# Health of Older People Action Plan 2005 - 2010

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# COUNTIES MANUKAU DHB'S SHARED VISION IS:

To work in partnership with our communities to improve the health status of all, with particular emphasis on Maori and Pacific peoples and other communities with health disparities

- We will do this by leading the development of an improved system of healthcare that is more accessible and better integrated
- We will dedicate ourselves to serving our patients and communities by ensuring the delivery of both quality focussed and cost effective healthcare, at the right place, right time and right setting
- Counties Manukau DHB will be a leader in the delivery of successful secondary and tertiary health care, and supporting primary and community care.

## Values

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| Care and Respect | Treating people with respect and dignity: valuing individual and cultural differences and diversity |
| Teamwork | Achieving success by working together and valuing each other's skills and contributions |
| Professionalism | Acting with integrity and embracing the highest ethical standards |
| Innovation | Constantly seeking and striving for new ideas and solutions |
| Responsibility | Using and developing our capabilities to achieve outstanding results and taking accountability for our individual and collective actions |
| Partnership | Working alongside and encouraging others in health and related sectors to ensure a common focus on, and strategies for achieving health gain and independence for our population |

# 1.0 INTRODUCTION

The purpose of this document is to outline the actions that Counties Manukau District Health Board (CMDHB) plan to take from 2006 through to 2010 in order to meet the health and disability needs of older people in Counties Manukau.

The founding document underpinning this Action Plan is the national *Health of Older People Strategy* (2002). The vision of the Strategy is that:

> "Older people participate to their fullest ability in decisions about their health and well being and in family, whanau and community life. They are supported in this by coordinated and responsive health and disability programmes."

The NZ Health of Older People Strategy was developed in response to a number of drivers for change including:

- Concerns about the lack of strategic policy development and planning for health and disability support services for older people
- The rapid increase in the number and ethnic diversity of people over 65 years of age that is projected to occur from 2010.

The Ministry of Health (MOH) and the DHBs have the responsibility for implementing the Health of Older People Strategy. The MOH and DHBs have the responsibility to achieve the vision of the strategy by implementing the actions and key steps for the eight objectives of the Strategy by 2010.

The primary aim of the Health of Older People (HOP) Strategy is to develop an integrated approach to health and disability support services that is responsive to older people's varied and changing needs. It is a fundamental understanding that 'ageing in place' is preferred by older people ahead of residential care, and hence services are increasingly directed to supporting people to live in their own homes for as long as possible.

The focus of the HOP Strategy is on:

- Working alongside older people as members of families, whanau and the community
- Promoting wellness and quality of life to assist older people to age positively
- Working together to provide an integrated continuum of care so that an older person is able to access needed services at the right time, in the right place and from the right provider.
- Providing community-level health care and disability support to enable older people to "age in place".
- Planning for culturally appropriate services to meet the increasing diversity of older people.

(HOP Strategy. 2002. p.iii)

In addition to being based on the national Strategy this Action Plan has been informed by extensive consultation with the people of Counties Manukau to ensure the needs of our older people are identified and responsive actions are included. This document outlines the actions CMDHB has taken to-date and the planned actions for the next five years.

This document uses the CMDHB outcomes framework to outline the proposed work streams for the next five years. The district annual plan (DAP) will provide the detail of work streams and targets for each of those five years. Both the MOH and DHB will monitor progress on the implementation of the Health of Older People Strategy and the CMDHB action plan.

The CMDHB indicators for success will be:

- Improved coordination in planning for care of the older person
- Focus on ageing in place where appropriate for care and services planning
- Sustainable provider sector for the provision of services
- Sustainable funding framework for services
- Sufficient and well skilled workforce
- Recognition and support of carers/whanau/family
- Development of innovative options for care and service delivery
- Reduction of preventable admission to secondary care
- Inter sectoral collaboration in services planning

**Background**

In October 2003 CMDHB (along with other DHBs) was devolved responsibility for funding support services for people over the age of 65. These services, previously funded nationally by the Ministry of Health, include home based and community support services, carer support, and aged residential care. CMDHB was already responsible for funding personal health and mental health services for older people.

The DHB's provider arm is also a significant provider of support services for older people. These include Assessment Treatment and Rehabilitation (AT&R) service for older people, spinal rehabilitation, neurological rehabilitation, residential care (Pukekohe and Franklin Memorial Hospitals), respite care, Needs Assessment and Service Coordination (NASC) for those aged over 65 years, and Home Health Care (HHC), and Mental Health Services for Older People - MHSOP (see MHAP).

'"Older People' includes people aged 65 years and over, and people aged 50-64 who are 'close in interest' to 'older people'" Definition of older people, MOH, (2005/6), Final service coverage,pp.48.

# 2.0 CURRENT SERVICES IN COUNTIES MANUKAU

## A. Primary Health Care Services

Primary health care services are usually the first point of contact with health services for individuals and families. The aim is that each person and family/whanau is enrolled with a Primary Health Organisation (PHO). A PHO is a team of doctors, nurses and other health professionals (such as Māori health workers and health promotion workers) who are working with the community to provide health service. Almost all general practices in Counties Manukau are members of PHO networks.

There are a number of initiatives occurring in the implementation of the Counties Manukau Primary Health Care Plan that aim to benefit older people with long term health needs. These include:

- Chronic Care Management (CCM) programme
- Primary Options for Acute Care (POAC)
- East Health's Eldercare scheme
- ProCare Network for Manukau's multiple and complex case management pilot in Pukekohe.

## B. Secondary Care Services

The DHB's provider arm delivers a broad range of health services accessed by older people in both the inpatient and community setting.

**Inpatient services**

Inpatient services for older people include:

General medicine
General surgery
Urology
Gynaecology
Orthopaedic services
Plastic surgery
Ophthalmology
Rheumatology
Otorhinolaryngology (ENT)
Gastroenterology
Assessment Treatment and Rehabilitation
Mental Health
Renal
Emergency Care
Dental surgery

**Community home health care services**

Community home health care services are provided from four bases (Howick, Mangere, Papakura and Pukekohe). These provide community based health services including:

- District nursing
- Allied health care, eg occupational therapy, physiotherapy
- Meals on Wheels in urban areas
- Provision of ostomy and continence supplies
- Assessment for long term equipment and housing modifications.

