



Healthy Ageing 2020

*The Auckland District Health Board Plan to
Improve the Health of Older People
in Auckland City*

December 2006

Please direct all enquiries regarding this Plan to Planning and Funding, Auckland District Health Board, Private Bag 92 189, Auckland. (09) 367 0000.

Alongside *Healthy Ageing 2020* are Implementation Plans for Child Health, Mental Health and Cardiovascular Disease/Diabetes.

For electronic copies of other health improvement plans and Auckland DHB reports please go to: www.adhb.govt.nz

Foreword

Healthy Ageing 2020 is a plan developed by the Auckland District Health Board to show our commitment to older people living in Auckland city. Our intention is to improve health services for this group through increased collaboration, joint planning, and improved information sharing.

Healthy Ageing 2020 is also Auckland DHB's response to the national Health of Older People's strategy, showing how we will implement government direction in our local area. It has also been developed in line with recent national service pilots which culminated in the recent release of the ASPIRE report, demonstrating significant support for Ageing in Place models as alternatives to rest home care.

The concept of Healthy Ageing involves more than just health; it requires an attitudinal change that focuses on the whole person, considering all their needs. Auckland DHB will lead by example in promoting and valuing older people in society.

While this plan is focused on people over 65 years of age, we know that the makeup of this population group will look very different by the year 2020. The vast majority of our population do not access Health of Older People services until much later in life. The average age of entry into our Rest Homes is 82. On the other hand Maori living in our area experience disease at an earlier age than non-Maori, and may need services before they turn 65. Similarly, we recognise that palliative care is not limited to persons over 65; this plan however includes actions to improve our responsiveness to both of these key population groups.

Consultation took us into the hearts and lives of many older people, ensuring that as health planners, our ideas were shaped by those most directly affected. This also led to the establishment of many new key relationships, and in several cases the development of strategic partnerships which in turn have paved the way for several cross sector projects to be initiated under the Healthy Ageing banner. More details of these are included within the plan.

We present *Healthy Ageing 2020* to you as part of an ambitious vision which Auckland DHB is proud to lead. We invite you not only to be part of the document, but also a part of the way in which we begin to change perceptions, support service quality and ensure that the overall ageing process is one that is valued and treasured.

Denis Jury
Chief Planning and Funding Officer

Contents

Foreword	3
Contents	5
PART ONE: A PLAN FOR ACTION	7
Introduction	7
Our Approach to Older People's Health	7
How we Developed this Plan	9
Actions for the future	16
1. Reducing Health Inequalities	17
1.1 Maori Health	17
1.2 Pacific Health	19
1.3 Asian Health	20
1.4 Disabled Older People	21
2. Improving Community Services	23
2.1 Health Promotion	23
2.2. Needs Assessment and Service Coordination	25
2.3 Vocational and Socialisation Skills	26
2.4 Home-Based Support Services	27
2.5 Specialist Services	29
2.6 Meals on Wheels	30
2.7 Environmental Support Services	31
3. Other Service Improvements	33
3.1 Residential Care Services	33
3.2 Mental Health Services for Older People	35
3.3. Palliative Care	36
4. Improving Performance across the Sector	38
4.1 Quality	38
4.2 Polypharmacy	40
4.3 Workforce	41
4.4 Information Technology and Management	42
4.5 Intersectoral Collaboration	43

PART TWO: BACKGROUND INFORMATION	51
Auckland's Ageing Population	51
The health status of the population	53
Conditions that affect us as we age	54
Use of services	57
Appendix 1:	58
Documents Reviewed in the development of this strategy	58
Steering Group Members	61

PART ONE: A PLAN FOR ACTION

Introduction

The process to develop *Healthy Ageing 2020* has involved many individuals, groups and organisations capturing a wide cross section of views. Consultation underscored the most pressing needs of service users and their families/whanau. The top priority is for:

- the DHB to be inclusive in decision making and to keep communities well informed about service development or change. This is especially important when it comes to changes that affect older people

Other needs and problem areas identified include:

- the DHB is not seen as supportive of carers of older people. The decision to keep a spouse or family member at home rather than in rest home care is not recognised
- community services are not currently structured correctly. Alternative models are needed that promote recovery rather than dependence
- the ability of residential care to meet the growing demands from increasing numbers of older people
- there is a need to establish the best bed models and service mixes. More options for the planning and management of this issue are needed.
- quality concerns are paramount, especially the need to support all aspects of the sector in delivering a high quality, safe service to our older people
- service users and the general population hold in high esteem the specialist services which operate as part of the A+ links hospital service. However there is also frustration at the lack of integration and coordination between services.

Our Approach to Older People's Health

The plan has a 20 year vision and focuses actions achievable in the next five years. Auckland DHB will:

1. Lead by example in ensuring that older people within our community are valued and respected
2. Work with key agencies and stakeholders to ensure that adequate planning for our ageing population is undertaken today, for tomorrow
3. Support older people and their families in their decision to age in place – wherever that place may be

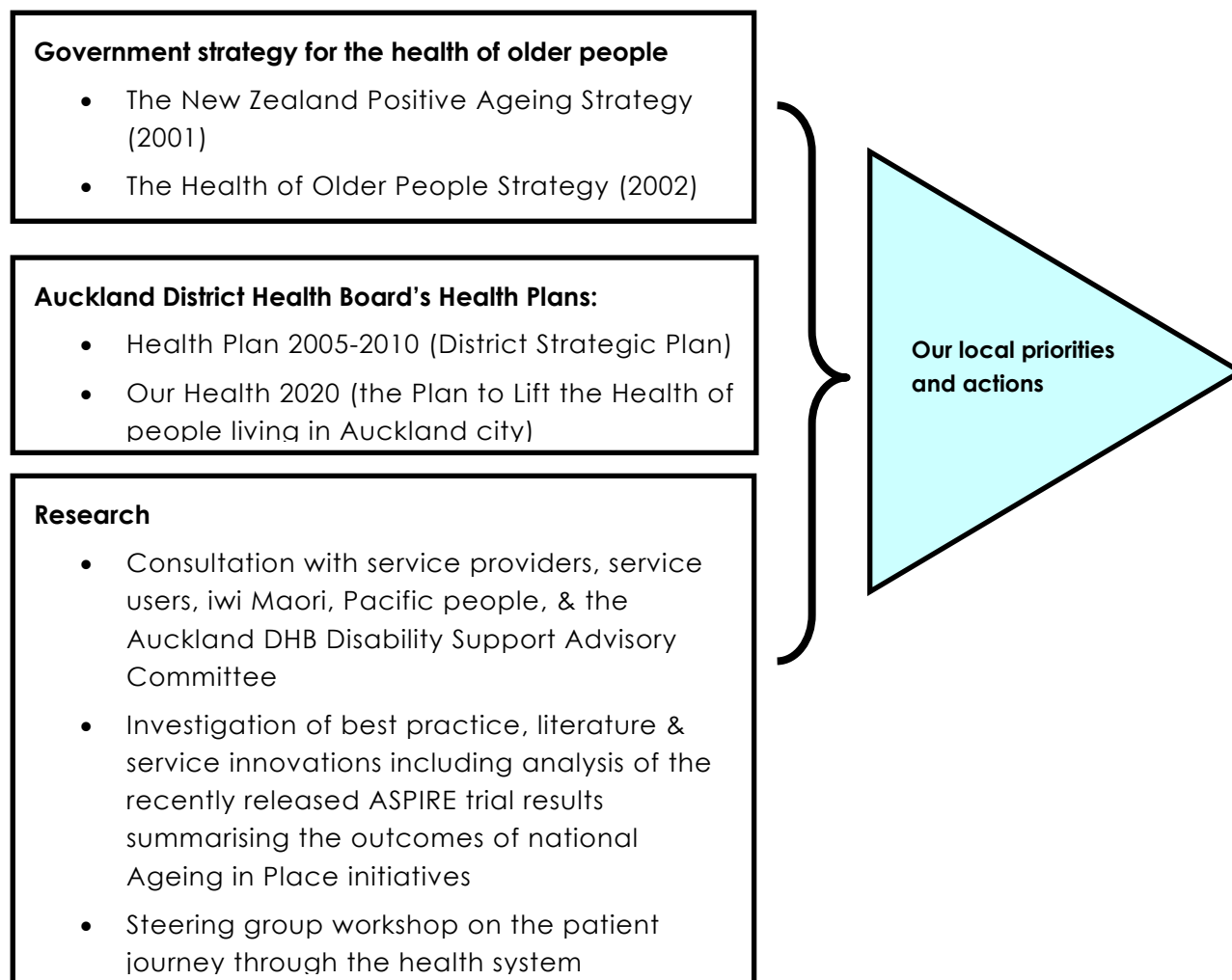
4. Work with providers of services and advocacy groups to ensure that service provision is aligned to best practice
5. Design programmes in older people's health that are appropriate to the needs of Maori
6. Recognise and respond to the diverse needs of the ethnic minorities within our ageing population
7. Ensure that older people feel safe within our communities
8. Create a culture where quality is paramount
9. Ensure that services are developed in line with best practice
10. Listen to the perspectives of our older people to ensure that service design is consumer focused
11. Work with other sectors to ensure that unnecessary duplication among services is avoided
12. Provide information to ensure that access to services for older people is timely and appropriate
13. Introduce quality measures to performance indicators to allow benchmarking against best practice to occur
14. Enhance relationships between specialist hospital and community services to improve overall patient experience

and most importantly, we will

15. Remain accountable to our service users and their families and whanau by being inclusive in our planning of services for older people, and by being transparent in our funding decisions made on older peoples behalf

How we Developed this Plan

This plan was developed locally based on a considerable amount of stakeholder consultation and alignment to national policy work. The diagram below shows the three main areas of input that contributed to our local priorities.



Government strategies for older people

The two major government strategies for older people's health are recognised as national guidelines for setting the direction of services relating to older people:

- The New Zealand Positive Ageing Strategy (2001)
- The Health of Older People Strategy (2002)

Both of these promote the value, participation, and empowerment of older people. There is a strong emphasis throughout on integration and coordination, especially in

respect of the Positive Ageing Strategy, which is a joint sector initiative, securing commitment from all government agencies that have accountability to older people.

The National Health Committee has also been very involved in the Health of Older People with several publications since 2002:

- Living at Home
- Self Assessment: A Process for Older People
- Guidelines for the Support and Management of People with Dementia
- Care for Older People in New Zealand
- Health Care for Older People
- Health and Disability Services for Older Maori

The national vision

Older people participate to their fullest ability in decisions about their health and wellbeing and in family, whanau and community life. They are supported in this by co-ordinated and responsive health and disability support programmes.

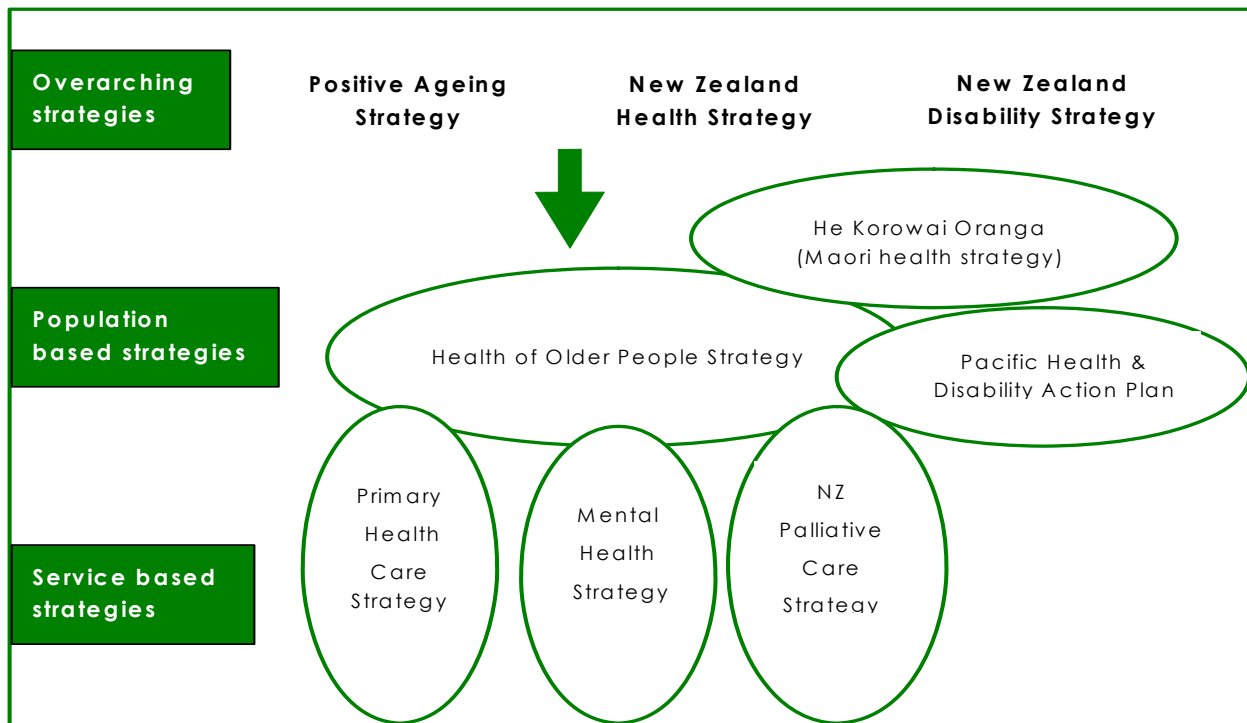
(The Health of Older People Strategy, (Ministry of Health, April 2002)

Objectives

National Health of Older People Strategy Objectives

1. Older People, their families and whanau are able to make well informed choices about options for healthy living, health care and/or disability support needs
2. Policy and service planning will support quality health and disability support programmes integrated around the needs of older people
3. Funding and service delivery will promote timely access to quality integrated health and disability support services for older people, family, whanau and carers
4. The health and disability support needs of older Maori and their whanau will be met by appropriate, integrated health care and disability support services
5. Population based health initiatives and programmes will promote health and wellbeing in older age
6. Older people will have timely access to primary and community health services that proactively improve and maintain their health and functioning
7. Admission to general hospital services will be integrated with community-based care and support that an older person requires
8. Older people with high and complex health and disability support needs will have access to flexible, timely and coordinated services and living options that take account of family and whanau carer needs

The relationship between strategies



Ref: Health of Older People Strategy , Ministry of Health 2002

The Auckland DHB Strategic Plan for Population Health

Healthy Ageing 2020 continues the objectives set out in the national Health of Older People Strategy, but also aligns to the key outcome areas defined with ADHB's Strategy 'Our health 2020' which focus on healthy lifestyles, the impact of long term conditions, reducing inequalities, achieving systems changes in primary care and more appropriate use of secondary care.

