HOSPITAL AUTHORITY
STRATEGIC SERVICE FRAMEWORK
for ELDERLY PATIENTS
INTRODUCTION

Issued in 2012, the Hospital Authority Strategic Service Framework for Elderly Patients (“the Framework”) will guide the development and provision of HA elderly services over the next five years.

Recommendations of this Framework reflect the culmination of an intense period of research, stakeholder engagement and consultation, and expert views on the HA service needs of elderly people in Hong Kong, both now and into the future.

NEW SERVICE DIRECTION

HA services for elderly people will increasingly move towards an integrated care model, requiring a comprehensive approach to improve the coordination of HA services for elderly patients and promote greater collaboration in the delivery of care. The aim is to offer seamless and high-quality care in primary, community and hospital settings, in order for elderly patients and their carers to receive services appropriate to their needs.

*Our vision for HA elderly services is to enhance the well-being of elderly people, and to contribute to healthy ageing, by raising the standards and quality of healthcare wherever care is given.*

Emphasis is on improving the identification and integrated care of elderly patients at high risk, or with complex needs, through joint efforts of various professionals. In addition, patients and their carers will be empowered for better self-management and there will be a strengthening of collaborations with partner organisations involved in elderly care.

The Framework will help HA to manage future elderly service demand and anticipate workforce needs, supporting the training, skills development, competence and well-being of staff.

A new sustainable model of care that is oriented to the proactive prevention and management of illness in elderly patients should contribute to the improvement of patient experience, better health outcomes and more efficient care.
HA elderly services will be operated under a new model of care, as illustrated below:

**Old** ........................................... **New**

- Reactive & episodic care
- Specialty approach to complex care
- Sub-optimal coordination and collaboration between acute & community services
- Patient & their carers as dependent & passive recipients of care
- Workforce managing increasing elderly service demand
- Variable care pathways & quality of care

- Proactive individualised care, appropriate to patient needs
- Multi-disciplinary approach to integrated & coordinated care
- A focus on wellness, patient transitions and close collaboration with non-HA partners
- Patient-centred services – promoting patient & carer engagement, enablement & empowerment
- A well developed, skilled workforce in elderly care
- Standardised care pathways & guidelines for HA elderly services – quality, outcomes-driven

**KEY RECOMMENDATIONS**

Meeting the needs of an increasing number of elderly patients should be a priority. The Framework recommends the following five key long-term strategic objectives for HA elderly services over the next five years, to meet the identified challenges of (i) managing growing elderly service demand, (ii) ensuring service quality and safety, and (iii) maintaining an adequate workforce that is skilled in elderly care.

1. Develop multi-disciplinary integrated elderly services across the continuum of HA care.
2. Promote patient-centred care and engage patients and their carers as active partners in their healthcare.
3. Greater collaboration with partners involved in elderly care outside of HA.
4. Enhance HA workforce capacity and engage staff.
5. Develop quality, outcomes-driven HA elderly services.
Objective 1
Develop multi-disciplinary integrated elderly services across the continuum of HA care
The HA will:

- Adopt a **system-wide approach** in the development of an integrated care service for elderly patients
- Perform **integrated patient assessment** for identified high risk elderly patients to determine their specific needs upon admission to hospital
- Perform **early discharge planning** and formulation of **individualised care plan** to allow for better care planning of elderly patients requiring frequent attention
- **Enhance coordination** of multi-disciplinary services, to better support elderly patients who have chronic disease and complex needs
- Improve evidence-based **rehabilitation care** for elderly patients who have chronic disease and complex needs (e.g. chronic obstructive pulmonary diseases, chronic heart failure and stroke), to enable optimal recovery and transition to the community
- Strengthen **integrated community care** to facilitate multi-disciplinary HA health professionals to fulfill their roles in providing timely coordinated assessment and management of elderly patients

Objective 2
Promote patient-centred care and engage patients and their carers as active partners in their healthcare
The HA will:

- Advocate **dignity, respect and autonomy** for elderly patients in all HA settings, such as through listening to their concerns about their care, and **promoting the concept of the patient as an active partner in their healthcare**
- **Promote communication** and information sharing with elderly patients and their carers to **enable them to participate and make informed shared decisions** related to their care, where appropriate
- Support **self-management** of chronic diseases through better patient empowerment to enable elderly patients, their families and carers to better manage post-discharge care, management of risk factors and acute flare-ups of illness in the community

Objective 3
Greater collaboration with partners involved in elderly care outside of HA
The HA will:

- Develop improved **service networks with community partners**, including primary care practitioners, Department of Health (DH) Elderly Health Service and non-governmental
organisations (NGOs) to enhance service continuity and appropriate transitional care for elderly patients

- Work with Social Welfare Department, NGOs and private practitioners to further support **better long term care** provision for elderly people who live in **Residential Care Homes for the Elderly (RCHE)**
- **Work with DH and other stakeholders in the development of primary care strategies for the elderly**, to ensure that future development of primary care services take into account the different needs of elderly people

**Objective 4**

**Enhance workforce capacity and engage staff**

**The HA will:**

- **Use workforce planning**, which addresses the implications of an ageing population, to anticipate HA elderly service needs and help develop the supply of a sufficiently trained workforce
- **Design and implement specific educational and training programmes** for different HA staff groups, including medical, nursing, allied health and other health professionals, to bring them up-to-date with this Framework and developments in HA elderly services
- **Work towards improving the training and continuing professional development needs of staff** involved in the care of elderly patients, such as through up-skilling courses, clinical exposure and mentorship, as part of HA’s commitment to spreading the knowledge and expertise of geriatric specialists to the wider workforce, so that staff are equipped with the necessary knowledge, skills and competencies in caring for elderly patients
- **Support the dissemination of knowledge of elderly services** available within the community to facilitate HA staff to engage and empower elderly patients and their carers

**Objective 5**

**Develop quality, outcomes-driven elderly services**

**The HA will:**

- Support development and implementation of **agreed principles, referral pathways and care protocols** for elderly people in acute settings, as part of the “Acute Care for the Elderly” project, so hospital services can respond effectively and appropriately to the needs of elderly patients
- **Explore the development of quality indicators**, with corresponding areas aligned to the HA hospital accreditation program, to benchmark the performance of acute, rehabilitation/convalescence, transitional and community HA services
• Develop guidelines to inform the **future planning** and development of HA hospitals and facilities to ensure elderly patient needs are considered in the design of the environment. For example, consideration of problems common to elderly patients, such as reduced balance, lack of stamina and strength, sensory impairment and way-finding, as well as increased risk of confusion in unfamiliar environments.

• Advocate and promote **better care standards for elderly people** in non-HA settings, including RCHE, such as through HA being an exemplar of best practice care in community settings.

• **Utilise development of the HA’s Clinical Management System**, where possible, to support and improve the quality and continuity of care delivery and workflow efficiency.

The strategic objectives are described in more detail in the Framework, each of which are underpinned by operational priorities and key actions, which will need to be implemented to take the recommendations forward (examples of these operational priorities are given here). All recommended proposals will be assessed, reviewed and monitored through the HA’s Annual Planning mechanism.

HA is well aware of the mental health needs of elderly people. Given its importance, in particular dementia, it is regarded to be more appropriately addressed through a separate strategic service framework.

**SUGGESTIONS AND COMMENTS**

HA welcomes suggestions and comments from colleagues, service users and other key stakeholders on the new service directions and key recommendations on its elderly services. Feedback may be directed by email to: str.planning@ha.org.hk

The full document is available for download from the HA website (http://www.ha.org.hk).