Our focus for the first two years

Ageing well

Acute and restorative care

Living well with long term conditions

Supporting people with high and complex needs

Respectful end of life

Implementation, measurement and review

Priority actions for the first two years

- Supporting age-friendly communities through interagency promotion, developing advice and tools and building partnerships
- Increasing resilience through promotion of strength and balance programmes, healthy lifestyles (incl. food and nutrition, physical activity, reducing alcohol-related harm) and social connections
- Building cross government alliances to reduce family violence and other social factors for healthy ageing
- Improving health literacy by supporting take-up of technology, online content and awareness of advance-care planning.

- Supporting initiatives to reduce avoidable acute admissions
- Streamlining acute assessment tools and processes
- Improving the patient journey, quality of care, discharge planning, family engagement and cultural responsiveness of services through sharing best practice
- Smarter use of data to identify older people at risk of falls
- Improved rehabilitation by building relationship with primary care, allied health and other partners
- Incorporating ‘restorative’ care models where appropriate and ensuring teams are deployed effectively

- Improving models of home and community care by focusing on the needs of older people and their families, and respecting cultural differences
- Enhancing the needs assessment processes for individuals, and the use of data for service development
- Improve conditions for kaiāwhina workforce, and develop a workforce plan for healthy ageing
- Better support people to live well with:
  - dementia
  - diabetes
  - stroke
  - muscular-skeletal conditions
  - mental illness and substance abuse
  - low vision.
- Promoting self-management by giving older people the tools and support they need, including guidance, technology and information to support self-care and reduce social isolation.

- Work with the sector to identify and test frailty identification tools for primary care settings
- Agree standard referral and discharge protocols for people moving into and out of residential care facilities
- Facilitate access to medicines management for people living at home and in residential facilities

- Complete and implement a palliative care action plan
- Implementation of Te Ara Whakapiri
- Develop options for surveying patient and family experience.

- Plan and deliver a coordinated programme of work towards the Healthy Ageing Strategy goals
- Improving collection and use of older people’s experiences of care, and engaging older people in DHB forums
- Co-design of minor ailments/referrals service as part of the Pharmacy Action Plan
- Reviewing implementation progress and publishing indicators for DHBs
- Improving our knowledge base through greater collaboration in research development and dissemination

Results/changes we expect to see

- Greater awareness of the concept of age-friendly communities and development of tools and resources to create and support them
- Increased awareness of and tolls to support healthy ageing
- The wider health and social systems understand and work together on healthy ageing
- Older people are supported to be health-smart and plan for their future in order to live well and age well

- Innovations and research support best practice triage, assessment, integrated care, discharge planning, rehabilitation strategies, and follow-up support
- Targeted in-home strength and balance programme for frail elderly over 75
- Older people are supported through recovery by specialists and general staff who are competent to deal with common conditions, including frailty, delirium or dementia. Hospital staff and processes respect cultural preferences and differences
- Family, whānau and carers are included in discharge planning and receive training and support to provide ongoing rehabilitation in home and community settings
- Quality measures include patient experiences as well as clinical outcomes.

- Home support services are configured around the needs of individuals
- The home support and aged-care workforces are better trained, more stable and reflect the diversity of the population
- A greater focus on partnerships with people and across the system in managing common long-term conditions
- People are supported to manage their conditions using tools such as smart technology and targeted information

- Early identification of and responsiveness to frailty helps maintain people’s independence, reduce acute events and supports longer term planning of care
- Different parts of the sector work together to ensure people with complex care needs experience more integrated care when moving between services

- A co-ordinated programme of work improves adult palliative care services
- DHBs have access to best-practice guidance and tools to manage care for people who are dying
- A mechanism is established to ensure patient and family views improve service delivery and quality.

- Older people’s experiences (and those of their carers and families) are valued and contribute to ongoing service development and quality improvement
- Outcomes and accountabilities help to drive the changes sought in the strategy
- Greater liaison and collaboration between researchers and policy-makers, ensures research questions inform policy and practice