WISE

West Coast Improving Services For Elderly

Plan for Older People's Health and Disability Support Services 2006 - 2016

Contents

Executive summary

The rising tide of demand

People aged 75+ years are the highest users of services, and their numbers are expected to grow by around 3-4% a year to 2021, faster than the West Coast DHB's yearly funding increase. By 2021 we can expect a much higher demand for long-term support services in particular. For example:

- 130 more people needing general long-term hospital care at $53,000 a year each, or a possible total yearly extra cost of around $6.9 million.
- 10 more hip fractures a year. At $22,000 each, this will necessitate an extra $250,000 pa
- 20 more strokes a year, 20% of whom are likely to go on to long-term residential care

Much of this need for services could be averted

The pressure of an ageing population means we must make very best use of the resources we have. Much could be done to reduce people's need for health services by taking a more proactive and preventive approach. For example:

- Falls prevention programmes are effective in reducing falls and fractures, especially among people aged 80+ years and those at highest risk.
- Secondary strokes and stroke-related disability can be reduced by fast effective intervention by staff skilled in stroke management.
- Older people have a better uptake and a better success rate in smoking cessation programmes than the average person.
- The availability of supportive/sheltered housing reduces the need for rest home care – West Coast has very little supportive housing.

Preventive initiatives show a faster result with older people – this is not a 20-30 year time frame as with health promotion aimed at younger people, but a reduction in projected hospital admissions and residential care entry within a year or two.

It is important to be very proactive in helping frail older people stay fit and well. A fall, a bereavement, a bad bout of flu in a cold house etc often lead to a cascade of problems – hospital admission, delirium, carer burnout, a drop in functioning and the need for rest home entry.

Health disparities show where we can make the most difference

The average 65 year old lives longer and more healthily now than 20 years ago due to better prevention (e.g. smoking cessation, diet) and better treatment (e.g. hypertension medication).

But this has happened less for people on low incomes and not at all for Maori. Efforts need to be directed to ensuring these groups get the preventive and primary care services they need if we are going to be effective in managing the rising tide of demand that is coming.

We can make effective changes within existing resources if we start now

Many of the WISE initiatives entail a change in approach or organisation rather than a high input of additional resources. For example some providers elsewhere have argued that they can deliver a restorative homecare model (including the intensive allied health/home support needed) within the existing long-term support budget, mostly through a reduction in rest home entry.

West Coast DHB has the highest rate of rest home entry. Spending on long-term support per person aged 75+ years is the highest in the country and 31% higher than the national average. If West Coast DHB had spent the same as most other DHBs of comparable size did in 2006-07, we would

have saved over $2 million. Even reducing this to allow for rurality and poorer overall health, it allows scope for reconfiguring services to be more sustainable in the long run.

The West Coast can expect a slower increase in the number of older people compared to other DHBs, because fewer people live to older age and a significant number move away from the Coast.

We have the opportunity now to configure services to meet the growing demands of the older population in the future. This should be possible within current resources if we start now.

A model of care for older people's services

The goals of the WISE plan are:

- To protect older people's health, independence and interdependence
- T catch illness and disability before they worsen
- To ensue a smooth path into and out of specialist services
- To put in place a strong organisational infrastructure for older peoples services

The model of care to meet these goals includes:

- **A Community Coordinating Service** to streamline and integrate access to community services and to manage the total long-term support budget. National comparisons show that long-term support expenditure is directly related to how the needs assessment and service coordination function is configured and managed.
- **Long-term support** (both residential and home-based) seen as a local service, closely linked to primary and community health services and with a preventive and restorative focus
- **Home support** services funded and delivered on a flexible and restorative model, with up-skilled homecare workers and greater rehabilitation input.
- **Supportive/sheltered housing options** actively encouraged.
- **Residential beds** - probably a gradual reduction in rest home beds per head of older population, replaced by intensive homecare packages and the encouragement of a range of supportive housing options. Probably a gradual increase in the number of long-term hospital and specialist dementia beds to match the rise in the older population.
- **'Non-acute' beds** for slow-stream rehabilitation, 'step-down' care, palliative and terminal cares, and respite care/carer support.
- **Pro-active health promotion/prevention services** – including falls prevention programmes and physical activity opportunities.

Rehabilitation – the next area of rural excellence

West Coast DHB has successfully attracted medical and nursing staff through innovative and exciting projects. The strong rehabilitation focus of WISE could do the same for allied health workers and home- and community-based services. .

A model for community services that complements the changes in hospital services

West Coast DHB is considering how to reconfigure its hospital and specialist services to meet future needs for 2020. The WISE plan complements the Grey Base 2020 Project by starting to plan for the community services that will be needed once Grey Base Hospital is reconfigured. This includes 'non-acute' beds and a more community-focused AT&R service.

If we get it right for older people, it will be right for everyone needing community services and disability support.

Background

The context of the plan

This plan describes the West Coast District Health Board's intentions for developing health and disability support services for older West Coast residents over the next ten years to 2016.

The plan takes account of the West Coast DHB's Strategic Plan 2002-2021, Te Poari Hauora a Rohe a Tai Poutini/Maori Health Plan 2003-2006, draft Primary Health Care Plan, Chronic Care Management Project and Grey Base 2020 Project, as well as the New Zealand Health Strategy, NZ Health of Older People's Strategy, NZ Disability Strategy, He Korowai Oranga/Maori Health Strategy and NZ Primary Health Care Strategy.

The plan describes how West Coast DHB will improve the integration of services for older people along the continuum of care, and enable more older people to 'age in place', as required by the New Zealand Health of Older People Strategy.

At the end of the plan is a summary that shows time-frames, responsibilities and how the results of each activity will be measured.

How the plan was developed

During 2003/2004 a planning advisory group, West Coast Improving Services for Elderly (WISE), was established to help the DHB develop a strategy to address the needs of older people on the West Coast over a ten year period. This group prepared a plan to improve services for older people and to develop an Integrated Continuum of Care, based on information collected during the needs assessment phase of the project and on their own skills, knowledge and experience as health professionals and service users. Although numerous aspects of the plan have been implemented successfully, for about 12 months there was a loss of momentum in implementing the plan.

In mid 2006 the WISE group was reconvened and advised on updating and developing the ideas of the original draft. A Westport-based subgroup of the WISE group has also met to consider issues and solutions specific to the Buller region. Discussions with the Reefton Health Trust group held during mid-late 2006 have also contributed to the plan.

In May 2006 a revised review of data on the health and support needs of older West Coasters was completed.[1] Other recent inputs to the plan include the ongoing discussions on the reconfiguration of Grey Hospital (the Grey Base 2020 Project), the results of the national evaluation of the three 'ageing in place' initiatives that formed the ASPIRE trials[2], and a review of cost-effective ways of planning health and support services for older people prepared by SISSAL.[3]

Implementing the plan

Once approved by the West Coast DHB Board, this plan will be incorporated into the West Coast DHB's District Annual Plan for 2007-08 and subsequent years, and progress will be reported regularly to the Board, Ministry of Health and WISE stakeholder groups.

At the end of this document there is a summary of the work-plan, timeframes and responsibilities for implementing the plan. These will be reported on and updated on a regular basis.

[1] SISSAL, May 2006 'The health and independence of older West Coasters – a health needs analysis'

[2] The projects that were evaluated were: a) Canterbury's Coordinator Of Services for the Elderly (COSE) project, where NASC staff were linked to local health centres and used a more flexible and community-focussed method of case managing frail older people; Hutt Valley's Masonic Lodge Rehabilitation project, where a residential facility provided a form of slow-stream rehabilitation; and Waikato's Community First project where Presbyterian Support Services provided an intensive home-based alternative to rest home care.

