NORTHLAND DISTRICT HEALTH BOARD

Health of Older People

Strategic Action Plan 2008-2013

Acknowledgements

Northland DHB acknowledges the significant contributions of those who have contributed to the vision and direction of the Health of Older People Strategy, and for their dedication to achieving positive ageing for Northland's senior citizens, Kaumatua and Kuia.

Northland DHB recognises the contribution of Dr Jill Calveley (QSM) who in 2005/06, supported Northland's Health of Older People Sector, communities and consumers to communicate what was important and to set priorities in each of Northland's four regions. This formed a solid platform for the HOP projects and pilot programmes implemented over the last two year period, which have been focused on redesigning and realigning current and future services for older people across Northland.

Northland DHB acknowledges the following key contributors:

Dr Matthew Parsons and the Research Team, Auckland UniServices

John Baird, Project Support

Northland DHB Provider secondary/ community services

Ministry of Social Development (MSD) Northland Region.

Mid Central DHB, Primary Health Team.

Age Concern, Whangarei, Mid North and Far North Officers.

Northland DHB's valued HBSS, Age Related Residential Care (ARRC), Disability Support, Palliative Care and PHO providers.

Northland's community agencies and fieldworkers.

Kaumatua / Kuia Strategic Reference Group (2003-2006)

The Northland DHB Health of Older People Strategic Action Plan (2008) was developed by:

Portfolio Manager, Health of Older People, DSS and Palliative Care, Service Development and Funding, NDHB

Te Tai Tokerau MAPO

Health Planner, Service Development and Funding, NDHB

Project Manager, Chronic Diseases, Service Development and Funding, NDHB.

Mihi

Tihewa mauri ora ki te whei ao ki te ao marama. Ko te wehi ki a Ihowa, koia tena te timatanga o te matauranga me te whakaaro nui.

Tena koutou I o tatou tini mate, no reira I nga mate haere, haere, haere atu ra.

Hoki mai ki a tatou katoa, nga waihotanga i o ratou ma, tena koutou, tena koutou, tena koutou katoa.

Ka mihi atu ki nga kaiwhakahaere o tenei kaupapa hohonu, e pa ana ki te hauora i o tatou kaha kaumatua.

Kei a ratou te matauranga me nga tikanga I tuku iho, I o tatou maatua tupuna, hei tohutohu I a matou.

Ma te Atua e arahi e awhinatia I o koutou mahi rangatira.

Mauriora!

Table of Contents

Executive summary **1**

PART A: NEEDS ASSESSMENT **6**

1 Introduction **8**
1.1 Aim of the plan 8
1.2 How the plan was developed 8
1.3 What is ageing anyway? 9
1.4 So why do we need a Health of Older People Strategy? 12
1.4.1 The issues 12
1.4.2 The solutions 13
1.4.3 Anticipating the changes this strategy will bring 14
1.5 Policy framework 16
1.5.1 New Zealand Positive Ageing Strategy 2001 16
1.5.2 New Zealand Health of Older People Strategy 2002 16
1.5.3 The Primary Health Care Strategy 17
1.5.4 Northland DHB strategies 18
1.5.5 An integrated approach 18
1.5.6 Population based service planning 19

2 Older people's demographic characteristics and health related needs **21**
2.1 Population characteristics 21
2.1.1 Ethnicity 21
2.1.2 Population projections 22
2.1.3 Regional trends 24
2.1.4 Deprivation 26
2.2 Health risk and protective factors 26
2.3 Health status 27

3 Stocktake and gap analysis **29**
3.1 Specialist Disability Support Services 29
3.2 Health of Older People Services 29
3.2.1 Contracted services budget 29
3.2.2 Needs Assessment and Service Coordination (NASC) 30
3.2.3 Carer support (for the carer) 30
3.2.4 Day care 30
3.2.5 Respite care (for the client) 30
3.2.6 Home Based Support Services (HBSS) 31
3.2.7 Aged Related Residential Care (ARRC) 32
3.2.8 Care and support for people with dementia and their carers 33
3.2.9 Services for Kaumatua and Kuia 34
3.2.10 Kaupapa Maori Research Project 35
3.3 Service delivery issues 36
3.3.1 Workforce 36
3.3.2 Decision support and quality monitoring systems 37
3.4 General health services needs for older people 37
3.4.1 Pharmaceuticals 37
3.4.2 Meeting the needs of people with chronic conditions 38
3.4.3 Palliative care services 39
3.5 Projected Aged Related Residential Care capacity 39
3.5.1 Aged Related Residential Care beds 39
3.5.2 Dementia care beds 41
3.6 Summary of what Northland is doing well 41
3.7 Summary of gaps and issues 42

3.7.1 Non-existent services or limited access to services 42
3.7.2 Gaps in the level and location of services available, including equity of access and timeliness 42
3.7.3 A gap in access to service due to the historical funding model for NGOs, community and specialist services....43
3.7.4 Receiving a good quality and client centred service....43

PART B: STRATEGIC ACTION PLAN 44

4 Guiding principles 46
4.1 Treaty of Waitangi 46
4.2 Whanau Ora 46
4.3 Reducing inequalities....46
4.3.1 Inequalities for Maori 47
4.3.2 Inequalities related to age....47

5 Vision and goals 49
5.1 Ten year vision 49
5.2 Goals....49

6 Implementing the plan.... 50
6.1 Working in partnership....50
6.2 Reorienting the historical purchase model to a restorative model of care....50
6.3 Evaluation, monitoring and review 50

7 Strategic implementation plan 52
Goal 1 Develop sustainable health promoting communities....53
Goal 2 Develop and fund integrated continuum of care for older people in all regions of Northland 55
Goal 3 Develop and fund specialist in-reach dementia services in Northland 57
Goal 4 Develop community based Kaupapa Maori services for Kaumatua and Kuia 59
Goal 5 Develop Health of Older People, and Disability Support Services' workforce capacity and capability to meet Northland's population and health needs....60
Goal 6 Deliver quality services, 're-tooled' patient information flows, connected IT, and evaluate the impact of service enhancements 61

Bibliography.... 62

Glossary 63

Appendix 1 Summary of stakeholder workshops 67

Appendix 2 Population projections for 85+ 76

Appendix 3 Contracted Disability Support Services 77

Appendix 4 ARRC beds by area, Jan. 2008 78

Appendix 5 Projected ARRC beds under the 'do nothing' scenario 79
ARRC beds 79
Dementia beds 80

Appendix 6 Summary of comparisons from *Older People's Chart Book* 81

Appendix 7 Pilot studies currently underway in Northland 84

Appendix 8 The Reducing Inequalities Framework and Health Equity Assessment Tool (HEAT).... 86

Executive summary

Northland DHB's vision for health of older people is that by 2016 in Northland:

> The longevity gap between Maori and non Maori will be significantly reduced.
>
> All older people in Northland will be living long meaningful lives and able to complete their lives with dignity.

The aim of the Northland DHB's *Health of Older Persons Strategic Action Plan* is to set the strategic priorities for the five year period 2008-2013. The strategy will guide us in the achievement of equitable access to quality Health of Older People primary, secondary and community services, that are responsive to the changing needs of all older people, their family, carers and whanau across Northland.

Consultation

An extensive consultation process occurred in 2005. This led to the establishment in 2006 of several funder-led projects to pilot and promote new ideas of service provision. The information gained during consultation and from the pilot projects was used to develop a draft Strategic Action Plan. This was sent out to stakeholders whose feedback was used to help revise and improve the plan. Information gained from stakeholders was invaluable in assembling the stocktake and gap analysis of services in this plan.

To engage with Maori the Kaumatua / Kuia Strategic Reference group was established in 2003. This was to enable feedback and involvement in the planning process of health and disability service needs, achieve a level of integration into support services, improve access to services and act as a point of information dissemination.

The need for change

There are two key factors driving change.

The first is the need to restructure services for older people. At the moment there is a significant mismatch between needs and services provided. As a result, inequities abound and pressures on funding are ever increasing. A more planned approach will enable needs to be better met and encourage more flexibility and innovativion in service delivery. It will raise service quality and improve equity of access according to ethnicity, geography and assessed level of need.

The second factor is the expanding older population. For a few years, until perhaps 2016, the main increase in the 65+ population will come in the 65-74 year group as the baby boomers age, and while it is expected that they will be relatively fit and healthy, the numbers involved are large. Beyond that time, into the 2020s, the numbers of 'older old' (those over 85) will increase significantly.

We cannot afford to "do nothing". If service trends continue unchecked, Northland will be faced with ever-increasing numbers of older people with ever-higher needs in hospitals, residential care and the community.

Two phases

The strategy has two phases:

- Phase 1, the main focus of this strategy, is to better manage the provision of services and their associated funding, as suggested above.
- In Phase 2, the focus will shift to improving the health of the older population. The long-term aim is to dispense with the current fixation on providing services to people because they are old (or perceived as old), and move towards a system which deals with people primarily according to need, not age. Gaining control over funding and services in Phase 1 will in enable a more planned approach in Phase 2. This will include raising the quality of services and making access to services more equitable (according to ethnicity, geography and assessed level of need).

Philosophical shift

The strategy argues for a philosophical shift over time. We need to abandon the idea of ageing as a problem in itself, because by and large the needs of older people do not differ from those of other age groups in the population. At the moment though, we need a strategy for older people because funding streams and service contracts are organised under that heading, and because of the growing pressures on that funding.

"Like in interest and age" and needs of Maori

The strategy addresses not just people aged 65 and over, but those "like in interest and age", those under 65 but whose health or disability support needs have been assessed as if they were 65 years or older. This applies more often to Maori, because proportionally more Maori acquire chronic conditions and age-related diseases at younger ages. For Maori, the 65+ age threshold is not appropriate and a flexible approach has to be taken when planning and funding Health of Older People services for them.

Two types of inequality in service provision affect Maori:

- Kaupapa Maori-specific services to meet the early onset of age-related conditions have not been developed
- remote rural areas, which typically have a higher proportion of Maori, have the poorest access to services such as home based support services, respite and day care.

Links with other NDHB strategies

The health of older people will be improved significantly if we reduce the prevalence and impacts of chronic conditions. NDHB's strategies on Maori health, public health, diabetes, cardiovascular disease, cancer control and palliative care are addressing these, and close links between those strategies and this one need to be established and maintained.

The *Te Tai Tokerau Maori Health Strategic Plan 2008-2013* and the *Te Tai Tokerau Strategic Public Health Plan 2008-2011* will be vital in developing healthy environments and communities, facilitating positive ageing, maintaining health and independence, enhancing social inclusiveness, and allowing older people to contribute to society for longer.

National priorities

The Ministry of Health's 2007/08 priorities were:

- community based services
- assessment
- workforce

The current Minister of Health added:

- linkages to primary health care
- strengthening the mental health / dementia care review
- quality and safety

Implementing Phase 1

Northland DHB's phase 1 (immediate) priorities are:

- Establish primary health service co-ordination service (SCOPE) for older people, including kaumatua and kuia, living in the community to support and maintain their independence, reduce their frailty, and functional and social decline.
- Pilot and develop community clinical pharmacy services.
- Implement a restorative model for home based support and community services (including developing appropriate service design and processes for Maori and developing NASC capacity and capability).
- Participate in the national DHB benchmarking programme to monitor Northland's performance against key restorative home based support performance indicators.
- Implement a clinical/ restorative pathway for respite care in designated Aged Residential Care Services
- Review frail elderly and dementia day care service specifications and associated contract prices.
- Contract for residential aged care capacity based on demographic trends in Northland and the impact of service changes in primary and secondary services resulting from the pilots currently being undertaken
- Establish a dedicated dementia service framework and clinical pathways.
- Provide access to specialist hospital, residential and respite care bed days within Northland for: comprehensive specialist assessment, diagnosis, hospital and treatment services; secure residential placement; respite care.
- Improve access to dedicated specialist dementia day care services.
- Engage a Maori specific researcher to carry out Kaupapa Maori research investigating community based residential care and day care services for Maori.
- Complete agreed research activities.
- Implement a planned approach to strengthening the development of HOP and disability support workforce.
- Develop data systems to integrate patient assessment, information and service utilisation data.

Essential to Phase 1 is dealing with issues regarding workforce, assessment and information systems. The workforce must be of sufficient number, stable, cover all areas of service provision, willing to innovate and adapt, and able to meet professional, legislative and best practice requirements. Making available complete and timely data on patients and services would make a distinct difference to the quality of assessment, advice and care planning. It would also support sustainable and consistent planning and service provision.

Solving current issues in provision of services for older people must involve:

- working intersectorally
- acknowledging the critical importance of informal carers
- recognising that ageing baby boomers may be more assertive and demanding

- keeping people healthy, active, independent and contributing to society for longer.

The following goals, each of which has been developed into a detailed high-level plan, address the gaps and issues identified during the planning process:

Goal 1 Develop sustainable health-promoting communities.

Goal 2 Develop and fund an integrated continuum of care for older people in all regions of Northland.

Goal 3 Develop and fund specialist in-reach dementia services in Northland.

Goal 4 Develop community-based Kaupapa Maori services for Kaumatua and Kuia.

Goal 5 Develop Health of Older People and disability services' workforce capacity and capability to meet Northland's population and health needs.

Goal 6 Deliver quality services, 're-tooled' patient information flows, connected IT, and evaluate the impact of service enhancements.

PART A:
NEEDS
ASSESSMENT

1 Introduction

1.1 Aim of the plan

The aim of the Northland District Health Board's Health of Older Persons Strategic Action Plan is to set the strategic priorities for the five year period 2008-2013. The strategy will guide us in the achievement of equitable access to quality Health of Older People primary, secondary and community services, that are responsive to the changing needs of all older people, their family, carers and whanau across Northland.

1.2 How the plan was developed

The consultation process commenced in 2005. Four regional focus group meetings were held throughout Northland in 2005/06, with key stakeholders including consumer representatives, including the Kaumatua and Kuia Strategic Reference Group. The purpose of the meetings was to update information and priorities from a stakeholder perspective. Participants in each group completed SWOT (strengths, weaknesses, opportunities and threats) and gap analyses, and identified issues and specific priorities for their communities. In addition to this, two workshops were held to establish the priorities within dementia care and home health monitoring. A summary of the feedback from each region and workshop is contained in Appendix 1.

Based on this feedback, Northland DHB funder-led projects commenced in October 2006 to review and redesign current service provision and to improve access to primary and community services. These projects were designed to promote and pilot:

- A restorative model of service delivery for Home Based Support Services (HBSS) including all community providers, contracted HBSS providers and iwi based services which assist older people to remain in their homes.
- An industry partnership with the Ministry of Social Development (MSD), to raise the profile and employment conditions within the HBSS sector, establishing a sustainable workforce development plan. This has now been extended into the Aged Related Residential Care sector, who are seeking to establish a pool of staff available to work in both residential care and HBSS.
- The recruitment and retention of MSD clients returning to the workforce including young Maori.
- Consultation with NorthTec to align sustainable service development through accessible education and training across Northland.
- Nine priority actions to be included in the planning process, to improve access to dementia care and support services.
- A Primary Contact and Service Coordination Service, is currently being piloted within two PHOs/ general practices to support older people to remain independent in their community.
- Access to community based clinical pharmacy services to support well elderly to stay well and remain in their own homes and communities of choice.
- A clinical and restorative pathway for respite care with an emphasis on reducing carer stress, improving the options for carer relief and supporting carers to maintain their own health and wellbeing.
- Rest home liaison and discharge/ admission pathways to secondary services (led by NDHB Chronic and Complex Care Service).

From this information a draft Strategic Action Plan was completed and peer reviewed by external and internal stakeholders including consumers. The Strategic Action Plan was revised, and planning and funding priorities set within the goals and objectives contained in section 7 of this document. Feedback from stakeholders was used to assemble the stocktake and gap analysis contained in section 3 of this document.

1.3 What is ageing anyway?

The official definition

For the purposes of funding and planning within District Health Boards, an older person is defined as being:

- an individual over 65 years of age who is eligible under section 32 of the New Zealand Public Health and Disability Act 2000
- or 'like in interest in age' where a person is under 65 but their health or disability support need is assessed as if they were 65 years or older.

Needs don't increase just because we get older

People's need for services seldom relates to their age alone, but is more a result of the impact of chronic disease and disability in the later years of life. Within Northland's older population, 86 percent are well and independent, and only 14 percent could be labelled as 'frail' because they access age related or disability support services. Although many people develop functional disabilities with increasing age (especially those aged over 85), most have also developed ways of coping with illness and incapacity from the wisdom and personal resourcefulness that comes from life experiences.

Large numbers of 'baby boomers' currently in their middle years already have, or will develop, chronic and progressive illness. To cope with the needs they pose as they age, Northland needs to develop and monitor flexible approaches to provision of services.

Subgroups within 'older people'

It is important to differentiate within the age groupings in the population of people over the age of 65 years. 'Older age' covers several cohorts and more than one generation of older people. In the analysis of statistical data from the 2001 census, Davey (2003) records differences across the age ranges of 60-74 years, 75-84 years and 85 years or more that reflect a decline in the capacity for independent living over the passage of time.[1]

Patterns of growth within the older population are not uniform (see details in section 2.1.2). The number of people in the 'younger old' 65-74 age group will grow in the next 20 years as the 'baby boomers' reach retirement age. It is anticipated that this age group is likely to be fitter and healthier than it has been in the past and be more assertive.

Very old people over the age of 85 are the fastest growing group in the older population and by 2051 could account for 25 percent of all older people in New Zealand.[2] A statistical review relating to this age group has concluded that they are distinctive as a group because of their special needs and their potential to make high demands on government expenditure.[3] People of advanced years are likely to have less wealth and be in poorer health than

[1] Davey J (2003). *Two Decades of Change in New Zealand: From birth to death).*
[2] Davey J and Gee S. (2002). *Life at 85 plus: A statistical review.*
[3] Ibid.

younger old people. Their expectations of life and support services may also differ. A recent English study found them to be more concerned about having their needs for food and nutrition met and less concerned about their need for social contacts than those under 85. Those people interviewed indicated that provided *"they did not feel totally isolated, they were prepared to put up with not seeing people as much as they would like"*. [4]

John Waldon's study *Oranga Kaumatua: Perception of Health in Older Maori People*[5] found that 'Kaumatua' is a functional term rather than an indication of age. The study also found that Kaumatua were crucial to the preservation of taonga (treasures for future generations) and that the the premature loss of Kaumatua was a risk to the health and wellbeing of Maori in society.

Waldon's study found that in the main, Maori interviewed saw older age as a time of increased opportunities to follow their own interests. Their main source of worry was their level of health and financial matters, and they were not overly concerned about accommodation, independence, personal mobility, transport or leisure time on Marae.

What is ageing, really?

Ageing is a socially constructed phenomenon which is conventionally marked by chronological age in years. Although the number of years lived is a convenient measure, it may not reflect biological ageing or social ageing (defined by changes in social and economic roles).[6] The timing of life events and their effects differ markedly among older people.

Arbitrarily imposed, rigid chronological markers create difficulties when life expectancy and onset of disability varies across ethnic groups. In high-need, deprived populations such as Northland's, higher levels of chronic illness and need for complex care are more prevalent among those younger than 50 years of age, creating service gaps and reduced access to funded health and disability support services. Maori and Pacific peoples, with their early onset of chronic disease and disability and lower life expectancy, are disadvantaged because eligibility for income and health entitlements associated with ageing is determined by an arbitrarily imposed entry line of 65 years.

Attitudes to ageing

Attitudes towards ageing are particularly important because they influence how we design services, and a commitment to investing in independence and wellness will reduce demands on health and disability services. Arbitrarily imposed chronological markers mould our perceptions of the ability of people to 'age in place', or stay in their communities of choice – once over 65 you may be deemed 'retired' or 'over the hill' and no longer a fully functioning member of society. In fact, within the over 65s, the younger and middle age cohorts are relatively fit and healthy and will create few extra demands; only the over 85s will require significantly more services and therefore engender more costs. Some myths about ageing are not supported by facts. There is a widely held belief, for example, that older people are higher users of emergency services, but NDHB data shows a decline since 2004 in

---

[4] Netten A., Ryan M., Smith P., Skatun D. et al. (2002) *The Development of a Measure of Social Care Outcome for Older People.*

[5] Waldon, J. (2004) *Oranga Kaumatua: Perceptions of Health in Older Maori People*. Ministry of Social Development, Social Policy Journal of New Zealand. Issue 23

[6] Armstrong, J (2002). *Grandmothers: Ethnic approaches to social ageing.* In S Gee (Ed) *Ageing in a diverse New Zealand/Aotearoa (*pp 49-54).

Emergency Department attendances among those aged over 65.

'Ageing in Place'

With the changing composition of the older population and greater recognition of people's health and social needs, many governments have been seeking ways to support wellbeing in later life. An approach that has been favoured in recent years is that of 'ageing in place' which promotes the ability of older people to remain living in their home and communities of choice whenever possible.[7] Smaller and more mobile families mean that fewer older people will be able to rely on children or family as nearby carers. With greater diversity in family types and ethnic groups, older people are looking for different living arrangements for themselves. Anecdotal evidence suggests that Maori come home to Northland from their mid fifties, returning to Marae and whanau responsibilities. Some are in poor health.

