**Health of Older People Strategy 2016–2026**

**Consultation submissions**

**132 – 151**

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| **Submission 132** |

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| Organisation (if applicable): | Canterbury Clinical Network Health of Older PeopleWorkstream (HOPWS) – see background below |
| Position (if applicable): | Chair and Clinical Lead |

This submission *(tick one box only in this section)*:

[ ]  comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity)

[x]  is made on behalf of a group or organisation(s)

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[ ]  Service provider [ ]  Government

[ ]  Non-governmental organisation [ ]  Union

[ ]  Primary health organisation [ ]  Professional association

[ ]  Academic/researcher [x]  Other *(please specify)*:
Workstream within Health Alliance

**Organisation background: CCN Health of Older People Workstream (HOPWS)**

The Health of Older People Workstream is a focus area for the Canterbury Clinical Network. Established in 2009, it has been instrumental in establishing several Service Level Alliances and new initiatives to transform services for older adults in Canterbury, including the Medicines Management Service (MMS), Community Rehabilitation Enablement Support Team (CREST) and Falls Prevention.

The Health of Older People Workstream is enabling older adults to live well at home and in their community through clinically led service transformation. The Workstream provides oversight of the Canterbury health system’s strategic direction for older people, with a view towards an integrated system with accessible, organised and coherent services for older adults in the community.

Working towards the aspirational target of extending independent living for older adults, the Health of Older People Workstream is working towards outcomes including system-wide restorative approaches to the care of older people, fewer falls and fall injuries in adults over 75 years, reduced incidence and severity of pressure injuries, timely access to urgent care, and earlier diagnosis with improved support throughout the course of their illness for people with dementia.

**For further information on the Canterbury Clinical Network (CCN) or the Health of Older People Workstream please visit our website –** www.ccn.health.nz

### Healthy ageing

1a. The draft Strategy sets out a vision for the goal of healthy ageing: see page 14 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Congratulations on this draft. It is good to see how the development of the strategy has progressed.Answers to questions have been set out in point form, focussing on the details you have asked for, instead of providing an overall viewpoint, which we provided when suggestions were called for at the beginning of the process (copied at end of this document for reference).• Draft strategy sets outs clear and wide reaching vision for care of older people. Focus on a life courseapproach is to be commended, recognising the heterogeneous nature of older people living in NZ.• Key areas of staying healthy, and independent, focus on workforce development, recognition of needsof families and communities and the need for integration across the health and social sectors alongside systems development are important issues to be addressed.• In particular, appreciating that **investing in healthy ageing** is important, as is recognising that **frailty is not inevitable** are important messages for the public.• Health inequities: Equity for **rural** communities (as a potentially vulnerable group with barriers to accessing care) is important in all aspects of the strategy, not just those with high and complex needs. One example is that receiving care closer to home for patients from rural areas often means moving to a care facility in a small town, which doesn’t always have the same access to clinicians, after hours services and other infrastructure that a facility in an urban area may have. |

1b. The draft Strategy includes actions that are intended to achieve the goal of healthy ageing: see page 31 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| Agree broadly with identified crucial areas. These would be strengthened through a concurrent focus on health and social sector agencies sharing information for improved identification and co-ordination of services.• 4b. Health promotion: Primary Care should be included as a lead provider of public health information. This would include the whole primary care sector, ie pharmacies, community providers, allied health professionals and non-government organisations.• 4e. Uptake of technology by older people. Query priority for this & involvement of primary care as lead – not sure it can be influenced by primary care. Suggest downgrade priority.• A greater focus on educating and promoting healthy nutrition at all ages, leading to resilient older people could be included as a priority action.• We would also like to see at least one of the actions under 5 (oral health) be adopted as a priority (preferably 5b.) |

### Acute and restorative care

2a. The draft Strategy sets out a vision for the goal of high-quality acute and restorative care: see page 17 in the draft document. Do you have any comments or suggestions regarding this vision?

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| • **Support and education for informal carers during rehabilitation** and restorative care, especially those who might need to put on hold their usual occupation to care for older people, should be mentioned.• The ability of carers, both formal (home and community support workers, NGOs) and informal (whānau) to help recognise acute deterioration and act quickly to prevent acute admission should also be recognised and utilised.• The role of communities in understanding the model of restorative rehabilitation should form part of the vision.• All health professionals, including those not actively involved in rehabilitation (eg. pharmacists, general practice team) must understand and reflect goal setting and the restorative model.• There is no indication that actions relating to the restorative model are extended to aged residential care facilities (however there is no indication that they are excluded either). Clarification may be necessary. |

2b. The draft Strategy includes actions that are intended to achieve the goal of high-quality acute and restorative care – see page 33 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| 6a is critical to progress alongside integrated teamwork. Greater focus on mechanisms to support timely, organised transfer of care between hospital and primary and community care to support coordinated recovery closer to home.• Under 7a), Primary care allied health involvement and workforce operating at top of scope will need to be recognised as there is likely insufficient capacity under existing service models.• Integration with general practice is key to ensuring successful co-ordination of rehabilitation and continuing emphasis on gains and goals. Under 8, resourcing and empowering primary care and general practice to manage acute conditions so that older people are treated closer to home is important. Use of acute plans http://tinyurl.com/hb9lvg2• or http://preview.tinyurl.com/hb9lvg2), action plans or similar (and ultimately advance care planning) must be emphasised as a mechanism for reducing unnecessary transfers and acute admissions. |

### Living well with long-term conditions

3a. The draft Strategy sets out a vision for the goal of living well with long-term conditions: see page 20 in the draft document. Do you have any comments or suggestions regarding this vision?

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| • We feel the vision insufficiently addresses the significance of living with multiple long term conditions (LTC) and need for strong links to primary care for management and support. Some older people with LTC are also carers themselves for frail partners, grandchildren and whānau with disabilities and are particularly in need to cross sector sharing of information and co-ordination of services.• Under prevention and detection, it seems that information provision alone is seen as a route to a ‘health smart’ population. The strategy needs to take into account the principles of health literacy, in that people need to obtain, process and understand information to be able to make informed health decisions.• Recognition that human motivation is a factor in health smart behaviour is lightly addressed when talking about connection with groups to help manage conditions. A stronger message around tackling behavioural motivators may be necessary when expecting individuals and whānau to become involved in self-management of long term conditions. |

3b. The draft Strategy includes actions that are intended to achieve the goal of living well with long-term conditions: see page 34 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| Agree \* are crucial• Enhancing cross sector working is crucial to progress within next 2 years – should not be limited to those with mental health, alcohol and other drug problems. Again links to primary and community care support could be strengthened. Integrated primary care and community teams are key to supporting older people to live well with LTC.• Strengthen communication with the wider community of people living in New Zealand regarding restorative care and self-management approach to achieve living well longer in the community.• Recognising a One Team approach for the multidisciplinary clinical workforce (as well as kaiāwhina) is important. It would be good to see an action which recognises this amongst the current workforce, outside of the undergraduate and graduate curricula (9b).• Suggest including the Health Regulatory Authorities as leads under 9b.• We feel that 9e (utilising allied health workforce) should have a priority star, especially as gains may take some time to become realised. |