Health Improvement Plans such as this one have also been tasked with taking a 'whole systems approach' which for *Healthy Ageing 2020* means looking at the whole health experience, from entry to exit, not excluding any service areas, and being mindful of cross cutting themes such as integration, Maori and Pacific Health need, and Palliative Care.

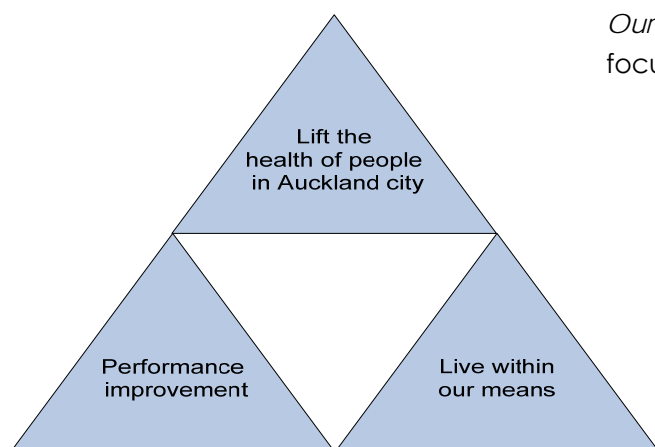
The overall vision for the Auckland DHB is healthy communities, quality health care. This vision is achieved through three strategic goals.

The goal 'Lift the health of the people in Auckland city' is being implemented through a district-wide planning process called *Our Health 2020*. Key themes underpinning

Our Health 2020 is a whole system/whole society view of health which takes a long term approach.

This plan, as well as the Ministry of Health Plan develops an integrated approach to the services and supports that meet the needs of older people. Elements of an integrated approach are:

- Services are older person focused
- A wellness model is promoted, as opposed to a sickness model
- Services are coordinated and responsive to needs
- Family, whanau and carer needs are also considered
- There is information sharing and a smooth transition between services
- Planning and funding arrangements support integration and this plan



Our Health 2020 has five key outcomes to focus activity in the medium term:

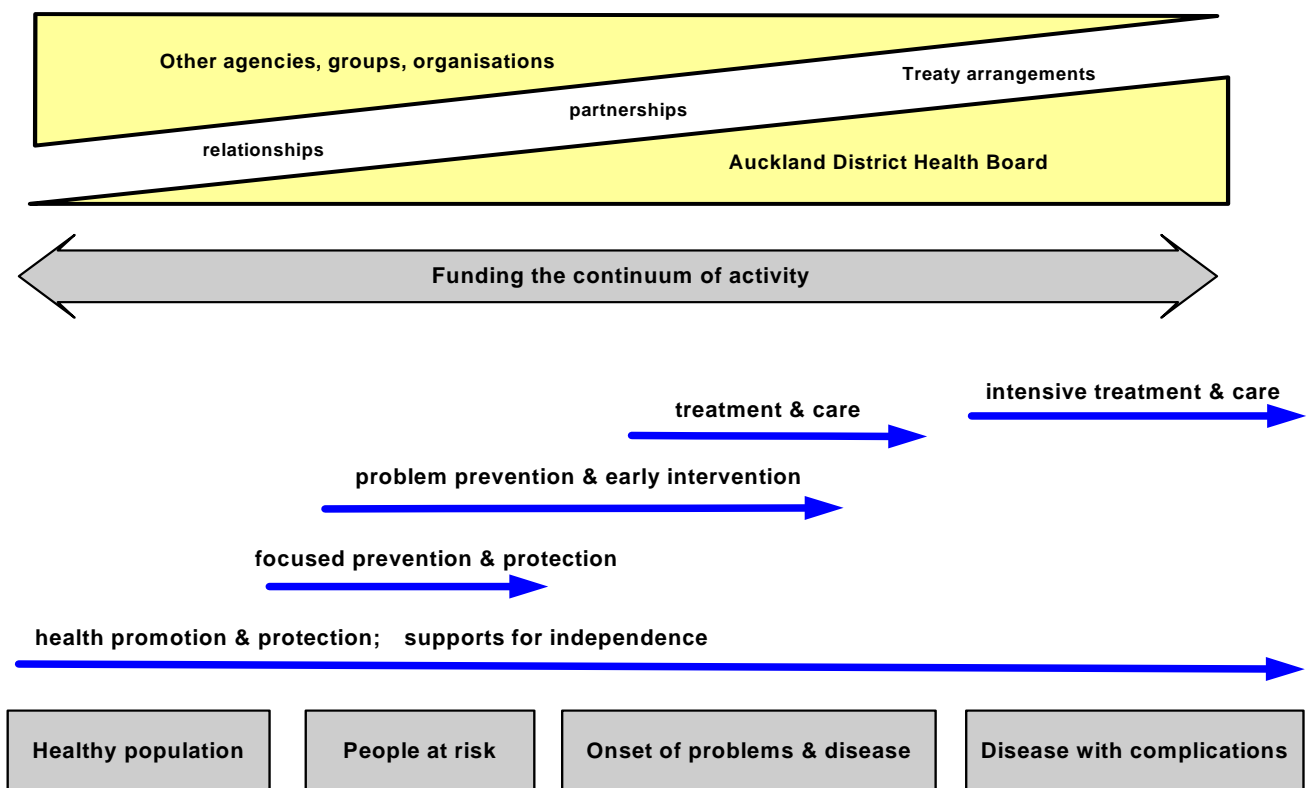
- Improve healthy lifestyles and environments
- Reduce the incidence and impact of long term conditions
- Reduce inequalities in health outcomes
- Achieve NZ Primary Healthcare Strategy system change
- Support appropriate use of hospital services

There are five priorities areas for action:

- Health of older people
- Cardiovascular disease/diabetes
- Mental health
- Child Health
- Cancer

As outlined in the Auckland DHB Strategic Planning overview document for 2006/07, the new approach to health improvement brings all the possible health and wellbeing interventions together, from health promotion to specialist treatments, including the range of support services which are available to help people maintain independence.

The diagram below shows what a whole system approach to health looks like through the progression from good health to disease and the interventions which are possible at each stage.



The Life Course approach is the focus for the Health of Older People services within Auckland DHB. The actions contained in this plan will over time shift the balance of resources, services and investment.

Our local approach: Healthy Ageing 2020

Healthy Ageing 2020 is based on the understanding that our older population is changing, and that we need to plan for the anticipated growth in our older population, and also for the change in service demands to meet that need.

'We want sustainable health and disability support services that can meet the needs of current and future generations of older people and support them to age positively. That means starting to plan for those services now, so that the structures and funding are in place by 2010'

(Hon Ruth Dyson, Health of Older Persons Strategy, April 2002)

Because Auckland's population characteristics are not all aligned to national trends, we need to constantly assess local need and service levels by working alongside providers and stakeholders.

The Health of Older People sector is unique in that it is comprised of a large number of providers, the majority of whom are independent businesses. These independent service providers cover a diversity of services including vocational, home-based, advocacy and residential care services. The actions in this plan show how Auckland DHB will foster leadership and collaboration within this provider group. Our immediate focus will be on quality improvement, collaboration and transparency.

Consultation and key issues

The development of *Healthy Ageing 2020* involved two consultation phases; the first to identify issues with the current system and to get ideas on how the sector could better meet the needs of our service users. This phase was followed by several public meetings, focus groups and agency discussions, some of which were specific to communities of interest. Consultation took place with Maori to assess the needs of Kaumatua and Kuia in the central Auckland area.

Of the 45 total written consultations, 67 percent were from external agencies or individuals, and 33 percent were from staff within the Auckland DHB.

Themes from the consultation have been summarised as follows:

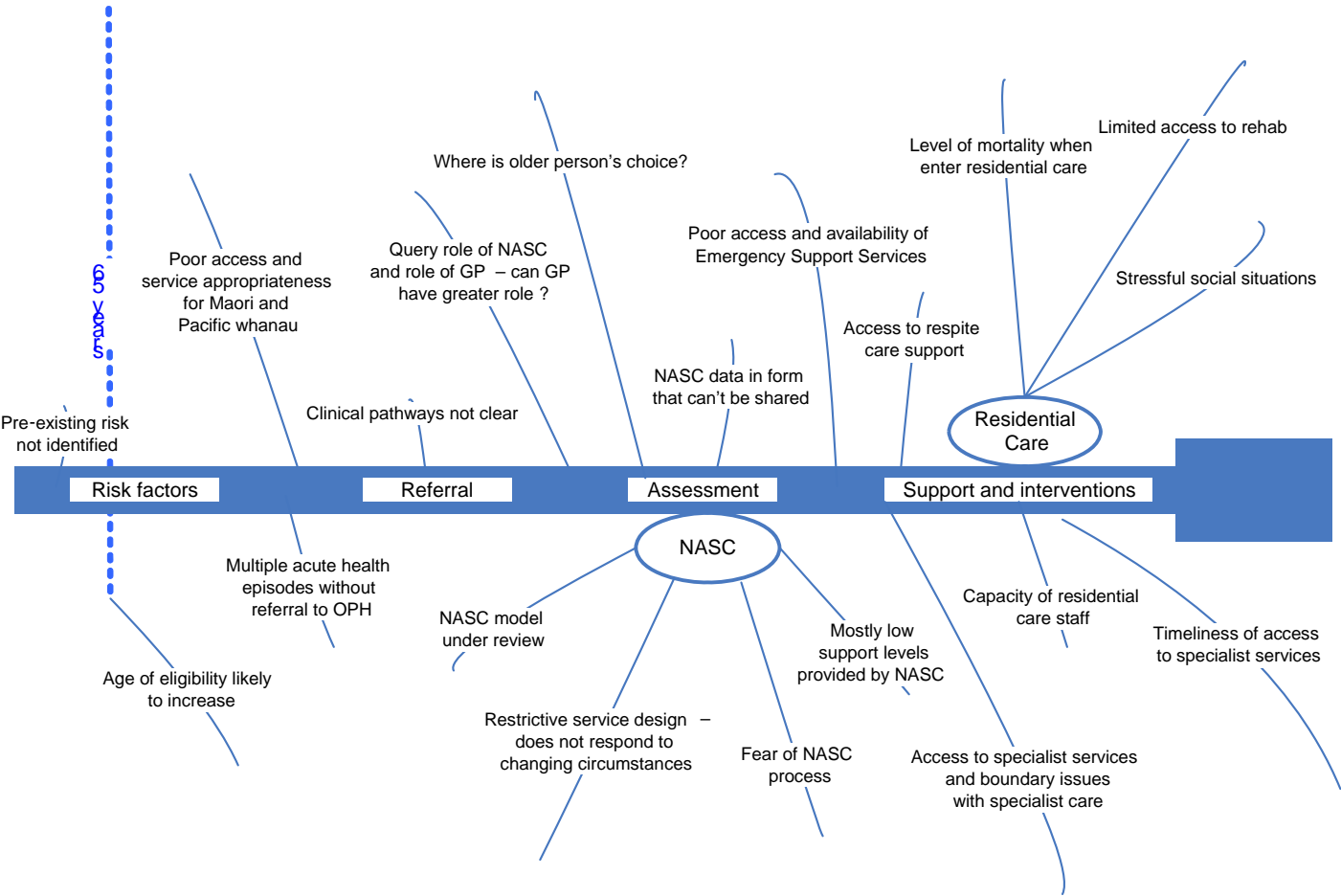
- Difficulty accessing information
- Lack of support for informal carers (family/whanau)
- Dissatisfaction with home-based support services
- Quality concerns regarding residential care
- Issues with discharge planning from hospital services
- Dissatisfaction with boundary issues between different funding groups within health
- Confusion about the role and expectations of PHOs in care for older people
- Health of Older People services are currently not adequately responsive to the needs of Maori, nor do they adequately address the cultural aspects of either our Pacific or Asian ethnic minority groups
- Rest Home providers expressed a range of views on the current managed bed policy. The policy was implemented across all three metropolitan Auckland DHBs in 2004, enforcing a restriction on providers of residential care, and prohibiting additional rest home capacity through new development

Alongside consultation, we also studied the research on the health of older people, international best practice and alternative models of care. The key aspect of care delivery that emerged from this work was in the area of home-based support services. This area of activity is critical to ageing in place strategies and restoring function through goal-based support.