Research by the New Zealand Institute for Research on Ageing[8] indicates the complex and often cross-sectional factors that impact on an older person's ability to 'age in place', including:

- lack of access to a variety of housing options that take account of changing needs, changing support needs and income levels
- the inability to participate in the social domain, highlighting the need for access to transport
- loss of strong social and support networks, raising issues such as availability and accessibility of family and friends
- the reluctance or preparedness of older people to ask for help
- the management of bereavement and loss, and the importance of maintaining good mental health
- reduced access to church and spiritual networks, particularly for older Maori and Pacific people
- insufficient income or access to the range of benefits available to promote choice
- limited access to appropriate and individualised health and home-based services that are responsive to different degrees of fragility
- inconsistent support for carers with no dedicated carer assessment or service brokerage
- no formal inter-agency coordination.[9]

The importance of carers and managing isolation

Many people in New Zealand support a friend, family or whanau member to live with the dignity, independence and security which the rest of us take for granted. Carers often describe their role as being undervalued, unrecognised and with fewer opportunities to participate in work, education or social activity. Their informal caring role often sees their usual lifestyle and community participation altered for long periods of time leading to their own social dislocation, health risk and isolation.

Many carers are older people who, like anyone else, require planned time away from their caring and relationship responsibilities in order to maintain

[7] Ministry of Social Development, Office for Senior Citizens (2001). *The New Zealand Positive Ageing Strategy*.
[8] NZIRA (2005). *Ageing in Place. Issues Paper for Ministry of Social Development Centre for Social Research and Evaluation Working Group.*
[9] Ministry of Health, 2007. *Care and Support in the Community for Older People In New Zealand.* Issues Paper.

their own social networks and activities, and to attend to their own business, personal and health needs. This is distinct from the services dedicated to the person being cared for, such as respite care or carer support.

Social isolation is one of the most pervasive conditions of ageing. There is a two-way relationship between isolation and health, in that ill health can both cause and be caused by being isolated from others.[10]

Waldon's Oranga Kaumatua study showed that older Maori with a lower level of health and wellbeing were less likely to have any current involvement on Marae when compared with Older Maori showing high health status[11].

1.4 So why do we need a Health of Older People Strategy?

1.4.1 The issues

Why focus on older people?

The main message in section 1.3 is the need to abandon the idea of ageing as a problem in itself. Why then do we need to develop a strategy for older people?

Primarily because funding streams and service contracts are organised under that heading. There are growing pressures on that funding because:

- improvements are needed in the way services are structured and funding is provided
- the older population is not only growing faster than other age groups, but will itself increasingly age.

Timeframes: this strategy and the longer term

The main focus of this strategy is to better manage the provision of services and their associated funding. Action needs to occur now. If nothing changes, provision of services will become increasingly out of step with needs, and already significant inconsistencies and imbalances within services will only become more difficult to pull back. Gaining control over funding and services will enable a more planned approach in future, and raise the quality of services. It will also make access to services more equitable according to ethnicity, geography and assessed level of need.

Once these issues are under control ('Phase 1'), the focus will shift to improving the health of the older population ('Phase 2'). The long-term aim is to dispense with the current fixation on providing services to people because they are old (or perceived as old), and move towards a system which deals with people according to need, not age. The ideal would be, as far as possible, for older people's needs to be dealt with as a matter of course within planning for other priorities. Planning specifically for older people would become limited to specialised residential care services for the very frail and for dementia.

Funding pressures

Following the devolution of Health of Older People Services to District Health Boards in October 2003, the focus for Northland DHB has been on

[10] McMurray A., 2003. *Community Health and Wellness: a socioecological approach. (2nd ed).*
[11] Waldon, J. (2004) *Oranga Kaumatua: Perceptions of Health in Older Maori People*. Ministry of Social Development, Social Policy Journal of New Zealand. Issue 23

managing:

- the funding deficits incurred in the years following devolution
- the impact of new policy and business rules (such as changes to income and asset thresholds)
- rules relating to Northlanders receiving health and disability services in DHBs outside Northland (Inter-District Flows)
- cost pressures on non-government organisations (NGOs).

More older, fewer younger people

Increasing longevity, combined with declining birth rates, has resulted in a rapid increase in the number and proportion of older people in the population. This unprecedented development is transforming sectors and institutions of societies worldwide. Further demands on funding will arise from a declining proportion of working to older non-working people. (Further details about population trends are in section 2.1.2.)

More mobile older people

Residency flows across District Health Boards' boundaries indicate that older people are likely to be more mobile at the time of their retirement from the labour force or at onset of disability. At those times, ageing parents often relocate near their adult children for support, which may mean living in an unfamiliar area where they have few support networks. This makes them more vulnerable, increasing the likelihood they will need support, which in turn increases the cost of providing services. Isolation, as noted in the previous section, is perhaps the highest risk to older people's wellbeing.

Unmet need, imbalanced service provision

Northland DHB wants to target health resources towards those assessed as having higher and more complex needs. Those assessed with 'non-complex' needs should be supported by rehabilitation and recovery services and by social and community supports rather than health resources. However, home-based support service (HBSS) resources are not currently allocated fairly according to need. Approximately 51% of HBSS hours are spent on non-complex care and household management such as housekeeping tasks. This has been reduced from 61% over the past two years and is a key target area within the current HBSS Restorative Project (described further in Appendix 7).

Shifting resources requires planning

Most older people prefer to receive care at or close to home, with greater emphasis on day care, respite care and social supports to improve health outcome. While there is the potential to shift care out of secondary services into the community (including social care), simply redirecting resources without coordination and integration of services will lead to an ineffective strategy.

1.4.2 The solutions

New solutions needed

The combined effects of the factors described in section 1.4.1 mean that the current approach to service delivery will be unsustainable.

There is considerable literature on ways of managing the demand for both specialist hospital care and long term residential aged care and the most cost effective mix of primary care, home based support and community and intersectoral support services.

Intersectoral approach needed

An intersectoral approach is required across services, linking community agencies and groups to:

- improve transportation
- improve access to health and social services
- reduce social isolation (such as through befriending, caring callers)
- increase health promotion
- improve access to information on available services and how to access them.

Informal carers

The care of older people relies heavily on informal carers. Older people themselves supply a disproportionate amount of informal care. The numbers of informal carers in the future may not keep pace with increased demand as the Northland population ages, particularly in rural areas that are more remote from services. Informal care will remain critical to supporting older people and we will need to continue to seek relief for carers, and provide dedicated support services.

Baby boomers more demanding

Expectations are changing. The baby boomers (born 1945-64) are likely to present a cohort of more assertive and demanding social care users in the future, strongly objecting to age discrimination and insisting on greater choice and quality of services.

More innovation and a healthier population

Our Phase 1 strategic direction is on facilitating innovative and sustainable solutions to manage longer term disability support costs while maintaining an acceptable level of population health for older people. This is the primary challenge.

The only real solution longer term lies in keeping people healthy, active, independent and contributing to society for a longer period. There is a need to have robust strategies around the 86% of people over 65 years who live independently in their communities and not focus solely on the 14% who utilise Northland DHB's contracted Health of Older People Services.

1.4.3 Anticipating the changes this strategy will bring

Limited evidence base

Northland is one of several DHBs trialling innovative ways of organising services and leading the way towards new service models. While that is exciting, it also means that there is little other remodelling work or evidence-based practice to draw from. International evidence gives us some confidence, but we cannot guarantee that overseas approaches will apply in New Zealand, or that they will meet Northland's unique characteristics. We are however getting strong guidance from the Northland projects that are currently piloting new methods of service provision and organisation (described further in Appendix 7).

Changes are complex and hard to quantify

It is hard to anticipate the impact of the changes proposed by this plan because there are numerous, complex factors, many of which inter-relate. For example, what will happen to the costs of care? Higher quality services for those in residential care (and higher wages for staff) will mean higher costs, but these may be offset by a more healthy older population able to remain in the community for longer. It makes sense to provide community-based services in preference to residential care, but if home-based support

services are restructured (as described towards the end of section1.4.1) and the number of people needing them continues to grow, what will be the cost implications?

The need to think well ahead

For a few years, until perhaps 2016, the main increase in the 65+ population will come in the 65-74 year group as the baby boomers age. Though they are expected to be relatively fit and healthy, the numbers involved will be large. Beyond that time, into the 2020s, the numbers of 'older old' will increase significantly. We need to find new ways of working now. The longer we wait, the less time we will have to 'get it right' and to manage the growing needs.

Cannot afford to 'do nothing'

We cannot afford to 'do nothing'. If service trends continue unchecked, Northland will be faced with ever-increasing numbers of older people with ever-increasing needs in hospitals, residential care and the community. As changes are implemented, ongoing monitoring of trends in the population and in services provided will be critical to the success of this strategy. In a wider sense, because of the growth in the numbers of older people and the prevalence of chronic conditions, monitoring will be critical to achieving effective use of scarce health resources overall. NDHB's strategies on diabetes, cardiovascular disease and cancer control are addressing these, so close links between those strategies and this one need to be established and maintained (section 1.5.4 further describes NDHB's strategies). Links with NDHB's plans for Maori health and public health, which address the cultural, social and economic factors underlying ill health, are an integral part of the picture.

1.5 Policy framework

1.5.1 New Zealand Positive Ageing Strategy 2001

The founding document underpinning this Action Plan is the *New Zealand Positive Ageing Strategy*.[12] This strategy sets out the Government's commitment to positive ageing and re-affirms the value of older people in society.

The concept of "positive ageing" embraces a number of factors, including health, financial security, independence, self-fulfilment, community attitudes, personal safety and security, and the physical environment. The underpinning premise is that the years of older age should be both viewed and experienced positively.

Given limited resources and competing demands, the role of government in supporting Ageing in Place is predominantly one of harnessing capacity in society and underpinning assistance provided by families and the voluntary and private sectors.

1.5.2 New Zealand Health of Older People Strategy 2002

A key health action from the 'Positive Ageing Strategy' was the development of New Zealand's Health of Older People Strategy[13] which sets out the government's future policy direction for health and disability support services for older people.

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

- concern 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.

It has a vision 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 support programmes."*

The primary aim of the Health of Older People Strategy is to develop an integrated approach to health and disability support services that are responsive to older people's varied and changing needs. It is fundamental that Ageing in Place is preferred by older people ahead of residential care. Hence the service changes proposed in Northland, which are already being demonstrated in the pilot projects (see Appendix 7) are directed to supporting people to remain well in their communities and remain in their own homes as long as possible.

The focus of the Health of Older People Strategy is on:

- working alongside older people as members of families, whanau and communities
- 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

[12] Ministry of Social Policy (April 2001). *The New Zealand Positive Ageing Strategy – Towards a Society for All Ages."*
[13] Ministry of Health (April 2002). *Health of Older People Strategy.*

- 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.[14]

The Ministry of Health (MoH) and DHBs have the responsibility for implementing the Health of Older People Strategy and for achieving the vision and eight objectives within the strategy by 2010. In addition to DHB-led workstreams, the MoH seeks to coordinate effort in key directions for service improvements and efficiency gains. The following work programmes are in progress and will need to be aligned to local DHB activity:

- IT advances/ MoH Socrates project, which will have an impact on contract payment systems, performance and reporting
- InterRAI: a business case has been prepared for the national CEOs Group to support the phased implementation of two interRAI minimum data set assessment tools, home care (MDS-HC) and contact assessment (MDS-CA)
- NZ Carer Support Policy (April 2008).

The Minister of Health's priorities for 2008/09 directly align with the current projects and initiatives being led by Northland District Health Board. The priorities are that:

- Health of Older People Services "continue to give priority to new service models"
- there is value for money and that DHBs "continually try to generate efficiencies and create efficient ways of working".

1.5.3 The Primary Health Care Strategy

The direction of New Zealand's Primary Health Care Strategy[15] and the introduction of Primary Health Organisations (PHOs) mean that primary health care plays a fundamental role in developing integrated continuum of services for older people. PHOs have responsibility for maintaining and improving the health of their enrolled populations, not just responding to episodes of individual disease or injury. Primary health care services are expected to include services that improve, maintain and restore people's health.

Improving health involves health promotion, education, counselling, and helping people to adopt healthy lifestyles, working closely with public health services and working one-to-one with those who could improve their health through lifestyle and behaviour changes.

Maintaining health and independence involves preventing the onset and progression of disease and disability. This includes early detection and careful management and support for those with or at risk of ongoing ill health.

There are six key directions of the Primary Health Care Strategy with similar directions within the Health of Older Persons Strategy. Key themes are: coordination, integration, working with people and community.

[14] Ibid, ppiii.
[15] Ministry of Health (2001). *Primary Health Care Strategy.*

Figure 1 Comparison between key elements of the New Zealand Primary Health Care Strategy 2001 and the Health of Older People Strategy 2002[16]

PHC Strategy six key directions	Health of Older People Strategy six key elements
Work with local communities and local populations	Services are older people focussed
Identify and remove health inequalities	The wellness model is promoted
Offer access to comprehensive services to improve, maintain and restore people's health	Family, whanau and carer needs are also supported, to maintain and restore their health and wellbeing.
Coordinate care across service areas	Services are coordinated and responsive to needs
Develop the PHC workforce	There is information sharing and smooth transitions between services
Continuously improve quality using good information	Planning and funding arrangements support integration

1.5.4 Northland DHB strategies

Since 2005 when our District Strategic Plan was completed, Northland DHB has been progressively developing strategies to deal with our priorities (those adopted by the Board are on our website www.northlanddhb.org.nz/publications/). The strategies, each of which has had wide stakeholder involvement, are the vital drivers of our planning activity. Collectively they describe how we intend to raise health status, reduce inequalities and improve the way services work.

Strategies with particular relevance to older people are those dealing with chronic conditions (diabetes, cardiovascular disease, cancer control and palliative care) because the health of older people will be improved significantly if we reduce their prevalence and impacts. The plans for public health and Maori health will be vital too, because developing healthy environments and communities facilitates positive ageing, maintains health and independence, enhances social inclusiveness, and allows older people to contribute to society for longer.

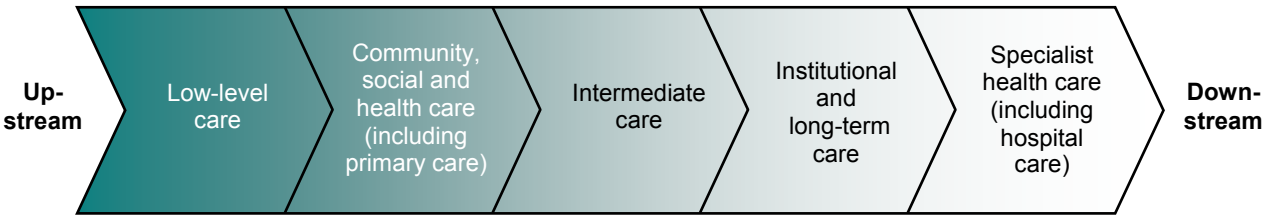
1.5.5 An integrated approach

A functioning continuum of care covers the whole range of services provided for older people, from health promotion and primary care to rehabilitative and restorative approaches.

Wanless[17] summarises an integrated continuum of care in the following diagram.

[16] Mid Central District Health Board (2006).
[17] Kings Fund (2006). *Wanless Social Care Review – Securing good care for older people – taking a long term view.*

Figure 2 The Wanless integrated continuum of care



Community based low-level services will include health promotion activity. This includes healthy eating, healthy activity, healthy housing and restorative support services, primary mental health, and services within general practice. There is international evidence that low-level services provided to older people with lower levels of need, provided in the community, can delay entry into hospital or residential care.

If people requiring services are moved too quickly to the intensive end of the spectrum, cost-effectiveness and sustainability of funding become key issues. If people remain at the lower intensity end for too long, safety and risk concerns can arise (also refer to Figure 3 "Services accessed by older people during the course of their ageing").

The provision of care and support services from the voluntary, private and government sectors is a crucial factor in the achievement of both policy objectives and individual life satisfaction. Only 15% of New Zealanders aged 85 and over live in the community independent of all service provision.[18] The *Health of Older People Strategy* states that: *"Particularly for frail older people, the way health and disability support services are provided is a key component of their quality of life."*[19]

A range of public sector measures is needed to support Ageing in Place. These measures include ensuring the availability of support and care services, and of appropriate forms of housing, whether through changes to existing housing or through specialised developments.

1.5.6 Population based service planning

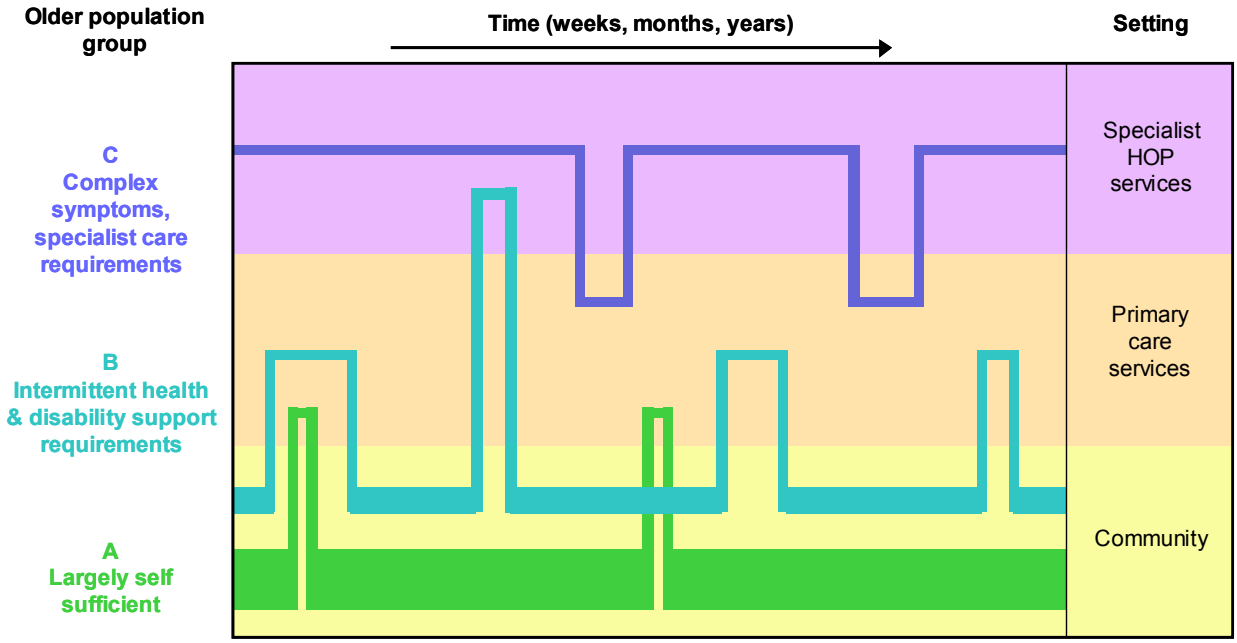
This seeks to:

- understand and plan for the health needs of a target population as a whole, defined on the basis of geography (such as Northland) or clinical need (such as level of disability)
- implement and evaluate interventions to improve the health or wellbeing of that population.

Importantly, population-based health strategies should account for all members of the targeted population, including those who may not choose to access services or have no knowledge of them. Within any target population there will always be a small subset of people with a defined condition who require the most attention and who will consume the most resources.

[18] Statistics NZ (2002).
[19] Ministry of Health (2002). *Health of Older People Strategy.* Pp13.

Figure 3 A needs-based model of care [20]



Adapted from *A Guide to Palliative Care Development: A population based approach*, Palliative Care Australia, Feb. 2005

As Figure 3 shows, for older people there are 3 broad subgroups of older people:

- the largest group, who do not require access to secondary or complex care as their needs are entirely met through their own resources with the support of primary care services (the green bottom line)
- a group with intermittent complex requirements who require occasional input from specialist, secondary or community based services, 'dipping in and out' of services provided by hospital, community, home based , residential aged care or disability support resources (the blue middle line)
- a small group with complex and variable symptoms and one or more of physical, social, spiritual and psychological needs, who require specialist palliative, rehabilitation, mental health and dementia care services (the purple top line).

Figure 3 suggests we should have a needs-based model of care with communication and referral links between services, while encouraging providers to see themselves as part of a continuum of service delivery. This approach is driven by the level and intensity of an older person's goals, aspirations and support needs, primary carer and family needs as well as their strengths and limitations, rather than by organisational and service structure or objectives, or traditional patterns of service delivery. Significantly, this model emphasises the importance of primary care.

[20] Palliative Care Australia (Feb 2005). *A Guide to Palliative Care Development: A population based approach.*

2 Older people's demographic characteristics and health related needs

2.1 Population characteristics

Northland's total population in the 2006 census was 148,470, an increase of 8,337 people (6.0%) since 2001. The Far North District increased by 1,269 people (+2.3%), Whangarei District by 6,369 people (+9.4%) and Kaipara District by 672 people (+3.9%).