### Support for people with high and complex needs

4a. The draft Strategy sets out a vision for the goal of better support for people with high and complex needs: see page 24 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Agree with vision statements, however primary care seem to be absent from this vision.• Integrated primary care teams play a key role in supporting older people with complex needs and their whānau who are living in the community and in aged residential care.• The trusting relationship and longitudinal span of time that a primary care team is likely to have been involved with an older person by the time their needs become high or complex, and the depth of knowledge that this therapeutic relationship creates needs to be recognised as it can have a significant impact on health outcomes.• The vision for support of people with high and complex needs talks about these people moving ‘easily and through care settings that best meet their needs’. Given the risks of harm occurring at each transfer of care (eg. medication errors), it would be responsible to recognise that moving through care settings should also be safe.(?typo spotted pg 24, second column, 3rd para under Knoweldge and Communication, should this read“high and complex needs” not “high and complex conditions”?) |

4b. The draft Strategy includes actions that are intended to achieve the goal of better support for people with high and complex needs: see page 37 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| • Agree with \* however crucial to achievement is sufficient numbers and range of healthcare providers with skills in care and support of people with high and complex needs both in the community and in ARC (at all levels) alongside integration, co-ordination and sharing of information not only between health teams but also disability and social care providers.• Nurses, and Nurse Practitioners working in and alongside primary and community care, form a large part of the workforce along with Kaiāwhina, supporting those older people with high and complex needs. Supporting growth in their ability to deliver specialist care to older people with high and complex needs should be seen as a high priority.• Better support for access to out of hours care options for people living in ARC is crucial.18c. Development of an acute plan (http://tinyurl.com/hb9lvg2 or http://preview.tinyurl.com/hb9lvg2) and/or an advance care plan in the patient’s health record may mean that whānau, residents and facilities can agree in advance on priorities if urgent care is needed, reducing the need for urgent communication prior to care decisions. Having said this, systems for effective communication with primary care health professionals (eg. GP, Pharmacy) at the point of discharge from hospital (and sometimes when urgent care is needed), are imperative for safety and best patient outcomes.• We welcome the integration of information actions under 19, but feel that universal accessibility of interRAI assessments by everyone involved in the care team may need to be addressed in a specific action. Widening training and increasing uptake of this key assessment may also need attention.• 21a. The HOPWS discussed this and felt it should be a priority item. It was felt that access to ‘carer support’ has barriers currently, in particular the mechanism of claiming and the exclusion of carers who are working. We did not feel this could wait 2 years or more, given the level of carer stress we are aware of in Canterbury. |

### Respectful end of life

5a. The draft Strategy sets out a vision for the goal of a respectful end of life: see page 27 in the draft document. Do you have any comments or suggestions regarding this vision?

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| The description of the outcome area ‘making sure people…are in control’ does not seem to take into account those with cognitive impairment or dementia. The phrase ‘as much as they are able’ may be insufficient to encourage quality end-of-life care for this group of people. Given that more and more older people will reach the end of life with some form of cognitive impairment, it would be good to have this recognised in the bullet point.• The implications that a ‘fresh’ approach to palliative care is necessary to meet our future needs may give the reader the impression that palliative care has not kept pace with a commitment to continuous and responsive improvement. Making palliative care a fundamental part of usual healthcare ‘standard practice’ in all settings (as opposed to a specialty service) is probably the intention, as signalled in action 23a.• In the vision for enabling a respectful end of life, the struggle of those with cognitive dysfunction may not be fully recognised in the statement ‘people talk comfortably about dying and preparing for death’. The word ‘enabled’ could also be included to strengthen the meaning of the statement. |

5b. The draft Strategy includes actions that are intended to achieve the goal of a respectful end of life: see page 40 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| The HOPWS believes that palliative care in patients with cognitive impairment/dementia is an important part of enacting the strategy. There are unique challenges which may warrant an action point of their own, tying into the NZ Dementia Framework. |

### Implementation, measurement and review

6 The draft Strategy includes proposals for implementing, measuring and reviewing the proposed actions: see page 41 in the draft document. Do you have any comments or suggestions regarding these proposals?

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| • 25a. A regional response to some aspects of any implementation plan may already be in place. HOPWS suggests that this is taken into account and a regionally relevant approach is adopted. • 26f. HOPWS clinicians feel that the Pharmacy service model for managing minor ailments needs to recognise the philosophy that older people are not a homogenous population group. It needs to take into account the complexities of ‘seemingly’ minor ailments in frail older people or those with complex or high needs, but also that it is not feasible to exclude *all* patients over 65 from receiving as many of them will be suitable for effective management under this service.• 28a. Clinicians on the HOPWS support 28c. (research informs policy) as a priority. |

### Other comments

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| The CCN HOPWS aimed to take every available opportunity to be involved in this consultation. We would like to congratulate the Ministry of Health on this draft and thank you for taking the time to consult widely, not only with groups like ourselves, but also with consumers and carers. We would appreciate being included in any future correspondence about this Strategy and we look forward to celebrating its release and implementation. |

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| **Submission 133** |

**Health of Older People Strategy Consultation Draft**

**Submission from the Health of Older People Team, Planning Funding and Outcomes Unit, Auckland and Waitemata District Health Boards**

Thank you for the opportunity to make a submission on the Health of Older People Strategy. We support the vision and objectives of this Strategy. Below is our feedback on the Consultation Draft including general feedback and feedback that relates to specific actions.

**General Feedback:**

**Integration**

* Integration across health and social sectors is an important component of the Strategy. The need to ensure there is a formal relationship with other agencies/Ministries around this Strategy and its implementation is essential and it is unclear where in the process this will occur
* For Health, much of the Strategy will be implemented through priorities being signalled to DHBs as part of their Annual Planning requirements. Are there similar pathways for other agencies/Ministries to ensure this happens and will this be agreed with these agencies as part of developing the Strategy?
* The Action Plan needs to clearly define lead agencies; in most cases there should be a single Lead Agency with supporting agencies. Use of the term ‘Government Agencies’ and ‘All’ as the Lead also does not clearly define responsibility

**Models of care**

* There appears to be limitations on the development of new models of care borne out by a tendency to focus on, and refer to, ‘Aged Residential Care’ and ‘Home and Community Support Services’. In effect this constrains the type of future models of care and services that could be developed
* A ‘continuum of care’ from other funding services (ie mental health, LTS-CHC, DSS etc) to health of older people services needs to be developed to ensure that services are both age and care appropriate. For example, a number of people with long standing mental health or addiction conditions are being placed in aged residential care when they turn 65 years, where the average age is 82 years old. Similarly for people with intellectual disabilities. There is a need to investigate alternative models of care as part of the continuum of care for these groups

**Gaps**

* An emerging issue is older people who are at risk and require emergency housing; this issue is not currently addressed
* There is a lot in the Strategy on the need to address the workforce supply, capability and skill mix for the future. However, there is no specific section on workforce that would lead to a workforce action plan. Instead this area is integrated into other actions and sections yet it is pivotal for delivering on the Strategy and a more focused approach to workforce seems appropriate
* It would be useful to include a glossary to define some terms used in the Strategy that may be open to interpretation; to ensure all parties are working within the same parameters

**Strategy name**

* It has been signalled that the Strategy is being rebranded and will have a name change to ‘Healthy Ageing Strategy’. We have received feedback concerned that this new title does not acknowledge/reflect that many older people are struggling with poor health and disabilities, and the inevitable decline of their health status and how this should be managed (eg frailty, dementia). ‘Healthy Ageing Strategy’ is a more appropriate title for a strategy focused on health promotion rather than the wide range of community, primary, secondary health services and social services covered in this Strategy.