**Needs Assessment and Services Coordination (NASC)**
NASC provides assessment of an older person's needs, with involvement of the client and their family/whanau, and coordinates a package of care from DHB contracted eg Home based support services, aged residential care and non DHB contracted services eg Stroke foundation, to support them.

**Assessment, Treatment & Rehabilitation (AT&R)**
Sub-acute assessment and rehabilitation inpatient care is provided for older people through AT&R services.
AT&R Inpatient services are available at:

- Middlemore Hospital (3 wards, 56 beds)
- Pukekohe Hospital (4 beds – shared AT&R, hospice and respite)
- Franklin Memorial Hospital (6 beds - shared AT&R, hospice and respite)

AT&R Outpatient clinics are provided at:

- Middlemore Hospital
- Pukekohe Hospital (includes outpatient physiotherapy and occupational therapy rehabilitation unit)
- Franklin Memorial Hospital (Waiuku)
- Botany SuperClinic
- Manukau SuperClinic

AT&R Community based rehabilitation services are provided by:

- Community Based Rehabilitation Team ( CBRT)
- Mental Health Services for Older People (MHSOP) Community Team

## C. Residential Care Services

CMDHB contracts for the provision of subsidised aged residential care. Residential care services are categorised as long stay hospital, psycho-geriatric hospital, rest home and dementia services.

**Residential care providers**
The following contracted residential services are provided in Counties Manukau:

- Rest homes:1094 beds, 37 providers
- Dementia residential care: 80 beds, 5 providers
- Long stay hospital : 720 beds, 20 providers
- Psychogeriatric care: 24 beds for Auckland region. No facilities located in Counties Manukau.

**Quality**
In October 2004 the requirement for all residential providers to meet new national standards for certification was instituted. In addition, to ensure the quality of service provision, the DHB has implemented process for contract, financial and issue based audits for all aged residential care providers.

**Growth**
The number of home based services and residential care beds required by older people in Counties Manukau will increase as a result of population growth and ageing. The DHB has the responsibility for ensuring there is an adequate supply of residential care beds for people assessed as needing this care.

**Subsidy Eligibility**
In July 2005, changes to income and asset testing for residential care came into effect. These progressively raise the threshold for subsidy and as a result the DHBs will fund a greater proportion of the people accessing subsidised aged residential care.

**Respite**
There are a small number of older people who will use residential care for a shorter time, ie for post-hospital recuperation prior to returning home, short term CMDHB funded respite care and carer support.

## D. Community Support Services

CMDHB funds the provision of community support and information services for older people and their families. These include:

- Home Based Support Services (HBSS) including personal care and household management to support people at home. There are seven providers of these services in Counties Manukau
- Information and advisory services provided by Age Concern, Alzheimer's Society, TOA (Treasured Older Adult) and PIASS (Pacific Information Advisory Service)
- Carer support services provided for those caring for people aged over 65 years with a mental health disorder or age related disability
- Day care services provided by Elrond, Howick Baptist, and Te Oranga. These services support older people and their family/whanau to remain in the community
- Orthotics services (provision of prostheses)
- Elder abuse and protection and home visiting services provided by Age Concern

A range of support and information services for the older person and their families are provided in the community and which are not funded by the DHB. These services often identify and provide services to fill the 'gaps' and do so with ad-hoc funding arrangements. These include:

- Support groups which provide specific information and support to people affected by illness or disability, eg Alzheimer's Society, Arthritis NZ, Foundation for the Blind
- Telephone based support, eg Homeline, Caring Caller
- Advocacy groups which provide older people with information, action and support on a wide range of issues including health, eg Grey Power, Age Concern, Probus, Returned Services Association
- Voluntary, religious and cultural organisations, eg Red Cross, churches, marae.

# 3.0 SERVICE DEVELOPMENT INITIATIVES IN COUNTIES MANUKAU

To achieve the objectives of the Health of Older people strategy CMDHB initiated a number of work streams. The activity to date is outlined below:

**'Service mix' model**
The provision of community, home based and residential services are all essential components for support for the older person. CMDHB is currently developing a 'service mix' model which will project future requirements for each type of support services.

These projections will be based on current usage, demographic growth and policy direction. It will aid workforce planning and funding decisions by both the DHB and providers, and reflect the increasing needs of the growing and ageing population.

**Nursing workforce development framework**
A nursing workforce development framework is being developed to improve primary health care nursing to older people. The intention is that this will assist with the development of gerontology nursing skills and the development of nurse specialists and nurse practitioner roles.

**NASC workforce review**
The NASC service has recognised the need for diversity of skills for assessors to respond to the increasing demand for clinical and social evaluation in the needs assessment for the older person. A review is underway to explore the future workforce and skills needs of the NASC agency.

**Franklin Integration Project ( FIP)**
The FIP's objective is to work towards improved integration of health services across the Franklin district. The project steering group has identified information and transport as two key areas and is developing initiatives and strategies to address the identified deficits, The steering group is working closely with CMDHB, Franklin District Council, and the Auckland Regional Council to address these.

**Home Based Support Services (HBSS) Review**
The importance of HBSS in supporting ageing in place people at home is recognised by CMDHB. The existing service model has been reviewed and currently work on the assessment tools, funding models, care provision models and capacity building is underway.

**Health Needs Analysis**
The Health of Older People in Counties Manukau: Population Health Needs Analysis was completed in 2006. This report presents a range of key indicators of the demographic profile and health of Counties Manukau adults aged 65 years and over and is available on www.cmdhb.org.nz.