In 2006, a third (50,355) of Northland's population lived in the Whangarei urban area. Approximately 18,000 people lived in the four largest rural centres of Kaitaia, Kerikeri, Kaikohe and Dargaville. The remainder of the population (just over 80,000 or 54%) were spread fairly evenly across the region, with many living in rural and often remote circumstances.

Northland has a population profile that is older than the national average. In 2006 14.4% of Northland's population was over 65 years, compared to 12.3% for the whole of New Zealand.

The rate of growth for this group is also faster in Northland. Between 2001 and 2006 the proportion of the population aged 65+ rose by 1.1% (13.3% to 14.4%) compared to New Zealand's increase of only 0.2% (12.1% to 12.3%).

While the gain in Maori life expectancy over the whole period 1985-1987 to 2000-2002 (4.1 years for males, 2.7 years for females) was less than that for non-Maori, Maori gained more than non-Maori in the last five years of that period. As a result, the gap in life expectancy at birth between non-Maori and Maori, which widened by 2.4 years between 1985–1987 and 1995–1997, reduced by 0.6 years in the five years to 2000–2002[21].

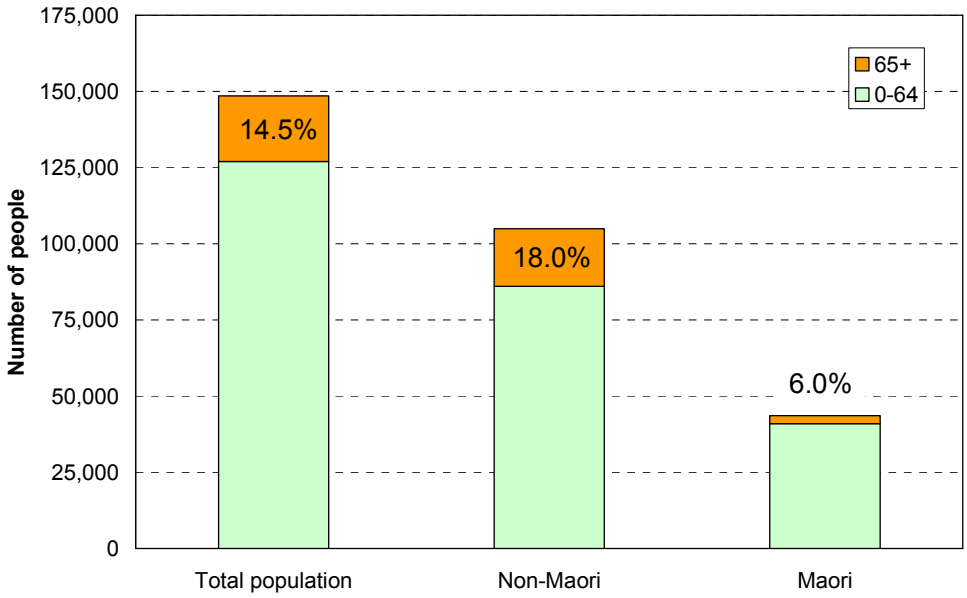
2.1.1 Ethnicity

Northland has a high Maori population, 31.7%, in comparison to New Zealand's14.6%.

Figure 4 shows that in 2006 only six percent of the total Maori population was aged over 65 years, compared with 18% for the Non Maori population.

[21] MSD, The Social Report (2008), Pg 24-25

Figure 4 Older (65+) population and all-ages population by ethnicity, Northland 2006



2.1.2 Population projections

Official population projections point to a significant acceleration in the growth of the older population in coming decades, as the baby boomer generation (born post World War 2, 1946-1965) enter these ages after 2011.[22]

Increases in the 65+ population compared with ages 0-64

Older age groups are growing much faster than the rest of the population, as Figures 5 and 6 show. Between 2008 and 2016 the 65+ population is projected to increase by 31.2% (+7,354 people), while ages 0-64 by only 0.9% (+1,186 people). Projections for future years show even more of a disparity between the age groups. Between 2008 and 2021 65+ growth is projected to be 54% (+12,724 people) with ages 0-64 more or less static. By 2026, ages 0-64 will actually drop by 2% (-2,744 people) since 2008, while ages 65+ will increase by 78.8% (18,584 people). Figure 6 shows the same data graphically.

Figure 5 also shows that between 2008 and 2026, ages 65+ will increase from about 15% of the total population to about 25%.

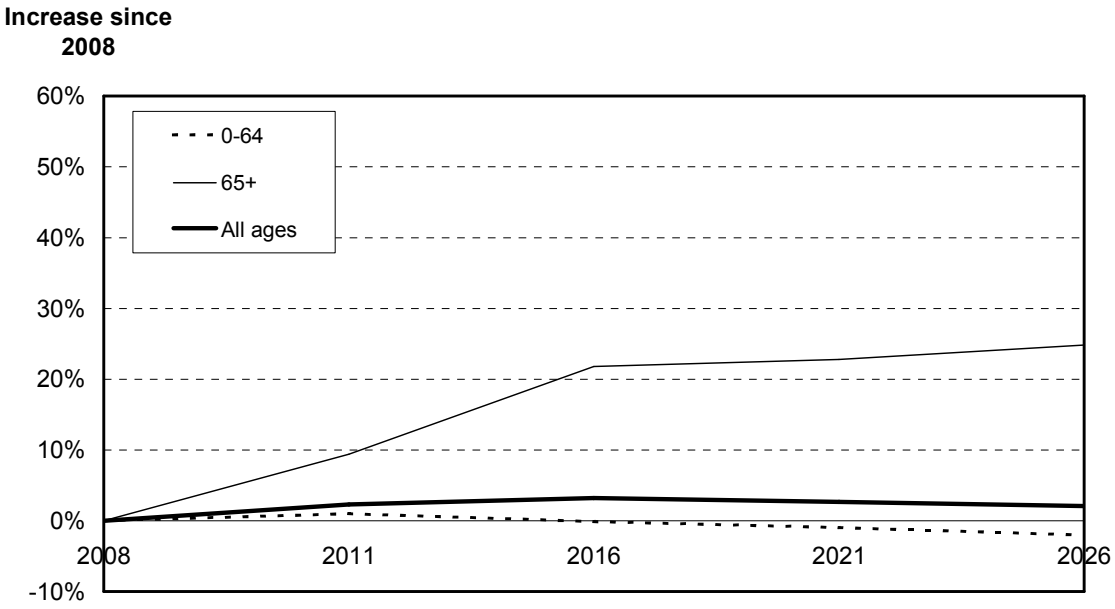
Figure 5 Increases in Northland population by age from 2008

Year	Number of people			Increase since 2008			65+ percent of all ages
	0-64	65+	All ages	0-64	65+	All ages	
2008*	131,484	23,576	155,060	-	-	-	15.2%
2011	132,810	25,790	158,600	1.0%	9.4%	2.3%	16.3%
2016	132,670	30,930	163,600	0.9%	31.2%	5.5%	18.9%
2021	131,400	36,300	167,700	-0.1%	54.0%	8.2%	21.6%
2026	128,740	42,160	170,900	-2.1%	78.8%	10.2%	24.7%

* Projected 2008 population derived from 2006-base projections.

[22] Statistics New Zealand. 2007. *New Zealand's 65+ Population: A statistical volume,* pp 1

Figure 6 Increases in Northland population by age from 2008



Increases within the 65+ population

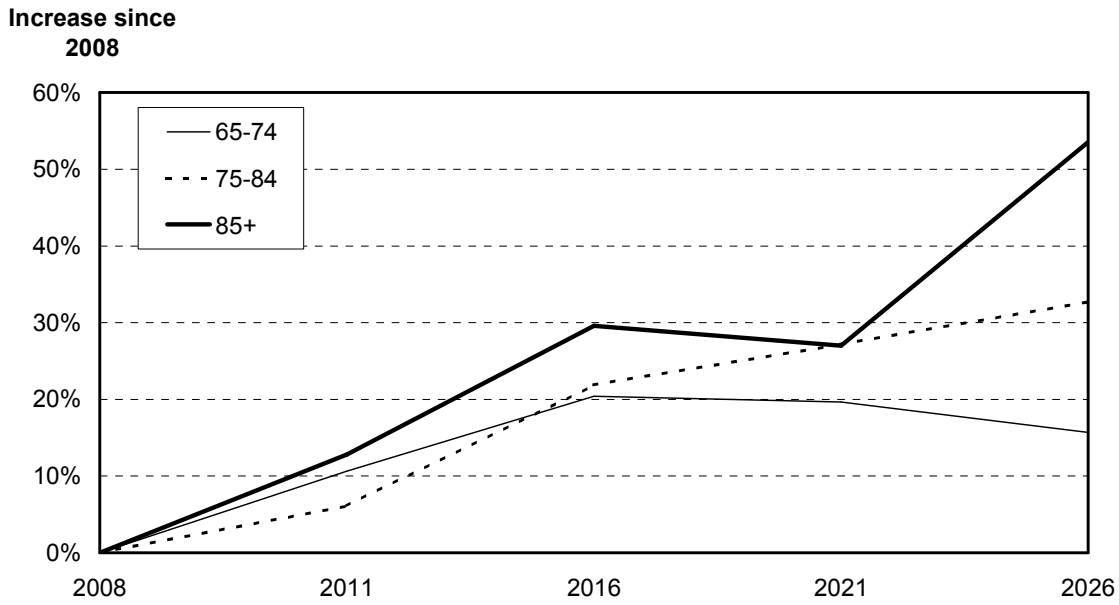
When the numbers of people in subgroups within the 65+ population are examined, the increases are even more startling (Figures 7 and 8). Between 2008 and 2016, the 85+ age group will have grown about one-third as fast again than ages 65-74 (42% compared with 31%). By 2026, the increase in ages 85+ will be about twice that of ages 65-74 (123% compared with 66%).

Figure 7 Increases in Northland population within 65+ from 2008

Year	Number of people			Increase since 2008		
	65-74	75-84	85+	65-74	75-84	85+
2008*	13,702	7,578	2,296	-	-	-
2011	15,160	8,040	2,590	10.6%	6.1%	12.8%
2016	17,960	9,700	3,270	31.1%	28.0%	42.4%
2021	20,650	11,760	3,890	50.7%	55.2%	69.4%
2026	22,800	14,240	5,120	66.4%	87.9%	123.0%

* Projected 2008 population derived from 2006-base projections.

Figure 8 Increases in Northland population within 65+ from 2008



2.1.3 Regional trends

Key points from Figures 9 and 10:

- Just over half of Northland's 65 and over population lives in Whangarei District (51.5%, only slightly higher than all-ages at 50.2%).
- More wealthy and urbanised areas have proportionally more older people than rural areas: compared to the total population, Whangarei and Bay of Islands North East have more; Bay of Islands South and West, Hokianga and Whangaroa have fewer.
- More wealthy and urbanised areas have, within their older populations, proportionally more 'older old' people: Whangarei and BOI NE have proportionally more 85+ than BOI S&W, Hokianga, Whangaroa.

Figure 9 Older population age bands (65-74, 75-84, 85+), total population, areas within Northland, 2006 numbers

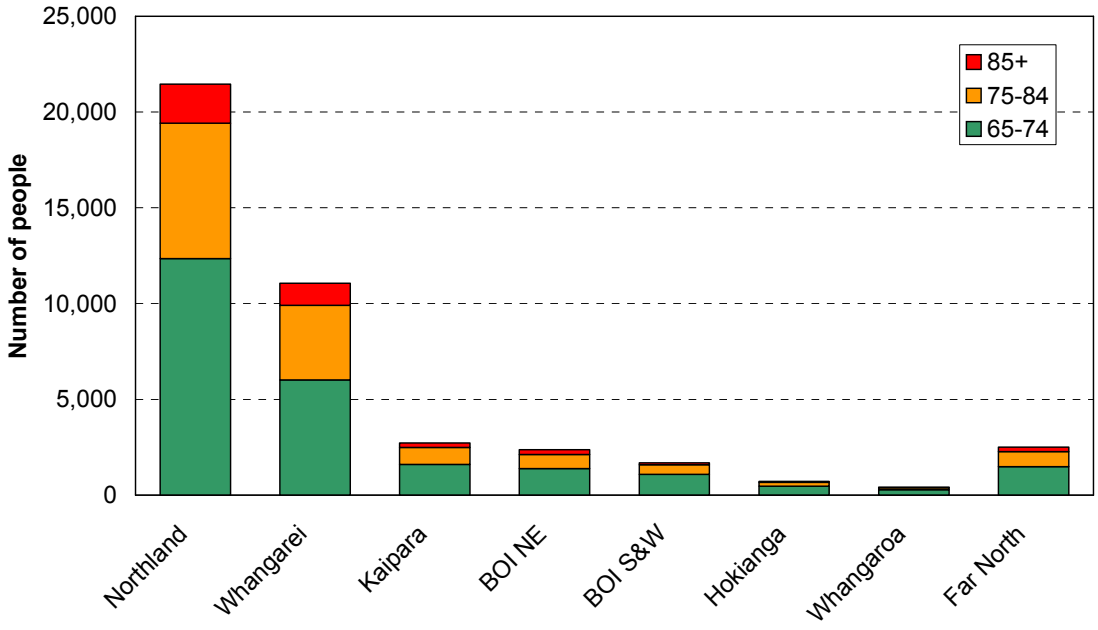
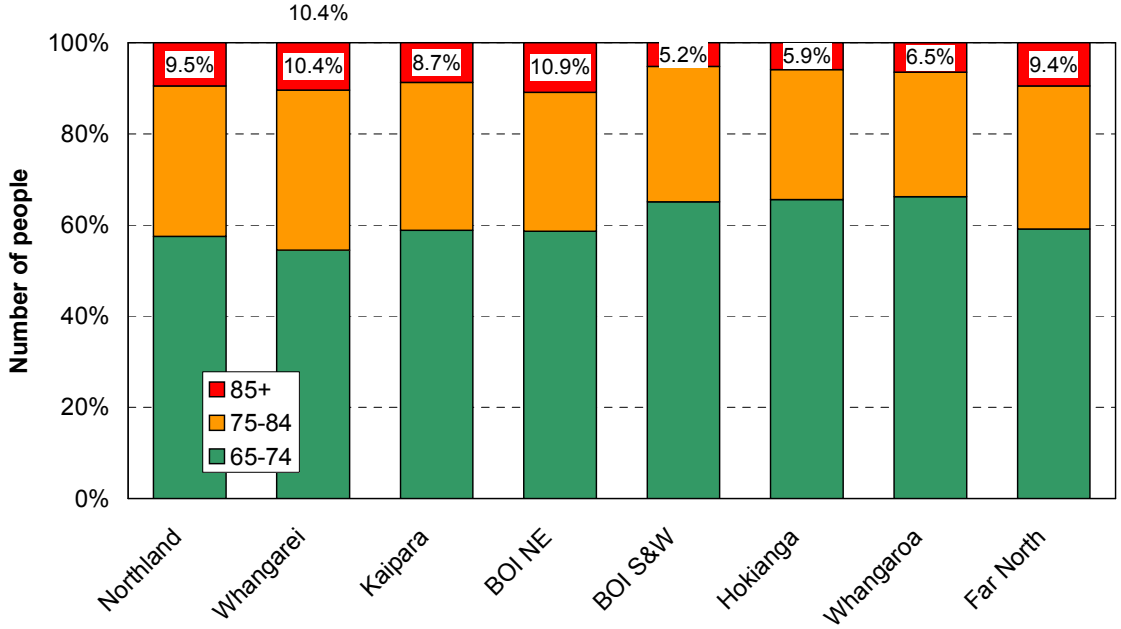


Figure 10 Older population age bands (65-74, 75-84, 85+), total population, areas within Northland 2006 percentage distribution

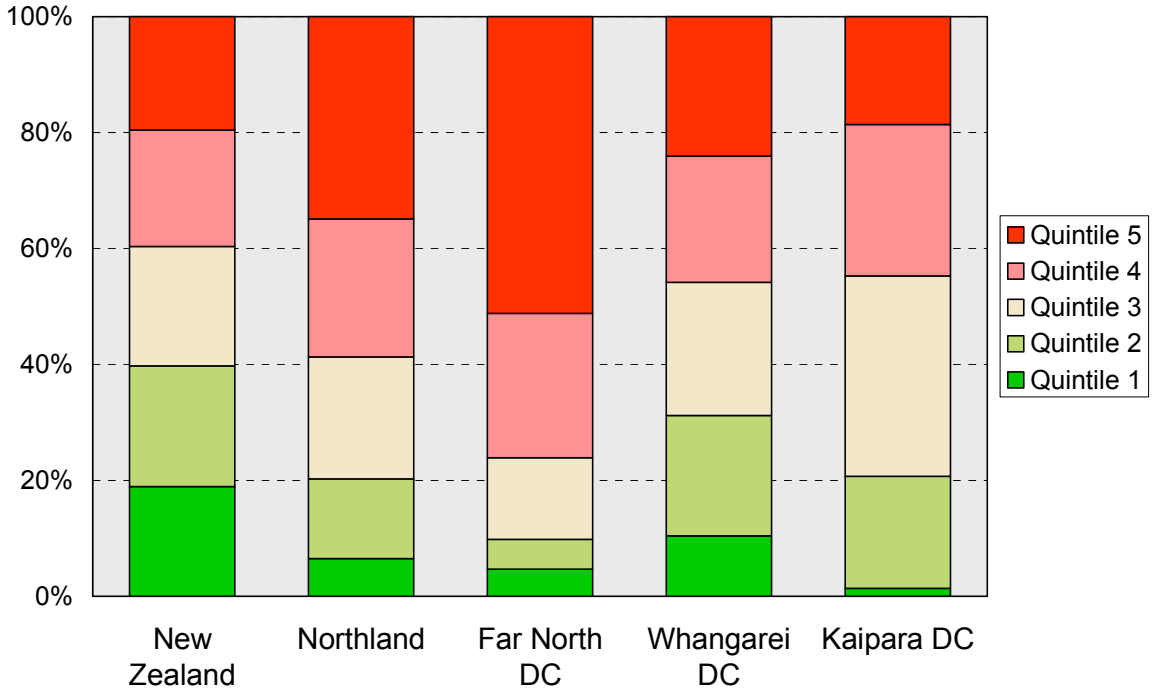


2.1.4 Deprivation

The *Older People's Health Chart Book*[23] reports that within New Zealand, older people are fairly evenly distributed across the socioeconomic deprivation quintiles (NZDep 2001). The distribution of older Maori is skewed toward the high deprivation end of the scale. Older Maori (female and male) aged 50+ years were more likely than their non-Maori counterparts to have no access to telecommunications or motor vehicles, not own their home and live in a crowded home.

Northland is one of the most deprived areas in the country. In 2006, 35% of our population was in the lowest quintile, compared with the New Zealand figure of 20%. Figure 11 shows that within Northland, by far the most deprived District Council area is the Far North, with 51% of its residents in the lowest quintile, compared with Whangarei 24% and Kaipara 19%.

Figure 11 Distribution of meshblocks by deprivation quintile, New Zealand, Northland and Northland District Councils 2006



2.2 Health risk and protective factors

It is difficult identifying data by age group for small populations such as Northland. The NZ Health Survey 2006/07 has data on lifestyle, but the sample size for Northland is too small to enable valid conclusions to be drawn from analysis by age group. Below is a summary of national data from the *Older People's Health Chart Book*.[24]

The good news

Males aged 75-84 were significantly more likely to eat the recommended daily number of servings of fruit and vegetables than were males aged 50-64. The intake of fruit was significantly higher among females than males in all age groups.

[23] Ministry of Health. 2006. *Older People's Health Chart Book 2006.* Wellington: Ministry of Health.
[24] Ibid, pp11

For people aged 85+, the combined prevalence of overweight and obesity was significantly lower than for those aged 50-64. The prevalence of being overweight or obese was significantly higher among males.

The prevalence of current smoking was generally lower in older people, particularly for those aged 75-84.

Older people were less likely to drink alcohol or to engage in potentially hazardous drinking than people aged 50-64.

The not-so-good news

The prevalence of physical activity and regular physical activity was considerably lower in older age groups than in younger groups, particularly for females.

Overall impression

The overall impression from this information is that older people generally live more healthily than those in middle age, presumably because 'lifestyle' diseases cause high rates of death in middle age, leaving a comparatively healthy older population to survive.

2.3 Health status

Older people generally experience poorer physical health than younger people.

When discussing good health in older people, Statistics New Zealand (2004) differentiates between the two major dimensions of length of life and quality of life. With increasing life expectancy and the predicted growth in numbers of people living into very old age, issues around both these dimensions become extremely important for maintaining independence in one's own home. Older people with disabilities are likely to be more severely limited by their disability as they age and are more likely to have their health affected by more than one disability (Statistics New Zealand 2002). Furthermore, older people may be living with their disabilities for a lengthy period. In 2001, nearly 55 percent of older people with disabilities had been disabled for 10 years or longer. Subjective well-being is a strong indicator of physical health status. In old age, individual expectations of health gains may be set too low. For instance, the potential for rehabilitation may be reduced if an older person is demoralised by public perceptions that falling is the beginning of a slippery slope of functional decline.