The strategy steering group took part in a patient-journey workshop, focusing on issues along the continuum of care as might be experienced by a service user. Service managers, planners and funders shared the experience of older people; negotiating the health system as if they were a service user. This exercise highlighted the shortfalls in our system and has prompted an exploration of areas such as hospital discharges and the assessment of need.

The following diagram illustrates problem areas, barriers to access, and areas where service users are 'falling between the cracks'.

Problems in health services for older people



Actions for the future

This plan provides a position from which to move forward. From this platform we will remain responsive as best practice and growth in our population dictate. To ensure the plan remains up to date, it will be accompanied by implementation plans, focused on highly practical and achievable actions.

Support and care services are fundamentally different to clinical services. The NZ Disability Strategy is clear that disability is a process not a personal characteristic. Disabled people do not want the Auckland DHB to focus on "treating", "curing" or rehabilitating individuals. Our efforts should instead go to reduce long-term disability and provide assistance so people can maintain an ordinary life. This requires a focus on the environments around people: physical, social, service, civic, and information.

The specific actions will be allocated to expert working groups, who remain accountable to the Project Steering group and will be supported by an overall project manager.

Auckland DHB will provide committed funding to support the core leadership functions of the initiative and some operational investment. Individual interventions will be funded when they have been developed in detail and can provide evidence of clear benefit and sound investment.

Performance indicators are being developed and will form the basis of the accountability framework to ensure that we are achieving our target objectives. Regular public forums will also serve as another means to hold us accountable.

1. Reducing Health Inequalities

Although Maori and Pacific (islands) older people are under represented in long term care (source: Statistics New Zealand, 1996 census) the demographic projections show the potential for considerable increase in the proportion over age 75 years in the next half a century (source: statistics New Zealand Demographic Trends, 1999), and it is likely that there will be increased need for culturally appropriate rest home care to assist aging minority groups (source: Residential Care Workers and Residents: The New Zealand story, 2005).

1.1 Maori Health

Maori people over 65 years of age make up 3.2 percent of the total Auckland DHB population over 65 years. This group is growing at a rate faster than the rest of our population.

Issues

- Consultation with Kaumatua and Kuia has identified different needs for Maori, the most fundamental being that conditions associated with the health of older people are becoming prevalent much earlier for Maori
- Maori have a considerably shorter life expectancy of 73.9 years compared to 80.6 years for the remainder of the Auckland city population. Maori therefore need to be considered by Health of Older People Services from an earlier age than non Maori
- Older people's services need to be more responsive to Maori. Cultural responsiveness requires a structured and supported approach to up skill mainstream services for older people
- We need to also examine services which operate according to a Kaupapa Maori model, as is the case with many of the mental health services

Themes from the hui, Te Ora o Te Kaumātua Kuia

Kaumātua Kuia want:

- to live long, productive lives amongst their whānau and friends and want to make contributions to their communities
- the Treaty of Waitangi to provide the framework for good service design
- more services based on tikanga Māori and whānau values
- whānau to be the basis of Kaumātua Kuia care
- services located around marae, Kaumātua flats etc
- the fundamental ethic of all care workers to be arohanui (unconditional love) for those they care for regardless of culture
- the provision for caregivers to continue to provide care when elders are admitted to hospital
- the ability of Māori to use culturally responsive residential services when they need to
- ensure that the recognition of Maori needs and provision of responsive services is seen as a positive thing
- a forum driven and led by Kaumātua Kuia regarding their needs
- health promotion and prevention actions that improve health education and knowledge amongst Kaumātua Kuia
- the habits formed over the years e.g. diets high in fat, to change through health promotion
- inflexibilities within current services to be addressed
- help with transport to appointments in outpatient and specialist services

Actions for the future

National objective	Local actions
<p>The health and disability support needs of older Maori and their whanau will be met by appropriate, integrated health care and disability support services</p>	<ul style="list-style-type: none"> • Explore models of rest home care which promote Kaupapa Maori values and recognise the value in promoting responsive service delivery to Kaumatua and Kuia • Explore options for Maori elders to age in place where this is the preferred option, with responsive care and support programmes such as recognised whanau carers where appropriate • Work with Maori providers and communities to help them develop their workforce capability • Facilitate regular meetings with stakeholders to ensure an inclusive approach to planning

1.2 Pacific Health

People over 65 years who identify as Pacific Peoples represent 4.9 percent of the Auckland DHB population over 65 years. This group is made up of six main cultures, led by Samoan and followed by Tongan, Cook Island, Niuean, Fijian and Tokelauan.

Issues

- Like Maori, Pacific people have a shorter than average life expectancy compared to the Auckland DHB average, with males living an average of 70.2 and females 78.7 years
- Access to health of older people services is of primary concern
- There are high numbers of Pacific presenting to emergency services within acute services. These people are not getting access to early intervention, screening and health promotion initiatives

Consultation with Pacific

Pacific Elders want:

- more acknowledgement of the importance of elderly people
- to be taken seriously – older people are the key to our communities
- to build capacity within Pacific communities to allow us to take care of ourselves
- more community workers
- ethnic specific services that spell out cultural values and practices and economic factors that affect health
- the criteria for home-based support to change so they can stay in their own homes
- transport assistance so they can get to services
- daycare so their care givers can get some time out
- respite care that is culturally responsive to Pacific needs
- to develop Pacific youth leaders for the future
- cultural needs regarding palliative care to be addressed
- the resources that will ensure there are good outcomes

Actions for the future

National objective	Local action
Older people will have timely access to primary and community health services that proactively improve and maintain their health and functioning	<ul style="list-style-type: none"> • Older people's services will work with Pacific community groups to develop holistic day centres based on the Healthy Village Action Zone concept • Pilot services such as church-based activity centres to promote health in Pacific elderly and which take advantage of opportunities for screening and health promotion initiatives • Work with other agencies such as WINZ and the Ministry of Health to combine resources and realize the collective gains for the health and social needs of this high risk population group

1.3 Asian Health

Over the last twenty years Asian peoples in New Zealand have grown from a small group of "others" into a distinct and considerable sector of our society. The 2001 census indicates that 240,000 people in New Zealand were of Asian ethnicity, of which approx 63,000 are residents within the Auckland DHB area.

Four percent of this group are aged 65 years old or older. While Asians are the second-smallest group of Older Adults in the district next to Maori, they are unique in having the highest life expectancy - 85.2 years for males and 90 years for females. This means the few older Asians living in the Auckland DHB area will live longer than people from other ethnicities. Their numbers will increase as the working-age group ages. Elderly women without a spouse are a noteworthy sub-group within this population.

Issues

- Although Asian elders live longer than other cultures within our population, they experience increasingly poorer health than the general population as they age
- This older group of Asian elders has more functional impairments, more limited education, lower incomes and higher costs for health care
- Language and transport barriers also limit access to health services
- There have been reports of negative experiences with providers of Asian health care services, such as rest homes within our area promoting themselves as 'Asian speaking' and 'specialists in Asian culture'

Actions for the future

National objective	Local actions
Older people will have timely access to primary and community health services that proactively improve and maintain their health and functioning	<ul style="list-style-type: none"> • Increase the accessibility of Auckland DHB services for older Asians and change the way they interact with the health system • Provide culturally competent health care services which build on community traditions and which respect cultural beliefs • Promote research in health policy and programmes to identify the needs of Asian elders in the design and delivery of health services • Work with agencies such as the University of Auckland Centre for Asian Health Research and Evaluation to establish best practice models of care • Work with key figures in the community to help pilot new models of care

1.4 Disabled Older People

Disabled people have the right to receive a range of quality services and appropriate health services. Health care must, with informed consent, provide a maximum of choice and personal input and take full account of the particular needs that disabled people may have. (source: Guidelines about Disability for Councils and District Health Boards, DPA NZ, 2004) This is especially true for older disabled people as often their issues become compounded as they age with factors such as access, mobility and technology becoming more prevalent.

One in five New Zealanders have impairment; in 2001 this amounted to a total of 743,800 people, which equates to approximately 72,892 within the ADHB catchment. Older people are substantially more likely than younger people to experience disability, with 54% of adults aged 65 years or over, including 87% of people aged 85 or over reporting impairments.

An ageing population means that increasing numbers of people in New Zealand have impairments. Human Rights in New Zealand Today/Nga Tika Tangata O te Motu concluded that disabled people lack authentic involvement in decision making and policy development in relation to health and other types of services. Disabled people face barriers to services and information and to many places, including buildings and transport. Local authorities have a significant role in ensuring the accessibility of services.

Issues

- With such a significant number of the population over 65 reporting a level of single or multiple impairment, planning and funding for the provision of health services for this group is a complex undertaking
- There are significant issues in respect of access to services for this group, especially to specialist services which are often co-located on large sites as opposed to within communities.
- Older disabled people report difficulties with being included in service planning discussions as forums that present these type of opportunities are often conducted in non-disability friendly ways

Actions for the future

National objective	Local actions
<p>The Ministry of Health and DHBs will make appropriate information about health and support programmes and services easily available and accessible to older people, carers and service providers.</p>	<ul style="list-style-type: none"> • ADHB will actively seek input from disabled people to ensure that services for people over the age of 65 years are appropriate to older people who may also have lived their life with a disability. This will be undertaken via the Disability Support Advisory Committee, and also via external ongoing consultation with community groups and national agencies such as DPA NZ • ADHB will ensure that responsiveness training is promoted throughout both Auckland City Hospital inpatient and community services to up skill front line staff on issues that are faced by older disabled people • ADHB will continue to promote the allocation of services to older people with a disability based on functional need as opposed to disability, and ensure that these supports are able to be accessed in a timely and efficient way

2. Improving Community Services

Several service areas sit under the umbrella of Health of Older People Community services. These are provided by non-government providers based in the community, and by the A+ links service owned by the Auckland DHB. They include:

- Health Promotion
- Needs Assessment and Service Coordination (NASC)
- Vocational and Socialisation services
- Home-Based Support Services
- Nutritional services such as Meals on Wheels

The role these services play in providing a continuum of care has become increasingly important with the move to an 'ageing in place' model. This is especially relevant with the shift from rest home care to providing the packages of care which help older people maintain independence and stay in their own homes.

2.1 Health Promotion

Health promotion includes activities aimed at keeping people well. Examples include screening for problems, targeted advertising, and programmes aimed at preventing people from coming into contact with acute services.

In keeping with the direction set in the national Primary Health Care Strategy, Auckland DHB is increasingly recognising and responding to its role in keeping older people well rather than purely treating those who become unwell.

Specialist services should only take the form of a brief intervention in people's lives. The focus for planning and health service delivery should be on services which are delivered in primary care settings. Health promotion involves promoting services through health information that is both timely and easy to access.

Issues

- Our focus needs to be in improving the health of older people as a whole population group, and not just on treating people once they are sick
- The level of investment from treatment to intervention services needs to be refocused in line with the move to community based care
- More collaboration is required across all services so they are planned, funded and delivered cohesively

- The role of Primary Health Organisations (PHOs) in our communities need to be strengthened to reflect the fact that they are now responsible for the majority of grass roots service delivery and health promotion

Actions for the future

National objective	Local action
<p>Population based health initiatives and programmes will promote health and wellbeing in older age</p>	<ul style="list-style-type: none"> • Develop programmes that keep people well and improve the health of older people as a whole population group e.g. <ul style="list-style-type: none"> ○ Promote flu vaccinations ○ Exercise programmes in rest homes such as the one operating as part of the LIFE model ○ Nutrition programmes ○ The SNUG homes in Auckland programme in conjunction with EECA • Provide input into nutritional services such as comprehensive assessments and the provision of supplements by registered dieticians for high need groups • Establish partnerships with PHOs, community groups and the DHB to focus on specific interest groups • Work with other funders e.g. the Otago Exercise Programme and the Hip Protectors intervention with ACC • Research our actions to establish if increased interventions and support improves overall health and reduces health inequalities • Develop an 0800 number to form the basis of a comprehensive information line providing information about all services for older people • Use the phone service to give general advice about access, referral processes and entitlements. Promote the number through media, GPs and primary care practitioners • Provide comprehensive, up to date information on the Auckland DHB website, and promote useful links to community services for older people • Host forums with interested stakeholders and members of the public to provide information on the Implementation of the Plan and remain responsive to local issues

	<ul style="list-style-type: none"> • Establish a consultation register to keep people informed on local issues, consultations and service changes • Build intergenerational capability by introducing school and rest home exchanges • Support champions in our community who promote Healthy Ageing • Take a stronger advocacy role, e.g. on issues like the equity gap between ACC and Ministry of Health funding • Build credibility with community and service sector stakeholders through advocacy and demonstrate the full leadership responsibilities of a true District Health Board
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2.2. Needs Assessment and Service Coordination

Needs Assessment and Service Coordination (NASC) is a key function within health services for older people. This can be an important determinant in shaping the overall health experience for many older people and their families. NASC are responsible for assessing the level of support required by an older person, and then linking them to services that will help to keep them safe and supported within their own home.

NASC are also responsible for identifying when a person's level of need has changed. Where there is increased need, the NASC service provides information to a family about residential care options including rest homes, dementia services and private hospitals.