# 4.0 REGIONAL PLANNING

From the time of devolution of HOP services to DHBs in 2003, the three metro-Auckland DHBs have worked together to establish a HOP regional framework within the Northern DHB Support Agency (NDSA) to enable regional co-operation and collaboration, and to minimise duplication of administrative activities.

Specific areas of focus for regional collaboration include:

- The Home Based Support Services Information Project which has improved the information available on home based support services
- The Aged Residential Care Project which addresses the shortfalls in information required for complete reporting of residential care facilities
- Regular forums with residential care and home based service providers, to promote opportunities for discussion around service development, planning and funding issues
- A moratorium on residential care beds which has been in place since 2004 while decisions on future development and the process for implementing any changes are considered by the DHBs
- Development of a regional Mental Health Services for Older People Strategy

# 5.0 NATIONAL PLANNING

The HOP Strategy is a national strategy and the MOH, and DHBs recognise the importance of national collaborative planning and service development. A series of national projects has been agreed and these are contributed to by the Ministry of Health, Ministry of Social Development, DHBs and, in some instances, ACC. The national projects completed to date are:

- Assessment Processes for Older People: Best Practice Evidence-Based Guideline (New Zealand Guidelines Group, October 2003). This document outlines what is needed for effective assessment processes for older people
- Guideline for Specialist Heath Services for Older People (Ministry of Health, September 2004). This provides a framework for developing specialist services for older people
- Improving Quality Action Plan: Supporting the Improving Quality Approach (Ministry of Health, September 2003). This provides a check for quality systems, ensuring that there is a culture or quality improvement. The Ministry of Health's Disability Services Directorate began examining quality and safety workforce issues in disability support services in 2003/04, prior to devolution, and this has continued as joint work

CMDHB is currently participating in:

- Ministry of Health Information Strategy Project and National Assessment Project (InterRAI)
- Ministry of Health project to explore the minimum staffing ratios for residential care, and related quality, safety and workforce issues
- Ministry of Health review of issues relating to funding responsibility for assessment and service provision for older people, those 'close in interest' and others with chronic illness. It is intended that this review will address and resolve the funding interface between Disability Support (Ministry of Health) and Health of Older People (DHB) funding
- Provision of long term equipment and housing alterations

Other national strategies guiding development of HOP services in Counties Manukau are:

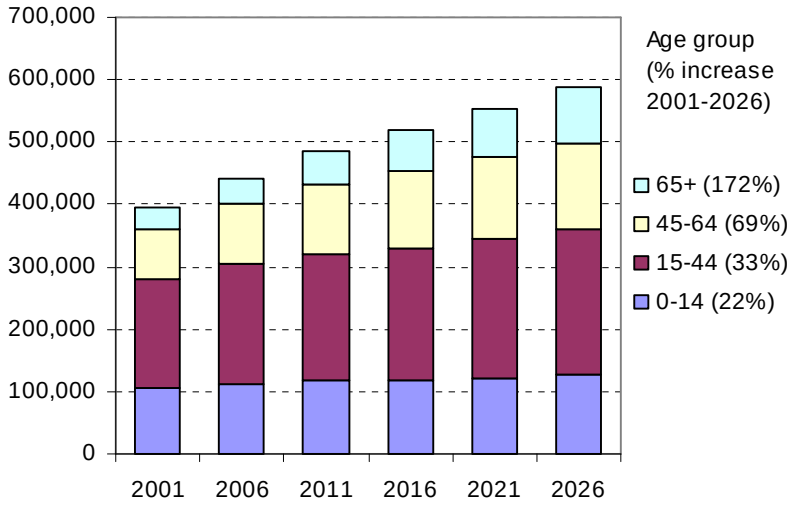
- Positive Ageing Strategy 2001
- New Zealand Health Strategy 2000
- New Zealand Disability Strategy 2001
- Primary Health Care Strategy 2001
- New Zealand Palliative Care Strategy 2001
- Improving Mental Health: the Second National Mental Health and Addiction Plan 2005-2015
- He Korowai Oranga – Maori Health Strategy 2002
- Pacific Health and Disability Action Plan 2000.

# 6.0 THE OLDER PEOPLE OF COUNTIES MANUKAU

Counties Manukau has been and remains one of the fastest growing areas in New Zealand. It has a diverse population with complex health needs and service requirements.

- Counties Manukau includes the territorial local authorities of Franklin, Papakura and Manukau, covering an estimated population of 440,600 in 2006, 10.7% of the total New Zealand population.
- The CMDHB population is predicted to increase between 2001 and 2026 by 50% overall, with the largest proportional increase being in the over 65 year age group - an increase of over 172% from 33,800 to 92,000 people. These increases are driven by increasing life expectancies and changing migration patterns.
- Counties Manukau population over 65 years is 33,800 (8.5%), made up of European/Other 29,000; Maori 1300; Pacific Island 3000; and Asian 2000.
- Life expectancy at birth in Counties Manukau in 2001 was similar to the New Zealand average; 81 for females and 76 for males

**Projected change in the % of total population by age group**




- Within the population over 65 years of age, the greatest increase will be in the 85+ age group – a nearly 3.5 fold increase over this time period (244%). In comparison, the total Counties Manukau population aged 65 years and over will increase by 172%, and the total Counties Manukau population by 50%. The larger increase in the very old reflects both increasing longevity and the baby boom generation nearing 85 around 2030. Thus, as well as growth of the population aged 65 years and over, Counties Manukau will experience a dramatic increase within this age band of those aged 85 years and over.

