Consumers experience seamless transitions between provision of care and support within and across the health sector	**Prevention and early intervention** • Transition between - Paediatric and Adult services; - Across specialties; - Between primary - secondary –Allied health-NGO-ARC and other providers of care and support Does not impact on consumer health outcomes and management • Admission/ readmission rates • Reduction in Amenable Mortality equity gap (SLM)	**Transitions of care and support are seamless for the consumer and lead to improved health outcomes**
	Collaborative Pathways	Providing consistency and equity in the delivery of care for our consumers based on best practice	**Ongoing development, implementation and review of collaborative pathways** • Timely access to services (diagnostics, FSAs, (c-SLM) • Clinical utilization rate of pathways/referrals • Referral decline rates • (timely) Transfer of care • Reduced Bed days (save 4000 beds) (c-SLM) • Disease detection and follow up rates (c-SLM)	**Consistent timely provision of services results in enhanced health outcomes and efficient use of resources**
	Integrated IT systems and enablement	Information Systems, and IT are easy to use, accessible and utilised at all levels for the purpose of system wide improvement.	**IT supports efficiencies** • Utilisation rates of IT patient /population information systems e.g. Dr Info – Karo Reports – Disease registers – population stratification – Service Utilisation statistic • Utilisation of shared patient care records • Utilisation of e-referrals (internal to DHB- Primary care) • Real time access to service specific data.	**Appropriate and easy access to information for patients clinicians and management**

[19] Population health profiling is used to proactively stratify the population to enable effective preventative and early intervention management.

	Components of each Aka	Objectives	Process measures	Outcomes Transform and Sustain
Workforce Development and Enablement	**Workforce capacity and capability**	The capacity and capability of the work force aligns with the population health needs and demand.	**Workforce able to respond to health service needs** • Population stratification data utilised for service design • Service workforce mapped – capacity and capability current and future state • Recruitment and retention rates • Professional development alignment to service needs	**Workforce representative of and able to respond to the needs of the Hawke's Bay Population**
	Clinical leadership	Identified clinical leaders provide direction, support and accountability for the uptake and dissemination of best practice models to optimise patient care.	**Services are supported with expert and innovative clinical leaders** • Membership of clinical bodies / leadership forum • Participation in LTC regional-national - international congress • Delivery at LTC fora • Publication and research	**Recognition nationally as Leaders in Long Term Conditions prevention and early intervention methodology (Māori, Pasifika, Q5)**
	Clinical expertise	Clinical staff, medical and nursing and allied health, provide services to the top of their scope supported by best practice guidelines under the direction of identified clinical leaders.	**Clinical best practice and expertise is supported** • Service workforce strategy in place • Alignment of workforce strategy with IDT approach • Clinical lead pathway identified and utilised for staff development / incentives • Consistent management and skills sets supported by new training.	**Clinical Leadership roles utilised to inform clinical expertise in all service areas.**
	Inter-sectoral development	Patient care is maximised through the utilisation of an Interdisciplinary Team (IDT) approach to individualised care inclusive of the lay workforce.	**Coordinated partnership approach to patient care** • Care teams utilising a shared record • Customer focused performance reporting • Aligned models of care and funding models • Care teams extend outside the health sector (patient determined)	**Coordinated partner approach to deliver of services with consumer (across agencies)**

	Components of each Aka	Objectives	Process measures	Outcomes Transform and Sustain
Risk identification and mitigation	**Population health**	Validated risk profiling is used to support and understand the needs of the population, for the purpose of mitigating and managing those at risk	**The system is responsive to the population in a settings based approach against a range of indicators** • Programs achieve individual whanau goals • Quality of Life measures – individual and population • Health Outcomes Indicators (System Level Measures and Health Targets • Service utilisation and metric outcomes • The use of co design for the development of services • Demonstration of Māori and Pasifika gains in health outcomes • Demonstration of diminishing equity gap in health outcomes across age, gender, locality.	**Elimination of the Health Equity Gap**
	Equity	The gap in consumer health outcomes is addressed actively through targeted approaches to the delivery of care.		
	Continuous quality improvement	Innovative practice is supported. Recognised improvement methodologies are used to achieve evidence based enhanced patient outcomes.	**Change is supported by system wide improvement practices** • Quality Improvement initiatives represented in all service units • Quality Improvement initiatives cross all service boundaries • IDTs collectively using agreed methodologies for planning and monitoring improvement • Celebration of innovative best practice that is evidence based • Uptake of research and development initiatives	**HBDHB recognised as leaders in the prevention and early intervention of LTC**
	Governance / advisory support	The support of an advisory group is used to evaluate services and advise on service design and improvement	**Change is supported by an Interdisciplinary Advisory Group** • Quality, Clinical, Nursing and Allied Health leaders form the membership of the advisory group across the health sector, inclusive of Māori and Pasifika • Consumer input is included on the advisory (focus area specific) • Demonstrated change within service provision that reflects performance against the LTC - SRM	**Long Term Conditions management is approached generically by the DHB vs only disease specific**

Section Four: The Methodologies that Informed the Framework

The Hawke's Bay District Health Board – Long Term Conditions Framework aims to operate from a strengths based approach. This involves looking at and for opportunities to change and improve through utilising existing expertise, systems and relationships. Highlighting high functioning, customer focused coordinated responsive care. What the framework aims to do through the **Service Review Matrix** (Appendix 4) is identify areas of excellence for the purpose of disseminating best practice within our local context, and utilise the following methodologies to effectuate change.