[3] SISSAL, April 2005. "Planning health and disability support services for older people over the next 20 years – a brief literature review".

The need for older persons' services

An ageing population

The number of West Coast residents aged 65 or more years grew by around 0.5%-1% a year during the 1990s. The rate of growth slowed during the second half of the 1990s, following a trend seen in other NZ districts. Recently released population projections from Statistic NZ show that the 65+ year old population is projected to increase by around 0.5% a year between 2006 and 2011, but then to rise by around 3-3.5% a year thereafter. The older age group of 85+ year olds, the highest users of long-term care services, is expected to rise at a faster rate of 1.1% a year to 2011 and by 4% a year thereafter. (See Appendix A).

Looking at past trends in the number of older people between 1991 and 2006 censuses, the growth rate appears to be a) lower than that which is projected by Statistics NZ for the next 10-15 years, and b) shows quite marked swings in the rate of growth over time. Further work is being done to find out the extent to which older West Coast residents move out of the district (e.g. for long-term residential care).

Information on age groups from the 2006 census will be available in November to show how numbers have changed over the past five years.

Table 1. The older population (65+ and 80+ years) in each West Coast district, from 1991 to 2006

People aged 65+ years

Resident population

District	1991 M	1991 F	1991 Total	1996 M	1996 F	1996 Total	2001 M	2001 F	2001 Total	2006 M	2006 F	2006 Total
Buller	594	744	1,341	639	738	1,377	675	762	1,431			
Grey	711	861	1,572	720	903	1,623	765	906	1,674			
Westland	441	516	960	444	516	969	480	489	969			
WEST COAST	**1,746**	**2,121**	**3,873**	**1,803**	**2,157**	**3,969**	**1,920**	**2,157**	**4,074**			

Percentage yearly change

District	1991 to 1996 M	1991 to 1996 F	1991 to 1996 Total	1996 to 2001 M	1996 to 2001 F	1996 to 2001 Total	2001 to 2006 M	2001 to 2006 F	2001 to 2006 Total
Buller	1.5	-0.2	1.1	0.7	0.8	0.8			
Grey	0.3	1	1.3	0.1	0.6	0.6			
Westland	0.1	-	1.6	-1	-	-			
WEST COAST	**0.7**	**0.3**	**1.3**	**-**	**0.5**	**0.5**			

People aged 80+ years

Resident population

District	1991 M	1991 F	1991 Total	1996 M	1996 F	1996 Total	2001 M	2001 F	2001 Total	2006 M	2006 F	2006 Total
Buller	75	150	225	99	183	282	105	207	312			
Grey	105	177	279	147	219	369	135	252	387			
Westland	60	135	195	63	150	216	81	123	204			
WEST COAST	**240**	**462**	**699**	**309**	**552**	**867**	**321**	**582**	**903**			

Percentage yearly change

District	1991 to 1996			1996 to 2001			2001 to 2006		
	M	F	Total	M	F	Total	M	F	Total
Buller	6.4	4.4	5.1	1.2	2.6	2.1			
Grey	8	4.7	6.5	-1.6	3	1			
Westland	1	2.2	2.2	5.7	-3.6	-1.1			
WEST COAST	**5.8**	**3.9**	**4.8**	**0.8**	**1.1**	**0.8**			

The older West Coast population has been and is projected to grow at a slower rate compared to the national average, which is around 3-5% a year for 65+ year olds and 5-8% a year for 85+ year olds. The relatively slower West Coast growth is likely to be due to a combination of a) some people choosing to leave the district once they reach an age where health and support services become necessary (this is reflected in inter-district flows for residential care), and b) the lower life expectancy of West Coast residents.

However West Coast DHB is funded on the basis of the area's total population so, like other DHBs, it is faced with a squeeze between relatively unchanging government funding but rising demand from a growing population of older people. In this situation it is important that the DHB makes best use of its scarce resources to meet the unique needs of its widely dispersed older population.

The health needs of the older population

Key messages from the review of older people's needs for health and support services include[4]:

More but healthier older people – it is the 'young old' 65-74 year age group that will increase fastest in the next 20 years, as baby boomers reach retirement age. However this generation is on average fitter and healthier than older people have been in the past. People's need for services is not related so much to their age per se as to chronic illness and disability and to the last year of life.

The impact of the 75+ year age group comes later - the biggest impact particularly on disability support services will come in 15 years time as baby boomers reach their mid-70s, when people's use of hospital services peaks and their need for disability support services steadily increases.

Finding diverse ways of supporting one another - the vast majority of older people live at home until they die. Smaller and more mobile families mean fewer older people will be able to rely on their children as nearby carers. As the greater diversity of family types and ethnic groups in our society flows into older age groups, they are likely to develop innovative living arrangements for themselves. The challenge for the DHB will be how to support these fairly and ensure that people don't slip through the protective net of social support.

A growing group of chronically ill/disabled - although most 'young old' people are healthy, a minority have chronic illnesses or disability and use health services more than average. This group has often experienced social and economic hardship from middle age onwards (e.g. job loss and/or separation). They may develop illness and disability in late middle age and enter older age with fewer supports, such as a mortgage-free home or nearby family.

Maori and Pacific health - Mäori people are disproportionately represented in the low-income group with chronic illness. In contrast to the rest of the older population, life expectancy for older Maori, as well as Pacific, people did not increase during the 1980s and 1990s and the disparity in health between older Maori/Pacific and non-Maori/non-Pacific has widened during that time.

[4] See [4] SISSAL, April 2005. "Planning health and disability support services for older people over the next 20 years – a brief literature review". Also http://peakoilmedicine.com/index/2006/11/12/how-local-health-care-authorities-can-prepare-for-peak-oil/a-local-health-department-plans-for-peak-oil/

Maori on the West Coast experience pressure to fit in with mainstream services. Health outcomes for Maori would be improved by supporting the healing ability of whanau through Whanau Ora and natural supports to help kuia and koroua.

Access to effective primary care is critical – the rising life expectancy of older people, especially among higher income men, shows what can be done with lifestyle changes (e.g. stopping smoking) and effective primary care (e.g. hypertension medication, flu vaccination, diabetic eye checks etc). The challenge for the DHB is to ensure that these are taken up by other groups, particularly low income people, Mäori and Pacific people. This would enable us to reverse the rise in avoidable hospital admissions which has occurred since the late 1980s.

Keeping physically and socially active is critical – keeping physically fit and active can reduce the likelihood or slow the progression of a number of illnesses common to older people, such as diabetes, osteoarthritis, cardiovascular and respiratory disease and hip fractures or other falls-related injuries. Keeping socially active is protective of people's mental as well as physical health.

Helping older people stay independent – a wide range of community services enable older people to stay active and independent. These range from active rehabilitation programmes to help people regain health and functioning after illness or injury, to long-term disability support services such as home help, special equipment or meals on wheels, and joint initiatives with local councils and other agencies for supportive housing, transport and social support.

Growing need for disability support services – nearly half of all people aged 75 years or over need some help to remain independent, with arthritis being the most common cause of disability. A very small minority need residential care in the last years of their life. It appears likely that the rate of severe disability in the older population may lessen but that the rate of mild or moderate disability may increase. The ageing of the population in itself means a rising need for support services as the actual number of people with disabling conditions increases.