The *Older People's Health Chart Book*[25] summarises data for older people and provides comparisons with younger age groups. The report's finding are summarised in Appendix 6, but in general, older people have:

- poorer self-reported health status
- higher prevalence of chronic conditions
- higher mortality from most causes
- a greater number of cancer registrations (exceptions: breast cancer, cervical cancer)
- higher prevalence of disability
- higher prevalence of unintentional injury
- higher rates of hospitalisations (exception: intentional self-harm)
- higher usage of primary health services (exceptions: dentist or dental therapist, alternative health practitioner)

[25] Ibid, pp11-14.

Maori rate more poorly than non-Maori on nearly all measures. The only reported exceptions are mortality from colorectal cancer and prevalence of osteoporosis among older females.

Older people in Age Related Residential Care generally have poorer health status than those in private dwellings. They are less likely to have seen a nurse or pharmacist, but more likely to have seen a physiotherapist or been admitted to a private hospital.

3 Stocktake and gap analysis

This section summarises the stocktake and gap analysis of health of older people and disability support services in Northland. It uses feedback from stakeholders acquired from consultation during 2005 and 2006.

Northland DHB is the funder and planner and a key provider of health and disability services for the population of Te Tai Tokerau (Northland), covering the area from Topuni in the south to the North Cape.

3.1 Specialist Disability Support Services

Northland DHB provides a number of specialist disability services throughout Northland. These include an inpatient Assessment, Treatment and Rehabilitation (ATR) Unit for 16+ years, an inpatient stroke unit, community rehabilitation and allied health team, wheelchair and seating assessments, Orthotic Services and a Needs Assessment and Service Coordination Service for those over 65 years of age. A full list of these services is contained in Appendix 3.

3.2 Health of Older People Services

Northland DHB funds Health of Older People Services. These are provided by the Northland DHB provider arm and also through contracted non government organisations (NGOs) and community services.

3.2.1 Contracted services budget

Contract focused service delivery has occurred in Northland with no established framework for achieving an integrated continuum of care across and between Northland DHB services, community, government and non-government, and iwi based services. This is the key challenge for supporting and sustaining the delivery of quality Health of Older People Services (HOP) across Northland. This is the focus of the current funder led HOP projects and pilot programmes operating in the mid and far north and Kaipara districts, with NDHB Provider Arm initiatives being developed in Whangarei (such as the rest rome liaison role).

Northland DHB operates both fixed and demand driven budgets. Services comprise: aged residential care (including dementia care), private hospitals, home based support services, carer support, day care, disability support, and information and advice services (such as Alzheimer's Society, and the Stroke Foundation).

The Northland DHB budget 2008/09 comprises:

Fixed budget	$1,862,901
This includes day care services, Hauora Hokianga Disability Support Services, Alzheimer's Society, Stroke Foundation, and Age Concern.	
Demand driven contracts:	
Home based support services	$9,856,404
Carer support	$1,118,273
Rest homes (includes RH dementia care)	$11,028,058
Private hospitals	$10,559,497
Regional psychogeriatric (4 hospital-level dementia beds, Waitemata DHB)	$400,000 approx.

3.2.2 Needs Assessment and Service Coordination (NASC)

The Needs Assessment and Service Coordination (NASC) Service is the key to the pathway for accessing contracted services.

NASC provides assessment of an older person's needs and coordinates packages of care to meet the assessed need and the individual's goals and aspirations within the context of their ability and social supports. All service allocations to contracted NGO services are through NASC.

3.2.3 Carer support (for the carer)

Carer support is allocated to relieve the primary informal carer and is based on an assessment of the level of support they are providing to maintain the care of a person at home. Subject to their eligibility, primary carers may be allocated up to 28 days funded relief, and the amount reimbursed depends on whether the carer uses informal or formal relief options. Examples of informal carer support include a neighbour or friend relieving the primary carer and providing regular or shorter periods of relief care for the person at home. Formal carer support is where the primary carer places the person they are caring for in a formal residential care setting, such as a rest home, in order to have a longer period(s) of relief from their caring role.

Total carer support days utilised for the 2007 calendar year were 12,141.

3.2.4 Day care

Day care is a key service with access to socialisation and age appropriate activities and outings. Day care services continue to operate on devolved and outdated service specifications and therefore unsustainable funding levels exist for future contract provision as the needs and expectations of older people change. Older people attending day care are not a homogeneous group; for example the aspirations of a 65-year-old may not be the same as someone in their 80s or 90s.

3.2.5 Respite care (for the client)

The respite care programme is aimed at providing regular relief to informal carers so that older people can stay at home and in communities of choice, delaying their entry into long

term residential care. A two:six week relief ratio has been the benchmark for the regime of respite care in each annual period.

The respite care programme also provides an essential service in supporting informal carers when they have exhausted their NASC-allocated carer support days.

Historically respite care was provided in Northland's regional hospitals. As these hospitals changed their role and function, respite care was contracted with NGO aged residential care providers in 2002.

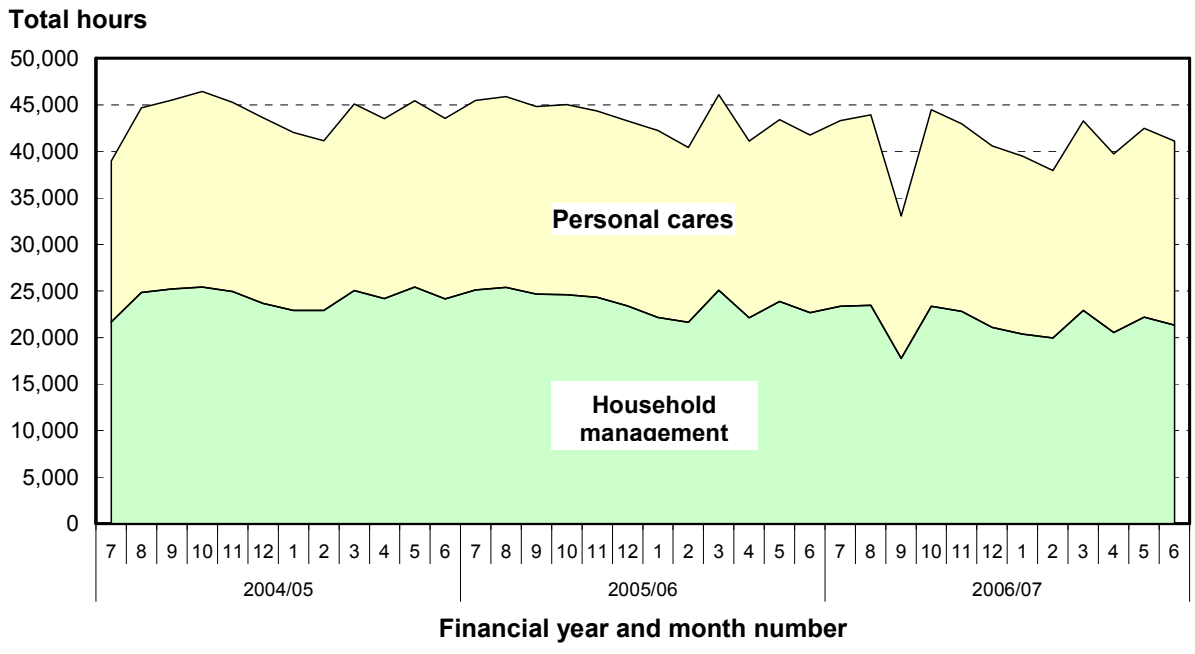
In 2004 the respite care contracts with aged residential care services ceased and there was debate over unoccupied bed days and cost to providers. From 2004 respite care has continued to be coordinated and scheduled by Northland DHB's Needs Assessment and Service Coordination (NASC) Service. However as the overall occupancy threshold within our aged residential care services increases, respite care is delayed or increasingly not available in some of our regions (for example, all but three of Kerikeri Village Trust's current respite care clients live outside of the mid north region).

During 2007/08 Northland DHB, with the University of Auckland, undertook a research programme to develop a clinical pathway for respite care. As respite care occurs in a formal setting (such as in a rest home or private hospital), it is an opportunity to reassess the health needs of the person and to identify and address the needs of carers.

3.2.6 Home Based Support Services (HBSS)

Northland DHB has disproportionately higher allocations for both household management and personal cares than any other DHB nationally (Figure 12). It is generally understood that the current purchase model, in particular the funding approach, does not support sustainable or appropriate home based support provision because the funding mechanism exacerbates dependency and demand driven outcomes.

Figure 12 Total funded hours for home-based support services in Northland by service component, July 2004-June 2007



The proportion of hours allocated has decreased during 2007/08 due to the piloting of the restorative approach to assessing and coordinating services to meet an older person's needs, and also carrying out regular reviews of people's needs.

The aim of a restorative model is to provide a service that works with people to where possible maintain or build their independence. This is achieved by working on what is important to service users and linking this to a practical programme of support. This builds functional ability where possible, reinforces their independence, and limits the impacts of ill health and disability. Improvements in service delivery are addressing referral processes, existing assessment tools, care coordination, client and carer participation, follow up and evaluation, carer impact assessment and staff training.

Holistic wellbeing is not new to Maori who have long standing models of health and wellbeing. Traditional HBSS purchasing does not account for the processes of whanaungatanga, whakapapa or tikanga.

3.2.7 Aged Related Residential Care (ARRC)

Northland DHB has service agreements with 24 Aged Related Residential Care and NGO providers.

In addition, Hauora Hokianga provides 10 long stay beds (flexi) under a DSS Service Agreement.

The provision of ARRC beds by provider and location is contained in Appendix 4. Between 2003 and 2008 the number of contracted aged residential care beds has decreased by 4.0%, a loss of 44 beds.

Both the Far North and Kaipara districts have had an overall decrease in the number of contracted aged residential care beds between 2003 and 2008, while Whangarei had a slight increase:

- Far North -5.4% (loss of 15 beds)
- Kaipara -6.3% (loss of 8 beds)
- Whangarei +1.7% (gain of 11 beds)

The occupancy of Northland DHB funded beds for January-March 2008 (excluding private payers) is:

- 90% for dementia care beds (with 97-100% occupancy inclusive of private payers)
- 62% for rest home level care (110% occupancy inclusive of all funding – that is, ACC, Ministry of Health and private payers)
- 71% for hospital level care (providers are changing their bed configuration to meet demand in response to rest home level care occupancy as noted above).

Barriers to accessing the full range of aged related residential care services need to be addressed. Older people and their often elderly carers are significantly affected and placed at risk when changes to their disability support needs or acuity require they move to a different level of care that may not be provided by their facility of origin.

If there are no vacancies in their current area, this means that people have to leave a familiar area with familiar staff and move to another facility, often in another town or locality. This has always happened with people transferred temporarily while awaiting placement back in their own community, but it is increasingly the case for long-term placements. This is

occurring for dementia patients and their families, and Northland has historically not provided specialist hospital dementia services. There is access to four beds within Waitemata DHB's Specialist Dementia Services.

There is growing concern that general practices are exiting aged residential care services with three larger facilities already affected. Northland DHB is working collaboratively with PHOs, aged care providers and after hours services to address a reduction in access to after hours GP services. This is a resource issue requiring longer term solutions and better coordination between GP, aged care and secondary services.

There is also an issue related to registered nurse capacity and capability in gerontology. This is compounded by difficulties in recruiting and retaining registered nurses in this sector.

3.2.8 Care and support for people with dementia and their carers

Dementia is a common ailment associated with ageing, especially in Western populations. Its prevalence nearly doubles for every five years after 65 years of age.

The rising number of people with dementia will be a significant determinant of the demand for social care over the next two decades. Longer life expectancy, and an expanding population of people over 85 years is projected internationally to be a main factor behind the increase of dementia.

Both the incidence and prevalence of the disease increase with age. Those over 80 years of age are at greater risk of dementia incidence and therefore require greater access to health and disability and residential services related to both cognitive and physical functional decline.

There is wide variation in prevalence rates reported by different studies. Estimates of the prevalence of dementia range from 1 percent for those aged 60-65 years, rising at a rate of about 1-2 percent per year of age, up to around 30 percent of those aged 85 years and older.

Alzheimer's disease is the most common form of dementia, and the risk of developing it increases with age. Dementia shortens life expectancy, with approximately one in seven nursing home patients surviving to late phase dementia.

Early diagnosis and intervention in people with dementia is known to be cost effective.[26] In the early and mild stages of disease people live at home and often start to rely on informal carers and information and support services such as those offered by the Alzheimer's Society. As the disease progresses through the moderate and severe stages there is a greater need for dedicated dementia services and secure residential and specialist hospital care.

In June 2006 Northland DHB's Needs Assessment and Service Coordination (NASC) Service conducted an audit and carried out reassessments of residents with dementia in secure residential care. They found that out of 72 residents, only 3 needed a higher level of specialist hospital dementia care, and only 2 could safely be placed back into ordinary age related hospital care (ARRC). This demonstrated significant confidence in NASC's assessment and placement capability and ARRC clinical nurse managers.

Those with pre-existing mental illness will require both mental health and aged care services. Such people have diverse needs, and strategies need to be in place to support a range of

[26] British Medical Journal, 2007. 335, 15 (7 July)

service users, their families, and formal carers. People who find it particularly difficult to access support or funded services include:

- people with multi-aetiology dementia (not age related), people with psychiatric conditions, people with younger onset dementia
- people living in rural and more remote areas
- people who are moved between family carers
- people or families who 'cover' for their situation due to the stigma or stress often attached to a decline in function or behaviour.

Issues and gaps

Specific service issues and gaps identified during the dementia consultation workshop 2006 included:

- lack of inpatient beds for comprehensive assessment
- lack of specialist hospital services in Northland for people with dementia. Northland admissions to dedicated beds in Waitemata DHB revolve around 4-7 people at any point in time. Based on bed days alone this would be an uneconomical stand alone unit, but could be part of a comprehensive specialist assessment, diagnosis and treatment unit, with proximity to specialist clinicians such as ATR, and Psychiatric Services for Older People (POP).
- occupancy threshold reached on current contracted secure rest home beds (71beds)
- cost of inter-district flows (IDF) to more expensive Auckland based facilities. This is now inclusive of rest home level care while Northlanders await vacancies back in Northland.
- appropriate services and funding required for younger dementia clients
- no contracted respite care bed days
- carer stress as limited or delayed respite care
- limited early intervention services
- current day care services make no qualified distinction between stages of dementia, targeted remedial or specialised dementia activity.
- cost of early entry in to residential care
- secondary service:
  - lack of understanding of dementia in clients admitted for other medical and surgical conditionsand inappropriate discharge
  - reduced gerontology capacity affecting clinical decisions and outcomes
  - inappropriate restraint management
  - differential diagnosis and management of delirium
- increasing incidence for Maori; currently 110 whanau are being supported by Alzheimer's Society Northland, an increase from 15 in 2004/05 following additional Maori focused case worker hours being employed.
- sporadic dementia-specific education and workforce development
- fragmented service provision based on historical funding

3.2.9 Services for Kaumatua and Kuia

Reducing inequalities is core to Northland DHB's purpose. It underlies every priority, strategy, meeting and discussion.

The need for culturally appropriate health and disability and social care resources for Maori and Pacific peoples is considerable.[27] Northland has a high proportion of Maori in its population, a projected increase in the number of older Maori and Pacific people (especially those aged 75 and over), and a higher incidence of what is commonly thought of as age-related conditions at younger ages.

The roles that older Maori are expected to undertake are both a risk and a benefit to their health and wellbeing. Remaining close to whanau and maintaining their participation within Maori society and the business of the marae is fundamental to positive ageing and reducing the premature loss of Kaumatua. Planning for future community based services for Kaumatua can not be separated from active policies for whanau development, or the role of government in recognizing the needs of current and future older Maori. Therefore, wide cross-sectoral planning is required to guarantee older Maori a positive and ongoing place in society, and to reduce the impact of age-related disabilities. Iwi have a definite role and planning function, and should be well placed to bring the strands of their communities together to moderate the impact of ageing on older Maori and their whanau.

Planning for older people's services has in the past focused on building 'capability' and 'responsiveness' within existing mainstream services. Never before has it specifically addressed future capacity from a Maori perspective.

Currently there are no Kaupapa Maori Residential Services for whanau in Northland, and only one mobile 'Korikori' day service programme operating in the mid north with one contact day per week. The Korikori day programme is intergenerational, with community wide participation. It does not, purely on the basis of age, separate Kaumatua and Kuia from their natural supports and aspirations.

3.2.10 Kaupapa Maori Research Project

A research proposal has been funded which fits Northland DHB's priorities:

> *"Reducing inequalities… equitably resource Kaupapa Maori programmes or any new expanded initiatives…. all workforce development initiatives to aim at a culturally responsive service, as measured by recipients*."[28]

The proposal is for investigative research specific to Maori, so Maori-specific researcher(s) must be engaged to undertake this work. Within the scope of this project there is a need to tap into the aspirations of Maori with capacity to engage Kaumatua and Kuia.

The proposed outcome of the research proposal is to establish a framework and service models for Kaupapa Maori community based residential care and day care services. Research activity will focus on collecting, collating and analysing information, asking questions such as: what are Maori preferences? what is the potential for Kaupapa Maori residential services? what will services look like? what is happening in other areas? what is Northland's intersectoral capacity? where is the greatest need? what whanau support services are required?

This research project aims to obtain evidence, in line with Mason Durie's work on models of care. It may result in findings and proposed residential care initiatives that would require funding for services outside of existing Age Related Residential Care service specifications and current HOP funding. This presents a challenge for seeking community, iwi and

[27] Ministry of Health, 2007. *Care and Support in the Community for Older People in NZ. Issues Paper.*
[28] Northland DHB, 2003, *District Strategic Plan.*

intersectoral partnership as sustainable funding and responsive service specifications will be required.

The research process will engage a range of stakeholders. It will be necessary to manage stakeholder expectations relative to lead-in times for future service development or innovation funding initiatives.

Models of Hauora Maori as seen and developed under the auspices of Mason Durie should be considered as integral to the research developed regarding literature review on Oranga Kaumatua.

3.3 Service delivery issues

3.3.1 Workforce

Disability Support Services constitute a complex and individualised range of services. They can be categorised into six main service areas, each of which entails its own set of skills:

- home based support
- day care
- carer support
- environment support
- aged residential care
- assessment, treatment and rehabilitation (AT&R)

The increasing population of older people will be accompanied by a proportionate decrease in the workforce. The predicted ratio of working age people (25-64 years) to retired people (65+ based on current retirement age) in Northland will almost halve from 3.5 in 2005 to 1.9 in 2026.[29]

This is a challenging prospect for a sector which has traditionally had a low paid workforce. In community based services in New Zealand and internationally, research links the 'pay per client per hour' purchase model to a low skill, casualised approach to the workforce, incurring high turnover of staff and perpetual loss of training incentives.

Fundamental to improving service quality is ensuring that each client in the community has a group of support workers who are consistent over time.

It is important that our future workforce is diverse enough to reflect the population they support and care for.

Future purchasing frameworks need to be established so that contracted providers can stabilise their workforce and minimise turnover before investment in training and standards development can gain any traction.

Workforce solutions are also required to support best practice and innovations for HOP services. Ironically this is at a time when age related services are relying on a shrinking workforce of allied health workers, general practitioners and registered nurses.

New workforce configurations with competitive recruitment and retention strategies will be common goals for funders, service providers, government, employment and disability support

[29] NDSA, 2006.

agencies. It will be essential to ensure the workforce continues to meet professional, legislation and best practice requirements (that is, work within regulated scopes of practice compared with adopting non-regulated roles and accountabilities) in response to the shrinking workforce.

3.3.2 Decision support and quality monitoring systems

The availability of patient data is extremely important to the effective relationship between primary/ generalist, residential, secondary and specialist services. Making available complete and timely data on patients and services would make a distinct difference to the quality of assessment, advice and care planning. It would also support sustainable and consistent planning and service provision.

To improve the quality of services the following is required:

- promote an evidence based approach
- develop best practice guidelines for assessment and service coordination
- develop performance indicators
- improve data quality, particularly regarding case and age definition, as it affects NDHB's current capacity and capability to plan across services
- monitor provider contract performance, informing NDHB service agreements
- develop service specifications to achieve population health outcomes
- regional and national activity to align funding and payment systems through HealthPAC
- regional and national benchmarking using integrated service utilisation data.

Northland DHB has contracted for both routine and issues-based audits for Age Related Residential Care (ARRC) services and Home Based Support Services (HBSS). The contracted audit provider is responsible for:

- development of the audit framework documentation
- routine audits:
  - focused on ensuring services are in line with contractual arrangements
  - conducted by the audit provider under an agreed 3-year schedule that submits ARC services and HBSS providers to an audit of contract, at intervals to be jointly agreed by the audit provider and NDHB
- issues-based audits, which are 'one-off' in nature and usually requested as a result of some concern about the quality of services, output of service volumes, accuracy of record keeping and/or billing, honesty, or financial viability of a provider.

