MINISTRY OF HEALTH
MANATŪ HAUORA

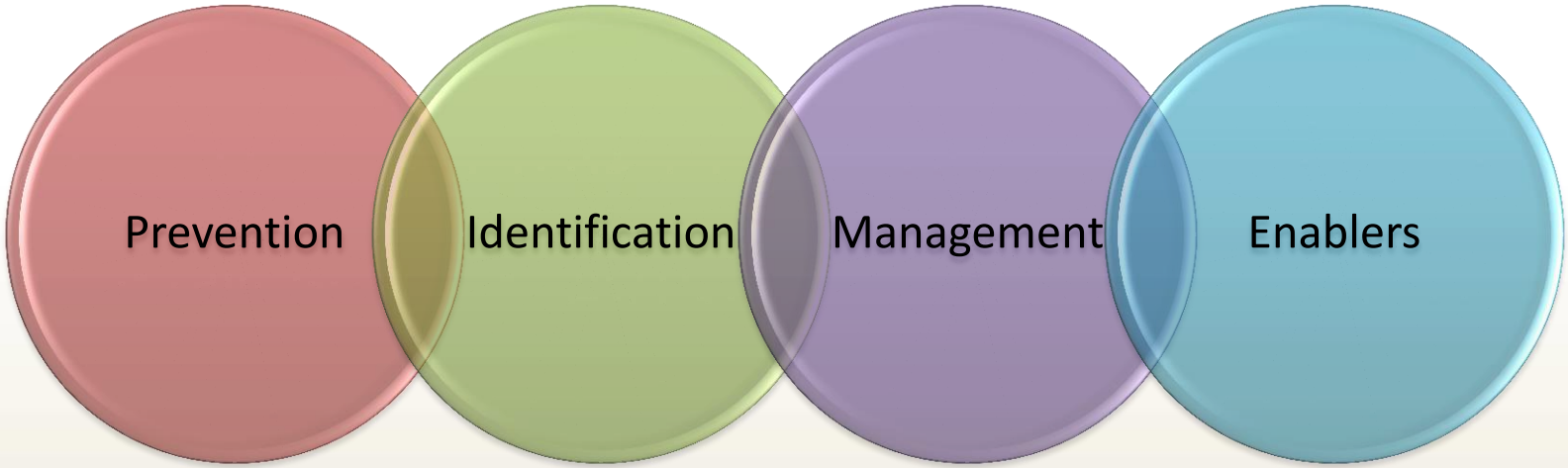
Annual Planning 2015/16

What we are trying to achieve?

- New Zealanders with **Long Term Conditions (LTCs)** live longer, healthier and more independent lives, with the assistance of an integrated health system

- People living with **diabetes** are regarded as leading partners in their own care within systems that ensure they can manage their own condition effectively with appropriate support.

How will we achieve it?



How will we achieve it?

Prevention for long term conditions relates to clearly outlined networks between general practice and community organisations to maximise physical activity, nutrition, quitting smoking and reduction in alcohol use. Examples include links to the green prescription programme and other programmes being run by the various groups in your communities.

For diabetes the **prevention** section should show that people with diabetes have access to healthy lifestyle support and adequate services to detect, prevent or delay the onset of diabetes related complications. This includes access to community services such as podiatry and retinal screening.

How will we achieve it?

Identification for LTCs refers to demonstrating that systems are in place for risk stratification of the population to identify people with Long Term Conditions and showing evidence of proactive recall and management of at risk populations.

Identification for diabetes should show proactive recall for retinal screening, foot checks, renal function tests to ensure the early identification of diabetes related complications.

How will we achieve it?

Management for LTCs refers to the development and/or implementation of models of care that support people with long term conditions.

This should include provision of multi-disciplinary teams including secondary services and allied health, supporting service delivery in primary care. It should also include provision of self-management support and education for people with long term conditions.

The Ministry has recently released advice on self-management support for people with long term conditions to support this. A copy is in your packs.

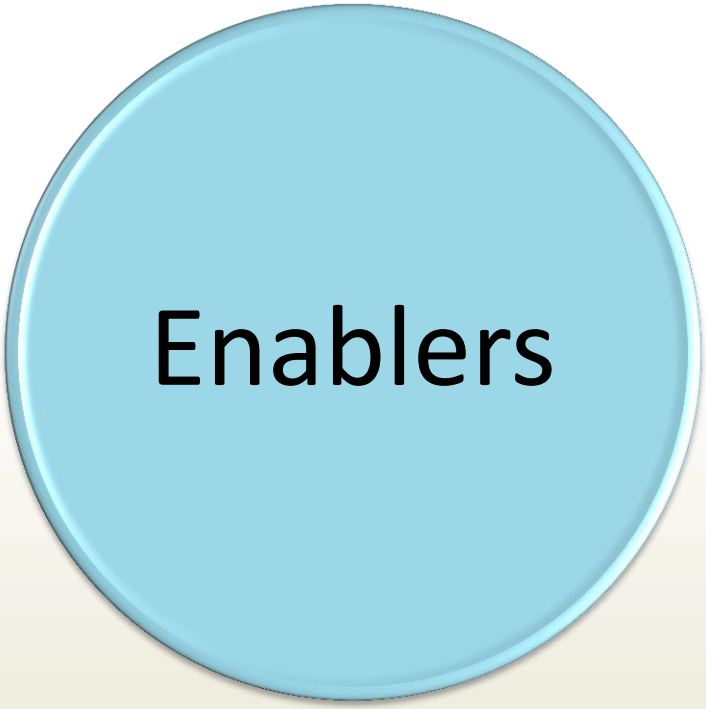
Management - continued

Management for diabetes should demonstrate self-assessment against the 20 Quality Standards for Diabetes Care, and using the toolkit, implementation of or changes to services as a result of that self-assessment.

The annual planning advice has a particular focus on:

- provision of services for people with Type 1 diabetes, especially youth,
- provision of specialist support in primary care, and
- provision of self-management support and education for people with Diabetes

How will we achieve it?



Enablers for LTCs should include demonstrating clinical governance for Long Term Conditions services, that is supported via Alliancing, having IT systems to support risk stratification, case management and shared care and showing evidence of staff education and training around goal setting, motivational interviewing and shared decision making concepts.

The diabetes **enablers** section has a focus on consumer engagement and co design, a commitment to performing data matching of the VDR against PMS systems and use of the HQSC atlas of variation for diabetes to identify possible gaps in service delivery.