Making the most cost-effective use of resources – the growing need for long-term support services will be the major cost on the health system in coming decades. It is therefore crucial that the DHB puts adequate resources into interventions to help people regain and maintain their ability to remain independent, and reduce the necessity for ongoing disability support services.

Planning for an uncertain future – any future planning must recognise the possible impact of climate change and oil shortages, and resulting global political and economic instability. In 20 years time we may face a need for greater local economic and social self-reliance. Preventive health care will become even more important for staying free from disease and disability.

Underlying principles

The aim of the plan is to develop health and long-term support services for older people that:

Allow 'ageing in place' - this implies a shift in focus away from services provided in institutions (hospitals, residential care facilities) and towards health and support services provided in people's homes and local communities.

Are preventive - have a strong focus on preventing the onset or worsening of illness and disability.

Are holistic and recognise the importance of social, economic, lifestyle and environmental factors in keeping older people fit and healthy.

Are consistent with whanau ora outcomes – specific initiatives are planned and implemented to achieve whanau ora for kaumatua.

Are well-coordinated and integrated over all health providers, including primary health, hospital, community and long-term care services, so that older people receive the right service from the right provider at the right time.

Are easily available to people when they need them, particularly to those at highest risk of illness and disability who have a lower than average uptake of preventive services.

Meet rural need - recognise the specific needs of remote rural communities

Are adequately resourced and well-managed, based on good information.

Make best use of resources, based on well-researched evidence of effectiveness.

Are developed in collaboration with the users and providers of services.

What will we do?

The following section describes four work-streams. These can be seen as a set of 'safety nets' for older people that are designed to:

- Help older people stay fit and healthy and independent and support their social networks of interdependence, including the whanau ora of kaumatua
- Catch illness and disability before it worsens
- Make sure people get the specialist treatment they need quickly and easily when they need it.

Each workstream has a number of activities. At the end is an Action Plan, which shows the timeframes, responsibilities and the ways in which progress in each activity will be measured.

While the plan has been designed to be implemented within current overall available funding, each activity will be subject to a detailed costing and an implementation plan.

Goal A – To protect older people's health, independence and interdependence

Achieving this goal is critical, both in the short-term and long-term, as it will help to manage the rising demand for health and disability support services over coming decades.

In the consultation, West Coast older people clearly identified housing, transport and other social factors as critical in staying fit and healthy. This is backed up by much evidence of the protective effect of warm secure housing, social connections, physical activity and good nutrition.

West Coast DHB will seek to work with other agencies and sectors to provide advice and influence areas that affect older peoples' health and well-being.

Objective 1 Work intersectorally to ensure warm, dry, safe housing

Research evidence confirms housing as a key factor in health. It is important that the housing stock is well maintained, and that older people have housing that is warm, dry, safe and adapted to their changing needs as they age. Although most older people currently own their own home, this proportion is expected to drop in coming decades. (See also below: 9a on supportive housing and 5b on housing modifications). Initiatives that will be started or continued include:

1a) **Home insulation** – West Coast DHB will work with West Coast Development Trust, Rata te Awhina and other organisations to ensure that all older West Coasters are living in warm, dry, insulated homes, through extension of the home insulation subsidy scheme and other initiatives.

1b) **Power discounts –** West Coast DHB will support efforts by Greypower and other organisations to seek discounts on power costs for older people

1c) **Housing standards –** WCDHB will actively work with Housing NZ and other relevant organisations for the adoption of disability-friendly standards for all new building and renovation of the public housing stock.

Objective 2. Work intersectorally and directly to improve access to transport

Transport becomes problematic for many people as they age and lose their drivers licence due to poor vision or other health problems. This is a particular issue for people living in Buller, Westland and other areas where taxi services are not easily available. Cost is a barrier to some people using taxis, even with Total Mobility discounts. Transport is a health issue - being able to get about, to go to the shops, the health centre, the bowling club and to visit family and friends is critical in helping older people stay physically fit and socially active. Initiatives include:

2a) **Work for better public transport –** West Coast DHB will continue to work with local councils through the Intersectoral Forum and in other ways to improve public transport options generally.

2b) Improved transport to hospital and health services – West Coast DHB will continue to actively explore ways of enabling people living in the more rural areas, such as Buller and Westland, to access health services, e.g. by adjusting outpatient clinic times and providing shuttle transport.

2c) **Review Total Mobility and other transport options –** West Coast DHB will look at flexible ways to improve older people's access to transport, as part of a general review of home-based support services (see 7a).

2d) **Car re-licensing education** – West Coast DHB will support Greypower's continuing role in car relicensing courses for older drivers.

Objective 3. Promote physical activity and reduce falls

Keeping physically active has been identified as one of the most significant factors in helping people maintain their health and fitness as they age, and reducing the risk of many common illnesses occurring or worsening, including arthritis, respiratory disease, heart disease, cancer, diabetes etc. Even at an advanced age (80+ years) muscle strengthening and balance exercises are effective in helping people avoid injury and hospital admissions due to falls and fractures.

3a) **Increase opportunities for physical activity** – West Coast DHB wants to increase the number and variety of opportunities for physical activity for older people, and will undertake a stocktake of what currently exists and work with Active West Coast, District Councils and other relevant organisations to develop services further in each local area.

3b) Encourage wide use of Green Prescriptions – West Coast DHB will support the PHO to develop and expand the use of Green Prescriptions and to monitor and evaluate their use.

3c) **Expand falls prevention programmes** – West Coast DHB will work with ACC and other appropriate organisations to plan the expansion of the Otago and Tai Chi-based falls prevention programmes in each local area to cover all older people at risk, particularly those over 80 years, for whom the benefit has been proven to be greatest, and including people in residential care.

Objective 4. Include older people in health promotion activity

Although much health promotion for older people has been done, it has been ad hoc, based on sporadic funding. It is important that older people are included in health promotion campaigns – there is much evidence that even at an older age it makes a difference to a person's health if they change to healthier eating habits, stop smoking and get more exercise - in fact, at older ages these changes are more likely to prevent a hospital admission than at a younger age. It is never too late to start living a more healthy lifestyle!

4a) Older person's health promotion campaign – West Coast DHB will work with Community and Public Health, Disability Information Service, the Primary Health Organisation (PHO), Active West Coast and other relevant organisations and groups to ensure that older people are specifically included in health promotion campaigns, and that their work is coordinated and adequately resourced for this. This includes the Ministry of Health's Healthy Eating, Healthy Activity (HEHA) campaign. Areas to cover include:

- Physical activity
- Nutrition
- Warm dry housing
- Smoking, alcohol and drug use
- Keeping socially active and in touch with others, and maintaining mental health

It is expected that this will be done in collaboration with older people and relevant organisations e.g. Greypower, iwi and other local community groups, so that it is effective in reaching those people at most risk, including Maori, people on low incomes and people who are socially isolated.

Goal B – To catch illness and disability before it worsens

For older people to stay healthy for as long as possible, it is important that illnesses are diagnosed and treated at an early stage. Having regular screening and checks for blood pressure, cholesterol, cancer, diabetes, glaucoma etc helps prevent these illnesses developing further.

Having support in managing chronic illnesses like asthma, diabetes, chronic respiratory disease, arthritis etc can also prevent these conditions worsening – e.g. good management of diabetes can prevent blindness and limb amputation.