**CMDHB projected population growth by age, 65 years of age and over**

| | 65-74 | | 75-84 | | 85+ | | Sub-total 65+ | | Total |
|---|---|---|---|---|---|---|---|---|---|
| Year | No. | % # | No. | %# | No. | %# | No. | %# | No. |
| 2001 | 19,560 | 5.0% | 10,940 | 2.8% | 3,290 | 0.8% | 33,790 | 8.6% | 393,710 |
| 2006 | 23,850 | 5.4% | 13,160 | 3.0% | 4,130 | 0.9% | 41,140 | 9.3% | 443,170 |
| 2011 | 29,940 | 6.2% | 15,080 | 3.1% | 5,370 | 1.1% | 50,390 | 10.4% | 484,080 |
| 2016 | 37,560 | 7.2% | 18,670 | 3.6% | 6,940 | 1.3% | 63,170 | 12.2% | 518,700 |
| 2021 | 44,130 | 8.0% | 23,710 | 4.3% | 8,570 | 1.5% | 76,410 | 13.8% | 553,780 |
| 2026 | 50,520 | 8.6% | 30,170 | 5.1% | 11,330 | 1.9% | 92,020 | 15.6% | 589,000 |
| % Change 2001-2026 | 158% | | 176% | | 244% | | 172% | | 50% |

# % of total population all ages.
Source: SNZ medium growth assumptions Sept 2004, produced for MOH

- The outlook for CMDHB older persons is very positive. It is anticipated that the population aged 65 years and over will live longer and be increasingly characterised by ongoing independence, continued participation in work, home and community, and health for a longer proportion of their older age than their predecessors. The increasing numbers of older people aged 85 years and over, increasing numbers of Asian, Maori and Pacific peoples, the high proportion of women in older age and likely increase in demand on health services are principal policy considerations for Counties Manukau.

- Those aged 75 years and over, and especially 85+ can be high users of health and disability services. The rapid increase in the over-85 population in the next 20 years will require additional integrated service provision to meet these needs and facilitate ageing in place. Most people want to remain in their own homes as much as possible - wider development of community based services including a greater range of supported-housing options are important strategies to support this.

- Counties Manukau has higher rates of admission to hospital compared to NZ as a total. Around a third of all hospitalisations and 42% of all inpatient bed days for adults with medical or surgical conditions in 2004 were for adults aged 65+. Around a third of these hospitalisations for adults aged 65+ might be considered potentially avoidable - including those for IHD, CORD, diabetes, congestive heart failure, and stroke. Creating socio-economic, socio-cultural and physical environments that favour prevention of smoking, improvements in nutrition and physical activity and facilitate timely access to quality primary care throughout the life course are needed.

A detailed needs assessment for older people has been compiled for CMDHB and is available on www.cmdhb.org.nz.

# 7.0 THE OUTCOMES WE SEEK

## Outcomes framework

This HOP Action plan has been developed using CMDHB's District Strategic Plan "outcomes framework". The outcomes framework links the DHB's longer term strategic vision with the activities occurring on a day to day basis.

The DHB's vision is "to work in partnership with our communities to improve the health status of all, with particular emphasis on Maori and Pacific peoples and other communities with health disparities". This is a very long term (10-20 years) outcome expectation. In the long term (5-10 years) the DHB's focus is improving outcomes such as community wellbeing through emphasising wellness and prevention, and in the medium term (1-5 years) the focus is on specific programmes and initiatives.

The measures to be used to monitor progress are shown for each medium term outcome.
NB: Outcome 2 of the District Strategic plan relates to Child & Youth Health and hence is not relevant to this action plan.

## Coordination of Planning

There are a number of existing CMDHB detailed plans with implications for this action plan. The HOP action plan has been developed to work in conjunction with other CMDHB plans and these are: Let beat diabetes, Healthy Eating- Healthy Action Strategic Plan, Primary Health Care Plan, Mental Health and Addictions Action plan, Chronic Care Management Plan, Maori Health Plan, Pacific Plan, Regional Maori Health Plan, Clinical Services Plan, Facilities Plan, Long Term Financial Plan, Workforce Plan, Quality Plan.

| Long term outcomes | Outcome 1<br>Improve community wellbeing | Outcome 3<br>Reduce the incidence and impact of priority conditions | Outcome 4<br>Reduce health inequalities | Outcome 5<br>Improve health sector responsiveness to individuals and family/whanau | Outcome 6<br>Improve the capacity of the health sector to deliver quality services |
|---|---|---|---|---|---|
| Medium term outcomes | Improve nutrition | Implement guidelines for comprehensive integrated assessment for older people and their carers | With Maori establish culturally appropriate, integrated health and disability support services for older Maori | Ensure health and support services information is available and accessible to older people, carers and service providers | Develop health and disability support services to provide coordinated support for older people to age-in-place |
| | Reduce depression and social isolation | Review access to specialist mental health services for older people | Develop a range of support service providers to provide older Maori and their whanau a choice of culturally appropriate providers | Involve older people and, where appropriate, their family, whanau and carers, in service planning and decisions about their care and support | Develop standards for quality support services for older people |
| | Reduce falls | Prepare a service development plan for older people with dementia | Facilitate the development of health advocacy structure for older Maori | Foster and model positive attitudes to ageing and older people | Facilitate smooth access to palliative care |
| | Promote intersectoral collaboration on housing and transport | | Plan for Pacific and mainstream health and disability services to meet the needs of older Pacific people and their families | Support primary and community health providers in health improvement and public health promotion programmes for older people | Support the opportunities for long term support providers to provide health promotion, disability prevention and rehabilitation. |
| | Reduce social isolation caused by continence issues | | Facilitate the development of health advocacy structures for older Pacific people | Facilitate work by service providers to assess and develop active approaches to care management | Work with providers to establish and apply a process for collecting reliable data to forecast future need for services, and plan supply of services to match need |
| | Collaborate with the local Chinese community, through the Chinese Positive Ageing project | | | Provide age and cultural appropriate care and treatment for older people | Implement a planned approach to strengthening the health workforce to meet the needs of an ageing population |
| | Develop and implement guidelines on the support service needs of ethnic minority groups | | | Assess option for intermediate level care to bridge the gap between hospital and home based services | |

## OUTCOME 1 - IMPROVE COMMUNITY WELLBEING

Health outcomes for the Counties Manukau population can be significantly improved only by a 'whole society' approach. CMDHB will work with our communities (in particular the Maori and Pacific communities) and other agencies (in particular Manukau City Council, and Franklin and Papakura District Councils, the Ministry of Social Development and Housing New Zealand) to improve the environments in which people live, work and play, and encourage healthy behaviours.