**Feedback on Actions:**

**Healthy ageing**

* 1a) *Establish age friendly communities in line with Positive Ageing Strategy.* This action requires significant societal and structural change yet it will be implemented in the first two years and no detail is provided on how it will be implemented
* 1c) *Work across government and with local interest groups to improve access to, and coordinate assistance to socially isolated older people and develop initiatives that better address the physical and social determinants of health.* There are two actions here: 1/ to improve access and coordinate assistance for socially isolated people; 2/ develop initiatives that better address physical and social determinants of health. The latter is huge in scope and no details are provided
* 2) *Increase resilience through local initiatives.* We support the actions in this section particularly around strength and balance programmes for which there is good evidence of effectiveness
* 3)We support the actions *for working across government to prevent harm, illness and disability and improve people’s safety and independence.* However, as suggested we believe an action is missing that addresses emergency housing for vulnerable older people eg at risk of abuse
* 4) We support the actions for  *improving health literacy and communication systems*
* 5b) *Identify and promote innovative care arrangements for oral health of people living in aged residential care.* The use of the word ‘innovative’ is vague in terms of what approach or service is to be implemented. Will this arrangement also be available to people living in the community who are often facing the same issues concerning their oral health?

**Acute and restorative care**

* 6 and 7) We support the actions in the a*cute and restorative care* section
* 7b) *Make use of big data to identify older people at risk of falls*…. ‘big data’ is an example of a term that could be defined in a glossary
* 8) We support the action to *reduce acute admissions*

**Living well with long-term conditions**

* 9) We support actions in *living well with long-term conditions*
* 9a) *Regularise and improve training of Kaiawhina workforce in home and community support services.* It’s noted that a regularised workforce is a requirement of the Settlement Agreement for Inbetween Travel and must be implemented by April 2017. In the context of this action, does Kaiawhina workforce refer to all support workers under the Settlement Agreement?
* 10) We support the actions to *enhance cross-sector, whole-of-system ways of working* but note the actions could be more explicit
* 11) We support the actions to e*xpand and sharpen the delivery of services to tackle long-term conditions.* Possibly replace the word ‘sharpen’ with ‘improve’?
* 11b) *Encourage health social services and communities to become more dementia friendly*. This action should sit under action 1 *age friendly communities.* Being age friendly essentially should encompass the needs of older people including those with physical, sensory, communication or cognitive deficits
* 11c) *Reduce the instance of complications from diabetes, particularly for people in aged residential care….*It is unclear why aged residential care is seen as priority over people who are living in the community; both are important
* 12) We support the actions to *inform individuals and the community*….
* 13) We support the actions *for u*se of *new technologies to assist older people….*

**Support for people with high and complex needs**

* 14) We support the actions to *reduce frailty in the community*
* 14a) *Explore possibilities for a frailty identification tool to enable primary and other health professionals to identify frail older people*. There has been considerable investment in interRAI and it would make sense to determine if there are appropriate interRAI tools for this purpose
* 15c) *Promote contracting models that enable people to move freely to different care settings most suited to their needs.* Models of care would need to come before contracting models. Unless this is reference to a specific issue with current contracting processes, if this is the case then this action needs to be more explicit
* 16) *Integrate funding and service delivery around the needs and aspirations of older people…..* Integrated service delivery is an important outcome however this may or may not require integrated funding; the latter should not be an outcome in its own right
* 17a*) Improve access to mental health and addiction services among older people with high physical needs, and improve integration of these services with residential care or home services*. This action does not appropriately address the continuum of care for mental health clients. For example, a number of people with long standing mental health or addiction conditions are being placed under Health of Older People as they turn 65 years old. This action attempts to address this but does not take into account a 65 year old with mental health or addiction issues being placed in an aged residential care service where the average age is 82 years old, and the need to investigate alternative models of care
* 18) *Better integrate services for people living in aged residential care.* We support actions a,b,c. However, we have concerns with action 18d *Explore options for aged residential care facilities to become providers of a wider range of services to older people, including non-residents.* This action is much broader than the overarching action and it is unclear why the opportunity to provide a wider range of services is specified for aged residential care facilities and not other providers. There are risks here with conflicts of interest particularly with facilities attached to retirement villages and with ‘resident capture’
* 19) We support actions to *improve integration of information*
* 20) We support actions to *improve medicines management*

**Respectful end of life**

* 22-24) We support actions for a *respectful end of life*

**Implementation, measurement and review**

* 25) *Implement the Strategy*. This is the overarching action to implement the strategy; it doesn’t make sense that it is action 25. Delivery on the Strategy will not happen without an implementation plan
* 26) *Include older people in service design….* Engagement of older people must include older disabled people and older people that are not always heard (older people without natural supports, living rurally or in poverty)
* 27) We support the actions *to establish an outcomes and measurement framework*….
* 28) We support the actions *to improve the knowledge base.*

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| **Submission 134** |

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**Submission from Occupational Therapy New Zealand Whakaora Ngangahau Aotearoa**

Health of Older People Strategy: Consultation draft Submission

Date of Submission: 5 September 2016

**Preamble**

This submission is sent on behalf of Occupational Therapy New Zealand Whakaora Ngangahau Aotearoa (OTNZ-WNA) following consultation and input from the associations Health of Older people” special interest group.

Occupational therapy is “the art and science of enabling engagement in everyday living, through occupation; of enabling people to perform the occupations that foster health and well-being; and enabling a just and inclusive society so that all people may participate to their potential in the daily occupations of life” (Townsend & Polatakjko, 2007, p. 372).

Occupational therapists enable people to lead meaningful and satisfying lives through participation in occupation.  The term 'occupation' is used in the widest sense - it is “everything that people do to occupy themselves, including looking after themselves (self-care), enjoying life (leisure), and contributing to the social and economic fabric of their communities (productivity); the domain of concern and the therapeutic medium of occupation therapy” (Townsend & Polatakjko, 2007, p. 369).