The people with the highest risk of ill-health are often those who miss out on health checks and screens, and who don't get to the doctor soon enough to get symptoms checked out. This could be from lack of information about the need for early diagnosis and treatment, difficulty in getting to the health centre due to cost, transport, distance etc, as well as cultural differences.

Long-term support - we have deliberately put long-term support services – home-care, supportive housing and long-term residential care – into this section to highlight the importance of long-term support services for keeping older people fit and healthy. West Coast DHB wants to develop this positive role for home-based and residential support services, link them more closely with primary health care and strengthen their rehabilitation and preventive aspect.

Both primary health services and long-term support services need to be available within people's local communities. This is likely to be an increasingly important consideration as the cost of oil and travel rises in the future.

Much of the planned work in this area is covered in more detail in West Coast DHB's Primary Health Care Plan, Plan for the Management of Chronic Conditions, and specific initiatives for diabetes, cardiovascular disease and similar activity.

Objective 5. Reduce barriers to access to primary health care and disability support services

It is important that people are able to get the services they need and that diagnosis or early treatment is not delayed because of a cost barrier. Ensuring that older people have good access to primary health and support services is a good use of resources, as it is likely to reduce the need for hospital admission or entry to residential care.

5a) Care Plus and pharmacy charges – West Coast DHB will work with the PHO to implement the Care Plus programme, and monitor any unmet need for primary health services, including pharmaceuticals. This is being addressed within the Primary Care Strategy.

5b) Equipment and housing modifications, including vision and hearing aids – West Coast DHB will review access to these services, as part of an overall review of home-care services (see 7a).

5c) Dental health – West Coast will review cost barriers for older people to access this service.

Objective 6. Ensure good management of chronic conditions

A relatively high proportion of older West Coast residents cope with chronic medical conditions. It is important that they get the support they need to manage these conditions, to reduce the risk of complications and worsening illness or disability. This will also help to reduce the pressure on acute hospital services in coming decades that is inevitable as the population ages.

6a) Chronic Conditions Management Strategy – West Coast DHB will implement this strategy in collaboration with the PHO and other organisations, such as Rata te Awhina, Greypower, community pharmacies etc. Activities include:

- Screening – increasing the uptake of screening and diagnostic tests for cancer, cardio-vascular disease, diabetes, glaucoma
- Diabetes awareness and checks, including retinal screening
- Patient registers for asthma, diabetes etc, so that patient gets reminders of checks etc
- Greater use of Green Prescriptions, including information in pharmacies

Objective 7. Introduce a more flexible and restorative model of home support services, including support for carers

Good home support services help to keep older people fit, healthy and able to stay in their own home for as long as possible. They help to reduce the need for hospital admissions and for rest home care. The way home support services are currently funded and delivered, however, could be improved to:

- Be more flexible and tailored to people's individual situations and needs.
- Have a stronger focus on rehabilitation and helping people retain and/or regain their abilities and fitness.
- Value the skills of support workers through greater training and inclusion in a health team.
- Value and support the work of unpaid carers.
- Encourage interdependence rather than just independence – that is, foster the social network that exists around every older person in their needing and giving support to and from others.

7a) Review home-based support services – West Coast DHB will review the funding and delivery of the full range of support services that enable people to remain in their own homes, and implement changes to make these services more sustainable and effective in keeping people fit and healthy.

This will be done in conjunction with reviews of access to the Total Mobility scheme (see 2c), Equipment and Housing Modifications (see 5b) and Carer Support (see 7b). It will also be done in conjunction with planning for supportive housing and residential care (see 9a and 10a), as home-based care, supportive housing and residential care are integral part of the continuum of long-term care.

7b) Review support for unpaid carers – unpaid carers are a crucial part of the support needed for older people to remain fit and healthy in their own homes. West Coast DHB will explore ways of improving support for unpaid carers, as well as ways of supporting local community networks, as part of the review of home-based support services.

Objective 8. Ensure an adequate skilled workforce - primary health, allied health, home-based and residential facility workers

The small population size and huge geographic spread of the West Coast produces challenges in attracting and retaining health workers in many areas, including primary health care, home-based and community services. This issue is being addressed by the West Coast DHB at a broader level. Proposed initiatives to address workforce issues specific to services for older people include:

8a) Ensure an adequate primary health workforce – ways of recruiting and retaining primary medical and nursing staff are addressed in the West Coast DHB's Primary Health Care Strategy, and includes initiatives such as neighbourhood nurses, rural nurse practitioners, and innovative ways of defining professional roles in the primary care team.

8b) Improve training and retention of home-based support workers – West Coast DHB will address the long-standing difficulty in attracting and retaining support workers through the review of home-based support services (7a above). This will explore the feasibility of changing the way these services are contracted and delivered towards a more rehabilitation-focussed model that gives support workers a more skilled and supported role and less casualised working conditions. This will be done in conjunction with the work being done nationally to improve the qualification and skill structure for support workers.

8c) Attract and retain more allied health workers – a move towards a more rehabilitation-focussed home-care service and a community-focussed AT&R service will require a greater input of physiotherapy, occupational therapy and other allied health skills in the community. The West Coast DHB will explore ways of ensuring these areas are adequately staffed (see also 12b).

8d) Support skill development in residential care facility workers – West Coast DHB will work jointly with residential providers to find ways of addressing the skill and staffing differences between residential and DHB facilities, to improve the capability and capacity of residential facilities. This might include consideration of joint training, more consultation and other forms of professional linkage.

Objective 9. Actively encourage the development of supportive housing

West Coast DHB has traditionally provided just two options for long-term support: home support services or full rest home care. Few in-between options, such as retirement villages or other forms of sheltered housing, are available in most West Coast communities, apart from council-owned pensioner units in some centres.

There is a wide range of different possible ways to support people stay in their own homes besides the traditional home help and equipment/housing modification services.[5] These include:

- Co-housing schemes where people buy/rent adjoining properties and provide informal support for one another – this is similar to the council pensioner unit model
- Sheltered housing arrangements, where people rent or own adjoining properties but also have access to a warden and communal facilities. Examples are retirement villages, kaumatua flats, and the Abbeyfields model where people live together in one house with a resident cook/warden.
- Home-sharing schemes
- Equity release schemes to enable people to make major housing modifications
- Disability-friendly design standards for public housing.

9a) Develop local supportive housing options - West Coast DHB will work actively and collaboratively with local councils, trusts, community groups, residential care providers, Housing NZ and other relevant organisations to develop a range of supportive housing options that will work for specific local West Coast communities.

Objective 10. Plan sufficient long-term residential care beds

West Coast DHB is working on estimating the number and type of residential care beds that will be needed over the next 10-15 years, to give providers some guidance in planning these services. Calculating this is complicated by the national aging in place' strategy, which envisages replacing some residential care with more intensive home-based services.

Altough there has been a detailed and positive national evaluation of three forms of 'ageing in place' initiative, which gives an indication of how to develop services, there are no national guidelines as to the number and type of beds needed for specific populations.

The future number of residential care beds has to be calculated in conjunction with the planned number of supportive housing beds and intensive home-care packages that could also be provided.

West Coast DHB wants to ensure that residential care facilities have the capacity and capability to provide the care needed for residents to maintain their health and fitness and avoid unnecessary admissions to public hospital.

West Coast DHB may also be interested in working with residential care providers to provide short-term non-acute beds for 'transitional', 'step-down' and 'slow stream rehabilitation', and for long-term palliative care (see 12a).