Issues

- Needs Assessment and Service Coordination work has been the subject of significant national policy debate over the last decade, with various changes to practice being promoted and tested over the years. This has resulted in various iterations of the model and increasing inconsistency of approach across the country as DHB's search for local solutions
- The area of assessment and the specific function of NASC services features strongly throughout the Auckland DHBs consultation with older people. Concerns are in three main areas:
 - The range of services able to be accessed through NASC is seen as limited and inflexible

- o Preference is given to initial assessments which means re-assessments are only undertaken on receipt of a subsequent referral or request
- o The model of NASC currently offered in no way supports culturally responsive access or service delivery

Actions for the future

National objectives	Local action
<p>The Ministry, in collaboration with DHBs, will develop an implementation plan and guidelines for comprehensive integrated assessment for older people and their carers.</p> <p>Older people, their families and whanau are able to make well informed choices about options for healthy living, health care and/or disability support needs</p> <p>Older people will have timely access to primary and community health services that proactively improve and maintain their health and functioning</p>	<ul style="list-style-type: none"> • Explore mechanisms for streamlining entry and access to both community and specialist services • Review how support services are funded to promote the move to packages of care and increase the level of responsiveness and flexibility • Introduce a goal-focused model of restorative support aligned to ageing in place and support older people to maintain their independence • Explore an enhanced model of community services that is strengths based and focuses on goal setting • Work with PHOs to pilot 'ageing in place' schemes to identify if working together can improve the health outcomes for selected communities of Older People

2.3 Vocational and Socialisation Skills

Vocational and socialisation services are purchased or supported by the Auckland DHB for the purpose of maintaining older people in the community. This recognises that isolation and loneliness are correlated with deteriorating health in older people and have a direct bearing on admissions to inpatient and secondary care services.

Issues

- As funding for health services becomes increasingly prioritised, and demand for services at the more acute end of the life course such as elective surgery and specialist care increases, services aimed at the wellness end of the life course come under increasing scrutiny

- As a funder of health services, Auckland DHB needs to develop partnerships with other government agencies. This will ensure that accountability for complementary services such as welfare and transport are provided to older people
- It is important that the DHB does not become the default funder for all services which respond either directly or indirectly to the wider determinants of health

Actions for the future

National objective	Local action
Older people will have timely access to primary and community health services that proactively improve and maintain their health and functioning	<ul style="list-style-type: none"> • Work with other government agencies involved in the provision of vocational and socialisation services to maximise collective health and socialisation in older people • Work with providers of cultural vocational services such as Pacific and Indian day service providers to ensure that they have a valid health promotion role • Maximise the link between cultural vocational services with Primary Health Organisations and relevant community providers • Promote and sponsor research to inform health policy and programmes so the needs of Asian elders are included in the design and delivery of services • Work with the University of Auckland Centre for Asian Health Research and Evaluation to establish best practice models and to access key figures in the community for the piloting of new models of care

2.4 Home-Based Support Services

There are approximately 3,500 clients within the Auckland DHB area who qualify for subsidised support services¹. Home-Based Support services for older people comprise the majority of individual service components which collectively make up the support services provided.

Although there are numerous services provided across both the community and specialist sectors, the majority of home-based support services include Domestic Assistance, Personal Care or a combination of both.

¹ Personal Cares are provided to any individual regardless of asset and income levels, but access to subsidised Domestic Assistance is limited to those with a CSC card.

Issues

- The current approach to support offers little chance of a person regaining or maintaining their original level of independence². This is partly as a result of the current funding framework, which is restricted to per hour funding and makes no provision for flexibility in meeting individual needs
- The way that Auckland DHB provides home-based support services is structured such that first time assessments for new clients are prioritised over reassessment of existing clients. This is a significant contributor to the ongoing dependence on support
- Auckland DHB began to improve home-based support provision by increasing the investment in this critical aspect of service delivery. Consultation and an exploration of best practice being developed elsewhere, has however, drawn attention to the need for a comprehensive service review. This will result in services that better meet the current and future needs of our ageing population
- The national direction is towards a more strengths based approach to home support services, which involves goal-setting and builds on the premise that older people can have independence maintained or restored following an acute event
- This model is being implemented in other DHB regions with encouraging outcomes. Goal setting with associated flexible 'packages' of funding are proving to be successful through pilots and trials within the metropolitan Auckland region

Actions for the future

National objective	Local action
Funding and service delivery will promote timely access to quality integrated health and disability support services for older people, family, whanau and carers	<ul style="list-style-type: none"> • ADHB will explore a more holistic community services model which can be examined in conjunction with assessment functions currently undertaken by NASC • Work with PHOs to set up pilot 'ageing in place' schemes to investigate if working together improves health outcomes for specific communities of older people • Purchase alternatives to rest home care services that allow flexible support to be provided in a person's home, and which is responsive to the health needs of individuals

² Baird, J (2005). 'Development of a Home-Based Support Services Plan' report prepared for Auckland, Counties Manukau and Waitemata DHB's

2.5 Specialist Services

The focus for planning and health service delivery for most people should be on services which are delivered in primary care settings. Specialist services should be episodic and coordinated by their general practitioner. Whilst specialist intervention may be intensive, it should wherever possible be brief, with supports from the community under the direction of a primary care practitioner who would be responsible for integration back into the community as and when appropriate.

Within the population however there is a group of older people that require a more ongoing range of interventions, and their specialist event may signify a need for a higher level of support from a range of services that primary care would not reasonably be expected to deal with. In these instances a well managed care plan to ensure that the service user is assisted to navigate his or her way through the specialist service is paramount. The end goal should always be to strive for eventual discharge back to primary care, recognising that the GP's role is one of a primary as opposed to specialist practitioner and in these instances that a shared care or peer support role may be most appropriate. These cases usually involve the management of chronic conditions and include palliative care management and complex conditions such as dementia with physical co-morbidities.

Issues

- The highly specialised and complex nature of the older person's health service offered by ACH within ADHB has meant that service users are often confused by the range of different services and their role, making for a potentially fraught patient journey.
- Several points of entry into the range of specialist services within A+Links can mean duplication of effort and in many instances a potential for duplicate assessments.
- Funding for personal health (community and hospital based) and targeted funding for mental health, Ministry of Health-administered funding for disability support services each has its own set of access criteria, service priorities and rules governing user charges. These complex funding arrangements work against service providers collaborating to develop coordinated responses to health and disability support needs at either a population or an individual level.

Actions for the future

National objective	Local action
DHB's will develop an integrated continuum of care for older people	<ul style="list-style-type: none"> • ADHB will work to implement a more streamlined access system, based on one point of entry and single assessment using the InteRAI tool • A case management approach accounting for not only specialist services but also integration to primary care and complementary services will be developed to ensure seamless movement through acute care

2.6 Meals on Wheels

There are over 500 elderly living within the community who benefit from the Meals on Wheels service; a meal preparation and delivery service which is offered to vulnerable elderly who otherwise would not have access to regular and nutritionally balanced meals.

Issues

- A review of older people at home who are supported by home care services has showed that many older people remained at high risk of malnutrition³. This has prompted discussion on the sustainability of the current way the nutritional needs of this group are being met
- Of the 500 or so people supported by the Meals on Wheels scheme, many use the service through convenience and choice rather than necessity. A review of the overall service user group revealed that only a small percentage (approximately one third) are actually in a high risk group i.e. nutritionally vulnerable. This means that meals on wheels is not addressing the specific needs of these individuals
- The availability of prepared frozen meals through supermarkets, along with the ability to have these meals delivered to homes, means that a significant number of clients currently accessing the service for convenience no longer need to do so
- Significant work has been undertaken within the A+ links service which has verified the assumptions outlined above⁴

³ Paul Goldstraw (date unknown). Nutrition: Ignore it at your older patient's peril

⁴ Thatcher, D (2004). Meals on Wheels: a cry for help! Unpublished masters degree thesis

Actions for the future

National objective	Local action
Population based health initiatives and programmes will promote health and wellbeing in older age	<ul style="list-style-type: none"> • Review Meals on Wheels to evaluate the value of the model and define alternatives to better meet the needs of high needs clients • Work with nutritional services to intensify their response to high need users e.g. comprehensive assessments and providing supplements via registered dieticians • Establish alternative services for older people who are using the current scheme for convenience reasons only

2.7 Environmental Support Services

Environmental Support Services (ESS) is the term used to describe a diverse and complex range of services to provide people of all ages with access to their environment to facilitate/encourage people to remain in the most appropriate environment for as long as practicable. ESS may also directly assist the families and whanau of people with disabilities, for example, through the provision of a hoist or home modifications.

ESS includes the provision of:

- equipment, such as wheelchairs and other mobility equipment; hearing aids, and other communication equipment that assists daily living such as shower chairs
- housing modifications, for example, installation of a ramp or accessible shower
- vehicle purchase financial assistance and modifications, and driving assessments for those eligible for vehicle assistance
- a range of subsidies, for example, for spectacles, wigs and breast prostheses, hearing aids and prosthetic eyes.
- cochlear implant services

The provision of ESS in New Zealand has been a major source of concern and frustration for people with disabilities and their families. This is a particularly relevant issue for older people given that 54% of people over 65 identify themselves as having a disability. Access to equipment and environmental supports is seen as a critical determinant of the quality of daily life, and the independence of and participation in community life of people with disabilities.

In August 2005, a Review Team commissioned by the Disabled Persons Assembly (DPA) provided a report to the Ministry of Health highlighting not only the

shortfalls of the current system but also making recommendations for improvement to the system.

Issues

- Services are only available to New Zealand residents who meet the standard Ministry of Health definition of disability, and are not covered by ACC. Funded services must be essential to deal with avoidable harm and ensure safety. Services must also be cost-effective. Some of the services for example are subject to asset and means testing whereas others are not. There needs therefore to be a more clear and uniform application of the service and a manner in which access information can be more clearly communicated and understood
- The current system is manual and cumbersome to administer with assessment and eligibility processes being inconsistent and therefore the outcomes not always predictable. A minimum of time, energy, and money should be tied up in making it work. The system should also be fair in the way it treats people in different circumstances, and the way it uses taxpayers' money.
- Decision making regarding access to equipment needs to be streamlined, with the role of the Accredited Assessors restricted to high cost, low volume activity and the process needs to take into account the positive impacts of the HPCA Act (2003) and ongoing competence of practitioners by registering authorities.
- A change in government policy in recent times has meant that DHBs are increasingly responsible for the provision of equipment, which is a shift from previous policy which saw provision managed and funded centrally.

Actions for the future

National objective	Local action
The Ministry of health will work to streamline both the access to and the process surrounding the review of ESS services nationally	<ul style="list-style-type: none"> • The ADHB via its Disability Support Advisory Committee will monitor the ESS review and ensure that the outcomes are in keeping with service improvements for older disabled people in our community • Submissions will be prepared to ensure that all efforts are made not to cost shift accountability for equipment provision to ADHB

3. Other Service Improvements

3.1 Residential Care Services

Currently Auckland DHB holds contracts for the provision of residential care across four care settings: Rest Home, Dementia, Private Hospital and Psycho-geriatric.

The following table outlines the breakdown of these facilities by service category:

Bed type	No. of contracted facilities
Rest home	67
Private hospital	31
Dementia	8
Psychogeriatric	1
Total	107

Forecasting demand

As we begin to plan for services to meet the needs of older people into the future, using demographics and assumptions we are able to begin modeling the need of our population into 2010, 2015 and beyond. The following shows the growing need of our population in respect of residential care services into the future, which although it has factored in the offset effect of ageing in place initiatives, still shows a significant increase in demand over time.

Bed type	2005	2010	2015	2020	2025
Rest home	1972	2013	2219	2281	2416
Private hospital	1998	2039	2251	2294	2446
Dementia	251	255	282	293	311
Psychogeriatric	30	31	34	35	37
Total	4251	4338	4786	4903	5210

* Sum of services in the table, not representative of unique NHI numbers

Issues

- As previously outlined, forecasts for all of New Zealand's over 65 age group is set to rise - currently this is gradual but the rate of ageing will increase significantly from about 2011 as the 'baby boomer' generation enters this age group
- This may mean increasing demand for rest home care beds, however offsetting this trend is the trend for improving health and wellbeing of the over 65 age group with time. Ageing in place initiatives should offset some of future demand
- Future bed numbers need to take account of the number of people over 65 and those who choose to move into the ADHB area. This has historically been difficult to quantify, but more accurate data collection over the last two years has shown that on average 360 people over 65 transfer into ADHB residential care facilities per annum, while only 60 transfer out⁵.
- It is likely that inflow demand for residential care from other population groups will continue to rise, with nearness to a tertiary hospital and specialist services continuing to be a significant draw card.
- To offset this rise in demand for rest home care beds however, is the national promotion of 'ageing in place' which is a concept that enables and encourages people to be able to make choices in later life about where to live, and receive the support needed to do so. It is in everyone's interest that older people are encouraged and supported to remain self reliant, and that they continue to participate and contribute to the well-being of themselves, their families, and the wider New Zealand community. Factors influencing their ability to access services and participate in their community include not only health status and income but also access to and availability of transport.
- In 2004, ADHB entered a moratorium with both Counties Manukau and Waitemata DHB's imposing a regional restriction on the contracting of new residential care capacity within the sector. Collectively these restrictions became known as the Bed Moratorium.
- In the two years since the policy has been in place there has been a significant amount of work done in terms of bed modelling and forecasting, which has provided the basis for a greater understanding of the bed market within ADHB.

