



NT Chronic Conditions Prevention and Management Strategy 2010-2020

Evaluating the last ten years, developing the next strategy

The Northern Territory (NT) Chronic Conditions Prevention and Management Strategy 2010-2020 (the Strategy) is part of the NT Government's long-standing effort to address chronic conditions in the NT.

This document summarises findings from the recent evaluation of the Strategy.



The Strategy's KEY ACTION AREAS



Its CONCEPTUAL FRAMEWORK focused on strengthening:

- Individual, carer and family centred care
-
- Community capacity
-
- Strategic supports to enable effective implementation of interventions
-
- Interventions across the care continuum.

It prioritised CONDITIONS with common risk factors, including:

1. **C**ardiovascular disease
2. **R**heumatic heart disease
3. **T**ype 2 diabetes
4. **C**hronic airways disease
5. **C**hronic kidney disease
6. **C**hronic mental illness
7. **C**ancers associated with the common risk factors for other chronic conditions.

What did the evaluation involve?

The Department of Health engaged an independent evaluator, Nous Group, to assess how the Strategy was implemented and the impact it has had, to inform the next strategy.

The evaluation process included desktop research; quantitative analysis; and interviews, focus groups and surveys. The evaluation had a number of limitations, one of which was that consultation with consumers was out of scope.

The evaluation focused on **three overarching questions:**

How well was the Strategy implemented?

What impact did the Strategy achieve?

How can the Strategy be improved?

How was the Strategy implemented?

The Strategy **directed implementation** through its eight key action areas and more detailed accompanying plans.

It was **intended for** use by policy makers, health care providers, non-government organisations, Aboriginal Community Controlled Organisations, health consumers and the public.

It was primarily intended to **guide organisations** to formulate their own action plans and prioritise their work in chronic conditions.

How well was the Strategy implemented?

The Strategy was staged through three implementation plans

Each of the eight key action areas included an objective, strategies to achieve the objective, and indicators of performance. The actions stakeholders would undertake to achieve the objectives for each key action area were documented in an accompanying implementation plan, which was updated every three years for the duration of the Strategy. The implementation plans were produced by the Department with input from stakeholders across government, research institutions, the Aboriginal health sector and NGOs.

The Chronic Disease Network Steering Committee was intended to govern implementation but instead fulfils other functions

Consultation with members of the Chronic Disease Network Steering Committee, which was intended to govern implementation of the Strategy, highlighted they do not view it as a governance body, as authority and delegations rest with the Department. Instead, they view it as an advisory body to the Department, and a forum for information sharing and collaboration between sectors, particularly the government and non-government sectors.

Understanding of the Strategy varied among stakeholders, however, most agreed its conceptual framework is sound

Leaders in the Department, Top End Health Service (TEHS) and Central Australia Health Service (CAHS) generally had a good understanding of the Strategy.

Leaders in other organisations reported lower understanding of the Strategy. Some said there was a lack of clarity about their organisations' roles in the Strategy.

Many stakeholders in other roles stated they had not heard of or read the Strategy (at least for a number of years). They were nevertheless reasonably aware of its key activities. However, most stakeholders agreed the key action areas in the Strategy are still relevant and provide a good framework for chronic conditions prevention and management in the NT.

Planned evaluation, and to a lesser extent monitoring, was undertaken

Two evaluations of the Strategy were conducted, one in 2016 and one in 2019-20. Each of the three implementation plans were reviewed as well.

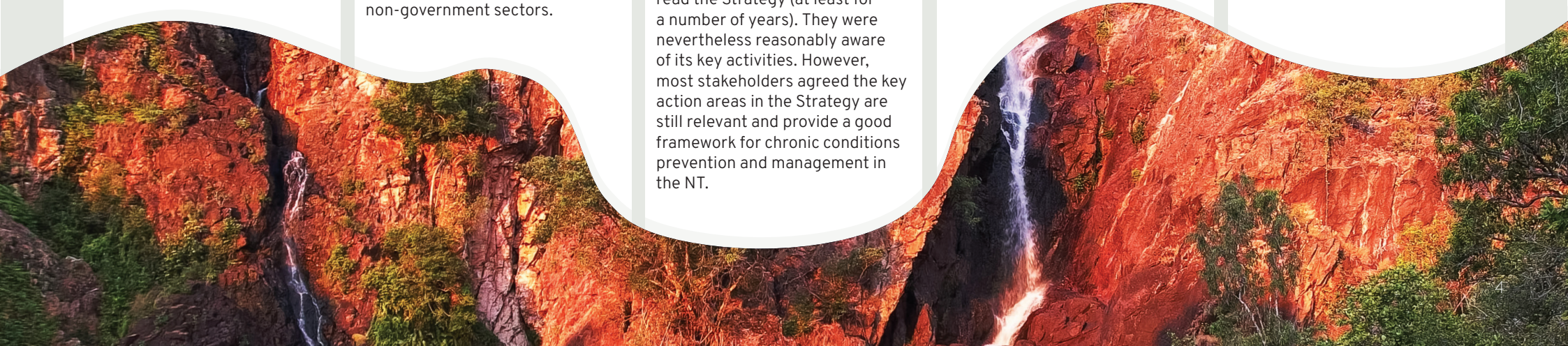
The Department produced annual monitoring reports for the first three years of the Strategy, but these were discontinued due to a lack of resources.