A number of the initiatives and strategies included in this outcome area could also be included in other outcome areas, but have only been included here to avoid duplication.

| **CMDHB aims to:** |
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| 1. **Improve nutrition** by<br>• Implementing the Nutrition Assessment Tool for older people at general practice level<br>• Reviewing the Meals on Wheels service model |
| 2. **Reduce depression and social isolation experienced by older people** by<br>• Investigating ways of enabling and supporting family members, residential carers, and community support services and volunteers, to provide care that minimises social isolation<br>• Identify and address barriers to recognition and treatment for depression |
| 3. **Reduce falls** by<br>• Implementing Falls Prevention programmes within CMDHB provider arm<br>• Working with ACC and residential care sector to implement the Falls Prevention programme<br>• Promotion of physical activity in the older person |
| 4. **Promote intersectoral collaboration on housing and transport** by<br>• Developing opportunities to create 'older friendly' and non-disabling environments and housing with Housing New Zealand, District and City Councils, and other agencies<br>• Continuing to work with other agencies to promote the availability of supported housing options across the district<br>• Ensuring that older people are aware of existing support options for transport assistance, including subsidised taxi fares, mobility taxis and volunteer drivers |

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| **5. Reduce social isolation caused by continence issues** by<br>• Ensuring access to continence diagnosis, treatment and support<br>• Working with District and City Councils to ensure access to public toilets |
| **6. Collaborate with the local Chinese community, through the Chinese Positive Ageing project** by<br>• Evaluating current support service provision for older Chinese people and identifying further developments<br>• Reviewing information services for older Chinese People<br>• Developing and establishing culturally appropriate, integrated health and disability support services for older people |
| **7. Develop and implement guidelines for DHBs on health and disability support service needs of ethnic minority communities** by<br>• Identify current service gaps and identify service models to meet support for ethnic minorities<br>• Reviewing access to information and translation services for older people of ethnic minorities |

## OUTCOME 3 - REDUCE THE INCIDENCE AND IMPACT OF PRIORITY CONDITIONS

CMDHB has identified the following priority conditions for focus as they are the leading causes of death and illness for our population, and particularly for Maori and Pacific people in Counties Manukau. Strengthened delivery of primary and community-based care, and improved linkage to specialist services are key to reducing the adverse impact of these and associated conditions, and reducing reliance on hospital-based care:

- Diabetes, Cardiovascular disease, Chronic respiratory disease, Cancer, Mental health.

Priority conditions specific to older people also include:

- Total joint replacement, Cataracts, Conditions requiring podiatry care, Dental, Vision, Hearing

| **CMDHB aims to:** |
|---|
| 1. **Implement guidelines for comprehensive integrated assessment treatment for older people and their carers** by<br>• Ensuring older people are assessed for, and can access, care for HOP priority conditions, e.g elective surgery, disability support services<br>• Develop and implement cultural component in all clinical and support needs assessment and care planning.<br>• Ensuring that older people have access to key CMDHB personal health initiatives, eg Primary Options for Acute Care, Chronic Care Management programmes, Lets Beat Diabetes, LotuMoui. |
| 2. **Review access to CM DHB specialist mental health services for older people** by<br>• Reviewing mental health services for older people to streamline the access/referral/service provision and support process<br>• Evaluating the need for local provision of psycho-geriatric residential care. |
| 3. **Prepare a service development plan for older people with dementia and ther carers** by<br>• Developing support services for family/whanau and others caring for those with dementia<br>• Developing and enhancing day care services for people with dementia<br>• Develop Maori and Pacific cultural appropriate day care services for people with dementia |

## OUTCOME 4 - REDUCE HEALTH INEQUALITIES

A key indicator of health status is life expectancy at birth. People living in Counties Manukau can on average expect to live one year less than the rest of New Zealand based on this measure. Maori people living in Counties Manukau have a life expectancy at birth 8 years less than their European and Other counterparts, and for Pacific peoples in Counties Manukau the difference is 5 years. Other groups with high health needs include refugees and migrants and those living in areas of high deprivation (deciles 9 and 10). CMDHB will strive to lift life expectancy for our people to the level enjoyed by the rest of New Zealand.

| **CMDHB aims to:** |
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| **1. Work with local iwi and Maori communities to establish culturally appropriate, integrated health and disability support services for Older Maori people** by<br>· Developing a mechanism to enable inclusion of appropriate Kaumatua and Kuia in priority service development areas.<br>· Evaluating support services provided by individual Maori and Service providers for older Maori people, and their future development and potential |
| **2. Develop a range of support service providers to give older Maori and their whanau a choice of culturally appropriate providers** by<br>· Developing culturally responsive services for Maori<br>· Evaluating and improving the cultural practices of contracted service providers<br>· Developing cultural support for the DHB provider arm's community based rehabilitation team |
| **3. Facilitate the development of health advocacy structures for older Maori** by<br>· reviewing and developing specific advocacy and information services for older Maori<br>· establishing a whanau education package to assist in the integration of kuia/ kaumatua back into the whanau<br>· developing an assessment tool to indicate the ability of whanau to assist in the care of kuia/ kaumatua |
| **4. Plan for Pacific and mainstream health and disability support services to meet the needs of older Pacific people and their families** by<br>· Evaluating current support service provision for older Pacific people, and identifying future requirements<br>· Reviewing information services for older Pacific people |
| **5. Facilitate the development of health advocacy structures for older Pacific people** by<br>· Reviewing and developing specific advocacy and information services for older Pacific people |

## OUTCOME 5 - IMPROVE HEALTH SECTOR RESPONSIVENESS TO INDIVIDUAL AND FAMILY/WHANAU NEED

Health services must be available when people need them. This applies to the services people most commonly use – primary and community health care – and to those hospital and specialist services that must be there for those less frequent occasions when a major health event occurs. CMDHB is committed to improve our people's access to timely and appropriate services.