Occupational therapists help people to identify the occupations that are difficult for them. This could be due to problems with physical abilities, for example, strength or co-ordination, or mental abilities, for example, memory or organization skills. In the context of the health of older persons an Occupational Therapists may make an assessment of the person’s ability to manage their everyday activities in their living situation. Recommendations for safe and easy ways to do activities and equipment and home modifications may be provided. This may include provision of a treatment plan to support and enable the person to achieve their goals.

Sector this submission represents: Professional association

**Note: Suggestions for text additions from this submission are in bold and highlighted**

### Healthy ageing

1a. The draft Strategy sets out a vision for the goal of healthy ageing: see page 14 in the draft document. Do you have any comments or suggestions regarding this vision?

* Focus is on physical effects of ageing but equally limiting can be the loss of confidence, cognitive ability, roles and routines, environmental and social factors.
* Talks about strong link between social isolation and poor health outcomes. What about the link between reduced independence/functional ability and poor health outcomes (depression, anxiety, cognitive and physical decline & subsequent heavier reliance on care sector)

Page 14 under subheading ”Why is thi simportant” Paragraph 3 – ‘Loss of strength and mobility’. This is quite specific. A more general term might read as ‘loss of meaningful roles and routines and decrease in ability to engage in everyday activities’

P 15 Paragraph 2 says “We need to increase physical activity and other healthy behaviours among older people – for example, good nutrition, not drinking alcohol or only drinking at low-risk levels, not smoking tobacco, and mentally stimulating activities that build people’s strengths and resilience. We need a strong shift of focus from treating illness and addictions to preventing them and optimising older people’s health, through healthy lifestyles and behaviours, improved strength and balance, improved oral health and improved health literacy”.

We suggest a change as follows:

“We need to increase physical **‘cognitive and productive activity’** and other healthy behaviours among older people – for example, good nutrition, not drinking alcohol or only drinking at low-risk levels, not smoking tobacco, and mentally stimulating activities that build people’s strengths and resilience. We need a strong shift of focus from treating illness and addictions to preventing them and optimising older people’s health, through **‘productive, purposeful activity; increased opportunity for social interaction,** healthy lifestyles and behaviours, improved strength and balance, improved oral health and improved health literacy”.

1b. The draft Strategy includes actions that are intended to achieve the goal of healthy ageing: see page 31 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

2) Focus again is on physical resilience.

Resilience also about confidence and competence to overcome barriers; to do things for ourselves – as above we need other skills (cognitive, psychological, motor, communication) as well as meaningful roles and routines and a supportive environment to achieve this

A lifestyle intervention such as evidence based ‘Lifestyle redesign’ or ‘ Lifestyle matters’ programmes address all life areas and have been proven to beneficial in pain reduction, vitality, social functioning, mental health and depressive symptoms (Clark et al 2011 Effectiveness of a lifestyle intervention in promoting the well-being of independently living older people)

Could add **Provide access to education/coaching to maintain independence through a programme such as Lifestyle redesign**

3) Talk of safety and independence but not how this will be achieved.

To achieve this older people have a right to an Occupational Therapy assessment to identify and maintain functional abilities, identify and overcome limitations, reduce safety risks and hence maximise independence and the ability for stay at home for longer.

e) Healthy ageing **and independence**

4)b) add in meaningful occupations (pitched at a level that facilitates independence)

**Residential providers to employ fully qualified health professionals (Occupational Therapists) to ensure functional abilities are maintained, limitations reduced and wellbeing enhanced through engagement in programmes that are tailored to the persons needs and abilities.**

### Acute and restorative care

2a. The draft Strategy sets out a vision for the goal of high-quality acute and restorative care: see page 17 in the draft document. Do you have any comments or suggestions regarding this vision?

Page 17 Paragraph 6*:.reduced physical ..long-term cognitive impairment*, **loss of independence**

Paragraph 7: preventable factors (such as...**lack of appropriate and timely interventions**...)

Paragraph 8: talks of *shift in philosophy from doing things for people to working with people to help them regain/maintain abilities* – this is Occupational Therapists (OT’s) core business – it is what OT’s do and are therefore well placed to take leadership roles – need to see an increase in OT positions in acute and community settings.

Page 18 – 1st paragraph - *health providers* (should read **health professionals**) *for example through strength and balance training* add: **or helping someone relearn how to manage ADL’s independently following an illness or injury**

States that district nursing services provide. . oversight of rehabilitation – this should include **allied health professionals**

NOTE: In UK OT input within emergency departments contributed to prevention of up to 67% admissions. Falls Response Service OT working with paramedic 75% were able to stay at home (COT 2015)

2b. The draft Strategy includes actions that are intended to achieve the goal of high-quality acute and restorative care – see page 33 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

Rehabilitation team to include Occupational Therapists whose core business is maintaining/restoring independence

8 Reduce acute admissions

Interdisciplinary teams to include Occupational Therapists (who are able to identify and reduce risks through practical strategies) working as part of general practice, in emergency departments and with paramedics

### Living well with long-term conditions

3a. The draft Strategy sets out a vision for the goal of living well with long-term conditions: see page 20 in the draft document. Do you have any comments or suggestions regarding this vision?

Page 20 top right: . . *can lead to a gradual deterioration of health and* **function** (change the word mobility to function).

NOTE: Through holistic observational assessments Occupational Therapists gain a true picture of a person’s abilities and limitations (when assessment is based purely on questionnaires i.e. Inter-rai mistakes can be made - people are given too much support or not enough) – early assessment/intervention by an Occupational Therapist enables independence to be maintained through appropriate and timely equipment provision, skill building, carer education, coaching, environmental adaptations etc).

***Recommendation:*** *Occupational Therapists (OT’s) to be employed as part of interdisciplinary team within general practice for preventative measures including involvement in older persons health checks to identify/reduce risks and supports/strategies to maintain safety and independence.*

3b. The draft Strategy includes actions that are intended to achieve the goal of living well with long-term conditions: see page 34 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

10b Page 35 - As well as physical activity need to address engagement in meaningful and purposeful occupation (helping people to do the things that they should and want to be doing provides them with sense of purpose/satisfaction and in turn will increase physical activity, increase independence, improve mental health status etc.)

12 page 36 - A lifestyle intervention such as ‘Lifestyle Redesign’ (see section 1b) would support people to remain physically and mentally active and strengthen skills they may have lost

### Support for people with high and complex needs

4a. The draft Strategy sets out a vision for the goal of better support for people with high and complex needs: see page 24 in the draft document. Do you have any comments or suggestions regarding this vision?

Agree that we need to reduce the barriers that currently prevent people from using their skills

People have the right to an accurate assessment from a health professional with specialist skills in facilitating independence. There should be a shift from support being about doing for the person to helping the person overcome their limitations. An Occupational Therapist will identify the person’s skills and limitations and find/implement solutions and strategies that support their independence.