The Strategy did not have a monitoring and evaluation framework in place until close to the end of its duration.

A range of enablers and barriers for implementation were identified

Enablers for the implementation of the Strategy included the Department's commitment of resources (though these were nonetheless modest given the scope of activity the Strategy included) and stakeholders' goodwill and support.

Barriers to implementation included the Strategy's complexity, inconsistent monitoring, the rapidly changing environment for health service delivery, and the convolutedness of funding arrangements for chronic conditions prevention and management in the NT.



What was the Strategy's impact?

There is evidence of improvement in Territorians' health and wellbeing and in chronic conditions prevention and management. However, there is a critical ongoing imperative to achieve further improvement and mitigate the impacts of chronic conditions in the NT.

Relative to national trends, life expectancy has improved in the NT for most population groups. This improvement is likely due at least in part to better chronic conditions prevention and management.

Rates of potentially preventable hospitalisations due to chronic conditions remained higher in the NT than nationally.

There were no statistically significant changes in the proportion of low birthweight babies or in rates of mortality due to chronic conditions.



Findings for each key action area in the Strategy:

Social determinants of health

Intersectoral action is evident to varying degrees across the NT. There has been improvement in some social determinants, but performance was poor to begin with and hence remains low.

Care for people with chronic conditions

Some indicators suggest quality of care has improved. There is room to improve accessibility, integration and coordination of care.

Primary prevention and risk factors

There have been improvements in some risk factors in some locations. For example, tobacco smoking has reduced, but to a lesser extent, if at all, in remote communities.

Workforce planning and development

Recruitment of staff has improved, but turnover remains high. The number of Aboriginal Health Practitioners has been declining.

Early detection and secondary prevention

The capability and systems of health service providers to identify and monitor disease markers appear to have improved. This may not always translate into consistent management.

Information, communication and disease management systems

Population health reporting and communication about chronic conditions are in place in primary health care settings. Technology such as electronic client health records and telehealth have improved information sharing and access to care, though further work is required to fully realise their benefits.

Self-management

Self-management is not consistently embedded in day to day care. Understanding of the concept of self-management varies.

Continuous Quality Improvement

CQI is embedded in the day-to-day practice of care delivery across the NT.

The Strategy has been an important influence on chronic conditions prevention and management in the NT, particularly in the government sector. The Department, TEHS and CAHS have used the Strategy to guide their actions, align investments and participate in implementation, monitoring and reporting. Stakeholders outside government have more variable understanding of and engagement with the Strategy.



How can the Strategy be improved?

While substantial improvements have been achieved over the life of the Strategy, there is a critical ongoing imperative to mitigate the impacts of chronic conditions in the NT.

The rising burden of chronic conditions in the NT was a key motivator for both the current Strategy and its predecessor. The burden of chronic conditions in the NT continues to be substantial for both Aboriginal and non-Aboriginal people.

There are also ongoing challenges requiring attention; for example, limited improvement in the social determinants, persistently high rates of smoking in remote communities, and difficulties in integrating and coordinating care.

The efforts of the numerous stakeholders involved in chronic conditions prevention and management in the NT could be directed in many directions and will have greater impact if focused toward shared priorities of the greatest benefit to Territorians' health and wellbeing.

The next strategy should be for the whole of the NT health sector, as the current one is

As the current strategy does, the next strategy should provide a framework to guide the actions of NT health sector organisations while articulating how they will collaborate with organisations in other sectors (for example, to improve the social determinants of health).

There is a need to strengthen stakeholder partnerships, engagement, ownership and shared accountability

There is opportunity for the next strategy to build upon the current strategy by strengthening stakeholder partnerships, engagement, ownership and accountability. This would require:

- a collaborative development process
- fit-for-purpose governance, accountability and reporting arrangements
- monitoring and evaluation that is built-in, conducted consistently and utilised to make ongoing improvements throughout the life of the strategy.

It would be enhanced by a clear picture of the current funding and resourcing for chronic conditions prevention and management in the NT, including how much is being spent by whom and on what. A shorter duration (for example, six years rather than 10) would also help to maintain currency and buy-in over the life of the strategy.

The effectiveness of the next strategy in directing the efforts of stakeholders would be further supported by clearly defining its audience, ensuring its content is clear and accessible, and setting a small number of priorities or “best buys”.

Aboriginal leadership of the strategy will be particularly important

Aboriginal leadership of the strategy and its development, shared with other stakeholders, will be particularly important. This reflects the disproportionate impacts of chronic conditions on Aboriginal people in the NT and the strong leadership that Aboriginal organisations already exercise in relation to issues such as social determinants.