3.4 General health services needs for older people

As well as disability support services, and 'Health of Older People' services, older people are users of general health services. These services are funded out of general budgets, rather than the HOP budget. This section discusses general service issues that have been highlighted through consultation or are subject to work being developed at the national level.

3.4.1 Pharmaceuticals

In 2006 Northland DHB carried out an analysis of pharmaceutical utilisation by age. It highlighted large variations across age groups in both the volume of prescriptions and the average cost per item incurred by the District Health Board.

Figure 13 Northland pharmaceutical utilisation by age 2006

	0-4	5-14	15-24	25-44	45-64	65+	All ages
Average no. of items	6.64	2.80	3.74	7.52	13.08	34.18	12.23
Average $/item	$10.52	$12.01	$17.77	$19.66	$22.73	$18.89	$19.33
Total cost	$69.85	$33.62	$66.43	$147.99	$297.33	$645.77	$236.31

Figure 13 identifies the 65+ age cohort as collecting, on average, more than 34 separate prescription items annually per person at a total cost to NDHB of $645.77, more than double the next closest age cohort.

This information highlights two significant issues for consideration:

1 *Cost of medication.* The cost of medication for ages 65+ to NDHB is substantial. If this pattern is allowed to continue, population projections suggest that dispensing volume growth will likely double by 2026. Alongside this volume growth is serious concern, for the funder, at the level of potential or actual wastage occurring due to multiple prescribers and non-completion of medication regimes.

2 *Effectiveness of medication regime.* Of particular concern is the effectiveness of a medication regime comprising 34 items dispensed annually per person. Assuming that most prescriptions are "stat" (to be dispensed for 3-monthly periods), this equates to about 8.5 distinct types of pharmaceuticals per person every year. Managing this volume requires a coordinated approach across all prescribers, health support workers and pharmacy.

Through the promotion of sustainable and preventive measures, patient understanding and concordance to medication regimes can be improved to enhance the wellbeing of the patient in a manner to support maintenance of the patient in a familiar home environment.

3.4.2 Meeting the needs of people with chronic conditions[30]

Older people are more likely than younger people to have a chronic condition such as cardiovascular disease or diabetes. The National Health Committee report *Meeting the Needs of People with Chronic Conditions* used many case studies to gain information to improve service delivery for people with chronic conditions. Concerns were expressed across all case studies which highlighted key barriers to a continuum of care:

Issue	Examples
Lack of coordination – assessments and appointments	Receiving multiple assessments. People having to retell their story and case history to different health professionals.
Lack of coordination – care provision	Having no individual nominated to coordinate their care, so patients are unclear about what was being provided and how it fitted into an overall plan. A void after discharge from hospital back home, including lack of follow-

[30] National Health Committee, 2007. *Meeting the Needs of People With Chronic Conditions.*

	up support and referral.
Lack of integrated service provision, both within the health sector and cross-sectorally	Needing a closer alignment between services for those with both mental and physical health issues.
	Difficulty accessing information about community entitlements and supports.
	Service providers not seeing an individual as a whole person in the context of their life needs.
	Not having health services closely linked to NGOs or local support services such as housing, social support and income support.

3.4.3 Palliative care services

Northland DHB adopted its *Palliative Care Strategic Action Plan* in 2007. Palliative care can be delivered by both generalist providers (such as general practitioners and residential providers) and by specialist providers (such as hospices).

The structure of age related care services and funding creates an imbalance in accessing the full range of palliative care services, and inconsistent levels of support. There is a risk of reduced access to quality end-of-life care for people over 65 years as the daily bed day rate does not always cover high cost treatments, specialist supplies, specialist equipment, increased number of medical visits or increased need to access local or regional specialist services.

3.5 Projected Aged Related Residential Care capacity

Due to amendments to the Social Security Act 2005, New Zealand is moving to an 'open market' approach for the provision of residential care capacity. Under this Act, when a person is assessed as requiring a certain level of care, the associated funding follows the individual, and it is no longer appropriate to operate managed bed policies based on limiting access to the required care or bed days by limiting provider contracts.

The number of age related residential care beds required will be directly correlated to the size and nature of population growth. It will also, however, be alleviated by initiatives aimed at reducing the cost and burden of care in secondary services and regional hospitals and progression to permanent care. Examples of such initiatives include:

- the development of 'first response' community based services such as providing non complex hydration, suturing, wound management (as currently reflected in Emergency Department attendances)
- working with providers to implement appropriate "advanced care directives".

Having advanced care directives in place is not the only consideration. In the NGO sector consistent GP oversight and having registered nurse capacity and capability is required to implement directives within the parameters of legislation and scopes of professional practice.

3.5.1 Aged Related Residential Care beds

This section describes projections of required bed numbers. Separately analyses have been carried out for ARRC beds (rest home and hospital categories combined) and dementia beds, each using different methodologies. Future numbers of beds have been projected

based on maintaining the current level of contracted beds as at January 2008, with the projected growth in the older population.

Figure 14 shows that the Far North District Council area is projected to have the most significant shortfall in Aged Related Residential Care beds up to 2011, both in absolute numbers (81) and as a proportion of current beds (35%). It is also projected that there will be shortfalls in the Whangarei and Kaipara district council areas. The bed projections reinforce the importance of reorienting funding and service delivery systems based on the restorative model of care, as the continuation of the status quo (the 'do nothing' option) is not sustainable.

Figure 14 Projected ARRC (rest home and hospital level) beds required to match the growth in the 85+ population, assuming the status quo is maintained

District Council area	ARRC beds 2008	Projected ARRC beds					
		2011			2016		
		Total	Additional	% of 2008 beds	Total	Additional	% of 2008 beds
Whangarei	632	659	27	4%	820	161	25%
Far North	234	315	81	35%	408	93	40%
Kaipara	109	128	19	17%	162	34	31%
Northland	975	1102	127	13%	1390	288	30%

While the projected shortfalls are significant, they could be underestimating actual need for the following reasons:

Current bed provision is inadequate

To start with, the current number of subsidised beds for ARRC is estimated to fall short by approximately 30 beds. This is based on:

- sustained occupancy of 100 percent in the Mid and Far North
- the size and distribution of facilities doesn't match population need
- no capacity for current or known carer support and respite care demand
- the number of residents currently accommodated outside their traditional area of domicile.

Unsubsidised beds are excluded

The projections are based on officially reported bed data from NDSA. This counts only subsidised beds, about three-quarters of all beds. It excludes beds which do not attract subsidies, those used for: (a) private payers, (b) respite care, (c) carer support, (d) ACC contracts. These are all valid and necessary uses of beds, so ideally should be included in the baseline data so that it represents the totality of need. However, data on unsubsidised beds is unreliable as a basis for planning because it doesn't represent real need. Provision of unsubsidised beds usually depends on subsidised beds being freed up temporarily from subsidised care, and on the motivation of ARRC providers to provide care in beds for which they do not receive subsidies.

The ageing population is not allowed for

The bed projections are based on the 85+ population, using the 2006 based projections. Ideally they should calculate usage separately for age groups within the 65+ population, since need increases with age and the age structure of the population will change over time. This has not been

possible though because utilisation data on beds occupied is not collected on this basis.

As it happens, this does not create significant problems for this strategy. Until 2016, the 'ageing' effect will be minor. According to the latest projections, the proportion of people aged 85+ amongst the over 65 population will remain at approximately 10% between 2008 and 2016. The ageing effect will be more significant after that, with ages 85+ projected to increase to 14% of the over 65 population by 2031.

New populations

Over the next two to three year period Northland will see a growth in retirement villages. In the mid north a development is planned for 150 residents with significant enquiry from Auckland residents. A large retirement village is planned for Whangarei. Retirement villages typically build care facilities as part of a continuum of care.

3.5.2 Dementia care beds

NDSA prepared projections in 2005/06 for levels of secured dementia care. A UK model (developed by Cumming) was used as the basis and updated by NDSA to ensure that it took into account any recent trends and that it had a New Zealand focus.

The NDSA projections accurately depict what is occurring in Northland. The projections (Figure 15) identify a gap for dementia beds in the Far North, and this lack of capacity has caused a flow-on 'domino' effect on dementia services in Whangarei. This in turn has resulted in an out-flow of Whangarei District residents to Auckland services.

Figure 15 Projected dementia beds (as per modelling carried out by NDSA in 2006)

District Council area	2006 (base)	2008 beds		Projected beds	
		Actual beds	Projected Need	2011	2016
Whangarei	44	48	47	51	60
Far North	27	21	30	33	40
Kaipara	10	11	11	12	14
Northland	81	81	87[31]	96	114

The dementia care bed projections clearly support the need for an increase in bed numbers in the Mid and Far North. Capacity in Whangarei and Kaipara is consistent with the number of beds required to meet projected need in 2008.

3.6 Summary of what Northland is doing well

There are many services within Northland that are working well. They should be acknowledged and celebrated. The following list of strengths is drawn from the strategic planning workshops:

Northland DHB and MAPO partnership.

Commitment, vision and engagement of provider and community stakeholders.

[31] Doesn't add up due to rounding

Positive ageing is a priority for the Northland Intersectoral Forum (NIF).

Consumer input into Health of Older People planning.

Contribution of volunteers and community support services.

Commitment to ensuring the health and wellbeing of all older people in Northland including Kaumatua and Kuia.

Established provider relationships and sharing of resources.

Dedicated staff and staff retention in residential care services.

Strong community ownership and support of intersectoral activity.

3.7 Summary of gaps and issues

From the stocktake and consultation processes the gaps and issues identified for Northland have been classified according to several categories.

3.7.1 Non-existent services or limited access to services

No dedicated Specialist Dementia Service.

Respite care occurs without formal contract arrangements.

Limited access to secure rest home dementia care in Northland.

Residential care placement for dementia in Northland (there has been an increase in the number of older people requiring placement outside their area of domicile, usually in Auckland facilities, while awaiting Northland vacancies).

NASC capacity and capability becomes inadequate as a result of reconfigured services (eg, changed as a result of the pilot projects currently underway).

Barriers to achieving a sustainable allied health workforce.

Service gaps for those requiring both mental health and health of older people services.

No primary service coordination for well elderly or informal carers.

No Kaupapa Maori residential care services (or equivalent level of care/ service for Kaumatua and Kuia).

3.7.2 Gaps in the level and location of services available, including equity of access and timeliness

Community based programmes aimed at providing older people with opportunities to carry out activities that improve their wellbeing (for example, tai chi programmes, physical activity programmes such as walking groups).

Insufficient influenza immunisation coverage.

Inconsistent links and coordination between levels of service delivery. Improvements are needed between, for example, general practice and home based support services (HBSS), HBSS and aged related residential care services (ARRC), and secondary care/ regional hospitals and ARRC.

Constrained patient information flow and duplication.

Discontinuous continuum of aged residential care (ARRC) requiring several transitions for those in rest home care who then need hospital or specialist dementia care. This is often out

of their area or region of domicile causing increased carer burden and stress on families, and a shrinking workforce.

The poor quality of Northland roads, lack of public transport and vehicle quality (reduced/ costly access to warrant of fitness services, cost of vehicle registration) mean that older people and the ageing population in Northland are disproportionately disadvantaged with reduced access to a range of essential services (including food provision, pharmacies, health services, social and community venues).

Carer burden and stress, which includes issues related to:

- ageing carers
- stress experienced by working carers
- limited financial support for family carers

The health impact of poor/ older houses is evidenced in Northland with 1,078 houses in need of an insulation retrofit package.

3.7.3 A gap in access to service due to the historical funding model for NGOs, community and specialist services

Disproportionally high use of HBSS in Northland. Northland HBSS service allocations had, up until June 2007, been 61% household management support and 39% personal care, with an average allocation of 47 hrs/person. This is well in excess of other DHB benchmarks.

HBSS have lacked the ability to meet the diverse and primary needs of older people.

Historical funding of day care services with outdated service specifications.

Outdated purchasing and funding frameworks limit service innovation and quality improvements.

There is a need to plan for suitable community based accommodation options for Maori.

Historically inconsistent purchasing of a range of services means that there is not equitable access across Northland to the core services required to support older people.

3.7.4 Receiving a good quality and client centred service

At present, there is an unacceptably large gap between current and optimum assessment practice. The needs of older people are neither described nor met as effectively as they should be.

Capital expenditure and ongoing operating costs will be required to implement these research based best practice assessment tools. These assessment tools underpin the projects and service initiatives being piloted across Northland.

The availability of complete patient data is extremely important to the effective relationship between primary/ generalist and specialist services, and it enhances seamless care between providers. Availability of data makes a distinct difference to the quality of advice and information available to multi-dimensional teams. It should support sustainable and consistent service provision and not be dependent upon individuals.

PART B:
STRATEGIC ACTION PLAN

4 Guiding principles

These principles are consistent with the approaches identified by the Northland District Health Board as being critical to the planning and delivery of services.

4.1 Treaty of Waitangi

The Treaty of Waitangi is considered the founding document of this nation and establishes the unique and special relationship between Maori and the Crown. Northland DHB participates in relationships with Maori that recognise and respect the Treaty of Waitangi principles of partnership, participation and active protection of Maori health interests, in order to improve health outcomes and reduce inequalities for Maori.

For Northland DHB, this means enabling Maori participation in funding, planning and decision making through active partnership with Maori at all levels of the health sector – in governance, operational management and workforce development, in supporting Maori health provider development, including Kaupapa Maori models of service delivery, and in acting to improve the health and wellbeing of Maori while safeguarding Maori cultural concepts and values.

4.2 Whanau Ora

To incorporate the four He Korowai Oranga (Maori Health Strategy) pathways[32] into service planning and resource allocation decision-making, analysis of service proposals includes an assessment of their contribution to Whanau Ora. They must:

- reduce inequalities in health status for Maori
- increase Maori participation in the delivery and utilisation of health and disability support services
- improve the health status of Maori
- improve independence for Maori with disabilities
- improve opportunities for Maori to participate in wider society as well te ao Maori (the Maori world)
- consider Maori values (as well as value for money) and be culturally appropriate
- increase the level of Maori participation in service planning, implementation and delivery.

4.3 Reducing inequalities

Reducing inequalities is one of the key strategic issues that permeate all of Northland DHB's planning and funding processes, and decisions. It is one of the main thrusts of our prioritisation policy to ensure that funding decisions are consistently driven by the need to reduce inequalities among population groups.

The most common inequalities relate to measures of health and health service usage by Maori. Pacific people also experience inequalities. Other inequalities that may be relevant to

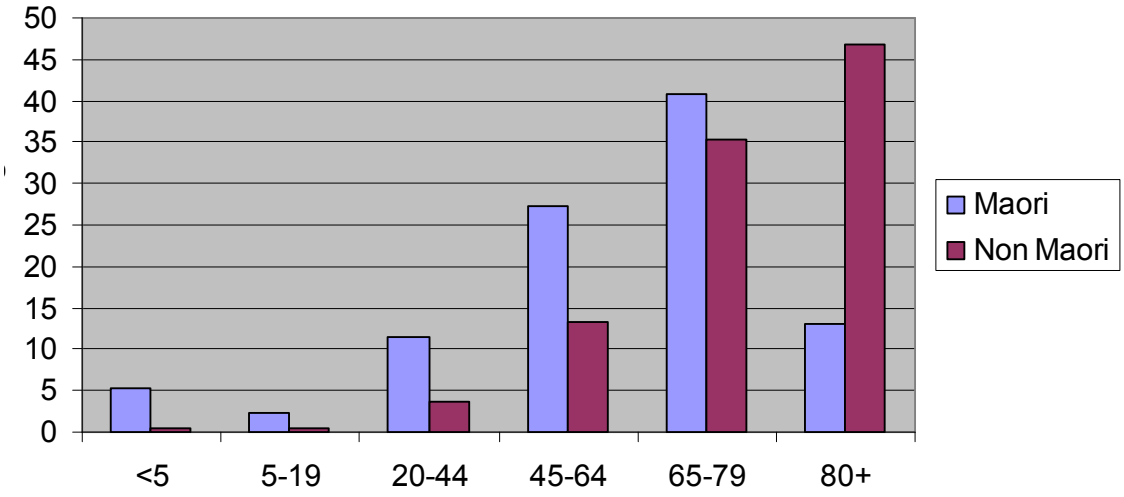
[32] The 4 pathways are: development of whanau, hapu, iwi and Maori communities; Maori participation in the health and disability sector; effective health and disability services; and working across sectors.

particular situations exist between rural and urban, deprived and wealthier populations, age groups, and males and females.

4.3.1 Inequalities for Maori

As noted in section 1.3 'What is ageing anyway?', chronic disease can create a need for clinical and support services. Maori are more likely to acquire a chronic disease at an earlier age than non-Maori, and are also likely to die at young ages. Figure 16 shows that over one quarter of Maori die in the 45-64 age group, compared with only 13% of non-Maori. For Maori, the age group in which most deaths occur is 65-79, whereas for non-Maori it is 80+. The earlier onset of age-related disease among Maori means that the 65+ age threshold is not appropriate and a flexible approach has to be taken when planning and funding health of older people services for Maori.

Figure 16 Northland mortality 2004 by age and ethnicity[33]



Initiatives to prevent and control long term conditions are also important for protecting the health of Maori. However, kaupapa-specific services to meet the early onset of age-related conditions have not been developed; that is one sort of inequality in service provision for Maori. Another is that remote rural areas, which typically have a higher proportion of Maori, have the poorest access to services such as home based support services, respite and day care.

To ensure inequalities are being reduced, Northland DHB uses the Health Equity Assessment Tool (HEAT). This incorporates within it the Reducing Inequalities Framework and the principles of the Treaty of Waitangi. The HEAT tool is in Appendix 8.

4.3.2 Inequalities related to age

Older people experience difficulties when their problems are seen as an inevitable part of ageing. Faced with this attitude, they may miss the opportunity to remain healthy and independent through rehabilitation, correction of health problems or provision of support services and access to non health agencies.

[33] NZHIS (2008) Mortality Data, 2004.

For older people, one of the biggest problems is being denied the opportunity to remain in their familiar surroundings and 'age in place'. Even in their own homes, some can feel isolated and insecure if they have limited contact with families, friends and their community.

In addition to the effects of genetic inheritance, health in later life is determined by a complex interplay of social and economic factors from birth, as well as by gender and ethnicity.[34] In their discussions on health status, a working group established by the Ministry of Women's Affairs stressed the need to adopt a wider public health perspective of ageing well, rather than concentrating on the deficits of ill-health and disability. Two areas of ongoing policy focus are:

Health promotion and protection. A community and environmental view is being promoted by local government in New Zealand as a result of territorial local authority responsibilities under the Local Government Act 2002 to develop, implement and monitor progress of Long-Term Council Community Plans to achieve community outcomes. These approaches mobilise sectors across the community and build social capital. They have a broad approach to improving community outcomes such as nutrition, social inclusion and housing.

Living with disability. The Disability Survey 2006 found that throughout New Zealand, 45% of people aged over 65 had a disability.[35] Disability increases with age. The 2001 Disability Survey showed the following rates of prevalence (the 2006 survey did not provide as detailed an age breakdown):

under 25s	130 per 1,000
65-74	421 per 1,000
75-84	582 per 1,000
85+	873 per 1,000

(Note that these figures include all sorts of disability from mild to severe and should not be taken as an indication of a need for services.)

The provision of a broad spectrum of initiatives with an emphasis on prevention and rehabilitation will maximise health and well-being for older disabled people. Assistance ranges from small to large items and includes dental work, hearing aids, housing adaptations or modifications, aids to mobility, footpaths, bus routes and community transport, and access to technology.

Effective remedies for this are information, education, action (such as tai chi) and community groups that support people to live with a disability.

Good emotional and mental health is also important to experiencing quality of life in old age. Anxiety and depressive illness can arise from deterioration in physical health and/or lifestyle changes associated with ageing.[36]

[34] Ministry of Women's Affairs, (2002)
[35] Statistics NZ, (2007). 2006 Disability Survey.
[36] Ministry of Health, 1998

5 Vision and goals

5.1 Ten year vision

By 2016 in Northland:

The longevity gap between Maori and non Maori will be significantly reduced

All older people in Northland will be living long meaningful lives and able to complete their lives with dignity.

In 2005/06, the priorities that emerged from the regional consultation meetings were:

- service development and processes established for effectively and efficiently integrating services around the needs of older people, their families, carers and whanau
- service development and processes to ensure people *"are part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care" (Primary Care Strategy 2001)*
- communication and consultation plans established for ongoing involvement of consumers and providers in service improvement
- person- and carer-centred, integrated, coordinated, effective and sustainable intersectoral and disability support services in place to achieve the 2016 vision (see *Health of Older People Strategy*)
- using electronic assessment suites to achieve best practice in health of older people services
- information systems in place to track and evaluate progress towards the vision from consumer, funder and provider perspectives.