Appreciative Inquiry (AI) – creating a positive atmosphere for change.

Appreciative inquiry is a change management approach that focuses on identifying what is working well, analysing why it is working well and then doing more of it. The basic tenet of AI is that an organization will grow in whichever direction that people in the organization focus their attention

Appreciative Inquiry is about the co-evolutionary search for the best in people, their organizations, and the relevant world around them. AI involves the art and practice of asking questions that strengthen a system's capacity to apprehend, anticipate, and heighten positive potential. AI paves the way to the speed of imagination and innovation; instead of negation, criticism, and spiralling diagnosis, there is discovery, dream, and design. AI seeks, fundamentally, to build a constructive union between past and present capacities: achievements, assets, unexplored potentials, innovations, strengths, elevated thoughts, opportunities, benchmarks, high point moments, lived values, traditions, strategic competencies, stories, expressions of wisdom, insights into the deeper corporate spirit or soul-- and visions of valued and possible futures. Taking all of these together, AI seeks to work from accounts of a "positive" change core.

Results Based Accountability: Not just measuring results – partnering up with those who contribute to a collective (agreed) outcome

Results-Based Accountability™ (RBA), also known as Outcomes-Based Accountability™ (OBA), used by organisations to improve the performance of their programs or services. It recognises that 'trying hard' outputs driven models, do not always result in anyone being 'better off'. RBA uses a data-driven, decision-making process to help (communities and) organisations get beyond talking about problems to taking action to solve problems. The strength of the framework is identifying partnerships and working together for the achievement of a common goal.

IHI Improvement methodology: Testing ideas-theories in controlled environments vs whole of system change

The Model for Improvement, developed by Associates in Process Improvement [20] , is a simple, yet powerful tool for accelerating improvement. This model is not meant to replace change models that organizations may already be using, but rather to accelerate improvement. The model has two parts; three fundamental questions which can be addressed in any order (refer Service Review Matrix[21]); What are we trying to accomplish, How do will we know a change is an improvement and What change can we make that will result in improvement? The strength of this cycle is it identifies specific aims, establishes quantitative measures associated with an agreed outcome (improvement) using those who use and work in the system. It does not call for whole of system change- but tests environments and builds on successes that have been achieved.

[20] http://www.apiweb.org/ (W. Edwards Demming)

[21] Long Term Conditions - Service Review Matrix (LTC-SRM) includes summary of the IHI methodology Plan Do Study Act model and questions. (Appendix Two of the SRM)

Driver Diagram (IHI Improvement Methodology)

(For - consultation)

Outcome	Key Drivers	Objective	Enablers	Service level Interventions
The population of Hawke's Bay expect to be well and live well	The burden of LTC on person-whānau - community	Supporting the creation of resilience within the communities of Hawke's Bay	Consumer driven and designed services (addressing determinants of health)	Designed by each 'team' and or Service inclusive of consumers
			Health Promotion Health Education that supports self-management	
			Focus activities on Health Literacy	
	Addressing the inequity gap in health outcomes for Māori and Pasifika	Prioritise work programs that address the determinants of health and well being	Raising expectations of health and well-being **(consumers and health professionals)**	Designed by each 'team' and or Service inclusive of consumers
			Activities focused on early detection (Risk identification) and prevention	
			Inter- sectoral combined work activities	
	Partnering is needed to build an integrated responsive system	Develop (Strategic) partnerships that collectively work towards common outcomes	Use of agreed common methodologies for Change – Planning – Reporting-Monitoring	Designed by each 'team' and or Service inclusive of consumers
			Workforce strategic development I line with population health needs	
			Collaborative pathways of care that cross health sector boundaries	
	Risk identification and Mitigation	Establish networks of expertise and experience include: clinical-non clinical skilled & lay workforce	LEAN methodologies focused on Safety – Effectiveness - Efficiencies	Designed by each 'team' and or Service inclusive of consumers
			Values and behaviours imbedded in practice (safe to challenge status quo)	

Bibliography:

References - Local Documents:

HBDHB Transform and Sustain (Refresh), Māori Health Plan, Equity Report 2016, Healthy Eating Strategy, Draft Youth Strategy, Primary Care Strategic and Annual Plans

References - Key NZ Documents

- The 2016 NZ Health Strategy- Future direction and its Roadmap of Actions,[22] in particular Action 8 Tackle long term conditions and obesity
- Te Korowai Oranga[23]
- Equity of Health care for Māori: a Framework
- Primary Health Care Strategy
- New Zealand Disability Strategy: make a world of difference[24] (to be revised 2016)[25]
- Disability Support Services, Strategic Plan 2014-2018[26]
- Health of Older People Strategy 2002[27] (update in progress due 2016)
- Positive Aging Strategy[28]
- 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018
- The Crown Funding Agreement and its schedules, the Operational Policy Framework and the Service Coverage Schedule and the Nationwide Service Specifications.[29]