All this implies:

- A more flexible approach to the contracting and delivery of long-term residential care, and more linkage to supportive housing and home-based support
- A more collaborative working relationship with residential providers, with the joint aim of keeping frail older people as fit and well as possible.

10a) Contract for long-term residential care – West Coast DHB will tender for a specific estimated number of long-stay residential care beds of each type in each local community, in conjunction with planning for supportive housing and home-based support services. These may include Marae-based or Papakainga arrangements.

[5] Judith Davey gives a good description of models being used in NZ and overseas – see Davey J et al (2004). *Accommodation options for older people in Aotearoa/New Zealand.* Wellington: Centre for Housing Research Aotearoa/New Zealand http://www.hnzc.co.nz/chr/publications.html

Goal C. To ensure older people experience a smooth path into and back from specialist services

It is important that older people can get appropriate access to specialist services when they need them. These include specialist older persons' assessment, treatment and rehabilitation, medical and surgical services, and mental health services including dementia.

For frail older people in particular, it is important to do as much as possible quickly to prevent illness and loss of functioning worsening once they have occurred. Once someone has a fall or minor stroke, it sometimes sets off a cascade of other problems, such as delirium and loss of continence. The older person can find themselves shifting from one health service to another in a way that can be confusing and distressing and quickly lead to further deterioration.

When a frail older person has to transfer between services – to go from home to hospital, or from hospital to temporary or permanent residential care - they can be at greater risk of needing more complex care. Where hospital admission is needed, it is important that this occurs quickly and smoothly, with good communication among all the health and support workers involved, and that they return home quickly and smoothly, with support services in place.

Objective 11. Streamline access to services

West Coast DHB has done detailed planning for a Community Coordinating Service to streamline people's access to both short-term and long-term home and community-based services. The Service will take referrals from GPs, hospital staff, community-based organisations etc for anyone needing home/community based services, and will triage and quickly send these referrals on to the appropriate service for assessment and/or treatment (e.g. home support services, district nursing, AT&R etc). (See December 2005 paper to Executive Management Team, and WISE subgroup report 2004 for more detail).

It is expected the Service will reduce the number of duplicate assessments older people go through, enable better access to more flexible and individually tailored home-based services, improve the pathways of care that people go through, improve communication and coordination among health and support services, and improve the budgeting, planning and management of community and home-based services.

The Service will complement the planned reconfiguration of Grey Hospital (Grey Base 2020 project) by enabling a clear, robust development of community and home-based services, as well as a stronger link between the specialist Older Persons Service (AT&R) and community and primary health services.

11a) Implement the Community Coordinating Service – West Coast DHB will implement the plan for the Service, taking into account the specific needs of outlying areas such as Buller and Westland.

11b) Timely access to specialist services, including surgery – it is important that older people can get the specialist help they need to prevent conditions worsening and resulting in long-term illness or disability. This includes surgery for cataract removal and hip and knee replacement, as well as assessment and treatment of continence problems, and physio and OT assessment and treatment of mobility problems. West Coast DHB will monitor waiting times and access to specialist services, particularly to interventions that have been shown to maintain people's functioning and to reduce the need for long-term care.

Objective 12. Develop more community-based rehabilitation services

The Grey Base 2020 Project proposes changing the focus of Older Persons specialist services away from inpatient admissions for assessment, treatment and rehabilitation (AT&R) and more towards these services being delivered on an outpatient basis, as well as in people's homes, residential care and other community settings. This would entail fewer inpatient AT&R beds and an equivalent expansion in non-inpatient services. This corresponds to national recommendations for the development of specialist services for older people.

There is a clear need for more rehabilitation services in the Buller area.

The Grey Base 2020 Project is also looking at the need for 'non-acute' beds as part of the reconfiguration of Grey Hospital. After an emergency hospital admission some older people need an extended period of recovery and rehabilitation, for which a stay in a busy acute hospital ward is not the best place. 'Non-acute' hospital beds are also needed for palliative and terminal care when people are unable to stay at home towards the end of life, and also for respite care and carer support.

From the older person's perspective, it is important that such beds/services have a strong rehabilitation component and a close linkage to the Older Persons Service.

12a) A stronger community role for Older Persons Services – West Coast DHB will move towards a stronger role for Older Persons Services in a non-inpatient setting, including having stronger links with and providing support and consultation to primary health centres, home support agencies, residential care providers etc. It is envisaged that the Community Coordinating Service will help to strengthen these links and ensure good triage. This may also entail a strengthening of allied health resources in areas such as Buller.

12b) Improved stroke services – West Coast DHB will move towards further developing stroke services according to the national guidelines.

12c) Establish rehabilitation-focussed non-acute beds – West Coast DHB will explore the options for establishing non-acute beds that have a strong rehabilitation component and are closely linked to the Older Persons Service. These may be in local outlying centres, such as Westport and Reefton.

Objective 13. Ensure excellent awareness of disability issues in all clinical services

As the number of older people in the population grows, more people entering hospital will already be coping with long-term disabilities, such as continence, mobility or vision problems, and using aids such as wheelchairs. It is increasingly important that all health workers are keenly aware of and know how to respond appropriately to the daily practical and emotional issues facing people with long-term disabilities. This is covered in the West Coast DHB's Disability Action Plan.

13a) Improve disability awareness and access – one function of the Coordinator of Older Persons' Services (see 14a) and the WISE group will be to monitor the implementation of the West Coast DHB's Disability Action Plan as it applies to older people.

Goal 4. Put in place a strong organisational infrastructure for older people's services

The following initiatives apply to all aspects of older people's health and disability support services.

Objective 14. A higher profile for Older Persons' Services on the West Coast

The WISE group felt strongly that there needs to be a stronger voice for older people's services within West Coast DHB and the sector, and that existing expertise in older people's health and disability services needs to be recognised more explicitly.

It is important that within West Coast DHB there is a strong advocate for developing services for older people – particularly home and community-based services and the preventive and intersectoral activity that helps to keeps older people fit and healthy. Developing community and home-based services is the necessary complement to the reconfiguration of Grey Base Hospital inpatient beds in the Grey Base 2020 project.

Given that it is impractical to have a separate department within West Coast DHB for 'Older Persons Health', it has been proposed that a position of Coordinator of Older Persons Services be identified, on the model of the existing Mental Health Coordinator.

This position could be combined with that of manager of the Community Coordinating Centre. (See paper to EMT December 2005).

A major task of this position would be to ensure that the activities described in the West Coast DHB's WISE plan are implemented.

Part of the Coordinator role will be to see if there is a need for a personal advocacy service for older people when using health and support services and how this could best be achieved.

14a) Coordinator of Older People's Services - West Coast DHB will implement the recommendation to appoint a Coordinator of Older Persons Services, as a position combined with that of manager of the Community Coordinating Service.

14b) Advocacy service - the need for a personal advocacy service for older people when using health services will be explored.

Objective 15. Protect and improve kaumatua health

While older Maori make up a relatively small proportion of the population, the numbers are increasing and Maori have a clearly greater than average risk of ill-health and disability, with an earlier onset for many chronic diseases. It is important that services for older people are responsive to the specific needs of kuia and kaumatua, following West Coast DHB's principles of partnership, participation and protection.

Issues of discharge planning and transfer of care between hospital/community services and Maori providers need to be explored and addressed.

15a) Build in partnership and participation – West Coast DHB will ensure partnership with Maori has been considered for each of the activities outlined in this plan.