The principles from these priorities have been embedded in the pilot studies (described in Appendix 7).

The District Annual Plan (DAP) will provide detail of ongoing workstreams and targets in each financial year.

Both Northland DHB and the MoH will monitor progress in implementing the Health of Older People Strategy through the required quarterly reports to the Ministry of Health.

5.2 Goals

The following goals, which form the framework for the implementation plan in section 7, address the gaps and issues identified during the planning process:

Goal 1 Develop sustainable health-promoting communities.

Goal 2 Develop and fund an integrated continuum of care for older people in all regions of Northland.

Goal 3 Develop and fund specialist in-reach dementia services in Northland.

Goal 4 Develop community-based Kaupapa Maori services for Kaumatua and Kuia.

Goal 5 Develop Health of Older People and disability services' workforce capacity and capability to meet Northland's population and health needs.

Goal 6 Deliver quality services, 're-tooled' patient information flows, connected IT, and evaluate the impact of service enhancements.

6 Implementing the plan

6.1 Working in partnership

Health status is affected or determined by many social and economic influences outside the direct control of health service providers. Working with other agencies enables the health sector to better address needs that affect and underlie health status. It can also be a way of reaching the most deprived populations, particularly as they form the client base for agencies such as the Ministry of Social Development (MSD) and Housing NZ.

6.2 Reorienting the historical purchase model to a restorative model of care

It is generally well understood that the current purchase model, in particular the funding approach, does not support sustainable or appropriate home based support provision, and this in turn is creating pressures on Aged Related Residential Care. Issues have been exacerbated by funding mechanisms which promote dependency and demand driven outcomes. There is a need to design and remodel Home Based Support Services to support client and community participation and orientate people towards a range of community and self help options or supported discharge from services.

The mid and far north pilot project focused on the development of a restorative model of service delivery in home and community based disability support services, designing an aged residential care clinical pathway for respite care and developing Maori models of home based support services and implementing a research project to identify the future community based residential care needs of Kaumatua and Kuia.

When working with whanau it is about understanding the dynamics of whanau. Inclusive in any service relationship is: whanaungatanga when supporting whanau to access services, through the process of powhiri-karakia-mihimihi; applying the principles of kawa-tapu-noa in their homes; establishing links through the use of pepeha; maintaining support worker links through whakapapa; working with all whanau during times of decision making and having Kaumatua and Kuia available to assist with korero.

The future direction of services will be on supporting older people to remain well in their communities, and as functional decline occurs, support people to remain at home. The developments occurring in primary health and home based services are geared to slowing the progression of older people into traditional rest home services, therefore altering the demand on future rest home bed days and configuration of these services.

6.3 Evaluation, monitoring and review

Information is vital to identify needs, determine patterns across population groups, trends over time, monitor needs over time and assess how well health services are meeting them.

Information is essential to reducing inequalities. Health services cannot meet all needs so we must focus on the highest priorities first. Without accurate and complete information we cannot prioritise, target intervention or monitor outcomes. Without this information we cannot set appropriate quality assurance measures.

We also need to develop a comprehensive and planned approach to the collection and analysis of the information collected that is tied to the measuring the goals of this strategic plan.

Information flow between health and disability service providers is frequently mentioned as a source of frustration because inadequate information handicaps the ability of providers to provide quality care.

7 Strategic implementation plan

This section is structured around 6 goals. Specific service gaps and issues identified in the gap analysis have been addressed under the relevant goal and appropriate actions developed. Implementation of the HOP Strategic Action Plan will be phased according to the phases described in the Executive Summary. Implementation will be monitored and the work programme reprioritised over time in relation to needs.

The "Resources required" column uses the following terminology:

Ongoing	Existing work programme with no extra funding required.
Service change	A change in delivery of services with no extra resources required.
Service enhancement	Extra resources for an existing service.
New service	A service that doesn't currently exist.

Goal 1 Develop sustainable health promoting communities

Actions	Agencies involved	Measures/ milestones	Resources required (see intro to this section)
1.1 Establish primary health service co-ordination service (SCOPE) for older people (senior citizens) living in the community to support and maintain their independence, and reduce their frailty, functional and social decline. Work inclusively with Iwi and Kaupapa services. Work inclusively with senior citizens and informal carers.	NDHB MAPO PHOs General practices Community support and government agencies. fieldworkers NGOs MSD	Completion of 9-12month pilot. Primary service coordination accessible to eligible population. Primary service coordination accessible to Maori. Primary service coordination accessible to informal carers. Increased independence and health status due to early intervention and referral strategies. Intersectoral and community engagement. Documented project evaluation. Service specifications quantifying inputs/ cost. Primary sector capacity.	**NEW SERVICE, PHASE 1**. Service Coordination FTE within PHOs (based on pilot evaluation by October 2008).
1.2 Pilot and develop community clinical pharmacy services.	NDHB Community Pharmacists	Increased medication compliance. Reduction in pharmacy costs.	**SERVICE ENHANCEMENT, PHASE 1.**
1.3 Identify and implement/ trial preventive, early intervention and health promoting initiatives within the context of the *Te Tai Tokerau Strategic Public Health Plan*'s priorities. 1.3.1 Develop and expand programmes promoting healthy food and physical activity to people with disabilities. 1.3.2 Apply food and nutrition and physical activity guidelines in residential care settings (linked to guidelines and legislation).	As per 1.1	As per 1.1. Age appropriate public health goals established. Age appropriate health promotion/ prevention strategies adopted within primary services. Healthy lifestyles being achieved. Reduction in episodic secondary care and ED presentations.	As per 1.1. New public health framework.
1.4 Continue to strengthen intersectoral relationships to address social need and development of elder friendly, sustainable and health promoting communities.	As per 1.1	As per 1.1. Three community initiatives (Kaipara completed by October 2008. Non-health funding accessible through available benefits, MSD and local government policy. Integrated intersectoral	As per 1.1.

Actions	Agencies involved	Measures/ milestones	Resources required (see intro to this section)
		planning and workforce development of capacity.	
1.5 Continue to strengthen connection and planning with Northland's three local government authorities, to support the implementation of positive ageing strategies.	NDHB MAPOs Whangarei, Far North, Kaipara District Councils	NDHB representation on Whangarei District Council Positive Ageing Advisory/ Reference Group. Kaipara District Council engagement in the Primary Assessment and Service Coordination pilot/ promoting positive ageing. Formal contact with Far North District Council Community Liaison team. Integrated planning with local authorities.	**ONGOING.** Community service and consumer reference funding alliance(s).
1.6 Ensure each person (and their primary carers) with longer term support needs have access to support services, based on needs assessment and service coordination.	NDHB MAPOs NGOs NASC	Access to funded support services. Ongoing funding responsibility established.	**SERVICE CHANGE.** National eligibility and funding decisions (Interim Funding Pool) for providing long term support needs to those with chronic/ complex care needs. New/ extension of existing NASC flexi funding.
1.6.1 Implement a Dedicated Carer Relief Service in each region of Northland.		Dedicated carer relief services accessible across Northland.	
1.7 Implement the National Carer Support Strategy (pending from April 2008).	NDHB MAPO NDSA MSD MOH	National Carer Support Strategy goals and objectives integrated into local and regional carer support policy, service development, consumer representation and funding initiatives. Carers have improved access to a greater range of support services.	**SERVICE CHANGE.** To be implemented by NDSA. Enhancement may be required.

Goal 2 Develop and fund integrated continuum of care for older people in all regions of Northland

Actions	Agencies involved	Measures/ milestones	Resources required (see intro to this section)
2.1 Establish a Residential Aged Care Liaison / Gerontology Nurse Specialist position to prevent avoidable admissions/ readmissions to secondary care services.	NDHB Contracted hospice providers NGOs	Improved coordination between secondary, community health, and residential care services. Improved admission and discharge procedures for older people. No discharges late in the day or at night without adequate support or access to medications. Further reduction in ED presentations. Reduced hospital admissions/ readmissions.	**SERVICE ENHANCEMENT.** Position located in Chronic and Complex Care Services (NDHB Provider).
2.2 Implement a restorative model for home based support and community services. Develop appropriate service design and processes for Maori, enhancing InterRai which does not assess for culture or identity. Develop NASC capacity and capability.	NDHB MAPOs HBSS providers MSD ARRC Providers Auckland UniServices Iwi based services	Staged roll-out of a restorative home based support service delivery model across Northland based on project evaluation and sustainable funding. Electronic access to InterRAI assessment suites for older people services. Service development and funding partnerships to sustain community based services. Improved access to a range of community and social services. Flexible, goal-orientated packages of care for community clients.	**SERVICE ENHANCEMENT, PHASE 1**, immediate implementation in mid and far north. With re-investment potential due to reducing HBSS volumes, and intersectoral funding.
2.3 Participate in National DHB benchmarking programme to monitor Northland's performance against key restorative home based support performance indicators.	As above Group of 10 DHBs on national benchmark programme	Monthly and Quarterly HBSS performance reports.	**ONGOING, PHASE 1.** For 2 years through national business case and potential contract with Auckland UniServices.
2.4 Implement a clinical/ restorative pathway for respite care in designated Aged Residential Care Services.	NDHB ARRC providers Auckland UniServices	Contracted respite care bed days accessible across Northland for resident populations, based on resident volumes and respite care demand and trends.	**SERVICE ENHANCEMENT, PHASE 1.** On current ARRC bed day rates.
2.5 Complete a feasibility study for establishing 'first response' non-complex treatment	NDHB provider	Feasibility and sustainability of first response service	**NEW SERVICE.** One off project

Actions	Agencies involved	Measures/ milestones	Resources required (see intro to this section)
services with contracted ARRC hospitals. Support the ARRC sector to develop advanced care directives.	NGOs Contracted ARRC providers ARRC sector Reps NDHB Legal and NDHB Professional Advisors	identified. Referral procedures and response times for the service established. Reduced avoidable admissions and unnecessary re-admissions.	funding.
2.6 Review frail elderly and dementia day care service specifications and associated contract prices.	NDHB NDSA	Regionally consistent service specifications and pricing.	**NEW SERVICE/ SERVICE ENHANCEMENT, PHASE 1.**
2.7 Contract for residential aged care capacity based on demographic trends in Northland and the impact of service changes in primary and secondary services resulting from the pilots currently being undertaken. Ensure access to a continuum of age related services as close as possible to service users. Explore supported living versus residential care options.	NDHB	A bed purchasing plan that recognises a 2-3 year lead in period for new or existing providers. Older people have access to aged care specific health services according to need. Feasibility study of rest home level 3 access in the Hokianga region.	**SERVICE ENHANCEMENT, PHASE 1,** immediate implementation in in mid and far north. Additional bed day costs.
2.8 Engage NDHB's Chronic and Complex Care Services in planning and service initiatives.	NDHB	Partnerships in delivering age appropriate services across all service groups.	**SERVICE CHANGE.**
2.9 Quality end of life care services are accessible wherever people are dying, including general practice services, smaller regional hospitals, Hauora Hokianga, Whangaroa Health Trust, Age Related Residential Care Services and the Regional Corrections Facility.	NDHB MAPOs NGOs PHOs	End of life care is documented using the Liverpool Care Pathway[37]. The incremental development or adaptation of 'end of life care contracts' for age related residential care services, recognising cost.	**NEW SERVICE.** Using some combination of SIA funding, PHO development funding and specialist palliative care and aged residential care service agreements.

[37] www lcp-mariecurie.org.nz

Goal 3 Develop and fund specialist in-reach dementia services in Northland

Actions	Agencies involved	Measures/ milestones	Resources required (see intro to this section)
3.1 Establish a dedicated dementia service framework and clinical pathways.	NDHB MAPO Kaupapa Maori Services PHOs NGOs Consumer reps	An integrated pathway for people with dementia and their carers established to improve access to services, and responsiveness to the complexity of this disease process. Links established between primary and secondary care, specialist and generalist care, and with quality research and education. Clinical pathways and in-reach/ regional services established for all affected age groups. Referral procedures and response times for services established. Establishment or regional links to cognitive dementia and memory service clinics.	**NEW SERVICE, PHASE 1**, immediate implementation. One off project funding.
3.2 Provide access to specialist hospital, residential and respite care bed days within Northland for: • comprehensive specialist assessment, diagnosis, hospital and treatment services • secure residential placement • respite care.	NDHB MAPO	Contracted in-reach specialist dementia services in place in Northland.	**NEW SERVICE, PHASE 1**, immediate implementation. Impact on Whangarei Hospital Site Master Plan.
3.3 Support early recognition and primary referral in general practice.	NDHB MAPO PHOs Alzheimer's Society	Early access to community based information, support and assessment services. Early referral to primary contact and assessment services (general practice). Reduction in falls risk and number of falls. Earlier practical support for informal carers.	**SERVICE ENHANCEMENT** Also refer 3.1.
3.4 Improve access to dedicated specialist dementia day care services.	NDHB MAPO Iwi based day care services.	Specialist day care provision by qualified activity and community agencies. Integration of people in the early stages of dementia, into frail elderly day care services.	**SERVICE ENHANCEMENT, PHASE 1**, immediate implementation. Increased funding on current per unit

Actions	Agencies involved	Measures/ milestones	Resources required (see intro to this section)
			price(s).
3.5 Improve access to services for those under 65 years of age.	Refer 3.1	Access to appropriate health and disability support and dementia specific services. Stronger interface with primary and secondary mental health services.	Refer 3.1
3.6 Provide education to health workers to raise awareness and develop skills and raise awareness in the community.	NDHB Alzheimer's Society Kaupapa Maori Services NGOs	Improved public awareness. Improved quality of care by strengthening workforce education and training. Increased utilisation of dementia services in early to mid stages of disease progression by those with dementia and their carers. Increased utilisation of dementia specific services by Maori and whanau.	**SERVICE CHANGE**.
3.7 Recognise and support the role of the Alzheimer's Society, developing early intervention services.	Refer 3.1	Additional service initiatives identified and funded (also refer 3.1). Links to primary counselling services. Behavioural support programmes. Café club.	**NEW SERVICE** for service initiatives.
3.8 Seek a review of the National Elder Abuse Contract (MSD) to address local incidence and risk.	NDHB MSD Age Concern Family Violence Coordinator NDHB	Abuse awareness and training across relevant sectors incorporated into the national agreement with MSD.	**SERVICE ENHANCEMENT.**

Goal 4 Develop community based Kaupapa Maori services for Kaumatua and Kuia

Actions	Agencies involved	Measures/ milestones	Resources required (see intro to this section)
4.1 Engage a Maori specific researcher to carry out Kaupapa Maori research investigating community based residential care and day care services for Maori.	NDHB MAPOs	Research design completed by June 2009.	**SERVICE CHANGE, PHASE 1.** Existing project funding.
4.2 Complete agreed research activities.	NDHB MAPOs Iwi Kaumatua/ Kuia Kaupapa services Maori nurse practioners Maori Health Strategic Alliance Maori workforce consortium Government and community agencies	Research data collection considers national, intersectoral and Northland direction. Kaumatua and Kuia aspirations and capacity are inclusive. Maori leadership achieves an inclusive plan.	**SERVICE CHANGE, PHASE 1.** Refer to 4.1.
4.3 Develop and document a framework and service models for Kaupapa Maori community based residential care and day care services.	MAPO NDHB Researcher	Documented service framework and staged funding plan by 1 July 2009.	**SERVICE ENHANCEMENT.** Enhances day care services. New innovations funding.

Goal 5 Develop Health of Older People, and Disability Support Services' workforce capacity and capability to meet Northland's population and health needs

Actions	Agencies involved	Measures/ milestones	Resources required (see intro to this section)
5.1 Implement a planned approach to strengthening the development of HOP and disability support workforce: • continue to align community provider and service development through MSD workforce partnership • increasing employment for younger Maori and those returning to work • participate in NDHB Maori workforce development • work collaboratively to fund additional NASC capacity and capability • improve access to disability awareness training.	NDHB MAPO Training consortium MSD	Sustainable workforce recruitment and retention in contracted provider services.	**SERVICE CHANGE, PHASE 1.**
		Full-time positions created by guaranteeing hours of work in home-based support services. MSD partnership and funding to achieve a stable HBSS and ARRC workforce. Workforce cost pressures and capacity reduced for NDHB and HBSS providers.	**CO/ALTERNATIVE NON-HEALTH FUNDING.**
		Workforce aligned to population health outcomes and funded service improvement initiatives. Competent workforce to meet the needs of older people and health needs of those with disability support needs.	**SERVICE ENHANCEMENT.**
5.2 Align national/ government workforce development and training initiatives with NDHB planning and funding.	NDHB MAPO	Service quality and risk management.	**SERVICE CHANGE.**
5.3 Continue to build relationships with NorthTec to support local training and education solutions.	NDHB	Access to local/ targeted training.	**SERVICE CHANGE.**
5.4 Develop specialist gerontology roles within NDHB specialist and regional hospital services and fund the development of a nurse practitioner position in gerontology.	NDHB	Improved capacity and provision of gerontology services. Gerontology leadership across the spectrum of service provision. Timely access to first response/ in-reach services.	**NEW SERVICE.**
5.5 Improve workforce data collection building benchmarking capacity.	NDHB MAPO Contracted providers Auckland UniServices	Improved data to inform funding decisions. National, regional and local benchmarking of workforce characteristics linked to provider and service performance.	**SERVICE CHANGE.** Through existing HOP projects. New IT enhancement.

Goal 6 Deliver quality services, 're-tooled' patient information flows, connected IT, and evaluate the impact of service enhancements

Actions	Agencies involved	Measures/ milestones	Resources required (see intro to this section)
6.1 Develop data systems to integrate patient assessment, information and service utilisation data.	NDHB MAPOs Contracted providers DHBNZ MoH	Standardised best practice assessment (InterRAI) and information systems in place. Reporting from shared patient information system. Improved data to inform funding decisions. National, regional and local benchmarking.	**NEW SERVICE, PHASE 1**, immediate implementation. Includes InterRAI assessment suite). In concert with national roll-out.
6.2 Share information within and across local sectors, agencies and communities to ensure the most effective and efficient utilisation of resources within Northland.	As above	Systems and processes developed for sharing service and client information within the constraints of the Privacy Act and requirements for informed consent.	**ONGOING / SERVICE ENHANCEMENT.**
6.3 Establish systems for negotiating, managing and monitoring contracts and service performance from consumer, funder and provider perspectives.	NDHB NGOs PHOs MOH/ HealthPac Other govt and community agencies.	Contract methodology that reflects changes in and sustainability of new service models. Revised service specifications/ data definition that support integrated service delivery and population health outcomes. Funding methodology considers trends in service volumes for core contracted services. Reduction in duplication and cost of service delivery. Funding equity achieved across Northland in partnership with other sectors and alternative funding sources.	**SERVICE ENHANCEMENT.**

Bibliography

Armstrong, J (2002). *Grandmothers: Ethnic approaches to social ageing.* In S Gee (Ed) *Ageing in a diverse New Zealand/ Aotearoa.* Wellington: 40+ Project/30 Tau Neke Atu: Victoria University of Wellington.

Davey J and Gee S. (2002). *Life at 85 plus: A statistical review.*

Davey J (2003). *Two Decades of Change in New Zealand: From birth to death).*

Kings Fund (2006). *Wanless Social Care Review – Securing good care for older people – taking a long term view.*

McMurray, 2003. A*. Community Health and wellness; a socioecological approach. (2nd ed).*

Mid Central District Health Board (2006). Presentation material.

Ministry of Health, 1998.

Ministry of Health (2001). *Primary Health Care Strategy.*

Ministry of Health (April 2002). *Health of Older People Strategy.*

Ministry of Health, 2007. *Care and Support in the Community for Older People in NZ. Issues Paper.*

Ministry of Health, 2007. *Older People's Health Chart Book*

Ministry of Social Development, Office for Senior Citizens (2001). *The New Zealand Ageing Strategy.*

Ministry of Social Policy (April 2001). *The New Zealand Positive Ageing Strategy – Towards a Society for All Ages.*

Ministry of Women's Affairs, (2002)

National Health Committee, 2007. *Meeting the Needs of People With Chronic Conditions.*

Netten A., Ryan M., Smith P., Skatun D. et al. (2002). *The Development of a Measure of Social Care Outcome for Older People.*

NZHIS, 2008. *NZ Mortality Data – electronic file.*

NZIRA (2005) (adapted from MOH 2007 *Care and Support in the Community for Older People in New Zealand Issues* paper)

Palliative Care Australia (Feb 2005). *A Guide to Palliative Care Development: A population based approach.*

Statistics NZ (2004). *Older New Zealanders – 65 and beyond.*

Statistics New Zealand. 2007. *New Zealand's 65+ Population: A statistical volume*

Glossary

Terms *in italics* have their own entry.