**CMDHB aims to:**

1. **Make appropriate information about health and support programmes and services easily available and accessible to older people, carers , family and service providers** by
   - Evaluating and developing links between PHOs and secondary care to allow access to specialist health and support services for older people
   - Ensuring PHOs have knowledge of the NASC agency, support services and eligibility criteria, and have a means of delivering this information to those who require a needs assessment
   - Building awareness of Webhealth and Healthpoint
   - Building awareness of the Health and Disability Advocacy Service
   - Evaluate the Franklin Integration Project and implement it across the whole district as appropriate
   - Extending the volunteer transport support system throughout wider areas of Counties Manukau
   - Extending local specialist clinics to Franklin sites
   - Instigating a regular visiting primary care service to rural and isolated areas
2. **Involve older people, and their families/whanau and carers where appropriate, in service planning and decisions about their care and support** by
   - Developing structures for regular input from consumers to ensure consumer and community participation in planning and service review
   - Work with the CMDHB Community Panel in planning and service review
   - Ensuring that membership of DHB's Community & Public Health Advisory Committee (CPHAC) reflects the older population
3. **In conjunction with service providers, foster and model positive attitudes to ageing and older people** by
   - Identifying and developing initiatives that promote the *Positive Ageing Strategy* intentions within Counties Manukau.
   - Working with PHOs, other local organisations and government agencies to promote the *Positive Ageing Strategy*

| |
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| intentions.<br>• Developing further community support through the Franklin Integration Project<br>• Investigating improvement of the coverage of information for older people who are at risk of elder abuse |
| **4. Work with primary and community health providers to reinforce their roles in health improvement and collaboration with public health promotion programmes** by<br>• To develop a HOP health promotion strategy<br>• Provide health promotion workshops across Counties Manukau |
| **5. Facilitate work by service providers to assess and develop active approaches to care management** by<br>• Evaluating the use of flexible funding to enable service developments that increase coordinated community support<br>• Commencing planning for the implementation of national work regarding the development of a standard assessment tool for older people, including the work to pilot and adapt the InterRAI tool<br>• Piloting and evaluating PHO based case management for people with high and complex needs in Franklin |
| **6. Provide quality, age and cultural appropriate care and treatment for older people** by<br>• Ensuring hospital and community patient care plans are adjusted to acknowledge a normal ageing process<br>• Increasing gerontological knowledge and clinical contribution in secondary care health services<br>• Developing mechanisms to support the safe use of medications by older people, eg regime, education, packaging<br>• Ensuring elective surgery funding to address waiting times incorporates consideration of older people's needs<br>• Ensure clinical and care information is uncomplicated and in language appropriate for service users |
| **7. Assess options for intermediate level care to bridge the gap between hospital and home based care** by<br>• Developing the NASC service and processes for post acute care<br>• Development of case management for people with high and complex needs<br>• Implement recommendations of CMDHB stroke guidelines review report 2005<br>• Completing the establishment of the community based rehabilitation team and evaluate outcomes<br>• Implement the recommendations of the CMDHB HBSS report 2005. |

## OUTCOME 6 - IMPROVE THE CAPACITY OF THE HEALTH SECTOR TO DELIVER QUALITY SERVICES

The people who work in the health sector are the DHBs biggest and most valued resource. To be successful, CMDHB must attract and retain health professionals by fostering an environment which is supportive of effective service delivery. The key ingredient of the environment is the infrastructure which supports health professionals, including the facilities, information systems, quality systems and processes, and workforce development activities.

| **CMDHB aims to:** |
|---|
| 1. **Develop a range of health and disability support services to provide flexible, coordinated support for older people to age in place** by<br>• Ensuring appropriate support services are available on hospital discharge and that arrangements are reviewed as the person recovers<br>• Investigating the development of a greater range of carer support options, including development of formal and informal care |
| 2. **Develop mechanisms to ensure continuity of service between DHB and ACC-funded services** by<br>• Developing and implementing quality and audit frameworks for service providers<br>Ensuring all providers have an active complaints system and monitor use of this as part of regular visits to providers |
| 3. **Facilitate smooth access to palliative care** by<br>• Developing a Counties Manukau Palliative Care Plan for older people in long term care<br>To ensure age and cultural appropriateness in the provision of palliative care |
| 4. **Enable long term support providers in community and residential care to build opportunities for appropriate health promotion, disability prevention and rehabilitation** by<br>• Developing a restorative model of services provision<br>• Further developing the model of interim care provision, ie ortho-geriatric service development<br>• Developing a quick response model to access community supports |
| 5. **Work with providers to establish and apply a process for collecting reliable data to forecast future need for services, and plan supply of services to match need** by<br>• Developing a 'service mix' model<br>• Establishing a regular reporting from the existing residential care providers' report on utilisation |

6. **Implement a planned approach to strengthening the health workforce to meet the needs of an ageing population** by
   - Developing and increasing the skill, size and range of the HOP workforce, with emphasis on community services
   - Prioritising workforce development for home based support services caregivers
   - Encourage Maori and Pacific people and people from ethnic minorities to join CMDHB or the wider health and support services in the district
   - Increasing the gerontology knowledge of the workforce

# APPENDIX

## APPENDIX ONE - FEEDBACK FROM THE COMMUNITY

To gather feedback on the CMDHB Draft Plan for Implementation of Health of Older People Strategy 2005, public consultation forums were held across the Counties Manukau region in November 2004 and between November 2005 and February 2006. Forums included general, Maori and Pacific Island specific, and for service providers. Written and verbal feedback also received from several sources.