15b) Explore transfer of care issues – work will be done to find ways of achieving greater collaboration between health professionals and Maori providers in discharge planning and home-based services, and DHB contracts with Maori providers will be made clearer and more collaborative.

15c) Improve access to indigenous healing practices and medicines – work will be done to ensure that West Coast kaumatua have access to indigenous healing practices and medicines.

Objective 16. Establish a collaborative planning structure

The WISE group and related Buller WISE group have acted as advisory groups for the West Coast DHB in developing this plan. The groups have also been useful in bringing together people across the various agencies to share ideas and information. Subgroups of the WISE group have and are likely to continue to work on implementing specific activities.

It is proposed that the two WISE groups continue to meet quarterly during 2007 to monitor progress on the implementation of the plan, and that the groups' function be reviewed at the end of 2007.

16a) Use the WISE groups to help monitor and implement – West Coast DHB will continue to facilitate meetings of the WISE groups during 2007 on a quarterly basis.

Action Plan – timeframes, responsibilities and outcome measures

GOAL A – TO PROTECT THE HEALTH, INDEPENDENCE AND SOCIAL NETWORKS OF OLDER PEOPLE		
What and how	**Who and when**	**How it will be monitored**
1. Work intersectorally to ensure warm dry safe housing **1a) Home insulation** – West Coast DHB will work with West Coast Development Trust, Housing NZ, WINZ, Rata te Awhina and other organisations to ensure that all older West Coasters are living in warm, dry, insulated homes, through extension of the home insulation subsidy scheme and other initiatives. **1b) Power discounts –** West Coast DHB will support efforts by Greypower and other organisations to seek discounts on power costs for older people. **1c) Housing standards** – West Coast DHB will actively work with Housing NZ and other relevant organisations for the adoption of disability-friendly standards for all new building and renovation of the public housing stock.	**1a)** Home insulation – through Intersectoral Forum at CEO level, and through health promotion initiatives contracted by GM Planning & Funding. **1b)** Greypower to progress. Aim to have made some progress by end 2007. **1c)** Intersectoral forum at CEO level; GM Planning & Funding at national/ regional planning forums.	**1a)** By 2012 all older people will be living in a well-insulated house. **1b)** By end 2007 an agreement reached with power companies for an older persons' discount **1c)** By end 2012, disability-friendly standards are used in building/renovating the public housing stock.
2. Work intersectorally and directly to improve access to transport 2a) **Work for better public transport –** West Coast DHB will continue to work with local councils through the Intersectoral Forum and in other ways to improve public transport options generally. **2b) Improved transport to hospital and health services** – West Coast DHB will continue to actively explore ways of enabling people living in the more rural areas, such as Buller and Westland, to access health services, e.g. by adjusting outpatient clinic times and providing shuttle transport.	2a) Intersectoral Forum at CEO level; GM Planning & Funding project 2b) GM Primary Care (Buller Health), GM Secondary Services and GM Planning & Funding work together on options	2a) Older people have better access to transport by end 2007 2b) Older people have better transport access to health services by end 2007

2c) **Review Total Mobility and other transport options –** West Coast DHB will look at flexible ways to improve older people's access to transport, as part of a general review of home-based support services, and also as a separate project for more isolated areas. 2d) **Car re-licensing education** – West Coast DHB acknowledges Greypower's continuing role in car re-licensing courses for older drivers.	2c) GM Planning & Funding to complete review by end 2007. Changes made by July 2008 2d) Greypower to continue ongoing education sessions for next 3 years. GM Planning & Funding to follow up any issues of pressure on allied support staff.	2c) Review completed, recommendations implemented, resulting in improvements to disabled older peoples access to transport 2d) Number and proportion of older people who have been through the education course
Objective 3. Promote physical activity and falls prevention **3a) Increase opportunities for physical activity** – West Coast DHB wants to increase the number and variety of opportunities for physical activity for older people, and will undertake a stocktake of what currently exists and work with Ministry of Health, Community & Public Health, Active West Coast, District Councils and other relevant organisations to develop services further in each local area. **3b) Encourage wide use of Green Prescriptions –** West Coast DHB will support the PHO to develop and expand the use of Green Prescriptions and to monitor and evaluate their use. **3c) Expand falls prevention programmes** – West Coast DHB will work with ACC, Ministry of Health and other appropriate organisations to expand the Otago and Tai Chi-based falls prevention programmes in each local area to cover all older people at risk, particularly those over 80 years, for whom the benefit has been proven to be greatest, and including people in residential care.	3a) GM Planning & Funding to complete a stocktake by end 2006. A funding proposal will b submitted to Ministry of Health end December. A plan for developing services in each local area will be completed by March 2007, and implementation started by July 2007. 3b) GM Primary Health Organisation, included in PHO work plan 3c) GM Planning & Funding to scope the options for further developing falls prevention services, using SISSAL resource. Options paper by April 2007. Expansion of falls prevention programmes by July 2007	3a) Increase in number of older people engaging in regular exercise; increase in number of exercise opportunities available (swimming pools & opening times, walking groups, exercise classes, etc) 3b) Increase in number of people using Green Prescriptions 3c) All people over 80 have had a opportunity to go through a falls prevention programme Falls prevention programmes being used in all residential care facilities.

Objective 4. Older people included in health promotion campaigns **4a) Older person's health promotion campaign** – West Coast DHB will work with Ministry of Health, Community and Public Health, Disability Information Service, the Primary Health Organisation and other relevant organisations to ensure that older people are specifically included in health promotion campaigns, and that their work is coordinated and adequately resourced for this. This includes the Ministry of Health's Healthy Eating, Healthy Activity (HEHA) campaign. Areas to cover include: • Physical activity • Nutrition • Warm dry housing • Smoking, alcohol and drug use • Keeping socially active and in touch with others, and maintaining mental health It is expected that this activity will be done in collaboration with older people and relevant organisations e.g. Greypower, iwi and other local community groups, so that it is effective in reaching those people at most risk, including Maori, people on low incomes and people who are socially isolated.	4a) GM Planning and Funding will use SISSAL resource to prepare a funding proposal for Ministry of Health by end December 2006, and prepare a work plan for older people's health promotion by March 2007.	4a) There are clear obvious messages in the public media, in primary health centres and other places designed for older people. The number and proportion of older people taking regular exercise, eating well and not smoking (or entering stop smoking programmes) has increased among Maori, low income and socially isolated people. The number of older people reporting depression or committing suicide has decreased.