Term	Explanation
acute	Used to describe an illness or injury, either mild or severe, which lasts for a short time. (See also *chronic*.)
advanced care directive	A "living will" established with a person while they are competent to make decisions about their wishes for their future care and treatment.
Age Related Residential Care (ARRC)	Rest home and hospital-level care for people aged 65 or over or *"like in interest and age"*.
ATR	Assessment, treatment and rehabilitation.
benchmarking	The process of comparing one organisation's service data with another. For DHBs this is typically with national data or other DHBs.
cancer registration	A system run by the Ministry of Health which contains a record of every cancer diagnosed in NZ. Once laboratories have diagnosed a cancer they must, under a special act, report it to MoH.
cardiovascular disease (CVD)	Related to the heart (cardio) and circulatory (vascular) system. The term includes both *coronary heart disease* and *stroke*.
carer support	Support to provide relief for the primary informal carer, typically a spouse, who is caring for an older person at home. A neighbour or friend may come into the family home so the primary carer can have time out ("informal carer support"), or the older person may be placed temporarily in a rest home if longer periods of relief are required ("formal carer support"). See section 3.2.3. Compare with *respite care*.
day care	A programme of activity and recreation provided for older people during the daytime, whose aim is to maintain and improve mental, physical and social functionality (see section 3.2.4).
decile	See *deprivation*.
deprivation, deprived	Describing those with high, often multiple, needs (often used loosely to mean 'poor', though income is only one of the factors considered). The most widely quoted source of data on deprivation is the NZ Deprivation (NZDep) scale which analyses 5-yearly Census data to describe deprived populations. Once 'deprivation index' scores are calculated across the whole of New Zealand, the data is divided into deciles, 10 population groups of equal number. (These deciles are calculated differently, and use a different scale to the school deciles used by the education system.)
FTE	Full-time equivalent
HealthPac	A division of the Ministry of Health that acts as the payment agency for contracts for all DHBs. Funding that goes to DHB provider arms is channelled through a separate mechanism.
HEAT	Health Equity Assessment Tool. A series of questions designed by the Ministry of Health that enable a service or plan to be assessed for its effectiveness in *reducing inequalities*.
He Korowai Oranga (HKO)	The national Maori health strategy published by the Ministry of Health (see also *Whakatataka*).
home based support services (HBSS)	Practical in-home services for older people who have been assessed as being able to remain in their own homes (see 3.2.6).

Term	Explanation
hospice	A facility that provides a programme of specialist palliative and supportive services to dying persons and their families/ whanau, in the form of physical, psychological, social and spiritual care.
hospitalisation	The process of attending hospital as a patient. It includes 3 main types: inpatient, a patient who stays at least one night in hospital outpatient, a person who is seen in a non-inpatient setting, or 'clinic', by a specialist after referral from a GP daypatient, a patient who undergoes an operation or other procedure in hospital and able to return home without staying overnight. The term 'hospitalisation' is often used loosely to mean one or any combination of the 3 types.
IDFs	Inter-District Flows, money paid by a DHB for care provided for its residents by another DHB (most of Northland DHB's IDFs are paid to Auckland DHB).
inequality	See *reducing inequalities*.
inpatient	See *hospitalisation*.
in-reach dementia services	Dementia services accessible within Northland and close to where people live.
Interim Funding Pool	A pool of funding held by the Ministry of Health to which DHBs can apply to provide disability support services for those aged under 65 who meet the criteria for this fund. (This funding applies to people with disabilities, as distinct from funding related to *"like in interest and age"* which applies to people with age-related conditions.)
InterRAI	(As it relates to health of older people) an electronic suite of assessment tools. InterRAI is an international collaboration of gerontologists, clinicians and researchers whose tools have been trialled in New Zealand and are in the process of being implemented nationwide.
intersectoral	Used to describe relationships between health and other sectors, often other government organisations, *TAs*.
"like in interest and age"	An assessment of a person aged under 65 as if their health or disability support need was the same as that of a person aged 65 or over. (This funding applies to people with with age-related conditions, as distinct from the *Interim Funding Pool* which applies to people with disabilities.)
mainstreaming	A term used internationally within palliative care circles to describe the provision of services by providers who are not specialists in palliative care. This includes general practitioners, hospitals and community services.
MoH	Ministry of Health.
NASC	Needs Assessment and Service Coordination; an NDHB provider service that provides assessment of older people who have identified health and disability needs. It coordinates packages of care to meet those needs and the individual's goals and aspirations which take account of their abilities, social and natural supports. Compare with *SCOPE*.
NDHB	Northland District Health Board, which has 2 parts, *NDHB Funder* and *NDHB Provider*. The NDHB Funder is that part of NDHB that has been legislated to carry out the funding function for health services in Northland. The funder assesses needs, sets priorities for services, allocates funds, lets contracts to providers, and monitors performance. The NDHB Provider is that part of NDHB that provides health services (as distinct from the *NDHB Funder*). The majority of the Provider Service's funding goes on *Secondary care services*. In the strategy documents, 'NDHB' refers to the whole organisation with involvement as relevant in each case from the funder or from the provider arm.

Term	Explanation
NDSA	Northern DHB Support Agency, the shared service agency which supplies common support and analytical functions to the 4 Northern Region DHBs (Northland, Waitemata, Auckland, Counties-Manukau).
NGO	Non-government organisation, any organisation which is not part of the public sector. In the health sector it usually refers to health service providers, though it applies more widely than that. It encompasses the private and voluntary sectors, therefore including many organisations which are funded wholly or partly from the public purse but are not part of a formal government structure. Major NGOs include hospices, PHOs and Maori providers and aged residential care services.
outcome	The result of an action. As distinct from an output, which is a measure of an activity rather than the result it has. An operation to mend a broken leg is an output, while the return to full function of the leg is the outcome. In a bigger picture sense, a focus on outcomes aims to analyse how effectively health services are provided and how well they work together.
outpatient	See *hospitalisation*.
palliative care	According to WHO, an approach that improves the quality of life of patients and their families facing the problems of a life-threatening illness. It aims to prevent and relieve suffering by means of early identification and assessment and treatment of pain and other problems physical, psychosocial and spiritual. It can involve a range of providers including hospices, hospitals, general practitioners and community health services.
PCO	Primary Care Organisation.
PCS	Palliative Care Strategy for New Zealand 2001.
primary health care	Health services provided in the community which people can access themselves. The most well known are those provided by general practitioners, though they also include pharmacy services, private physiotherapists and, increasingly, nurse practitioners. (See also *secondary services*, *tertiary services*).
Primary Health Organisation (PHO)	A group of providers of *primary health care* services whose responsibility is to look after the people who enrol with them (those who are 'on the register'). PHOs include GPs as well as a whole range of primary health care providers and practitioners (Maori and community health service providers, nurses, pharmacists, dietitians, community workers, and many others). As well as providing traditional primary health care services, PHOs must improve access to services for those with higher needs (such as Maori or those with chronic health conditions), have a focus on preventing ill health (rather than waiting till they are visited by sick people) and improve the way services work together.
progressive disease	An incurable disease whose symptoms become gradually more severe over time, often resulting in disability and eventual death. Treatment is limited to lessening the effects of the disease and its symptoms. See also *terminal*.
reducing inequalities	Inequalities in the health status of populations exist by *socioeconomic status*, *ethnicity*, gender, age and geographical areas. The reducing inequalities approach is about recognising these and proactively planning, funding and delivering services to reduce these differentials.
respite care	Support to provide relief for a person over 65 years (see section 3.2.3). The older person has repeated short stays in a residential facility (usually a rest home, and usually in a two:six ratio) so that they have time out, are able to remain at home longer and entry to residential care is delayed. Compare with *carer support*.
SCOPE	Service Coordination for Older People in their Environment; primary contact and service coordination for older people who are living at home but who don't yet have an identified health need. The aim is to maintain their citizenship by enabling them to remain living at home. Compare with *NASC.*
secondary services,	Hospital services which people can access only through a referral from a primary

Term	Explanation
secondary care	health care worker. (See also *primary health care*, *tertiary services*).
socioeconomic status (SES)	Social position along a scale (which runs, in everyday terms, from 'rich' to 'poor'), as measured by criteria such as income level, occupational class or educational attainment.
specialist	A physician or surgeon, usually based in a hospital, who has undertaken extra training on top of the normal medical degree to specialise in a particular type of service or disease. Also called a consultant.
target population	A group of people within a larger population which has been identified for special attention, usually because they have higher needs. Target populations are most commonly defined by ethnicity, age, gender or geography, or any combination thereof.
terminal	Describing a condition which results inevitably in death. Also used to describe the final stages of such a condition. See also *progressive disease*.
Whanau Ora	A Ministry of Health-driven process aimed at supporting healthy Maori families which emanates from He Korowai Oranga. It aims to identify and extend whanau strengths and build them into initiatives throughout the health sector.

Appendix 1 Summary of stakeholder workshops

(A) Whangarei HOP Stakeholders Workshop: identified priorities

1 Continuum of care, Ageing in Place – there is none - why?!
- barriers
- funding

2 Community Services
- staffing - wages
- funding
- training

3 Discharge planning (for public hospital services) – why:
- hierarchy
- inflexible systems
- staff, in hospital
- systems in general
- inadequate knowledge of needs of older people and community service
- lack of recognition of support in home or rest home – food, relatives, staff, medication
- the Friday thing
- timing – early morning!
- discharge documentation

4 Lack of 'proper' standards of care in hospital for older people, including continence, ADLs, risk management, falls etc – why?
- training of staff
- status of older people
- negative attitude

5 After-hours medical services for residential care
- lack of knowledge by doctors
- PHO problem

Summary of priorities

1 Service coordination
- discharge planning
- transfer home

2 Continuum of care - not all rest homes can offer full range of care

3 Transitional care
- information on services (to patients and providers)
- funding
- convalescent care/ intermediate care
- good discharge planning
- workforce
- quality and consistency of information.

(B) Mid North HOP Stakeholders Workshop: identified priorities

1 Why is there ↑ in % in HBSS in Northland? Are we providing better care? How does continuation affect service delivery?

Is there consistency among NASC Assessors? If so what?

2 Travel/ transport

- FNDC priorities – taxi service?
- what are ways we can work together to limit travel?
- shared care → formalize arrangements
- home-based support → utilisation of money (transport)
- volunteer drivers
- shuttle services versus taxi services
- SIA funding – ?attend clinic

3 Allied Health Workforce

- ? within context of health and safety
- for safety of caregiver workforce
- Board policy needs reviewing – review model of service delivery & Allied Health Workforce
- attracting staff – recruitment/ retention
- PA support
- regional case – in BOI, Whangarei, Far North
- fundamental to restorative models/ ?well in place
- can we maximise the hours – admin support to release professionals to do their job
- more timely referrals (for example, refer at preplanning to THJR op)

4 Service coordination and integration

- Whangarei
- Mid north
- Far north

? Use NASC service to co-ordinate
? Outreach nurses/ expand their roles elsewhere
? GP based – a link nurse/ SIL for each practice

5 Transitional care

- one Whangarei area
- drive from Home Support perspective

6 HBSS model/ packages

- work to come after Christmas
- open book trial and one Home Support provider working with Auckland model

(C) Far North HOP Stakeholders Workshop: identified priorities

When looking at gaps we first need to deal with what the perception is, that is, demand exceeds supply, is the perception real? how do we measure?

Communication within community providers

Dementia – no carer support, care unit (permanent care)

Intermediate care – discharge before fully recovered

Stubbornness for general wellbeing → fear based

Age gap for this generation, kuia and kaumatua – whanau, mokos

Information – not understanding

Education – nutrition, diet, exercises

Dementia

Living alone – disadvantaged, no other eye

Sensitivity – to meet needs

Right health professionals – rehab – hospital/ home based – whanau

Transport – taxis, rural

Programmes out to the community

Wellness – Maori – marae based, being used for community based – training/ educational/ cooking

Home services – home help/ health and safety

NASC Assessors, Whangarei (someone who doesn't know the person, decides the services to be delivered)

Discharge from hospital (such as Auckland), no equipment in place for person to go home safely

Training gap for HBSS/ caregivers re ↑ age and dependency of older person

Funding gap to implement the strategy

People asset/ cash poor – would benefit from rehab and return home – go to residential care FT

Workforce gap – allied health (nutrition, dietitian, rehab/ rehab assistants, rehab physios and OTs, podiatry)

Dementia – Sp dementia residential care. memory clinic (GP training)- correct diagnosis of dementia versus anxiety/ depression

Older people want to live at home – need? Residential village in rural areas

Wellness – health surveillance – not available, such as drop in centre at Age Concern for checks (screening/ exercise etc)

Hospital → home for older person living alone

Timeframes – resources staffing, waiting time

Equipment availability

Over-assessed – streamlining assessment service

Maori (male) Needs Assessor

Transport – local, regional hospital, public

Palliative care – HBSS/ personal health funding

Dementia – secure

Nutrition/ hydration/ medication – monitoring and management

Information/ communication

Fragmentation – various services – tied together

Discharge process, hospital to community

Multiple provision of services needing multiple assessments, therefore gap in seamless service co-ordination, and need for single point of reference.

Need for services to work together for the common cause

Intermediary care/ rehab to transition hospital to home

Common courtesy – that is, talk to the person (older person), remember they are there when planning their care/ recovery.

Early memory group for dementia clients

Mobile services to rural areas

Continuity of personnel

(D) Kaipara HOP Stakeholders Workshop: identified priorities

1 Lack of support workers

2 Training for support workers – high complexity of need

3 Rural isolation, lack of ability to place cares, including support worker, Meals on Wheels, rehab

4 Lack of community awareness of the function of KCHT

5 Client expectations of services they are entitled – family and service providers expectations, including bathroom facilities

- no supervised care - village levels of care
- no continuum of care
- no transitional care into/out of hospital
- Council lack of social responsibility
- lack of facilities for people with disabilities – footpaths, kerbs, mobility issues
- St John ambulance reliant on volunteers – people waiting for ambulance from Whangarei, clients miss appointments
- no social visitors – Age Concern in Dargaville
- no taxi service
- no community day programmes, such as Forget Me Not
- no 'keyworker' or co-ordinator of elderly with high needs
- lack of early referral – GP $$
- lack of appropriate referral – for example, dressings not referred to DN service, clients brought back to practice

1 No 5/7 day care service

2 Lack of social support opportunities (??) for dementia clients

3 Delivery of 'client centred' needs based services

- No Age Concern local group that includes:
  - caring caller
  - small home maintenance
  - advocacy
  - social support - defensive driving (Paparoa twice a year)

- access and coordination to specialist services
- well organised OPF clinics for elderly
- travel to appointments – Dargaville Hospital/ Whangarei Hospital consideration given to timing
- no dedicated person (Maori) ADARDS
- gaps in geographically distanced areas for HBSS
- information for the community about who and what help is available
- lack of pharmacy services in Ruawai and remote rural areas
- access to meals on wheels in small rural areas

A general discussion identified a key project for the Kaipara area: Review the current home monitoring service looking at future development of service and alliances.

(E) HOP Strategy Development Dementia Care Advisory Group

The advisory group met on 5 October 2006. They brainstormed issues for the sector, writing up a list of strengths, weaknesses, opportunities and threats (SWOT). Each member of the group identified their top 5 planning issues by placing a dot against them – issues with their dots against them are shown below. The list identifies whether they are a strength (S), weakness (W), opportunity (O) or threat (T), and how many dots they received. During discussion, the group identified 9 priority actions to be included in the planning process; the table below shows these with the SWOT issues from which the priority actions were derived. During discussion, the group also identified a set of guiding principles for dementia service decision making.

Suggested planning priority		Relevant SWOT issues
1	Increase the number of beds available for: • comprehensive assessment • secure dementia • respite (new outside mid-north) • specialist hospital	Lack of inpatient beds for comprehensive assessment (W, 3) Lack of dementia and psycho-geriatric beds in Northland (W, 3) More secure unit beds (O, 5) Specific beds for younger dementia clients (O, 1) Contracting respite beds (O, 5) Cost of early entry in to residential care (T, 1) Lack of beds for respite (T, 1) *19 dots*
2	Create a comprehensive assessment service	Comprehensive assessment service (S, 2) Lack of inpatient beds for comprehensive assessment (W, 3) – also in 1) *5 dots*
3	Establish a dedicated dementia service	Have sector experience in dementia (S, 1) Good communication between providers (S, 1) No appropriate service for under 65s with dementia (W, 3) Dedicated service (O, 6) Culturally appropriate services (O, 2) Look at different models of supports (O, 2) In-reach services (O, 2) *17 dots*
4	Increase day care services	Alzheimer's Society: day care programmes and localities (S, 4) Mobile day care respite in at risk areas (O, 1) Increase day care (O, 4) Specific beds and day care services for younger dementia clients (O, 1) Lack of day care (T, 1) *11 dots*

Suggested planning priority		Relevant SWOT issues
5	Create services for under 65s	No appropriate service for under 65s with dementia (W, 3) Specific beds and day care services for younger dementia clients (O, 1) (also in 4) *4 dots*
6	Provide education to health workers to raise awareness and develop skills; raise awareness in the community	Have sector experience in dementia (S, 1 – also in 3) Insufficient number of suitably trained staff; availability of staff (W, 2) Secondary service: lack of understanding of dementia for clients admitted for other medical and surgical conditions; inappropriate discharge; lack of management (W, 1) PHO development: nurse specialist, GPs, practice nurses (O, 3) Dementia-specific education (O, 5) *12 dots*
7	Develop respite services throughout the district and across the continuum, promoting in-reach services	Lack of respite care in Whangarei and district, Kaipara and Far North (W, 1) Mobile day care respite in at risk areas (O, 1 – also in 4) Contracting respite beds (O, 5 - also in 1) In-reach services (O, 2) *9 dots*
8	Recognise and support the role of the Alzheimer's Society	Alzheimer's Society: support and education of clients/ families and age related facilities/ providers; day care programmes and localities (S, 4) *4 dots*
9	Support NASC capability and capacity	Good co-ordination of interface of families and NASC (S, 1) Comprehensive assessment service (S, 2 – also in 2) *3 dots*

Guiding principles

Services may be redesigned and new models developed. In both design and delivery stages, these principles will be followed:

- evidence base
- research
- best practice
- pathways
- cultural appropriateness
- sustainability.

(F) HOP Strategy Development Home Health Monitoring Group

The advisory group met in Dargaville on 11 October 2006. They brainstormed issues relating to home health monitoring, writing up a list of strengths, weaknesses, opportunities and threats (SWOT). Each member of the group identified their top 5 planning issues by placing a dot against them – issues with their dots against them are shown below. The list identifies whether they are a strength (S), weakness (W), opportunity (O) or threat (T), and how many dots they received). The table shows the priority actions with the SWOT issues from which they were derived. The group also identified the key stakeholders to be involved in any future project or pilot relating to home health monitoring in the Kaipara.

Suggested planning priority	Relevant SWOT issues
1 Redesign the health monitoring service and run a pilot to test the model. Include in the redesign brief for the steering group: • definition and description of service • identification of service providers and their roles • identification of communications structures and systems • development of client records and documentation systems and processes • development of discharge planning and service coordination systems and processes • integration of primary, secondary and specialist services • development of community pharmacy role, within national pharmacy framework • risk management	Clarify roles, gaps, overlaps and provide integration of services (O, 4) Definition of health monitoring (W, 1) Uncertainty about what is meant by health monitoring – not addressed; who benefits, by whom, best practice (T, 3) Overlap of services/ communication (W, 1) Lack of co-ordination/ fragmentation of services/ professionals' roles (T, 1) Gatekeeping $$ – other health professionals shut out (T, 4) Financial resources for ideal service (T, 1) Small community – close proximity of site (S, 1) One-stop site – ex pharmacy (colocation), lab, radiology, physio, OT (S, 1) Site/ links – regular (fortnightly) MDT meeting eg CART, multi-agency: DMC, iwi provider, ward (S, 2) Iwi provider on site (S, 2) 1 pharmacy (involved in MDT) (S, 1) Provide client choice of professional (O, 2) Provide an 'A' model for the rest of rural Aotearoa (O, 7) Implement the pharmacy framework (O, 7) Redesign the health monitoring service, eg pilot (O, 9) Establish formal and informal communication links between providers (O, 3) Lack of shared documentation between providers (W, 3) Redefine the role of DNs in home health monitoring (O, 1) Discharge planning (O, 3, W, 3)

Suggested planning priority	Relevant SWOT issues
	Gap for people who are convalescent (W, 1) Risk management – managing situations that are complex (T, 1) *62 dots*
2 Ensure access to services to support home health monitoring service	Lab/ radiology keeping on-site – being closed (T, 4) *4 dots*
3 Transport	No public transport; limited health shuttle service (W, 4) *4 dots*

Stakeholders

Dargaville Medical Centre – GPs, practice nurses (link with CarePlus)

Wellsford Medical Centre

Te Ha (mobile nursing service)

NDHB - provider (secondary, community, HOP), funder

NGOs – home health providers, Rodney Home Health Care

Pharmacists

Allied Health

Tihi Ora (MAPO)

Consumers

Appendix 2 Population projections for 85+

Source: Department of Statistics 2006-base population projections.