4b. The draft Strategy includes actions that are intended to achieve the goal of better support for people with high and complex needs: see page 37 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

15a agree with this (see above). The problem currently is that there are nowhere near enough Occupational Therapists to do this. For example there is one sole OT working specifically with this client group in Nelson and Marlborough. It is short sighted as there have been many cases where the Occupational Therapist has been responsible for a person staying home for longer or moving to a lower level of care.

### Respectful end of life

5a. The draft Strategy sets out a vision for the goal of a respectful end of life: see page 27 in the draft document. Do you have any comments or suggestions regarding this vision?

Enabling a person to die at home where they feel comfortable and safe and have the support and presence of their family and whanau is also the role of the occupational therapist in the care team. Some simple prescriptions of equipment can be enough to enable a person to die at home with dignity and emphasis/adaption of design/layout of a home can assist a person to engage and participate for longer. This can literally “transform a space into a place”. Supporting their spirituality at this time and making a space for this within a home, enabling choice and decision making( however small) and carrying out relaxation sessions , not just for the person but for the whole family/whanau are all areas OTs are skilled at doing.

5b. The draft Strategy includes actions that are intended to achieve the goal of a respectful end of life: see page 40 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

Need a national campaign re. palliative care and advanced care planning, to start this education early e.g. in schools and through intergenerational advertising.

### Implementation, measurement and review

6 The draft Strategy includes proposals for implementing, measuring and reviewing the proposed actions: see page 41 in the draft document. Do you have any comments or suggestions regarding these proposals?

Older people need to be included and asked what they want and what they see as a priority. What do they perceive as barriers and how could these be overcome?

They might feel more confident doing this through a group such as Grey Power, their local Marae or through one of the disability groups for example Stroke Club or Alzheimers.

### Other comments

We agree with your reference to increased use of the allied health team and would like to add that a consistent multidisciplinary team that works alongside the person from hospital admission to the community would be advantageous.  Regularly we evidence elderly who are confused by who they have seen and who is their contact person.  Streamlining of notes, assessments and visiting services including a key worker to who the elderly person can make all contact is suggested.

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| **Submission 135** |



Tēnā koe i nga ahuatanga o te wa

**Introduction: Te Pūtahitanga o Te Waipounamu**

Te Pūtahitanga o Te Waipounamu writes in response to the Health of Older People Strategy Consultation, following the request for submissions on how what targeted solutions can be put in place to ensure that people are appropriately supported as they age.

Te Pūtahitanga o Te Waipounamu is a limited partnership, supported by the nine iwi of Te Waipounamu through a Shareholders Council known as Te Taumata. Te Pūtahitanga o Te Waipounamu was launched in July 2014 as the South Island Commissioning Agency for Whānau Ora. Te Taumata has appointed an independent governance board which is responsible for the investment strategy. The name, Te Pūtahitanga o Te Waipounamu, represents the convergence of the rivers of Te Waipounamu, bringing sustenance to the people, and reflecting the partnership‟s founding principle of whānaungatanga.

Commissioning in the context of Whānau Ora is the process of identifying the aspirations of whānau and investing in them whether they are new or existing initiatives. These whānau-centred initiatives are expected to best reflect progress towards Whānau Ora outcomes.

Whānau Ora is an inclusive approach to support whānau to work together as whānau, rather than separately with individual family members. We consider that Whānau Ora outcomes will be met when whānau are:

* Self-managing;
* Living healthy lifestyles;
* Participating fully in society;
* Confidently participating in Te Ao Māori;
* Economically secure and successfully involved in wealth creation;
* Cohesive, resilient and nurturing;
* And able to act as responsible stewards of their living and natural environments.

Te Putahitanga o Te Waipounamu writes in support of the Health of Older People Strategy Consultation draft. As the consultation draft recognises, the increased longevity of the New Zealand population presents both great benefits and great challenges. The consultation draft comprehensively and articulately describes how these challenges can be met, and how older persons can be supported to continue to live their lives with freedom and empowerment.

However, Te Putahitanga o Te Waipounamu submits that there are several aspects of the consultation draft which could be strengthened. In particular, Te Putahitanga o Te Waipounamu submits that there should be greater recognition of the need for culturally competent and responsive health services for older people, especially for Māori, that greater attention should be given to how expanded and / or new services for older people will be resourced, and that the role of whānau should be more strongly recognised.

**Responsiveness of consultation draft**

Overall, the consultation draft is extremely positive in its approach to older people and the challenges that they may face as they age. It was heartening to see recognition of fact that there is no generic “older person”, and that the different experiences of aging will be unique.

The statement that health services should be focussed on the needs of the individual is a powerful one, and it is encouraging to see such that focus across the consultation draft. The inclusion of the needs of paid and unpaid carers, family and whānau of older persons was also valuable, as the contribution of those people to the wellbeing of older persons can often be overlooked, while having significant influence on the quality of life of older people. For kaumātua being cared for at home, day care provides a change, the company of different people and stimulation through other activities, while giving their carer a rest. For people living alone, it offers a day out and the opportunity to socialise with other people (Ministry of Health, 2013).

The consultation draft was strengthened by having both objectives and vision supported by clearly defined action items. This structure allowed the reader to see and understand what the goals of older people are, and how these goals will be implemented and achieved, and by whom, and in what timeframes. The consultation draft was also clearly supported by a strong consultation methodology, and responded well to the challenges which face New Zealanders as they age and the challenges faced by health services to appropriately support older people.

**Culturally competent services**

Māori are a youthful population, compared to the overall New Zealand population, with 76.6% of Māori in the South Island under the age of 44 (source: Census 2013). In 2013, only 5.1% of Māori in the South Island were older than 65 years. With increasing numbers of Māori aging, more kaumātua will require support. With large projected population increases predicted for Maori in the 65+ age group in Canterbury, this group is expected to more than double between 2006-2026, from 3.3% to 8.6% (Environment Canterbury, 2014)

Kaumātua hold a very special and significant place in Māori culture, and are hugely valued by their whānau and the wider community. It is vital that the needs of older Māori people should not be overlooked.

Furthermore, as the consultation draft recognised, the increasing Māori population will create significant changes in the demographics of the aging population over time, and the long term strategy needs to be responsive to these impending changes. As an example, despite there being 152 aged residential care facilities within the Canterbury region, there is a notable absence of facilities incorporating kaupapa Māori and offering a cultural perspective of health and wellbeing that would ensure protection, partnership and participation for kaumātua.

The distinct challenges faced by Māori in achieving positive health outcomes are well known, and are recognised in the consultation draft. Māori face shorter life expectancy than non-Māori, where non-Māori men will outlive Māori men by seven years, and non-Māori women will outlive Māori women by six years (figure 5: Ministry of Health. 2015. Tatau Kahukura: Māori Health Chart Book 2015 (3rd edition). Wellington: Ministry of Health). Furthermore, Māori face higher rates of disability (regardless of age), cardiovascular disease, cancer and respiratory disease than non-Māori, all of which will have significant impacts as they age. It is extremely positive to see in the consultation draft the commitment to guarantee that equity is ensured across the health system.