GOAL B – TO CATCH ILLNESS AND DISABILITY BFORE THEY WORSEN		
Objective 5. Reduce barriers to access to primary health care and disability support services **5a) Care Plus and pharmacy charges** – West Coast DHB will work with the PHO to implement the Care Plus programme, and monitor any unmet need for primary health services, including pharmaceuticals **5b) Equipment and housing modifications, including vision and hearing aids** – West Coast DHB will review access to these services, as part of an overall review of home-care services. **5c) Dental health –** West Coast DHB will review older people's access to dental health services	5a) GM Primary Health organisation - covered in Primary Care Plan 5b) GM Planning & Funding will include in Home Care Review (see 7a), by end 2007 5c) GM Planning & Funding to do by end 2007	5a) Use agreed measures of access to primary care (reference) 5b) Number of older people reporting problems with access to aids; waiting times for equipment and housing modifications 5c) Number of older people reporting problems with access to dental care
Objective 6. Ensure good management of chronic conditions **6a) Chronic Conditions Management Strategy** – West Coast DHB will implement this strategy in collaboration with the PHO and other organisations, such as Rata te Awhina, Greypower, community pharmacies etc. Activities include: • Screening and encouraging regular checks – increasing the uptake of screening and regular checks e.g. for cancer, cardio-vascular disease, diabetes, glaucoma etc • Diabetes awareness and checks, including retinal screening • Patient registers for asthma, diabetes etc, so that patient gets reminders of checks etc • Greater use of Green Prescriptions, including information in pharmacies	6a) Is covered in Management of Chronic Conditions Strategy	6a) See Management of Chronic Conditions Plan

Objective 7. Implement a more flexible and restorative model of home support services		
7a) Review home-based support services – West Coast DHB will review the funding and delivery of the full range of support services that enable people to remain in their own homes, and implement changes to make these services more sustainable and effective in keeping people fit and healthy. This will be done in conjunction with reviews of access to the Total Mobility scheme (see 2c), Equipment and Housing Modifications (see 5b) and Carer Support (see 7b). It will also be done in conjunction with planning for supportive housing and residential care (see 9a and 10a), as home-based care, supportive housing and residential care are integral part of the continuum of long-term care.	7a) GM Planning & Funding will undertake this review in conjunction with or following the setting up of the Community Coordinating Service (see 11a). Review to be completed by end 2007 and implemented by mid 2008	7a) Fewer older people entering residential care or admitted to acute hospital because they have not received services that could have helped them stay at home (e.g. aids, housing mods, equipment, social contact, carer support, rehab, step-down beds …)
7b) Review support for unpaid carers and social networks – unpaid carers are a crucial part of the support needed for older people to remain fit and healthy in their own homes. West Coast DHB will explore ways of improving support for unpaid carers, as well as ways of supporting local community networks, as part of the review of home-based support services.	7b) GM Planning & Funding, to be included in Homecare Review, completed by end 2007 and implemented by mid 2008	7b) Fewer older people entering residential care or admitted to hospital because of carer burnout and stress.

Objective 8. Paid workforce – primary, community and home-based		
8a) Ensure an adequate primary health workforce – ways of recruiting and retaining primary medical and nursing staff are addressed in the West Coast DHB's Primary Health Care Strategy, and includes initiatives such as neighbourhood nurses, rural nurse practitioners, and innovative ways of defining professional roles in the primary care team.	8a) GM Primary Care - covered in Primary Care Plan	8a) Covered in primary care plan
8b) Improve training & retention of home-based support workers – West Coast DHB will address the long-standing difficulty in attracting and retaining support workers through the review of home-based support services (7a above). This will explore the feasibility of changing the way these services are contracted and delivered towards a more rehabilitation-focussed model that gives support workers a more skilled and supported role and less casualised working conditions. This will be done in conjunction with the work being done nationally to improve the qualification and skill structure for support workers.	8b) GM Planning & Funding through Homecare review, completed by end 2007 and implemented by mid 2008.	8b) Turnover rate for home support workers; proportion of home support workers with training;
8c) Attract more community allied health workers – a move towards a more rehabilitation-focussed home-care service will require a greater input of physiotherapy, occupational therapy and other allied health skills in the community. The West Coast DHB will explore ways of ensuring these areas are adequately staffed.	8c) GM Planning & Funding through the Homecare review (7a). Also GM Secondary Services & Grey Base 2020 project through the planning for a more community-focussed Older Persons' specialist service (AT&R) – completed by end 2007 and implemented by mid 2008	8c) Waiting times for assessment and treatment; availability of allied health workers to supervise home support staff;
8d) Support skill development in residential care facility workers – West Coast DHB will work jointly with residential providers to find ways of addressing the skill and staffing differences between residential and DHB facilities, to improve the capability and capacity of residential facilities. This might include consideration of joint training, more consultation and other forms of professional linkage.	8d) GM Planning & Funding & GM Operations to discuss with residential providers and provider arm services, as part of discussions on using residential facilities for short-term patients – aim for changes to contracts and operating policies to be recommended by mid 2007 and implemented by end 2007	8d) Turnover rate for residential facility staff; number of joint protocols and agreements between residential facilities and provider arm services on patient care, joint training and supervision arrangements, consultation etc

Objective 9. Actively support the development of supportive housing **9a) Develop local supportive housing options** - West Coast DHB will work actively and collaboratively with local councils, trusts, community groups, residential care providers, Housing NZ and other relevant organisations to develop a diverse range of supportive housing options that will work for specific local West Coast communities.	9a) GM Planning and Funding will initiate discussions with other stakeholders if not already happening. Aim to have at least some additional form of supportive housing started in Greymouth, Westport, Reefton and Hokitika by end 2007	9a) Increase in beds available in each local area in different types of supportive housing at different levels (co-housing with no warden, sheltered housing with warden etc)
Objective 10. Plan adequate long-term care beds **10a) Contract for long-term residential care –** West Coast DHB will seek expressions of interest in providing a specific estimated number of long-stay residential care beds of each type in each local community, in conjunction with planning for supportive housing and home-based support services. This will be done in the form of a Request for Expressions of Interest in providing forms of long-term support services (both residential and/or non-residential), as a basis for starting and continuing discussion with local providers as to the shape of services in each local area. Probably will be done in a staged process over the districts, first covering Buller, then Greymouth, then Westland	10a) GM Planning & Funding will put out a Request for Expressions of Interest. The aim is for an ROI to be offered by March 2007, and for recommendations on the configuration of long-term services and providers to be decided by mid 2007.	10a) People living in long-term residential care have been assessed as appropriate for that level of care; short or no waiting time for long-term residential care beds & no delay in transfer out of acute hospital; residential facilities are viable and sustainable; incentives on all providers to make sure the person has the level of care appropriate to their needs, whether residential or home-based; a more flexible use of long and short-term residential care needs, and of home-based and residential services

GOAL C – TO ENSURE OLDER PEOPLE EXPERIENCE A SMOOTH PATH INTO AND BACK OUT OF SPECIALIST SERVICES		
Objective 11. Streamline access to services **11a) Implement the Community Coordinating Service –** West Coast DHB will implement the plan for the Service, taking into account the specific needs of outlying areas such as Buller and Westland. **11b) Ensure timely access to specialist treatment –** West Coast DHB will monitor waiting times and access to specialist services, including cataract and joint replacement surgery, continence services, allied hath services and other interventions particularly important in maintaining older persons' functioning.	11a) GM Planning & Funding to coordinate an implementation group, aiming for manager appointed by March 2007 and the service to be operational by mid 2007 11b) GMs Planning & Funding and Secondary Services	11a) Fewer duplicated assessments; a standard assessment tool and care pathways adopted; better information sharing, better resource use 11b) Waiting times for specific interventions decreases
Objective 12. Develop more community-based rehabilitation services **12a) A stronger community role for Older Persons Services –** West Coast DHB will move towards a stronger role for Older Persons Services in a non-inpatient setting, including stronger links with and support and consultation to primary health workers, home support agencies, residential care providers etc. It is envisaged that the Community Coordinating Service will help to strengthen these links and ensure good triage. **12b) Improved stroke service –** West Coast DHB will move further towards implementing the national stroke guidelines **12c) Set up rehabilitation-focussed non-acute beds –** West Coast DHB will explore options for non-acute beds that have a strong rehabilitation component and are closely linked to the Older Persons Service. These may be in local outlying centres, such as Westport and Reefton.	12a) GM Secondary Services and GM Planning & Funding to work together on recommendations in relation to Grey Base 2020 – completed by mid 2007 and implemented by end 2007 (or in relation to Grey Base 2020 timeframe) 12b) GM Secondary Services 12c) GMs Planning & Funding and Operations to work together on recommendations – complete by mid 2007 and implemented by end 2007 (or in relation to Grey Base 2020 timeframe)	12a) The Older Persons Specialist Service provides more services on an outpatient ad community basis than now, including more consultation and support for primary health care workers, residential providers and home support agencies 12b) Stroke services will more closely follow the national guidelines 12c) A specific number of non-acute beds are provided in specific locations