		Far North DC	Whangarei DC	Kaipara DC	Northland
2006	All ages	57,500	76,500	18,550	152,700
	65+	7,950	11,370	2,780	22,100
	65-84	7,280	10,180	2,540	20,000
	85+	670	1,190	240	2,100
2008	All ages	58,300	78,020	18,610	155,060
	65+	8,534	12,094	2,944	23,576
	65-84	7,836	10,760	2,680	21,280
	85+	698	1,334	264	2,296
2011	All ages	59,500	80,300	18,700	158,600
	65+	9,410	13,180	3,190	25,790
	65-84	8,670	11,630	2,890	23,200
	85+	740	1,550	300	2,590
2016	All ages	61,200	83,600	18,750	163,600
	65+	11,390	15,680	3,870	30,930
	65-84	10,430	13,750	3,490	27,660
	85+	960	1,930	380	3,270
2021	All ages	62,400	86,600	18,600	167,700
	65+	13,490	18,300	4,510	36,300
	65-84	12,300	16,050	4,070	32,410
	85+	1,190	2,250	440	3,890
2026	All ages	63,200	89,300	18,350	170,900
	65+	15,850	21,160	5,160	42,160
	65-84	14,180	18,320	4,540	37,040
	85+	1,670	2,840	620	5,120
2031	All ages	63,500	91,600	17,900	173,000
	65+	17,750	23,870	5,660	47,280
	65-84	15,560	20,330	4,900	40,800
	85+	2,190	3,540	760	6,480

Appendix 3 Contracted Disability Support Services

Services contracted with NDHB Provider Arm using NDHB core funding

Inpatient Assessment Treatment and Rehabilitation

Domiciliary assessment & education sessions

Outpatient assessment, treatment and rehabilitation clinics

Community services – meals on wheels

Community services – continence service

Community services – professional services such as allied health advice

Community services – stomal service

Dietitian

Environmental support (wheelchairs)

Needs assessment for the 65+

Occupational therapy

Orthotics

Physiotherapy

Respite care beds

Service coordination for the frail elderly

Service coordination for the 32+

Social work

Speech Therapy – audio disability long term

Stroke foundation 'top up' funding

Services contribution to services hosted by other DHBs

Age-related assessment, treatment and rehabilitation

Pyschogeriatric assessment, treatment and rehabilitation

Dementia services

Age related care hospital services

Psychogeriatric assessment, treatment and rehabilitation

Rest Homes

DIAS – Residential Care Line

Orthotic services

Age concern accredited visitors service – North

Arthritis Foundation information and advisory service

Parkinsonism information services

Stroke foundation information services

Prosthetics – Northern (Artificial Limb Board)

Epilepsy Association Information Services

Services contracts with NGOs for services for over 65s

Carer support & respite

Community support

Day care services (frail elderly and dementia)

Elder abuse – Northland (Age Concern)

Hauora Whanui social rehabilitation and day care

Home based support services

Home maintenance

Needs assessment & service coordination

Residential aged continuing care

Stroke Foundation

Appendix 4 ARRC beds by area, Jan. 2008

Facility and location	Hospital-level beds	Rest home-level beds	Secure dementia (RH) beds
WHANGAREI DISTRICT			
Cairnfield House		59	
Kamo Home & Village		40	15
Merrivale Rest Home		38	
Morningview Village		41	
Mountain View Retirement Home		20	
Parahaki Court Rest Home		25	
Puriri Court Home & Hospital	28	43	
Potter Home	32	18	
Oakhaven	60		
Lester Memorial	35		
Seaview Retirement Park		34	
Ranburn Home & Hospital	16	39	18 (+10 pending)
Riverview Villa Rest Home		14	
Selwyn Park Rest Home & Hospital	12	48	15
Shalom Rest Home		20	
Total beds	**183**	**439**	**48** **+30 pending (20 RH, 10 psychogeriatric) (10 current provider, 20 new)**
KAIPARA			
Kauri Coast Hospital and Rest Home (Guardian Healthcare)	29	16	
Maungaturoto Rest Home		16	
Norfolk Court Rest Home		48	11
Total beds	**29**	**80**	**11**
MID NORTH			
Baycare Home and Hospital (Radius, Paihia)	18	32	
Kaikohe Care Centre (Puriri Lodge)	24	25	10
Kerikeri Village Trust	20	23	12
Kauri Lodge (Whangaroa Health Services Trust)	10	10	
Total beds	**72**	**90**	**21**
FAR NORTH			
Switzer Residential Care (Kaitaia)	24	48	0
(24 beds in the process of being changed from RH to hospital-level)	(48 soon)	(24 soon)	
Total beds	**24** **(48 soon)**	**48** **(24 soon)**	**0**
Total beds Northland	**308** **(+24 = 332)**	**657** **(-24 = 633)**	**81** **+ 30 pending (20 RH + 10 psychogeriatric)**

Appendix 5 Projected ARRC beds under the 'do nothing' scenario

This analysis quantifies the number of beds Northland will require if we 'do nothing' – that is, what is likely to happen if we do not make changes to the way ARRC services are currently structured. The analysis has been simplified by restricting it to the 85+ population, the main users of ARRC beds. Tables 1 to 3 analyse ARRC beds, while table 4 undertakes a separate analysis for dementia beds.

ARRC beds

Table 1 describes the current situation and calculates a ratio of beds to the 2008 85+ population.

Table 1 Current ARRC beds and their ratio to 85+ population

District Council area	85+ population 2008	Current beds 2008	Bed ratio (beds as % of 85+ population)
Whangarei	1334	632	47.4
Far North	698	234	33.5
Kaipara	264	109	41.3
Northland	2296	975	42.5

Table 2 applies the percentages from the last column in Table 1 to projected 85+ populations (see Appendix 2). For each area, two calculations have been done: applying the bed ratio that currently applies to that area, and assuming the Northland average bed ratio is applied.

Table 2 Beds required if current rest home and hospital level ARRC bed usage is matched to the projected growth in the 85+ population

District Council area	2011			2016		
	85+ pop. (proj.)	Beds required if we apply the bed ratio for...		85+ pop. (proj.)	Beds required if we apply the bed ratio for...	
		The DC area	Northland		The DC area	Northland
Whangarei	1,550	735	659	1,930	915	820
Far North	740	248	315	960	322	408
Kaipara	300	124	128	380	157	162
Northland*	2,590	1,101	1,101	3,270	1,390	1,390

** Totals may not sum due to rounding.*

Table 3 quantifies the difference between current beds (from table 1) and beds projected using the overall Northland bed ratio (the 'Northland' column in table 2).

Table 3 Difference between current ARRC beds and projected beds using the overall Northland bed ratio

District Council area	Current beds 2008	Projected beds 2011		Projected beds 2016	
		Total	Additional	Total	Additional
Whangarei	632	659	27	820	188
Far North	234	315	81	408	174
Kaipara	109	128	19	162	53
Northland	975	1,101	126	1,390	415

** Totals may not sum due to rounding.*

Dementia beds

Table 4 projects future numbers of beds for dementia. It uses figures from a 2006 study (described in section 3.5.2) by NDSA on usage of beds for dementia across the Northern Region (Northland plus Auckland). The table uses 2006 beds as a base because that is when the study was carried out.

Table 4 Projected dementia beds in Northland, using NDSA 2006 model

District Council area	Actual beds		Projected beds		
	2006	2008	2008	2011	2016
Whangarei	44	48	47	51	60
Far North	27	21	30	33	40
Kaipara	10	11	11	12	14
Northland	81	81	87	96	114

** Totals may not sum due to rounding.*

Appendix 6 Summary of comparisons from *Older People's Chart Book*[38]

The Older People's Chart Book reported the following comparisons of data for older people in general, Maori and those in Age Related Residential Care.

Measures for older people in general

Measure	Type	Compared with...	Older people rate...	...And within 65+
Life expectancy				Females live longer than males
Physical health	Self-reported	<65	Lower	
Chronic conditions	Prevalence	50-64	Higher	
High blood pressure	Prevalence	<65	Higher	Highest in 75-84
High blood cholesterol	Prevalence	<65	Higher	Highest in 65-74
Cancer	Registrations	<65	Higher	Except lower for breast and cervical cancer Higher in males than females
	Mortality	<65	Higher	Higher in males than females
Chronic obstructive pulmonary disease	Hospitalisations	<65	Higher	Highest in 75-84
	Mortality	<65	Higher	Highest in 85+
Diabetes	Self-reported prevalence, if diagnosed by dr.	50-64	Higher for 65-74	
Arthritis	Self-reported prevalence, if diagnosed by dr.	<65	Almost 2x	
Osteoporosis	Self-reported prevalence, if diagnosed by dr.	50-64	More than 2x	7x higher in females than males
Infectious diseases	Mortality	50-64	100x in 85+ females, 65x in 85+ males	
Intentional self harm	Hospitalisations	50-64	Lower	
Unintentional injury	Hospitalisations and mortality	50-64	Higher	Most common: motor vehicle accidents in 65-74, falls in 75+
Disability, moderate and severe	Prevalence	45-64	Higher	
Disabilities of hearing, vision, memory	Prevalence	<65	Higher	

[38] Ministry of Health. 2006. *Older People's Health Chart Book 2006.* Wellington: Ministry of Health.

Measure	Type	Compared with...	Older people rate...	...And within 65+
Seen a GP in the last year	Use of primary services	50-64	Higher	
Of the above, received 15+ prescriptions	Use of primary services	50-64	Higher	
Seen a specialist in the last year	Hospitalisations	50-64	Higher for females 65-74, males 65-84	
Seen an optician in the last year	Use of primary services	50-64 males	Higher for males 85+	
Used or been admitted to public hospital	Hospitalisations	<65	Higher	
Seen dentist or dental therapist in the last year	Use of primary services	<65	Lower	
Seen an alternative health practitioner in the last year	Use of primary services	<65	Lower	

Measures for Maori

Many of these measures relate to Maori under 65 years because of the early onset of disease and disability among Maori.

Measure	Type	For sex and age group...	Compared with non-Maori, Maori rate...
Consuming recommended daily servings of vegetables	Lifestyle	Females 65+	Lower
Doing physical activity	Prevalence	Males 50-64	Lower
Overweight or obese	Prevalence	Females 50+	Higher
Current smoker	Prevalence	All females	Higher
Life expectancy	n/a	50+	Lower
Ischaemic heart disease	Hospitalisations and mortality	All people	Higher (except for males 65+)
Cancer	Mortality	All people	Higher (except colorectal)
Lung cancer, cervical cancer	Mortality and registrations	All people	Higher
Chronic obstructive pulmonary disease	Hospitalisations and mortality	All people	Higher
Diabetes	Self-reported prevalence, if diagnosed by dr.	Males 50-64	Higher 2.5x
Osteoporosis	Self-reported prevalence, if diagnosed by dr.	Females 65+	Lower

Measure	Type	For sex and age group...	Compared with non-Maori, Maori rate...
Renal failure	Prevalence	All people	Higher
Lower limb amputation	Prevalence	All people	Higher
Infectious diseases	Mortality	Males 50-64	Higher
Unintentional injury	Hospitalisations	All people	Higher (except for males 65+)
Disability in general	Prevalence	Females 45+	Higher
Disability, hearing, vision, memory	Prevalence	Females 45+	Higher
Use of Maori health organisation in the last year	Use of primary services	45+	Higher
Seen a specialist in the last year	Use of secondary services	Females 65+	Lower
Seen a dentist or dental therapist in the last year	Use of primary services	50-64	Lower
Seen an optician or optometrist in the last year	Use of primary services	65+	Lower

Measures for older people in Age Related Residential Care (ARRC)

Measure	Type	Compared with people in private dwellings, ARRC residents rate...
Physically sedentary	Prevalence	Lower for all people
Health status (except physical and bodily pain)	Self reported	Lower for all females, and males 75-84
Stroke	Self-reported prevalence	Higher for females 75-84, and males 65-84
Likely to have seen a nurse	Self-reported use of primary services	Lower (less frequent)
Likely to have seen a pharmacist	Self-reported use of primary services	Lower (less frequent)
Likely to have seen a physiotherapist	Self-reported use of primary services	Higher (more frequent)
Likely to have been admitted to a private hospital	Self-reported use of secondary services	Higher (more frequent)

Appendix 7 Pilot studies currently underway in Northland

Many of the innovative ideas contained in this strategy have already been put into practice. Strategic planning discussions held with the sector over the past couple of years (documented in Appendix 1) have stimulated organisations to make changes within their services ahead of the strategy's completion. Solutions to some of the needs identified had not been attempted before, so pilot projects were set up to test them out. These cover the four areas of work described in the remainder of this section.

Restorative approaches to home-based support services (HBSS)

A project in the Mid and Far North to pilot the delivery of a restorative approach to home-based support services is being formally evaluated by UniServices Auckland. NDHB is working collaboratively with other DHBs (including those who have been operating the ASPIRE[39] projects), Auckland University, MSD, community, provider and consumer stakeholders. A partnership with MSD resulted in Work and Income clients being employed on merit with home-based support providers who guaranteed their hours of work. This initiative began in the mid north, has since been implemented in Kaitaia and Whangarei and there are plans to adopt it Northland-wide. The staff have not only been recruited, but retained.

NDHB is working with NorthTec (who is also talking to ARRC/ HBSS providers and MSD) on the feasibility of developing a Northland-specific qualification for caring for older people. This would be targeted to caregivers, potentially under community education, and have formal NZQA status under NorthTec. It will complement and supplement other key education and training initiatives already available to the home-based support and residential care sector.

Northland DHB has provided additional funding to develop client referral, assessment and service coordination processes for Maori. Te Hauora O Te Hiku O Te Ika and Ngati Hine Health Trust are directly involved in the pilot to develop home-based support services for Maori, and are including Te Ha O Te Oranga in the development of service delivery processes. These will be analysed during 2008.

Northland DHB has also increased funding for Northland DHB's Needs Assessment and Service Coordination service to expand its capacity and capability. This is critical to being able to achieve positive outcomes in the services being piloted.

As additional funding is available, we will support the ongoing implementation, equitable access and sustainability of a restorative model of HBSS service delivery. This will relate to supporting additional NASC capacity and capability, funding flexible time-bound packages of care with differential price allocations in the initial stages of service delivery, and recognising the additional processes required for Maori clients and whanau.

Funding support will be required to adopt InterRai assessment tools, integration of services and client information. This work will be done within the context of national and regional developments.

[39] Assessment of Services Promoting Independence and Recovery In Elders, a methodology for assessing people for ageing-in-place services.

The HBSS initiative also relies on aligning flexible service allocations with the funding and claiming mechanisms through HealthPac.

Residential aged care clinical respite care pathway

Auckland UniServices have assigned a researcher to evaluate the implementation of the residential clinical respite care pathway pilot. Switzer Rest Home and Hospital and Kerikeri Village Trust are participating in this research.

Effective and responsive respite care is more resource intensive and therefore more expensive than ordinary residential care. Northland DHB will 'top up' the current residential care bed-day rate to reflect true bed-day costs, and the spectrum of professions and organisations that need to be involved. The requirement for future funding which is additional to the current ARRC bed day rates will be analysed as part of the research evaluation.

A critical component of this research is to identify the needs of informal carers and the services required to support them.

Primary contact and service coordination project and pilot

Kaipara District is currently host to a pilot project on service coordination for those living independently in the community. It is a collaboration between Northland DHB, Kaipara PHO, Coast to Coast PHO, and their general practices and local pharmacies. The aim is to develop service specifications which can be rolled out across Northland PHOs. The pilot project began with six consumer focus group meetings held across Kaipara to identify priority health and social impacts. It encompasses extra community-based pharmacy services to encourage individuals' understanding of and compliance with medications, and to identify trends in the prescribing and use of particular medication groups associated with aging. Local service coordinators are working with the Kaipara District Council to set priorities for community development, such as transport options for elders, improving community access to information through local services directories, and improved paths and roading for those with mobility scooters.

Current provision of Age Related Residential Care beds

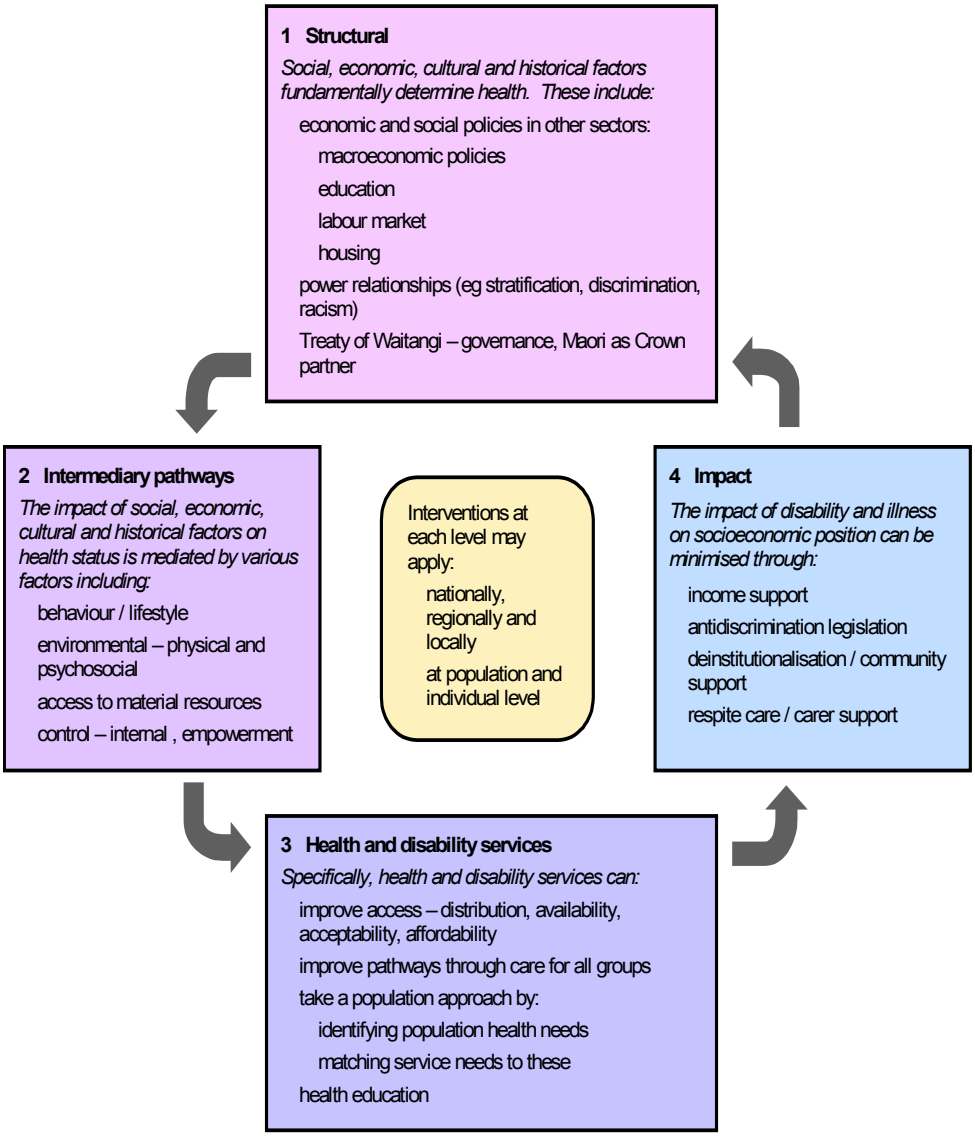
The current number of subsidised beds for ARRC is estimated as falling short by approximately 30 beds. This is based on sustained occupancy of 100% in the Mid and Far North regions, 96%-100% occupancy in contracted D3 dementia care beds, the number of smaller facilities and their location, reduced capacity for current/ known carer support and respite care demand, and increasing number of IDFs and number of residents currently accommodated outside of the area they live in or Northland DHB district.

The aged residential care sector is becoming dominated by major national and international providers who predominantly locate residences near larger population concentrations. This does not match with the needs of older Northlanders in remoter areas with sparse populations, who might want to live close to their communities of origin.

Northland DHB continues to work with current and prospective providers to address the demand on all ARRC beds.

Appendix 8 The Reducing Inequalities Framework and Health Equity Assessment Tool (HEAT)

The Reducing Inequalities Framework



The Health Equity Assessment Tool (HEAT)

The following set of questions has been developed to help in considering how particular inequalities in health have come about, and where the effective intervention points are to tackle them. This is the updated version of HEAT published by MoH in 2008.

1 What inequalities exist in relation to the health issue under consideration?

2 Who is most advantaged and how?

3 How did the inequalities occur? What are the mechanisms by which the inequalities were created, maintained or increased?

4 Where/ how will you intervene to tackle this issue?

5 How will you improve Maori health outcomes and reduce health inequalities experienced by Maori?

6 How could this intervention affect health inequalities?

7 Who will benefit most?

8 What might the unintended consequences be?

9 What will you do to make sure the intervention does reduce inequalities?

10 How will you know if inequalities have been reduced?