Key themes from the consultation discussions and how they have been incorporated in the Plan are as follows:

| **Feedback** | **How it has been incorporated in the Plan** |
|---|---|
| Nutrition | Healthy Eating – Healthy Action Strategic Framework included in Health Sector strategic inputs |
| Social isolation | Included in:<br>Outcome 1.2 Enabling and supporting families<br>Outcome 1.5: Continence issues<br>Outcome 5.1: Establish a communication system |
| Information dissemination for consumers, family/whanau and carers | Included in:<br>Outcome 5.1: Establish a communication system |
| Continence | Included in:<br>Outcome 1.5: Continence issues |
| Ageism | Included in:<br>Outcome 5.5: Foster and model attitudes to ageing |
| Medication | Included in:<br>Outcome 5.9: Provide quality, age appropriate care and treatment |
| Priority conditions | Explanation included in Outcome 3 |
| Workforce development – staffing and skill mix | Included in:<br>Outcome 6.6: Strengthening the health workforce |
| Need to develop more flexible styles of care – including mechanisms to support HBSS | Included in:<br>Outcome 5.6: Assess and develop active approaches to care management<br>Outcome 6.1: Provide flexible, coordinated support |
| Advocacy services | Included in:<br>Outcome 4.3 Health advocacy structures for older Maori<br>Outcome 4.5 Health advocacy structures for older Pacific Island people<br>Outcome 5.1 Appropriate information<br>Outcome 5.4 Foster and model positive attitudes |
| Ethnic minority service developments | Outcome 4.6 Support service provision for older Chinese people |

# APPENDIX TWO – Health of Older People in Counties Manukau, Population Health Needs Analysis 2006:

## Key themes – challenges and opportunities for health gain

This report presents a range of key indicators of the demographic profile and health of Counties Manukau adults aged 65 years and over.

A summary of the key findings from each section follows. The potential implications for health planning to maximise health gain for older people living in CMDHB are discussed.

**Demographic changes**

**Increasing numbers and relative proportion of the 65 year and above age group**

CMDHB currently has a youthful population relative to other NZ DHBs, with the lowest proportion of its population aged 65 years and over (8.9% in CM vs. 12% nationally). However, it has the fifth largest absolute numbers of adults aged 65 years and over, with a diverse ethnic and socioeconomic mix.

Based on Statistics NZ medium growth assumptions, the CMDHB population is predicted to increase between 2001 and 2026 by 50% overall, equating to some 589,000 people. The largest proportional increase is evident in the over 65 year age group, with an increase of over 170% from 33,800 to 92,000 people in this time period. These increases are driven by increasing life expectancies and changing migration patterns.

In the next 10 years the baby boomer cohort will start reaching retirement age. This group is on average healthier than its predecessors and as such it is anticipated the largest impact on health service demand will be not be seen until around 2030 when this age group reaches their 80s. However the impact of the growing obesity epidemic on subsequent cohorts when they reach older age is less certain.

**Persisting gender imbalance**

The average life expectancy of females exceeds that of men, leading to a preponderance of older females. This is projected to persist through to 2026 and beyond.

**Increasing ethnic diversity**

In Counties Manukau in 2004, Māori are estimated to comprise 5% of the population 65+, followed by Asian 8%, Pacific 9% and Others 78%. CMDHB can anticipate increasing diversity of its older population, in part reflecting increasing life expectancy of Māori and Pacific peoples and recent migration patterns. The fastest growth will be seen in the proportion of the older population identifying as Asian, followed by Māori, Pacific and then Other. There are clear ethnic disparities in socioeconomic status within the CM region. The overall pattern is persistent across all age bands, with Pacific, followed by Māori, and then Others (here referring to all non-Māori, non-Pacific) residing in the areas with lowest socioeconomic status as defined by NZDep01.

**Changing societal norms**

There is evidence that societal norms are changing, with people marrying later and having fewer children, being more likely to separate and live alone and more likely that their wider family will be geographically dispersed. Thus smaller more mobile families mean fewer older people will be able to rely on their children as care-givers.

This trend is compounded by the pattern of increasing labour force participation of both traditional family and informal caregivers and also amongst people aged 65 and over themselves, thus placing

pressure on family and informal support networks for older people, reducing those available for volunteer work and unpaid care giving.

**Adding years to life**

Overall the older population in CM has a life expectancy (LE) close to the NZ average, but marginally below that for neighbouring Auckland and Waitemata DHBs. In CM, females at age 65 at current age-specific mortality rates may expect to live a further 20 years, equating to 3.2 additional years above that for a similarly aged CM male (at 16.8 years). Ethnic disparities in LE persist for LE at age 65 years, with Māori or Pacific males aged 65 expected on average to live 3 years less than non-Māori, non-Pacific males and Māori females to live between 3.3 - 3.7 years less than for Pacific and non-Māori, non-Pacific females respectively.

In 2001 the Counties Manukau population aged 65 and over comprised 8.6% of the total Counties Manukau population, but accounted for 70% of the all deaths (1,507 out of 2,162). Mortality rates for the older CM population increase with age, and the rate of all cause mortality in CM is higher for males compared with females.

The four major causes of death across age groups and genders are cancer (all-cause), ischaemic heart disease (IHD), chronic obstructive respiratory disease (CORD), and cerebrovascular diseases. Approximately 60-69% of all deaths for CM adults aged 65 years and over are categorised as 'potentially avoidable' or PAM. The leading causes of PAM include IHD, CORD, stroke, lung and colorectal cancer and diabetes – all amenable to population-based primordial, primary and secondary prevention strategies.

**Adding life to years**

Comparing age-standardised hospitalisation rates across DHBs, Counties Manukau has higher rates of admission compared to Auckland, Waitemata, and NZ as a total, and lower rates than Northland for all age groups.

In CM, approximately 31% of all hospitalisations and 42% of all inpatient bed days for adults with medical or surgical conditions in 2004 were for adults aged 65 years and over. Hospitalisation rates increase with age amongst the 65+ year old cohort. Males have consistently higher rates of hospitalisation for all the older age groups. There is considerable variation in hospitalisation rates by ethnic group for older adults. The highest rates of hospitalisation in 2004 in CM were for Maori, followed by Pacific, Other and Asian peoples.