⁵ 2005/06 InterNASC transfer data from manual count, ADHB NASC service

Actions for the future

National objective	Local action
Admission to general hospital services will be integrated with community-based care and support that an older person requires	<ul style="list-style-type: none"> • Support ageing in place by purchasing a range of alternatives to current residential care services • Establish flexible support services provided in a person's home, and responsive to the health needs of individuals • Support residential care initiatives that promote Kaupapa Maori values and are responsive to Kaumatua and Kuia • Review the current managed Bed Policy, outlining the advantages and disadvantages of the decision to assist an informed debate

3.2 Mental Health Services for Older People

Mental Health services for older people (MHSOP) provide assessment and treatment for older people with psychiatric conditions or with dementia complicated by behavioural or psychological symptoms. The group of people seen by MHSOP have high rates of co-morbid medical conditions and physical disability. There is a dynamic interaction between these physical, cognitive and psychiatric problems.

Issues

- The vision for mental health services for older people is to support older people to remain as independent, and as well as possible for as long as possible through services that are regionally consistent and locally responsive.
- Effective response to the needs of this complex group requires co-ordination and effective communication between mental and physical services, needs assessment and service coordination, primary care and NGO providers such as community support and residential care.
- Responding to the huge increase in the numbers of people with dementia in the years to 2020 poses a particular challenge for MHSOP and all of the service providers outlined above, and a coordinated strategy and implementation approach across the range of services is required. The appended statistics suggesting an influx of people to residential care, compounded by a population skewed to the 'old old' makes it likely that

we will experience a disproportionate growth in the demand for dementia related care and services in the ADHB area.

- Funding silos potentially create barriers to accessing supports for people with complex needs
- MHSOP experience challenges developing a skilled workforce locally, and this is particularly true in areas where enhanced or specialist skills are required, as is the case of Dementia
- Discrepant approaches between older persons health and MHSOP to people under 65 with age related or 'close in age and interest' conditions potentially complicate effective service coordination further

The three most desired directions identified by service users and their families/whanau during consultation were:

- Support to stay at home
- Holistic assessment and service delivery; and
- Support of choice and equity

Actions for the future

National objective	Local action
Older people with high and complex health and disability support needs will have access to flexible, timely and coordinated services and living options that take account of family and whanau carer needs	<ul style="list-style-type: none"> • Ensure that clients under the care of Mental health services for older people are included in all consultation when it comes to service redesign and enhancement • Include this vulnerable group of service users as well as the providers responsible for their care in the implementation phases of the Strategy

3.3. Palliative Care

Palliative care is the total care of people who are dying from active, progressive diseases or other conditions when curative or disease-modifying treatment has come to an end. Palliative care services are generally provided by a multidisciplinary team that works with the person who is dying and their family/whanau.

Although not limited to people over 65, a significant number of palliative care clients within our community access services funded under the Health of Older people area, and there is significant overlap with services such as District Nursing, equipment use and residential care beds in Private Hospitals.

Issues

- There is a lack of clarity around the definitions of specialist and generalist palliative care
- There is a lack of integration in the way in which Palliative care services are funded, planned and delivered
- Service users require service access managed effectively and are frustrated when this doesn't happen
- There is a recognised need for increased recognition and support for rest homes and private hospitals who are managing Palliative care clients within residential care facilities

Actions for the future

National objective	Local action
<p>Older people with high and complex health and disability support needs will have access to flexible, timely and coordinated services and living options that take account of family and whanau carer needs</p>	<ul style="list-style-type: none"> • Develop an integrated palliative care plan for ADHB adult services using an expert group comprising all parts of the palliative care continuum • Ensure the plan sits alongside the Healthy Ageing 2020 plan and reflects care across areas of health gain • Complete the draft Implementation plan and undertake consultation by January 2007 • Focus expert group activity on the following objectives: <ul style="list-style-type: none"> ○ Integrate Primary, Community and Specialist Palliative care through models such as the Liverpool Care Pathway and the ADHB Front Door policy ○ Improve alignment of specialist and generalist palliative care services to their respective functions and responsibilities ○ Examine palliative infrastructure such as equipment and information technology

4. Improving Performance across the Sector

Many issues have relevance across the sector:

- Quality
- Managing Polypharmacy
- Workforce
- Information Management and Technology support

4.1 Quality

Quality is an all encompassing term which has become the collective title for all activity undertaken within the sector to ensure safety is upheld and satisfaction is provided for older people. Specifically quality includes the following components:

- Safety - physical, emotional, cultural and spiritual
- Monitoring –activities to ensure that quality and safety (including clinical and organisational governance) is being maintained
- Audit, certification and compliance – official activity undertaken to ensure a provider is operating to a set of quality standards set and agreed by the sector

A significant amount of work has been committed already to quality initiatives. A quality framework has been developed with detailed initiatives, and the partnerships required to achieve these.

Issues

- Since devolution, there has been only limited activity undertaken by the ADHB to support providers of aged care services in promoting quality initiatives and monitoring service delivery
- As families increase their expectations of the sector, and become more confident in alerting authorities to concerns, the number of service quality complaints has increased
- Residential care is under increasing attention partly due to the increased acuity level of residents within rest homes, but also because of a shortage of qualified staff and increasing competition associated with the sector operating in a commercial environment
- There is increasing expectation that residents will receive the highest quality health and residential care
- Although the way quality complaints are dealt with by the DHB follows an approach agreed with the Ministry of Health and the Health and Disability

Commissioner, we need to more formally recognise the role of each agency, and to ensure the best outcome is achieved for both service users and the sector as a whole

Actions for the future

National objective	Local actions
<p>Policy and service planning will support quality health and disability support programmes integrated around the needs of older people</p>	<ul style="list-style-type: none"> • Establish a comprehensive Quality Initiative (QI) based on a supportive model of collaborative quality improvement that protects older residents both within care facilities and within the community • Complete initiatives within the Quality programme to address these issues • Establish a combined Quality Committee made up of both community providers and hospital clinical experts to monitor all quality and safety issues that arise in respect of residential care facilities • Contract an independent audit provider to undertake routine quality and safety audits of all providers of aged care services in our area on an ongoing, cyclical basis • Follow-up on the results of audits with actions approved by the Combined Quality Committee • Enhance clinical safety by extending training initiatives run within the Auckland City Hospital A+ Links service to all community rest home staff to ensure that evidence based practice is being integrated throughout the entire sector • Employ two clinical nurse specialists to support the community aged care sector, and to act as the point of clinical liaison between community providers and specialist services within the hospital • Monitor the development of the InterRAI pilots to align a roll out of the system to compliment the proposed changes to home-based services • Pursue an interim solution with the Australian State Sector to encourage a performance management approach to quality among our residential care sector. Use this until InterRAI is available for implementation with the residential care sector • Work with other DHBs in the region and with the Ministry of Health on local responses to any national policy for enhanced recruitment, retention and training innovation

	<ul style="list-style-type: none"> • Work along side training institutions and providers to ensure that our workforce is prepared for the increased demand that will be placed on it in the future • Support specialist service within Auckland City Hospital to provide one clinical mentor and leader to the community providers who operate within our sector
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4.2 Polypharmacy

Polypharmacy is the use of multiple medications by a single patient, which is considered to not always be desirable or necessary. Older People are at high risk of complications associated with polypharmacy because people experience more health problems as they age.

Many patients over 65 years regularly take between two to six prescribed medications at one time, putting them at risk of adverse reaction and undesired outcome. The incidence of polypharmacy amongst older people is increasing with 19 percent of patients over 64 years old taking more than five medications in 1990-1991 compared with 25 percent in 1998-1999⁶.

The aim of better managed polypharmacy is to:

- Improve patient access to pharmacy services and adherence to prescribed regimes through consultations including advice, education, monitoring and practical assistance
- Improve drug use and reduce waste through pharmacist advice and support to general practitioners and rest home clinicians, including reviews of patients' medicine regimes and working with the provider to find solutions to medication problems, particularly with reference to polypharmacy
- Improve disease management and prescribing practices through pharmacist matching of patient records and prescribing with current best practice for the disease state, in conjunction with other primary health professionals

Issues

- The fragmented nature in which different components of the sector operate makes it hard for primary care practitioners to work in conjunction with other providers such as rest homes

⁶ As was reported in a Medications Information Bulletin in 2003,

- It is particularly important that medication compliance and adverse reactions are monitored and that drug regimes are viewed holistically in terms of lifestyle factors and pre-existing conditions

Actions for the future

National objective	Local action
Policy and service planning will support quality health and disability support programmes integrated around the needs of older people	<ul style="list-style-type: none"> • Work with community partners such as Pharmacists, Residential Care providers and PHOs to identify innovation in best practice to reduce polypharmacy

4.3 Workforce

The Auckland DHB health and disability sector workforce consists of a broad range of workers with widely differing educational and training requirements. In addition, family, whanau, individuals and a range of voluntary and community agencies play a significant role in providing care and support for older people.

One of the actions in the Health of Older People Strategy is for a planned approach to be implemented to strengthen the health workforce to meet the needs of an ageing population.

Issues

- Developing a workforce that is able to meet the needs of an ageing and increasingly culturally diverse older population presents a significant challenge to Auckland DHB and all funders and planners of health services for older people
- There is an issue of workforce development for example in Dementia care
- There is a recognised need for increased support and training in the area of palliative care
- There is increasing demand for a workforce in specialist rehabilitation services that are locally accessible to enable older people with disabilities (which may be either long standing or more recently acquired ie stroke) to maximise their function and enjoy social and community opportunities with the support of their family, whanau and/or local community.

Actions for the future

National objective	Local action
Policy and service planning will support quality health and disability support programmes integrated around the needs of older people	<ul style="list-style-type: none"> • We will continue to work collectively with both the sector and with other DHBs in the region, to provide solutions for enhanced recruitment, retention and training innovations. • We will continue to work alongside training institutions and providers to ensure that our workforce is prepared for the increase demand that will be placed upon it in the future. • We will look to the specialist services that sit within the Auckland City Hospital to expand the clinical leadership to community providers who operate within our sector. • We will look at innovative ways of valuing the non regulated workforce, in particular those involved in the home-based and residential sector to make it a more attractive full time, long term career option

4.4 Information Technology and Management

Information management and technology (IT) is becoming an increasingly important part of the way in which health services for older people are delivered. Not only can IT assist with the actual delivery of service components such as assessment, screening and diagnosis, but it can greatly assist in the communication between individual service components and reducing the need for duplication of diagnostics, information gathering and record keeping.

Nationally there has been an IT based suite of tools promoted by government and trialled by several DHB areas which are said to promote evidence-based clinical practice and decision making through the collection and interpretation of high quality data about clients within a variety of health and social services settings.

The application is known as inteRAI, and its family of tools and applications has been developed to work together to form an integrated health information system. InteRAI instruments all share a common language, that is, they refer to the same clinical concept in the same way across instruments. Using common measures enables clinicians and providers in different care settings to improve continuity of care, as well as to integrate care/supports for each individual. Common language also allows families and caregivers to track the progress of service users across settings and over time. Such information can yield important findings regarding what works to improve an individual's quality of life.

Issues

- The Health of Older People Sector within Auckland DHB and across the community is made up of several components, and part of the key challenge for delivering an effective strategy is to identify and reduce the current level of service duplication
- There are several areas of technological advancement that are assisting in this respect, and trials elsewhere in the country of various IT based screening and assessment tools make service delivery far more streamlined for both the service user and staff. This is achieved by creating one standard assessment tool and maintaining one database which stores information

Actions for the future

National objective	Local action
<p>Make appropriate information about health and support programmes and services available and Accessible to older people, carers and service providers.</p> <p>Establish a process for collecting reliable data to model current and projected demands for services.</p>	<ul style="list-style-type: none"> • ADHB will monitor developments of the InterRAI pilots with a view to aligning a roll out of the system to complement the proposed changes to home-based services • ADHB will also continue to pursue an interim solution with the Australian State Sector to encourage a performance management approach to quality among our residential care sector until such time as InterRAI is available for implementation within the residential care sector

4.5 Intersectoral Collaboration

In order to achieve the best health outcomes for older people, we must work with other government and NGO agencies to ensure a comprehensive suite of services are being delivered to meet the holistic needs of the older people within our communities. These services include housing, welfare, transport and local councils, as well as agencies such as SPARC who have an interest in keeping older people active, mobile and involved in community life.