However, while the health and wellbeing challenges faced by Māori are recognised in the consultation draft, Te Pūtahitanga o Te Waipounamu submits that there needs to be stronger prominence placed on the need for culturally competent and responsive approaches to the health of older people. Māori are currently under-represented as users of aged residential care (Statistics New Zealand; 1996, 2000). However, as the demand for such care continues to grow, changing population trends, burgeoning numbers of older Māori, and decreasing family size suggest that aged residential care will increasingly be considered by Māori in the future. Therefore, it is vitally important to develop a kaupapa Māori model of care and culturally responsive services in order to meet the needs of kaumātua and the wider community.

Some of the action items in the consultation draft respond to this well. For example, action item 2(b) (“expand the provision of targeted health promotion initiatives, and services to increase resilience among Māori and other vulnerable older populations who have poorer health status”), and action item 9(f) (“enhance workforce capability and training pathways to encourage more entry and retention of the workforce among Māori and Pacific peoples”).

While these and other action items which directly respond to the challenges faced by Māori, there is no overarching commitment to culturally appropriate engagement with older people across the whole consultation draft. Culturally responsive practices have been identified as crucial to create positive engagement, and in turn, positive health outcomes for Māori. Many older Māori do not engage with mainstream health services because they are unable to respond to their cultural needs, and the kaumātua feel unsafe and unsupported in these environments.

Te Putahitanga o Te Waipounamu submits that the consultation draft should include a stronger commitment to increased cultural competency across all aspects of health and wellbeing for older people, particularly for Māori. There should also be a requirement that all health and wellbeing services should be required to undertake cultural responsiveness training, so that they are able to respond to the needs of an increasingly diverse older population. Professor Mason Durie (2001) noted that a failure to appreciate the impact of culture on clinical realities has often led to misdiagnosis and mismanagement among ethnic minorities. Māori cultural responsiveness is central to improving Māori health, and requires a commitment by primary health care providers to ensure culturally responsive health care practices.

**Resourcing**

Many of the action items recommended extremely positive changes or strengthening to health and wellbeing services that will have outcomes for older people. However, there was a lack of clarity about how these changes will be resourced.

For example, there was a focus in the Acute and Restorative Care outcome area on reducing the delayed discharge from hospital. Te Putahitanga o Te Waipounamu supports such a focus, as increased time in hospital creates higher risk of complications due to contact with other unwell patients and many people feel more comfortable and safe in their own home. However, discharge from hospital, when appropriate for the patient, often means that the patient is then reliant on the assistance of non-hospital health and wellbeing services and community support services, as well as on support from family and whānau. It is inappropriate for these services and family and whānau members to be supporting an older person without proper resource and assistance. The impact of not accessing specialist health services may have detrimental consequences for kaumātua and for whānau, resulting in additional whānau carer stress and burnout.

Te Putahitanga o Te Waipounamu submits that the consultation draft should better articulate how any new services or changes to existing services will be resourced and supported to ensure that older people are receiving the best care possible.

**Role of Whānau**

The role of whānau in the lives of older people was mentioned throughout the consultation draft. For many Māori, whānau are the central mechanism of support when facing times of challenge, and many older Māori rely on whānau members as carers and sources of general support. Even in aged care facilities, kaumātua stated that a facility that connected whānau, hapū, and iwi could aid in minimising their feelings of isolation, loneliness and detachment, especially in times of need or illness.

Currently, the consultation draft does not sufficiently recognise the mutual relationship between an older person and their whānau, where the whānau provides support for a kaumātua, and in turn, kaumātua provide guidance and care to their whānau. For example, although the goals of the respectful end of life outcome includes consideration of the needs of whānau, there is guidance as to when the whānau become engaged in the process or structure as to how such guidelines could be developed.

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| **Submission 136** |

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| Organisation (if applicable): | ATAMU Incorp (on behalf of EFKS Porirua) |
| Position (if applicable): | Members of ATAMU Incorp & EFKS Porirua |

This submission *(tick one box only in this section)*:

[ ]  comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity)

√ is made on behalf of a group or organisation(s)

We will publish all submissions on the Ministry’s website. If you are submitting as an individual, we will automatically remove your personal details and any identifiable information.

If you do not want your submission published on the Ministry’s website, please tick this box:

[ ]  Do not publish this submission

Your submission will be subject to requests made under the Official Information Act. If you want your personal details removed from your submission, please tick this box:

[ ]  Remove my personal details from responses to Official Information Act requests

Please indicate which sector(s) your submission represents *(you may tick more than one box in this section)*:

[ ]  Māori [ ]  Regulatory authority

√ Pacific √ Consumer

[ ]  Asian [ ]  District health board

[ ]  Education/training provider [ ]  Local government

[ ]  Service provider [ ]  Government

√ Non-governmental organisation [ ]  Union

[ ]  Primary health organisation [ ]  Professional association

[ ]  Academic/researcher √ Other *(please specify)*:
Church community (EFKS Porirua)

### Healthy ageing

1a. The draft Strategy sets out a vision for the goal of healthy ageing: see page 14 in the draft document. Do you have any comments or suggestions regarding this vision?

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| We are happy with the vision but we highlight below in “Other comments” our suggestion. |

1b. The draft Strategy includes actions that are intended to achieve the goal of healthy ageing: see page 31 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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### Acute and restorative care

2a. The draft Strategy sets out a vision for the goal of high-quality acute and restorative care: see page 17 in the draft document. Do you have any comments or suggestions regarding this vision?

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| We are happy with the vision but we highlight below in “Other comments” our suggestion. |

2b. The draft Strategy includes actions that are intended to achieve the goal of high-quality acute and restorative care – see page 33 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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### Living well with long-term conditions

3a. The draft Strategy sets out a vision for the goal of living well with long-term conditions: see page 20 in the draft document. Do you have any comments or suggestions regarding this vision?

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| We are happy with the vision but we highlight below in “Other comments” our suggestion. |

3b. The draft Strategy includes actions that are intended to achieve the goal of living well with long-term conditions: see page 34 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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### Support for people with high and complex needs

4a. The draft Strategy sets out a vision for the goal of better support for people with high and complex needs: see page 24 in the draft document. Do you have any comments or suggestions regarding this vision?

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| We are happy with the vision but we highlight below in “Other comments” our suggestion. |

4b. The draft Strategy includes actions that are intended to achieve the goal of better support for people with high and complex needs: see page 37 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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### Respectful end of life

5a. The draft Strategy sets out a vision for the goal of a respectful end of life: see page 27 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Becoming comfortable about death and dying and accepting it demands immense spiritual courage, respect and acceptance. As a Samoan church community, we highlight and emphasise the need to acknowledge that pastoral care be included and incorporated in this outcome. This important part for many Pacific people prepares them for this last stage of their lives as it centres primarily on their Christian faith, principles and spiritual connection. Such pivotal aspects form their respectful end of life which in turn embraces cultural and holistic care. |

5b. The draft Strategy includes actions that are intended to achieve the goal of a respectful end of life: see page 40 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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### Implementation, measurement and review

6 The draft Strategy includes proposals for implementing, measuring and reviewing the proposed actions: see page 41 in the draft document. Do you have any comments or suggestions regarding these proposals?