[22] http://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-future-direction-apr16.pdf

[23] http://www.health.govt.nz/our-work/populations/Māori-health/he-korowai-oranga this link provides a description of its various elements – including its aim: Pae Ora– Healthy futures for Māori. Pae Ora (Healthy Futures) is the Government's vision and aim for the refreshed strategy. It builds on the initial foundation of Whānau Ora (Healthy Families) to include Mauri Ora (Healthy Individuals) and Wai Ora (Healthy Environments).

[24] http://www.health.govt.nz/publication/new-zealand-disability-strategy-making-world-difference

[25] Revising the New Zealand Disability Strategy http://www.odi.govt.nz/nzds/

[26] The Disability Support Services' (DSS) Strategic Plan, reflects commitment to the United Nations Convention on the Rights of Persons with Disabilities 2008, which aims to 'promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity'. http://www.health.govt.nz/publication/disability-support-services-strategic-plan-2014-2018

[27] The Health of Older People Strategy sets out a framework for improving health and support services for older people. http://www.health.govt.nz/publication/health-older-people-strategy

[28] The Office for Senior Citizens https://www.msd.govt.nz/what-we-can-do/seniorcitizens/positive-ageing/strategy/

[29] http://nsfl.health.govt.nz/

Specific Links

Obesity

http://www.health.govt.nz/our-work/diseases-and-conditions/obesity/childhood-obesity-plan
http://www.health.govt.nz/our-work/diseases-and-conditions/obesity/obesity-related-publications
http://www.health.govt.nz/our-work/diseases-and-conditions/obesity/weight-management-hiirc
http://www.health.govt.nz/our-work/diseases-and-conditions/obesity
http://www.health.govt.nz/our-work/eating-and-activity-guidelines
http://www.health.govt.nz/our-work/eating-and-activity-guidelines/current-food-and-nutrition-guidelines
http://www.health.govt.nz/publication/guidance-healthy-weight-gain-pregnancy

Smoking

http://www.health.govt.nz/our-work/preventative-health-wellness/tobacco-control/smokefree-2025

Health Literacy

Health Literacy Review: a guide http://www.health.govt.nz/publication/health-literacy-review-guide 2015

Evidence based research

http://www.health.govt.nz/publication/health-loss-new-zealand-1990-2013
http://www.health.govt.nz/our-work/life-stages/child-health/child-health-publications
http://www.health.govt.nz/publication/food-and-nutrition-guidelines-healthy-children-and-young-people-aged-2-18-years-background-paper
http://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/new-zealand-burden-diseases-injuries-and-risk-factors-study-2006-2016

Disease specific groups – best practice guidance

Cancers

http://www.health.govt.nz/publication/new-zealand-cancer-plan-better-faster-cancer-care-2015-2018 http://www.health.govt.nz/our-work/diseases-and-conditions/cancer-programme
http://www.health.govt.nz/our-work/diseases-and-conditions/cancer-programme/faster-cancer-treatment-programme/national-tumour-standards

Cardiovascular

http://www.health.govt.nz/our-work/diseases-and-conditions/cardiovascular-disease
http://www.health.govt.nz/publication/new-zealand-primary-care-handbook-2012

Chronic Kidney Disease

http://www.health.govt.nz/your-health/conditions-and-treatments/diseases-and-illnesses/kidney-disease
http://www.health.govt.nz/publication/managing-chronic-kidney-disease-primary-care

Chronic pain

http://www.ncbi.nlm.nih.gov/pubmed/21946879
Blythe, F. Dominick, C Nicholas, M. NZ Medical Journal (NZMJ) 24 June 2011, Vol 124 No 1337; ISSN 1175 8716

Chronic Respiratory Disease

http://asthmafoundation.org.nz/news-and-events/publications/
https://www.thoracic.org.au/
http://asthmafoundation.org.nz/wp-content/uploads/2012/03/COPDguidelines.pdf

Dementia

http://www.health.govt.nz/publication/new-zealand-framework-dementia-care

Diabetes

Living Well with Diabetes is the Ministry's plan for 2015 to 2020. It builds on this work already underway and seeks to improve outcomes for people with diabetes
http://www.health.govt.nz/our-work/diseases-and-conditions/diabetes
http://www.health.govt.nz/our-work/diseases-and-conditions/diabetes/quality-standards-diabetes-care
http://www.health.govt.nz/our-work/diseases-and-conditions/diabetes/diabetes-publications

Gout

http://www.health.govt.nz/publication/health-literacy-and-prevention-and-early-detection-gout

Mental Health and Addiction

https://www.rnzcgp.org.nz/assets/documents/Training-and-Beyond/Curriculum-Documents-2014/Mental-Health-CS.pdf
http://www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017
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