Issues

- Historically government agencies have worked in isolation from each other, largely to maintain the separation between funding accountability and respective responsibility. This has been the cause of great angst to older people as it creates uncertainty about who to deal with, and promotes frustration with the need to visit several agencies, often unnecessarily.
- There is potential for service users to miss out on provision of services due to a lack of knowledge or appropriate information on where the service can be accessed

Actions for the future

National objective	Local action
<p>The Ministry and DHBs will work with ACC to manage access to, and transition between, services they fund.</p> <p>There is a need to focus on health promotion activities and interventions that benefit all ages but with a focus on key areas for improving wellbeing in older age. Many of the actions recognise the need for collaborative or partnership approaches with primary and community health providers</p>	<ul style="list-style-type: none"> • ADHB will work with ACC on health promotion activities aimed at preventing injury; for example, physical exercise and falls prevention for older people • ADHB will work with ACC to further develop and enhance the falls prevention initiatives that are currently being delivered – such as the Otago Exercise Programme and Falls clinic • ADHB will continue to work with Housing New Zealand under the MoU that the two agencies share, and will actively seek to formalise other partnerships in this way • ADHB will continue to develop the SNUG homes initiative in conjunction with Housing NZ and ECCA for the improved insulation of older people's housing • ADHB will continue to explore further partnership opportunities, specifically with the Auckland City Council, and with retailers that can demonstrate that they place a value on making the lives of older people easier

5.0 Planning and Funding for Health Outcomes

Outcomes include, amongst other things, morbidity and mortality. Increasingly however we are recognising that there are other more measurable outcomes which provide more specific information. These include reduced polypharmacy, reduced hospital admissions or readmissions, nutritional status, and overall quality of life. By defining, capturing and analysing health outcomes we are helped to achieve them. Some of the improved outcomes that can be seen as a result include:

- Better health, reduced disparities, increased trust and security, and increased participation and independence are New Zealand's current high level health outcomes
- Health sector activities should lead to these outcomes absolutely
- Working or integrated relationships with other programmes and activities in and out of the health sector will help achieve these high level outcomes

Health sector activities should lead to these outcomes and working relationships with other programmes and activities in and out of the health sector will help achieve these high level outcomes

Some outcomes can be achieved and measured quickly, others will take many years. In order to ensure we are on the right track and that the investments are delivering expected results, we need a system of measurement that is based on a clear understanding of how short term outputs, link to intermediate outcomes and finally to our longer term outcomes. The measures need to be based on sound data and good evidence.

A comprehensive outcomes framework will be put in place to ensure that each of the projects, redevelopments or programme enhancements enacted under the strategy is aligned to a set of desired objectives. To ensure that this occurs, a staged approach will be developed to track the deliverables – initially these measures are likely to be in the form of activity data, but increasingly we will begin to move with the sector to more of a true outcomes based approach, where outputs (activity) are replaced with outcomes (results).

5.1 What it means

- A focus on populations not individuals recognising however that within each population are subgroups with specific and individual requirements such as Maori, Pacific and Asian initiatives.
- Increased accountability via indicators / monitoring great
- Healthcare delivery and organisational arrangements must be explicitly shaped by the outcomes we want to achieve
- Taking the perspective of continuum of health and illness – ‘life course’
- Includes change in care delivery for chronic diseases – ‘whole of government’ approach to prevent / postpone diseases
- Focus on populations not individuals
- Increased accountability via indicators / monitoring

The details of how each programme within the strategy will be monitored will be outlined in more detail in each of the Implementation Plans supporting this strategy.

5.2 Developing Outcomes

- Indicators chosen must be measurable and able to be influenced by societal or system actions
- Indicators chosen need not all be available today due to data limitations but it must be practical to obtain the needed data within a reasonable timeframe
- A significant number of the indicators chosen must have data available today or within the first year of the implementation of the strategic plan
- The display of the data must be flexible to allow the use by multiple stakeholders
- The indicators chosen must have face validity for professionals, consumers and managers
- The basic framework should be consistent with the overall ADHB outcomes framework and the outcomes frameworks of the other Health Improvement Plans
- All indicators, where possible, will be categorised by age, sex, ethnicity, social deprivation and other appropriate ways in order to identify and track progress in reducing inequalities

5.3 Healthy Ageing: Summarised Outcomes/Process/Quality Indicators

Primary Outcome: Older people within Auckland ageing safely in their place of choice		
Short Term	Medium Term	Long Term
General Health Indicators for Older People		
Improved reporting of satisfaction with individual services Improved availability of information on service access and entitlement in primary care settings	Reduction in falls Reduction in avoidable conditions such as skin ulcers (bed sores) Increased enrolment with Primary Health Organisations	Improved reported feeling of overall satisfaction and wellness Improved inclusion in society Heightened feeling of value and belonging Lower overall incidence of disease burden
Community Services		
Implementation of an enhanced, goal based Home-Based Support Model	Incidence of Avoidable admission to acute care Percentage of population over 65 enrolled with PHO Flu vaccination rate for over 65's increases	Relative reduction of people in residential care facilities
Residential Care Services		
Reduction of skin ulcers (bed sores) Reduction of falls Increased number of residents offered Hip Protectors Increased number of residents using Hip Protectors Improved access to primary care practitioners	Incidence of Avoidable admission to acute care Improved continence management	Improved overall patient and family satisfaction
Mental Health services for Older people		
Increased communication/ collaboration between MHSOP and Mainstream Health of Older People's services	Improved patient satisfaction with service Increased early referral for depression, isolation Increased leadership of	Reduced level of suicide and parasuicide amongst over 65's

Primary Outcome: Older people within Auckland ageing safely in their place of choice		
Short Term	Medium Term	Long Term
	specialist Mental health services for Older people within the residential care sector	
Palliative Care		
Integrated Plan for Palliative care within ADHB developed and signed off	Implementation of the front door policy within ACH Implementation of the LCP Model across primary and secondary care settings	Improved access to palliative care services One point of contact for palliative care clients Increased number of palliative clients seeing primary care as main practitioner for care
Health Promotion		
An increase in the number of people enrolled in Otago Exercise Programme (OEP)	Reduction in number of repeat fractures among OEP clients reduces Extend falls prevention programme into rest homes	Intersectoral awareness strategies co-sponsored by all govt departments involved in Health of Older People Social Marketing campaigns undertaken
Quality		
Quality committee established across Health of Older people sector Admission and discharge processes agreed between residential care and ACH Increase in number of aged care providers subject to independent quality audit	100% compliance with performance indicator data collection within the residential care sector Improved patient satisfaction surveys within residential care - both residents and families Reduction in the number of issues identified through audit as non-compliant	Sharing of performance related indicator/quality outcome information by residential care providers to allow benchmarking Provision of provider benchmarking/quality improvement information to residents/families and funders

Primary Outcome: Older people within Auckland ageing safely in their place of choice		
Short Term	Medium Term	Long Term
Workforce		
<p>Training package developed across ADHB – both community and acute care services for Health care assistants</p> <p>Increased uptake of orientation programmes by residential care workforce</p>	<p>Improved workforce retention within residential care</p>	<p>Career pathways identified and supported for Health of Older people workforce</p>
Polypharmacy		
<p>Increased medication compliance</p> <p>Reduction in medication errors in acute and residential settings.</p>	<p>Reduced admissions to acute care due to medication mismanagement</p>	<p>Reduction in adverse events associated with medication errors in acute and residential services</p>
Technology		
<p>Review evaluation of InterRai pilot elsewhere in country</p>	<p>More accurate goal setting for clients through streamlined application of InterRai assessment</p>	<p>Single assessment information available across all care settings including primary, community, residential and acute</p>
Maori Health		
<p>Increased enrolment of Maori within PHOs</p> <p>Increased uptake of care plus by Maori over 65's</p>	<p>Enhanced training opportunities for Whanau carers</p> <p>Access to transport services improved</p> <p>Reduced DNA for specialist gerontology outpatient appointments</p>	<p>Reduced inequity in overall health status</p>

Primary Outcome: Older people within Auckland ageing safely in their place of choice		
Short Term	Medium Term	Long Term
<p>Pacific Health</p> <p>Increased enrolment of Pacific within PHOs</p> <p>Increased uptake of care plus by Pacific Over 65's</p>	<p>Support and mentoring of providers undertaken by DHB and Pacific Provider development fund</p> <p>Improved monitoring processes followed by providers detailing health outcomes</p> <p>Reduced DNA for specialist gerontology outpatient appointments</p>	<p>Funding of culturally responsive services in line with consultation and joint planning with Pacific communities</p> <p>Funding of services aligned to needs of Pacific communities</p> <p>Integrated joint sector programmes to establish commonalities and savings</p>
<p>Asian Health</p> <p>Development of specialist advisory resource to develop and monitor outcomes specific to Asian Older Peoples health gain</p>	<p>Increase in workforce numbers who are Asian</p> <p>Development of ethnic specific services – beginning with day care services and building towards an entire continuum</p>	<p>Stable workforce with Asian staff numbers proportional to client base</p>

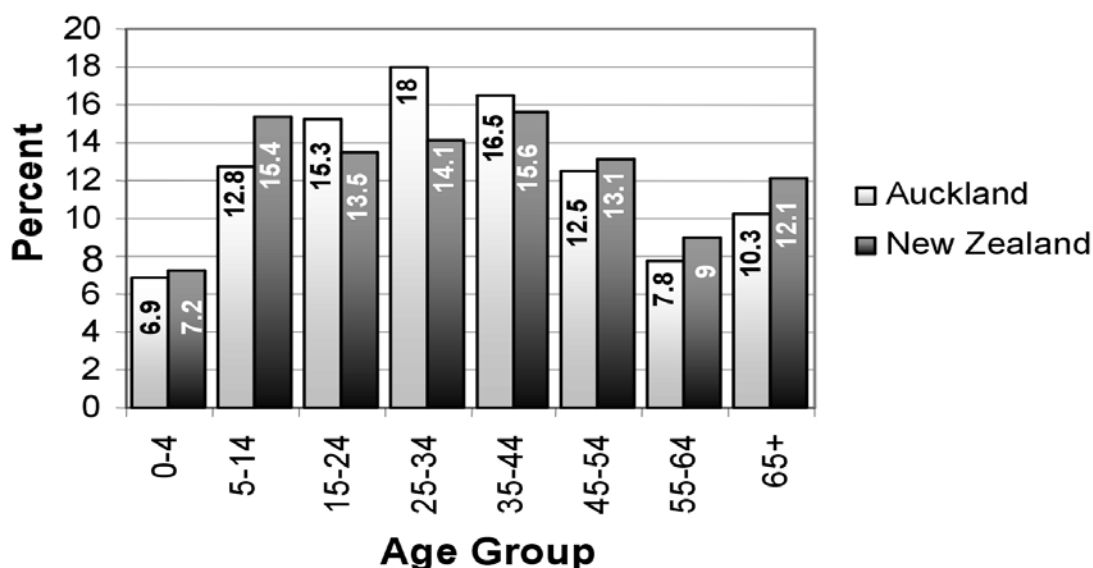
PART TWO: BACKGROUND INFORMATION

Auckland's Ageing Population

Between 1901 and 1999, the number of people over 65 has increased fourteen-fold, from 31,000 to 446,000 (Statistics NZ, 2000). As a share of the overall population, this represents an increase from 4 percent to 12 percent. The 15-64 year old portion of the population has remained at around 65 percent, whereas the proportion of those under 15 has fallen to 23 percent from 33 percent in 1901.

By 2051, older people are projected to make up 25.5% of the total New Zealand population. This growth will occur at the "expense" of both the child population (under 15) and other adult population (15-64). For example, the 15-64 population is expected to have a net increase of 308,000 between 2001 and 2051 while, during the same time period, the 65+ population will increase by nearly 800,000 to 1.22 million (Statistics NZ, 2002).

Although Auckland City has a lower proportion of older adults than New Zealand as a whole, with 10.3% of people in Auckland City aged 65 years and over, compared with 12.1% nationally, we need to ask ourselves what the implications of this shift in population composition for health service sustainability?

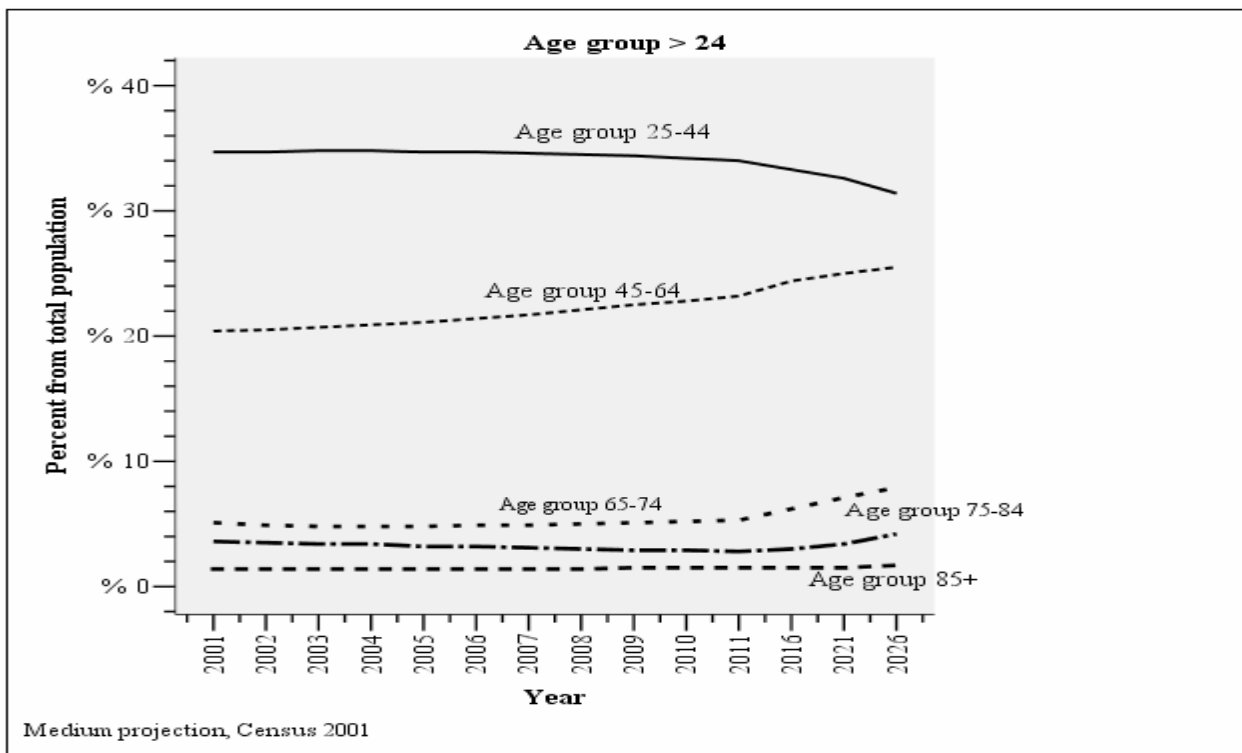


- Older people (65+ years) will make up 14% of the total population in 2021. Auckland District Health Board (ADHB) is the fourth largest DHB in the country. It had 367,740 people or 10% of total population of New Zealand in 2001.