GOAL D – TO PUT IN PLACE A STRONG ORGANISATIONAL INFRASTRUCTURE FOR OLDER PERSONS' SERVICES		
Objective 13. Ensure excellent awareness of disability issues in all clinical services **13a) Ensure Disability Action Plan is actioned** – part of the function of the WISE plan and stakeholder group will be to monitor the implementation of the West Coast DHB's Disability Action Plan as it applies to older people.	13a) GM Planning & Funding to continue contract for Disability Awareness education to DHB staff	13a) The number of DHB staff participating in education sessions; number of complaints concerning disability issues
Objective 14. A higher profile for Older Persons' Services on the West Coast **14a) Coordinator of Older People's Services -** West Coast DHB will appoint a Coordinator of Older Persons Services, a position combined with that of manager of the Community Coordinating Service **14b) Advocacy service -** the need for a personal advocacy service for older people when using health services will be explored.	14a) GM Planning & Funding - see Community Coordinating Centre (11a) 14b) Part of role of Coordinator of Older Persons Services	14a) West Coast DHB has a clear plan for developing community & older persons' services, based on good information on current expenditure, vols and outcomes. 14b) A recommendation for an advocacy service has been made.
Objective 15. Protect & improve kaumatua health **15a) Build in partnership, participation and protection** – West Coast DHB will ensure partnership with Maori has been considered for each activity outlined in this plan. **15b) Explore transfer of care issues** – work will be done to find ways of achieving greater collaboration between health professionals and Maori providers in discharge planning and home-based services, and DHB contracts with Maori providers will be clearer and more collaborative. **15c) Improve access to indigenous healing practices and medicines** – work will be done to improve this access for West Coast kaumatua	15a) GM Planning & Funding will ensure that each recommendation for action is reviewed by the West Coast DHB Maori advisor, or otherwise involves consultation with Maori. 15b) GMs Secondary Services and Primary Care - part of role of Manager Community Coordinating Centre. Aim to find solutions by end 2007 15c) GMs Primary Care and Secondary Services, in consultation with West Coast DHB Maori Advisor.	15a) Each activity has a clearly stated description of how it has engaged with Maori in planning and implementation 15b) Protocols exist between Maori providers and Community Coordinating Centre 15c) Kaumatua have access to indigenous healing practices and medicines

Objective 16. Establish a collaborative planning structure **16a) WISE groups to help monitor and implement -** West Coast DHB will continue to facilitate WISE groups quarterly in 2007 to monitor the implementation of the plan. This will include Maori representation.	16a) GM Planning & Funding	16a) WISE quarterly reports on progress on the plan

APPENDIX A

THE OLDER WEST COAST POPULATION - PROJECTIONS TO 2026 (updated)

Source: Statistics NZ, projctions made available to DHBs via Ministry if Heakth intranet, downloaded Ocober 2006

Projected Total Population by Age and Sex at 30 June 2006-2026 (2001-Base

***** Medium Projection : Assuming Medium Fertility, Medium Mortality, and Medium Migration *****

	2001(Base)			2006			2011			2016			2021			2026		
Age	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
55-59	880	870	1,760	1,130	1,020	2,150	1,170	1,030	2,200	1,310	1,200	2,500	1,190	1,160	2,350	990	1,000	2,000
60-64	780	740	1,530	860	840	1,700	1,100	980	2,080	1,140	1,000	2,150	1,280	1,170	2,440	1,170	1,130	2,300
65-69	680	580	1,250	730	700	1,430	810	790	1,600	1,040	940	1,980	1,090	960	2,050	1,220	1,120	2,340
70-74	540	550	1,090	590	520	1,110	650	640	1,290	730	740	1,470	950	880	1,830	1,000	900	1,900
75-79	410	470	880	430	480	910	480	460	950	550	580	1,120	620	670	1,290	820	810	1,620
80-84	210	330	540	280	360	640	310	380	680	360	380	730	420	480	890	480	560	1,040
85-89	90	200	290	120	230	350	170	270	440	200	300	510	240	320	560	300	410	720
90-94	20	50	70	30	60	90	40	80	120	60	100	160	80	120	200	90	130	220
95+	-	10	10	-	20	20	10	20	30	10	30	40	20	50	60	20	60	80
55+	3,610	3,800	7,420	4,170	4,230	8,400	4,740	4,650	9,390	5,400	5,270	10,660	5,890	5,810	11,670	6,090	6,120	12,220
65+	1,950	2,190	4,130	2,180	2,370	4,550	2,470	2,640	5,110	2,950	3,070	6,010	3,420	3,480	6,880	3,930	3,990	7,920
70+	1,270	1,610	2,880	1,450	1,670	3,120	1,660	1,850	3,510	1,910	2,130	4,030	2,330	2,520	4,830	2,710	2,870	5,580
75+	730	1,060	1,790	860	1,150	2,010	1,010	1,210	2,220	1,180	1,390	2,560	1,380	1,640	3,000	1,710	1,970	3,680
85+	110	260	370	150	310	460	220	370	590	270	430	710	340	490	820	410	600	1,020

Percentage increase in 5-year periods

	2001-2006			2006-2011			2011-2016			2016-2021			2021-2026		
55+	15.5	11.3	13.2	3.0	1.8	2.3	13.9	13.3	13.5	9.1	10.2	9.5	3.4	5.3	4.7
65+	11.8	8.2	10.2	2.5	1.9	2.0	19.4	16.3	17.6	15.9	13.4	14.5	14.9	14.7	15.1
70+	14.2	3.7	8.3	5.1	2.2	3.2	15.1	15.1	14.8	22.0	18.3	19.9	16.3	13.9	15.5
75+	17.8	8.5	12.3	4.1	1.7	2.3	16.8	14.9	15.3	16.9	18.0	17.2	23.9	20.1	22.7
85+	36.4	19.2	24.3	15.8	2.8	5.4	22.7	16.2	20.3	25.9	14.0	15.5	20.6	22.4	24.4

Yearly percentage increase during that 5-year period

	2001-2006			2006-2011			2011-2016			2016-2021			2021-2026		
55+	3.1	2.3	2.6	0.6	0.4	0.5	2.8	2.7	2.7	1.8	2.0	1.9	0.7	1.1	0.9
65+	2.4	1.6	2.0	0.5	0.4	0.4	3.9	3.3	3.5	3.2	2.7	2.9	3.0	2.9	3.0
70+	2.8	0.7	1.7	1.0	0.4	0.6	3.0	3.0	3.0	4.4	3.7	4.0	3.3	2.8	3.1
75+	3.6	1.7	2.5	0.8	0.3	0.5	3.4	3.0	3.1	3.4	3.6	3.4	4.8	4.0	4.5
85+	7.3	3.8	4.9	3.2	0.6	1.1	4.5	3.2	4.1	5.2	2.8	3.1	4.1	4.5	4.9