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### Other comments

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| As a church community founded on strong cultural and spiritual foundations, we feel that there is very little emphasism made to include the spiritual being of the individual within a holistic care approach in the strategy. As a Samoan community, we point out that for many Pacific communities in New Zealand, cultural and spiritual wellbeing are inextricably intertwined. The two are inseparable, therefore, when there is mention of “cultural sensitive” care packages, one must be mindful of the spiritual wellness too. The element of spirituality foregrounds the coming to terms with grief and loss for many members of the wider Pacific communities. It’s an essential element key to acceptance and eventual hope. We recommend you consider spirituality be incorporate in the Strategy and therefore, must weave right across the strategy, its visions, action points and implementation plans. |

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| **Submission 137** |

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| Organisation (if applicable): | Ageing Well National Science Challenge and NZ Association of Ageing (NZAG) |
| Position (if applicable): | AW Management Directorate and VP NZAG |

This submission *(tick one box only in this section)*:

[ ]  comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity)

[x]  is made on behalf of a group or organisation(s)

We will publish all submissions on the Ministry’s website. If you are submitting as an individual, we will automatically remove your personal details and any identifiable information.

If you do not want your submission published on the Ministry’s website, please tick this box:

[ ]  Do not publish this submission

Your submission will be subject to requests made under the Official Information Act. If you want your personal details removed from your submission, please tick this box:

[ ]  Remove my personal details from responses to Official Information Act requests

Please indicate which sector(s) your submission represents *(you may tick more than one box in this section)*:

[ ]  Māori [ ]  Regulatory authority

[ ]  Pacific [ ]  Consumer

[ ]  Asian [ ]  District health board

[ ]  Education/training provider [ ]  Local government

[ ]  Service provider [ ]  Government

[ ]  Non-governmental organisation [ ]  Union

[ ]  Primary health organisation [x]  Professional association

[x]  Academic/researcher [ ]  Other *(please specify)*:

### Healthy ageing

1a. The draft Strategy sets out a vision for the goal of healthy ageing: see page 14 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Suggested rewording of outcomes (see page 14):* people being health smart and ways to develop and maintain physical and mental wellbeing throughout ageing.
* helping people build resilience to age well
* addressing the physical, social, cognitive, environmental and financial risks to healthy ageing.
* achieving equity for Maori and vulnerable population groups
* supporting the development and sustainability of age-friendly communities that enable positive ageing.
 |

1b. The draft Strategy includes actions that are intended to achieve the goal of healthy ageing: see page 31 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| * This area needs clearer accountability and should be central point of coordination with consistent messaging and a priority of listening to older people.

Strength and balance can be improved through falls prevention programmes but other factors influence risk of falling such as impaired vision and weakened joints. More public health funding is needed for cataract surgery and joint replacement.* 3a should be a priority, especially given the focus of the social investment approach on data sharing for more effective targeting of support and services. The development of these systems is already well underway.
 |

### Acute and restorative care

2a. The draft Strategy sets out a vision for the goal of high-quality acute and restorative care: see page 17 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Suggest adding the following points:* increasing workforce numbers and training for those delivering home and community support
* increase the perceived societal value of this role with suitable career structure and remuneration
* train clinicians in how to have “difficult conversations” with patients

Vision page 19Add this bullet point* Share information from numerous assessment tools and avoid duplication or creation of new tools.

Revise* Health providers, ACC, social and community services share information and work together with people and their families/whānau throughout recovery in hospital and at home.
 |

2b. The draft Strategy includes actions that are intended to achieve the goal of high-quality acute and restorative care – see page 33 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| Given that premature hospital discharge is a significant predictor of (potentially avoidable) readmission, suggest one goal is the need to work toward comprehensive discharge planning for all hospitalised older people  |

### Living well with long-term conditions

3a. The draft Strategy sets out a vision for the goal of living well with long-term conditions: see page 20 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Outcomes were comprehensive except for there is no explicit language about managing long-term conditions in those with cognitive decline, dementia, or Alzheimer’s disease, which are long-term conditions in and of themselves. It is raised on pages 20—21.Also the current thinking is that frailty is a long-term condition and not a consequence of long-term conditions. The last point (page 20) could be reworded* improving our ability to slow or stop the progression of long-term conditions.
* page 22 Priority populations. More focus on Asian older adults is needed

The visions on page 23 were good and included support and training of workforce in the visions on page 23General comments:* MOH and DHBs are seen as taking the lead however more community involvement is needed. For example 9a on page 34 is an excellent action but wider than a health responsibility.
* Cross-government contracts should be integrated to enable access to multiple providers.
* A better link is needed in the strategy between needs of people with long term conditions and high and complex needs in areas such as appropriate housing.
* The aim of bridging research into policy and practice – through pathways to impact – should be incorporated into the strategy as a key outcome.
 |

3b. The draft Strategy includes actions that are intended to achieve the goal of living well with long-term conditions: see page 34 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| * 11f and 15b should be priorities from a health equity perspective; developing services that are culturally appropriate and responsive is critical to meeting outcomes for Maori
* Suggest that there need to be a focus on provision of comprehensive care support for older people with complex comorbidity, and a reduction in the current concentration on acute organ-specific care
 |

### Support for people with high and complex needs

4a. The draft Strategy sets out a vision for the goal of better support for people with high and complex needs: see page 24 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Comprehensive and well thought out, and consideration could be given to the need for regular assessments for iatrogenic diseases that can occur due to complex treatments. |

4b. The draft Strategy includes actions that are intended to achieve the goal of better support for people with high and complex needs: see page 37 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| Regrarding residential care: improve access of residents to general practioner (especially out of hours) 16a could be prioritised; this could also be a ‘one team’ initiative and it would make a good deal of sense to begin this with a whanau centred initiative such as a whanau ora serviceGeneral comments:* + Availability and quality of respite care is inconsistent across the country is an important consideration
	+ Discharge processes need improvement to avoid older people falling through the cracks. More involvement is needed by needs assessment personnel.
	+ Some communities lack capacity to help these people-more support is needed from clinicians.
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### Respectful end of life

5a. The draft Strategy sets out a vision for the goal of a respectful end of life: see page 27 in the draft document. Do you have any comments or suggestions regarding this vision?

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| * Making discussion of death and dying, and preparing for death and end-of-life care more accepted and wide-spread by all people and cultures.