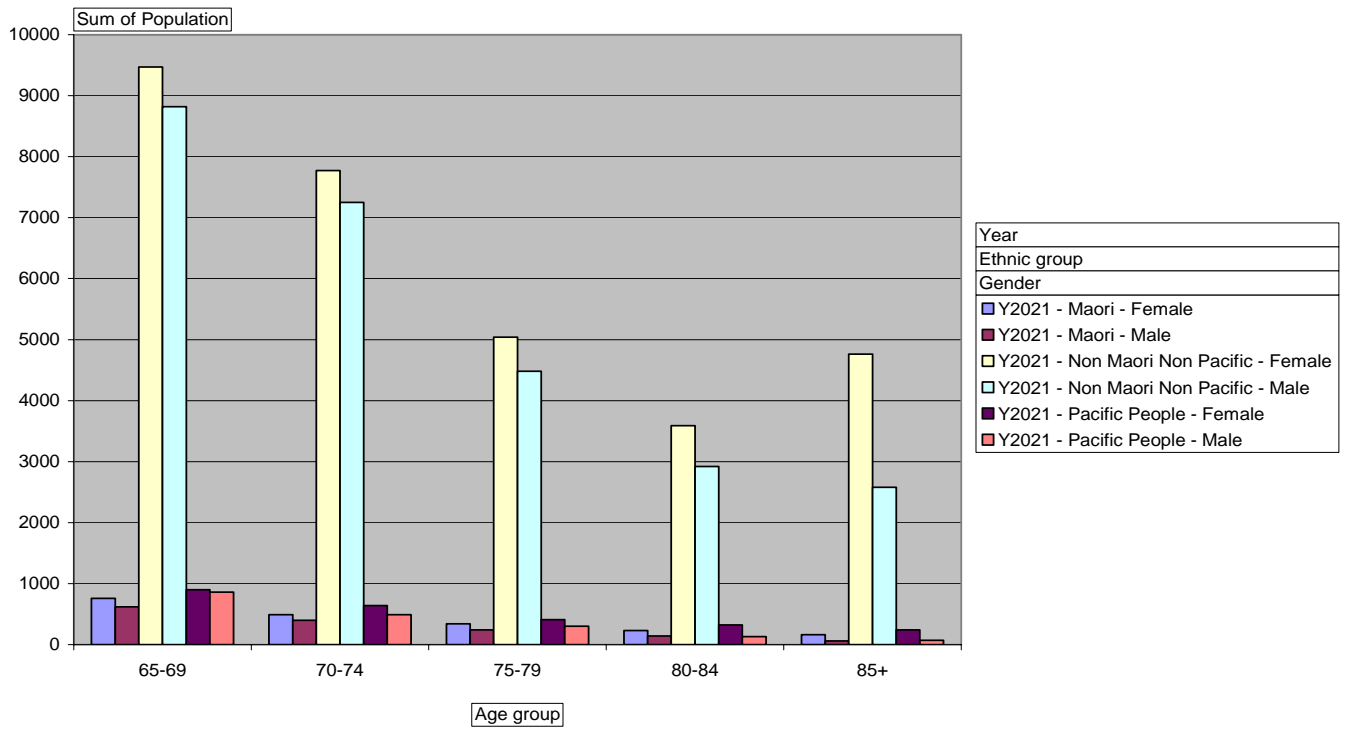
- It is expected that there will be about 110,000 more people in ADHB, a 30% increase from 1996, by the year 2021.
- The largest ethnic group was European (56%), followed by Asian (17%). 12% of the Population were Pacific Island people and 8% were Maori.
- Samoan followed by Tongan were the two largest cultural groups identified among Pacific people.
- About 30% of ADHB population lived in deciles 8-10 (DEP2001).
- 20% of ADHB population were children and 10% of them were older people aged 65+.
- Maori and Pacific Island people had a very young population with about 50% of the people aged less than 25 years old.
- Between 1996 and 2001 there was a 4% decrease in the number of the older population (aged 65+) but when broken down by age group, there was a 15% increase in the number of older people aged 85+ years old.
- It is expected that there will be about 130,000 more people in ADHB, a 36% increase from 1996, by the year 2021.
- There will be an increase in the percentage of older people and a decrease on the percentage of younger people in ADHB by the year 2021.

Source: New Zealand Census, 2001

The population of Auckland will be getting older on average over the next 20 years with increases in all age groups over 45 years of age. By 2021 over 14% of the people in Auckland will be over 65 years of age.



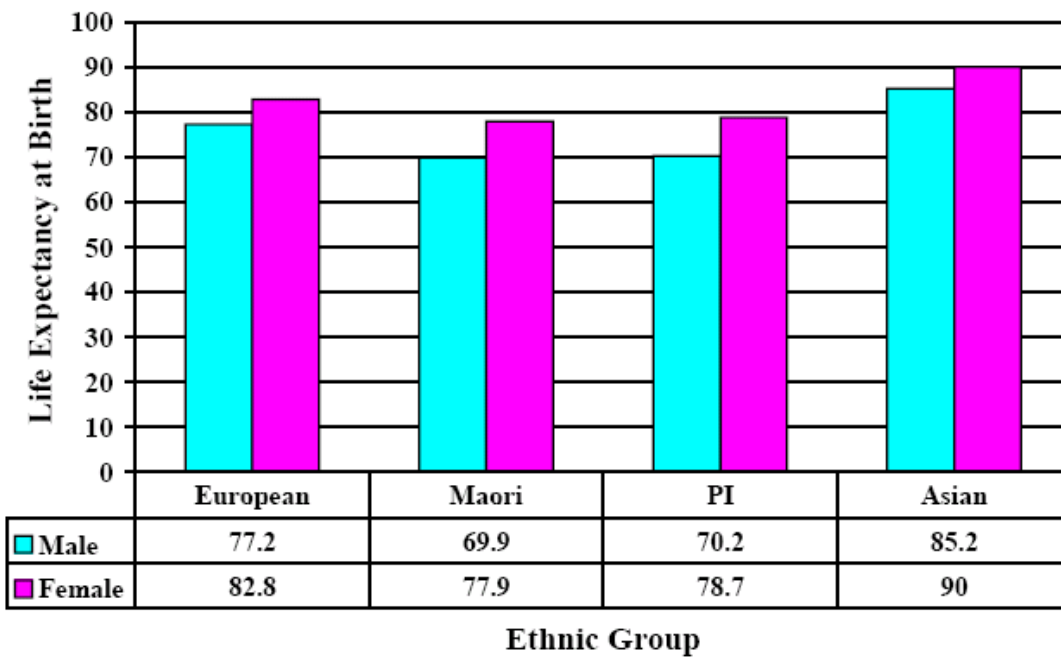
NZDep01 (All)



The health status of the population

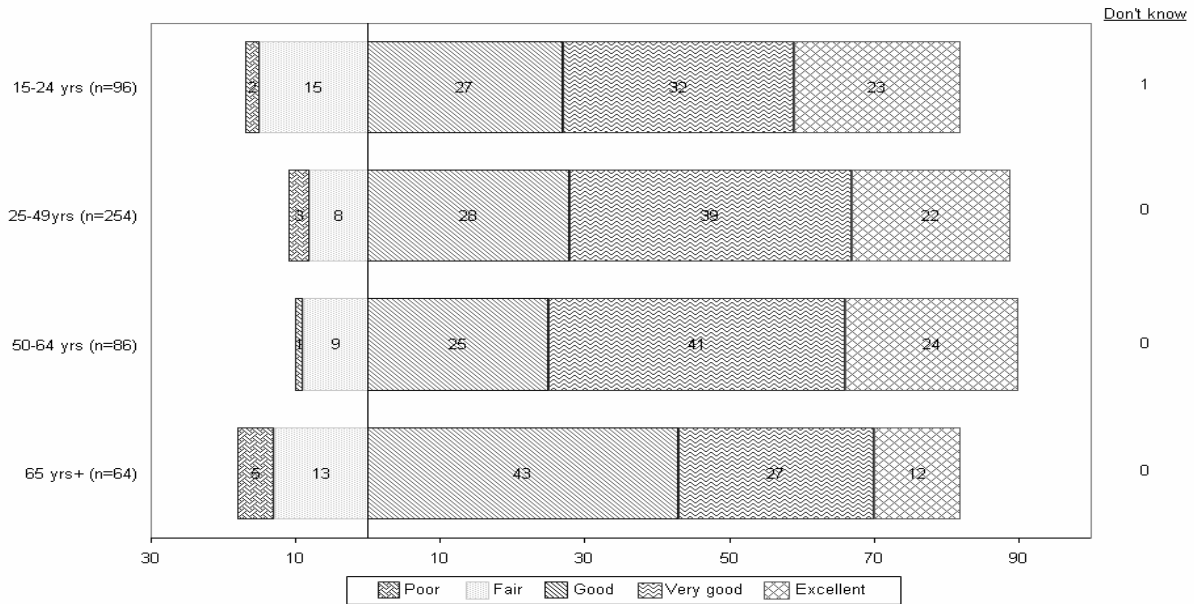
Life Expectancy

Life expectancy has been increasing steadily but is still significantly less for Maori and Pacific Islanders.



Perceptions of overall Health

Those aged 15-24, and those aged 65 years or over were most likely to rate their health as fair or poor.

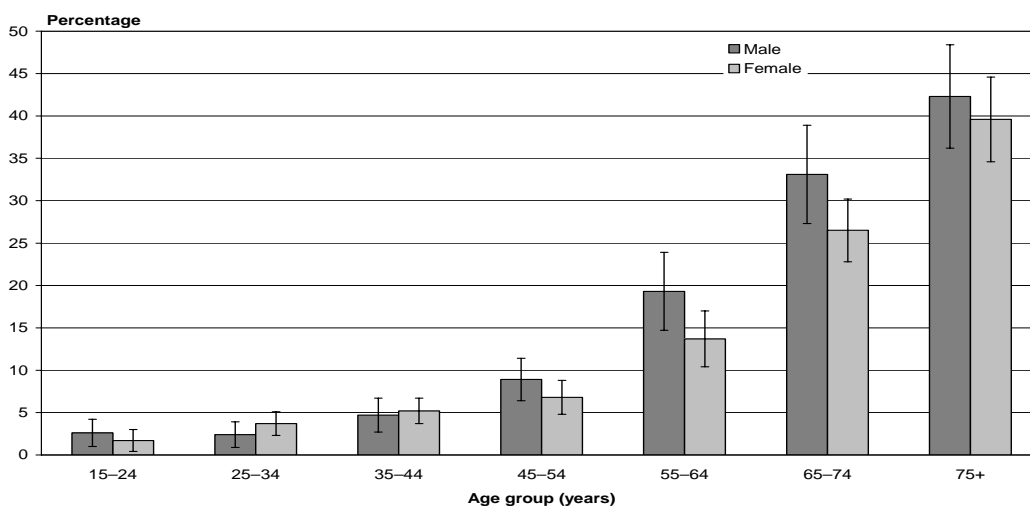


Conditions that affect us as we age

A number of conditions have a disproportionate impact for older persons. The following tables are taken from the 2002/2003 New Zealand Health Survey.