Of the total number of hospitalisations for adults aged 65+ between 36% - 41% would be considered potentially avoidable. The leading causes of potentially avoidable hospitalisation for this age group include those for IHD, CORD, diabetes, congestive heart failure, and stroke. Creating socio-economic, socio- cultural and physical environments that favour prevention of smoking, improvements in nutrition and physical activity and facilitate timely access to quality primary care throughout the life course are needed to address these leading potentially amenable causes of morbidity and to not exacerbate gender and ethnic disparities.

There is considerable ongoing debate in the literature about whether increasing life expectancy leading to largely healthy populations will compress ill health and disability into the last few years of life. The obesity epidemic and associated increase in diabetes and its complications are likely to increasingly influence the health of older people, with resulting increases in experience of disability and demand for services.

**Māori and Pacific experience a greater burden of disease and thus have the greatest potential for health gain**.

A disproportionate burden of morbidity and mortality is seen for Maori and Pacific in CM across the life course. This is likely to partially reflect intergenerational effects of inequality in distribution of the determinants of health, and differential access to and through health services.

**Address the underlying structural determinants of lifestyle behaviours – avoid victim blaming**

Healthy lifestyles throughout the life course are advocated. It is important to recognise the underlying socio-economic, socio-cultural and environmental structural determinants of these lifestyle patterns. Intersectoral population-based and targeted strategies are needed for primordial and primary prevention of the main disease burdens on our older population, namely cardiovascular, respiratory, musculoskeletal diseases, injury and cancers. There is good evidence that keeping physically active can reduce the likelihood or slow progression of these main illnesses, reduce fall related injuries and promote social interaction and protect mental health. Physical environments that enable mobility (walking, safe and accessible public and/or private transport) and permit regular communication and social contact are thus important. The development at Flat Bush is one example of a planned enabling physical environment.

**Tobacco exposure**

While the proportion of the older NZ population who smoke is likely to be declining (with the WWII cohort the peak), there is ongoing evidence of the differential exposure to tobacco throughout the life course manifest through cancer (in particular lung, throat, colorectal), cardiovascular and respiratory disease incidence and prevalence.

**Keeping physically active and maintaining optimal nutrition**

Many older New Zealanders have low levels of physical activity, with an estimated 26% of those aged 75 years and over sedentary. Maintaining physical activity has am important role in diabetes, CHD, respiratory disease, and fall prevention. It has additional benefits on mental health. Under nutrition is as big an issue as over-nutrition (obesity) in this age group.

**Housing has important role in assisting older people to age in place**

Housing is also an important mediator of the ability to maintain health and age in place. Home ownership is typically higher in the older population. However with increasing life expectancy and longer periods spent experiencing disability the pressure on existing residential care beds will be exponential. Thus the importance of developing housing interventions and a range of appropriate and acceptable housing options in conjunction with policies for health and social services for an ageing population is pivotal.

**Use of selected health services**

The older population are high users of health services. However in terms of demand on health service expenditure, demand is not related as strongly to age per say as to chronic illness and disability and to the last year of life.

**Primary Care**

The older population are more likely to have consulted a GP in the previous 12 months and more likely to have a higher frequency of visits annually (with exception of females in reproductive age range) than the under 65 year old population. The most common problems of people aged 65 years and over managed in general practice, by disease group, were cardiovascular, respiratory and musculoskeletal. The reported unmet need to see a GP is lower for the older age groups. In CMDHB there are 8 PHOs and the over 65 population comprise approximately 8% of the enrolled population (marginally less than the approximately 8.9% proportion of the total population). Currently, there are no CM PHO Health Promotion Plans that specifically target older people. However, several Health Promotion projects underway that have the capacity to benefit older people include the Walking Bus Programmes (exercise, social interaction, and increasing connectivity with community) and those with an explicit focus on increasing physical activity and healthy nutrition. There is potential for expansion of the role of PHOs in health promotion over the life course but also targeted at the older population.

**Health sector challenges**

1. workforce capacity,
2. technological advances,
3. managing consumer and provider expectations,
4. information limitations,
5. the right mix of residential vs home care support
6. meeting the growing demand for community-based disability support services and residential care

A key challenge, well recognised by the sector, is that of workforce capacity. Literature highlights need for: (1) more practitioners (2) more specialist services to deal with age-associated conditions such as cataracts and hip replacements (3) more expertise in older people's health due to prevalence of chronic and multiple co-morbidities (4) more support services for older people. Securing and retention of carers/care-assistants for home-based support and residential services is particularly problematic due to a lack of career progression, minimal wages, and often difficult working conditions including unfavourable working hours. This also raises the question of quality of care provided given lack of industry structure and regulations and high staff turnover.

With the increasing diversity of our older population the need for Māori and Pacific specific services will increase. Support should be given to both ethnic specific services and also ensuring mainstream services are responsive and accountable for Māori and Pacific health gain. The demographic trends will drive the need for innovative approaches to provide residential care and home support services. A key challenge for both the Ministry and DHB will be to manage both community and provider expectations.

Technological advances are major drivers of health expenditure. Expected increases in the range of treatments that are available and increased people's expectations to access to these services are likely. Technological advances also have the potential to change patterns of morbidity in future cohorts.

**Summary**

The profile provided illustrates the diversity of the current cohort of people aged 65 years and over. In general the current CM older population has life expectancy and mortality rates similar to overall NZ figures, but slightly below those for Auckland and Waitemata. Hospitalisation rates tend to be higher, particularly for IHD and diabetes.

The outlook for CMDHB older persons is very positive. It is anticipated that the population aged 65 years and over will live longer and be increasingly characterised by ongoing independence, continued participation in work, home and community, and health for a longer proportion of their older age than their predecessors. The increasing numbers of older people aged 85 years and over, increasing numbers of Asian, Maori and Pacific peoples, the high proportion of women in older age and likely increase in demand on health services are principal policy considerations for CM.

There is considerable scope for health gain and this data will help to inform the local HOP strategy to best meet the current and projected CM older population health

The needs assessment for older people has been compiled for CMDHB and is available on www.cmdhb.org.nz