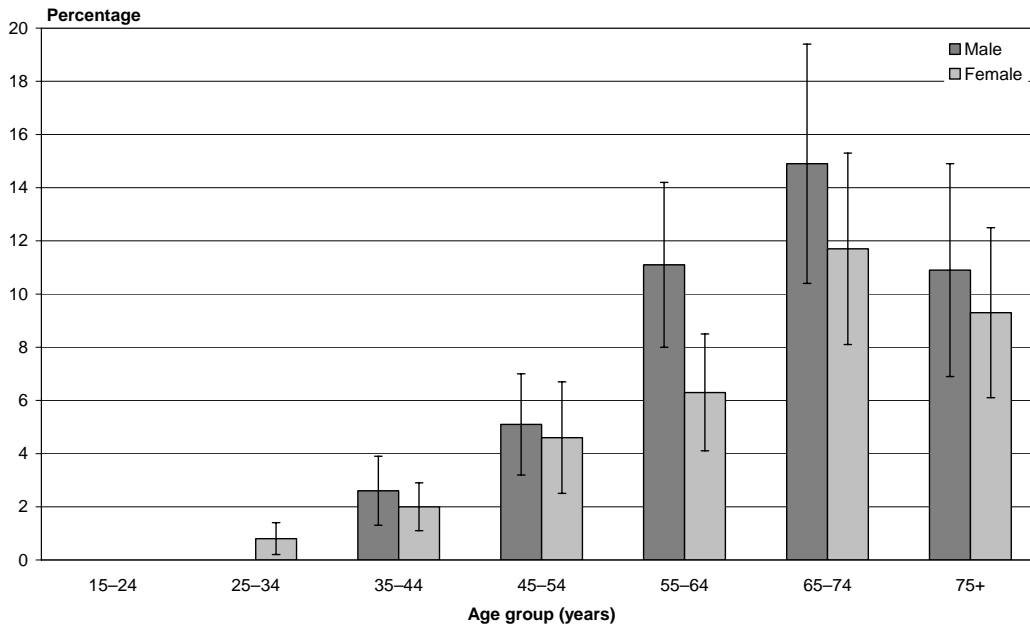
Coronary-vascular disease

In both males and females, the prevalence of heart disease increased significantly with age, peaking in the 75+ years age group



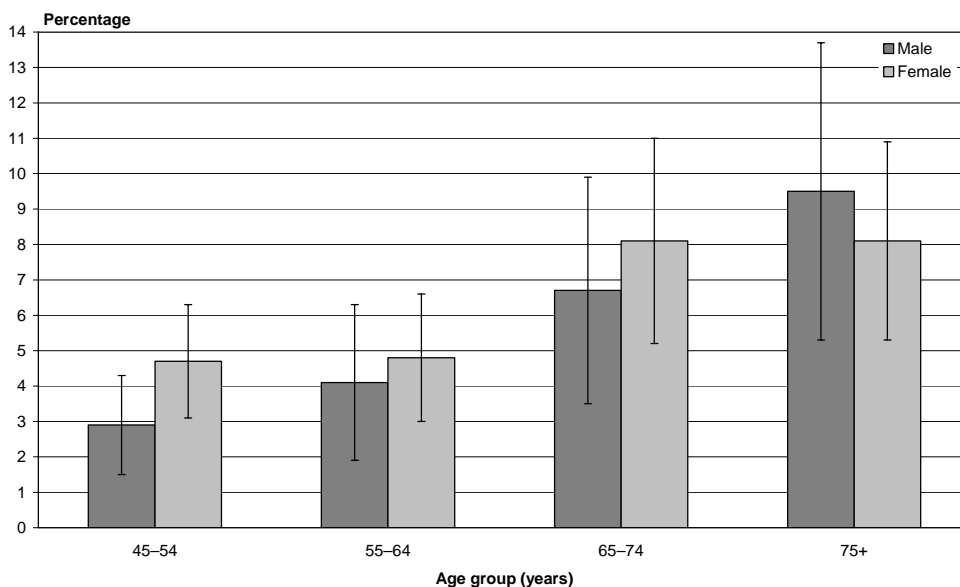
Diabetes

In both males and females, the prevalence of diabetes increased with age, peaked in the 65–74 years age group, and then declined slightly in the 75+ years age group



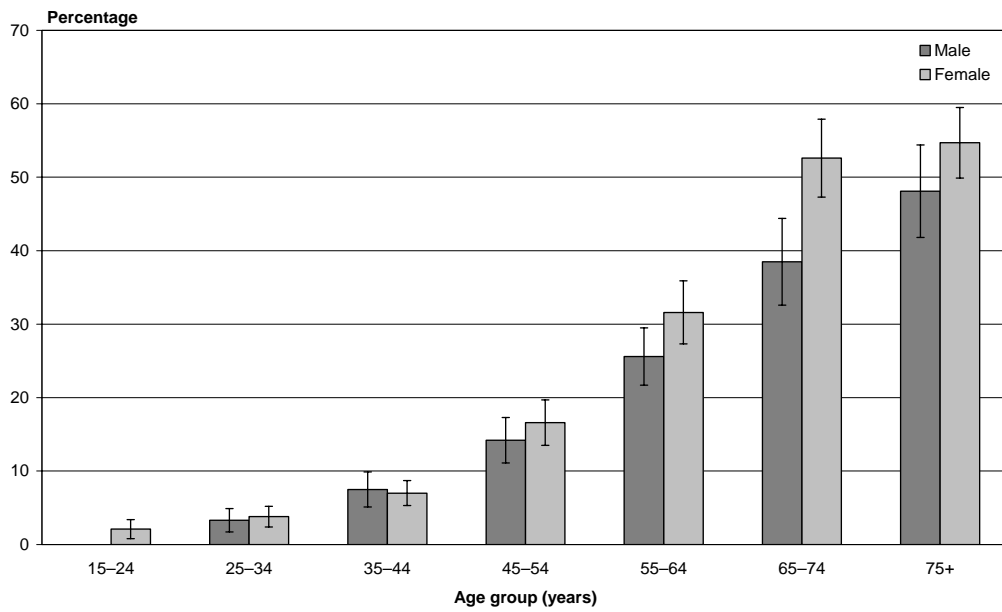
Chronic Obstructive Pulmonary Disease (COPD)

In both males and females, the prevalence of Chronic Obstructive Pulmonary Disease (COPD) increased with age.



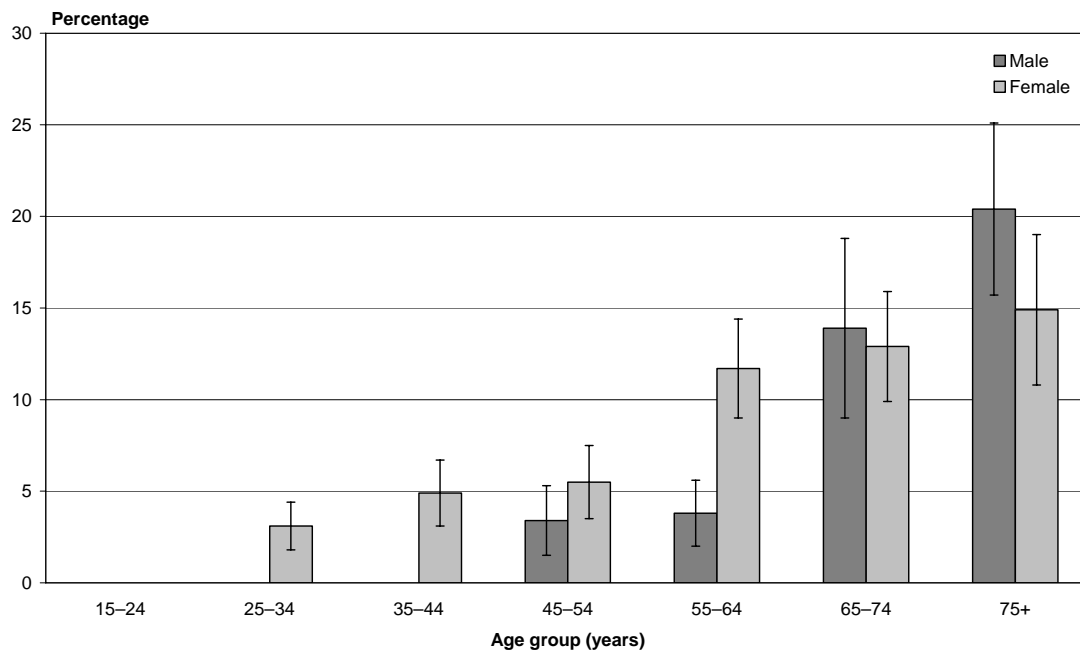
Arthritis

In both males and females, the prevalence of arthritis increased with age, peaking in the 75+ years age group



Cancer

In both males and females, the prevalence of a cancer diagnosis at any time increased with age, peaking in the 75+ years age group.



Use of services

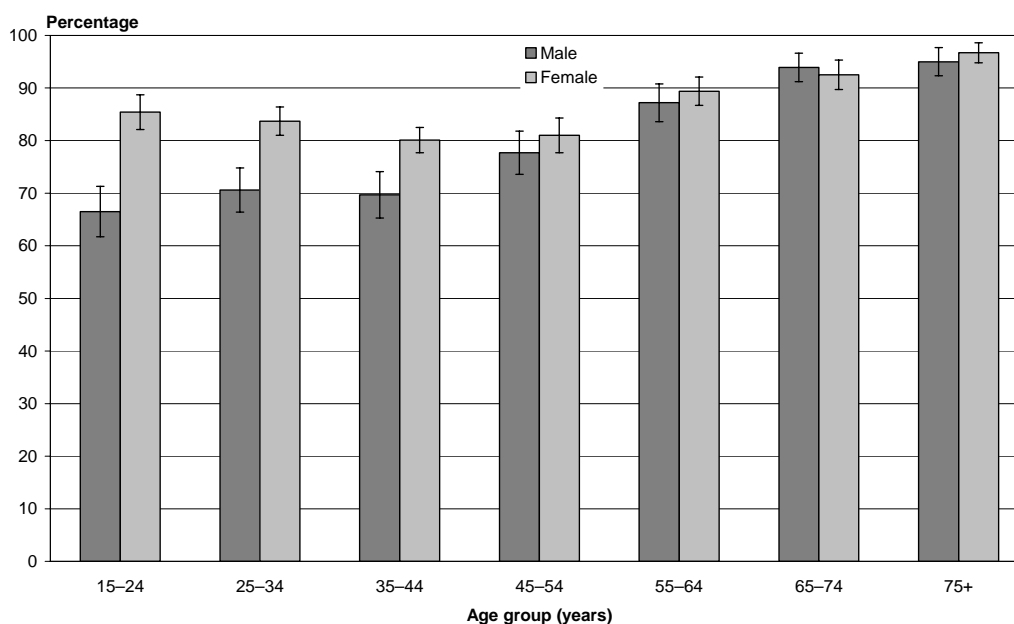
Hospital Admissions

The highest number of admissions, about 30%, occurred at age 25-44 which reflects hospital admissions due to childbearing age. However, those 75 and older were responsible for 15% of discharges but utilised more than 26% of the hospital cost weights. This reflects the severity of the conditions associated with this age.

Age group	Hospital Discharge 2004		Cost weight 2004	
	Sum	% of Total Sum	Sum	% of Total Sum
00-00	10,128	13.3%	5,554	7.6%
01-14	7,730	10.1%	4,476	6.1%
15-24	7,140	9.4%	4,866	6.7%
25-44	22,012	28.9%	16,083	22.0%
45-64	11,835	15.5%	14,179	19.4%
65-74	6,003	7.9%	8,808	12.1%
75+	11,435	15.0%	19,122	26.2%
Total	76,283	100.0%	73,091	100.0%

General Practitioner Visits

Males and females, age 65 years and over were significantly more likely than adults aged 15-24 years to have seen a GP in the last 12 months.



Appendix 1:

Documents Reviewed in the development of this strategy

Auckland District Health Board Mental health and Addiction Services: District Service Development Plan – Draft.

September 2006

Auckland Metropolitan DHBs: Draft establishment Plan for Older Peoples Services in Greater Auckland

May 2003

Capital and Coast District Health Board: Developing Home, Community, Primary and Specialist Care Services

2005

Capital and Coast District Health Board: Home and Community Care Packages Service Specification – Draft

2005

Counties Manukau District Health Board: Health of Older People Action Plan 2005-2010

August 2006

Department of Community Development Office for Seniors Interests and Volunteering: Generations Together, A guide to the Western Australian Active Ageing Strategy

March 2004

DPA NZ: Guidelines about Disability for Councils and District health Boards, 2004

Dr Chris Cunningham: Health and Disability services for Older Maori – A paper prepared for the National Health Committee

June 2000

John Baird, Development of Sustainable Home-Based Support Services, A Discussion Paper. Prepared for the three Metropolitan Auckland DHB's

September 2005

Lakes District Health Board: Plan for Improving the Health of Older People, Te Mahere Whakaora i te Oranga o te Matapuputu 2005-2010

November 2005

Liz Kiata, Ngaire Kerse, Robyn Dixon: Residential care workers and residents: The New Zealand Story.
May 2005

Liz Kiata, Ngaire Kerse: Intercultural Residential Care in New Zealand
March 2004

Martin Piquart, PhD, and Silvia Sorensen, PhD: Ethical differences in stressors, resources, and psychological outcomes of family caregiving: A meta-analysis.
February 2005

Max Robins, Healthcare Providers New Zealand: The New Zealand Aged Care System presentation to the Aged Care Association Australia National Congress
2005

Midcentral District Health Board: Assessment, Treatment and Rehabilitation Project – Enhanced Model of Service delivery 'Influencing Outcomes'
November 2005

Ministry of Social Development: Auckland Regional Plan for 2005/06
2005

National Health Committee: Report of the National Health Committee on Healthcare for Older People
May 2000

National Health Committee: Who Should Care for the Carers: Better Support for those who Care for People with Disabilities
June 1988

National Health Service: Our Health, Our Care, Our Say: A new direction for community services
January 2006

Office for Senior Citizens: The New Zealand Positive Ageing Strategy
April 2001

Office for Senior Citizens: New Zealand Positive Ageing Strategy Annual report 1 July 2004 - 30 June 2005
2005

Professor Ian Philp, National Director for Older People, Department of Health: A new ambition for old age.

Statistics New Zealand: Older New Zealanders - 65 and beyond
2004

Western Australian Aged Care Advisory Council: Appropriateness of the Home and Community Care Programme in delivering services to its target population in Western Australia, Final Report
October 2002

Western Australian Aged Care Advisory Council: Developing the State Aged Care Plan for Western Australia Planning Framework
March 2002

Western Australian Aged Care Advisory Council: Development of a State Aged Care Plan for Western Australia
November 2002

Whanganui District Health Board: Residential Care Purchasing Plan – managed Bed Policy, Consultation Document and Submission Booklet
March 2006

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Sharon Reilly, Programme Manager, Specialised Services, Healthwise ACC

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