The visions on page 28 appear very well articulated and comprehensive General comments:* + Diversity needs to be recognised and catered for as does spirituality.
	+ It needs to be highlighted that many more people are now dying in aged residential care (ARC) facilities. This has training and public policy and funding implications.
	+ Workforce issues include the need for highly trained community health professionals.
 |

5b. The draft Strategy includes actions that are intended to achieve the goal of a respectful end of life: see page 40 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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### Implementation, measurement and review

6 The draft Strategy includes proposals for implementing, measuring and reviewing the proposed actions: see page 41 in the draft document. Do you have any comments or suggestions regarding these proposals?

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| **Actions starting on page 31****Health Ageing****1a-** add the word continue as this is currently happening.1d- replace the word with promote to Financial and practical support3a-c- seem out of place for Healthy Ageing4b- move to 2Implementation1a-yes2- should be a and b3e, not b4- a and d, not e and f5- needs to be a priority in the first 2 years. Start with a and b**Acute and restorative care page 33** **Priorities**6a should be a priority7a-yes8a- should be a priorty**Living well with long-term conditions page 34-35****Priorities**9a-yes9b- at the least, discussions of changes in curriculum should be discussed. MOH in collaboration with teaching hospitals and allied health.9c-yes9d-yes9f-yesg- rather than information and training, this should say improved “support” for family carers.**Enhanced cross-sector, whole of systems ways of working page 35**10c- should be a priority**Expand and sharpen the delivery of service to tackle long-term conditions page 35**Agree with priorities, but also 11f should be included.**Inform individual and communities....**12a-yes**Use new technologies to assist older people to live well with long-term conditions pg 36**13a- no13b-yes13c- should be a priority over 12a**Reduce frailty in the community page 37**14a – no Do not develop a new frailty tool. There are already numerous validated tools. The only frailty tool that might need to be developed and validated is for rural communities.14b- this should be the priority **With service users, their families and whanau.....page 37**15a- should be a priority**Integrated funding and services...page 38**16a should be a priority**Improve the physical and mental health outcomes...page 38**17a should be a priorty**Better integrated services for people in aged residential care pa 38**18a-yes18d should also be a priority**Improved integration of information....page 39**Combine 19a and c and should be priority**Improved medicine management pg 39**20c-yes**Build the resilience and capability of family and whanau....pg 39**21a should be priority in cooperation with 12b**Ensure widespread and early participation...pg 40**22a-yes**Build a greater palliative care workforce...pg 40**23a- should be a priorty**Improve quality and effectiveness of palliative care pg 41**24b-d yes**Implementation strategy pg 41**25a yesInclude older people in service design....pg 4126 d-f yes, but expand e to more than just DHB forum and incorporate a-c into this.**Establish an outcomes and measurement framework....pg 41-42**27a, c and d-yes27 e could/should be reworded as DHB collaborates with academic researchers to generate research questions around performance and factors impacting on performance and delivery**Improve the knowledge base pg 42**28 band c-yes |

### Other comments

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| Some consultation with Asian older adults (or organisations/agencies who work in this area/with this population) needs to take place. |

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| **Submission 138** |

Health of Older People Strategy – Consultation Draft

**Feedback from The Selwyn Foundation**

*Introduction*

The following feed-back is in response to the consultation draft of the Health of Older People Strategy released in July 2016. The feed-back starts with a general comment on the proposed strategy followed by comments on three subjects that the Selwyn Foundation is particularly interested in.

*About The Selwyn Foundation:*

The Selwyn Foundation is an independent, Christian faith-based New Zealand Charitable trust providing services to older people and their families. We have been leading the way improving the quality of life of our elders for over sixty years, As pioneers of the retirement village model and of rest home care in this country, we are uniquely experienced in providing residential care, independent retirement living and community outreach services for older adults.

*Healthy Ageing*

We are pleased to see the combined approach of health and social services to contribute to healthy ageing. Indeed, the biomedical disease and disability focus has been less than effective in providing wellbeing to the older population. We applaud the focus on prevention with “healthy ageing and creating resilience” and the inclusion of “a respectful end of life”.

*The issue of Social Isolation*

The Selwyn Foundation has recognised that social isolation is a significant contributor of many health-related issues. Therefore, our charitable focus includes the running of Selwyn Centres in local communities, providing opportunities for socialisation as well as information in order to create resilience among the Centre guests.

Our experience tells us that social isolation is often caused by an inability to pay for glasses, hearing aids, dentists, transport, etc. Common aged-related disabilities, such as sight impairment, hearing impairment, memory challenges and limited mobility, cause the downward spiral into loneliness.

*Technology-Supported Innovative Models of Care*

The provision of support during the transition period back home after hospitalisation and acute care is pivotal for optimal recovery or the development of “a new normal” for those with a chronic condition. This thinking of “creating a new balance” is different from the “restorative care” thinking which has a rehab focus. In the restorative care model, health professionals still “do to” the older person. In the “creating a new balance” model, the older person takes charge of their health, informing themselves about their condition and learning through feedback how day-to-day activities influence the condition and how others manage to live well with the same symptoms, etc. The Selwyn Foundation’s Telehealthcare research project and new “Inviga” suite of services support this model.

*Ageing and Spirituality*

Spirituality is increasingly understood to be important in healthcare provision, as seen in policy, guidelines and practice across many western health systems. In addition to the mandated inclusion of spirituality in end-of-life care by the WHO, there is a growing consensus which The Selwyn Foundation supports, ie, that spirituality needs to be part of healthcare, particularly where chronic conditions leave (older) people significantly affected, resulting in their experiencing existential distress.

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| **Submission 139** |

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| Organisation (if applicable): | Grey Power Timaru Inc |
| Position (if applicable): | President |

This submission *(tick one box only in this section)*:

[ ]  comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity)

[x]  is made on behalf of a group or organisation(s)

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[ ]  Māori [ ]  Regulatory authority

[ ]  Pacific [ ]  Consumer

[ ]  Asian [ ]  District health board

[ ]  Education/training provider [ ]  Local government

[ ]  Service provider [ ]  Government

[x]  Non-governmental organisation [ ]  Union

[ ]  Primary health organisation [ ]  Professional association

[ ]  Academic/researcher [ ]  Other *(please specify)*:

Suicide rates are high in older people in most developed countries, and suicide rates and numbers can be expected to increase with the rapid expansion of the older adult population.  In New Zealand the rate of suicide among men aged 75-79 (23.8 per 100 000), and among men aged  85 and older (22.1 per 100 000) is twice as high as the rate in the general population (12.2 per 100 000) [1].  Older men often suffer from physical  illnesses, mental disorders (including depression and alcohol abuse) and loneliness, all of which are associated with increased suicide risk. Nonetheless, the draft *Health of Older Persons Strategy* document does not address the issue of older adult suicide at all.

The predominant risk factor for suicide in older people is depression.  However, depression in older people is often unrecognised, untreated or under-treated. Early recognition of depression and suicide risk is critical since a combination of careful planning, use of highly lethal methods, and physical frailty means that older people are less likely to survive a suicide attempt than younger people.

Suicide rates in older people can possibly be prevented by a series of evidence-based measures which include:

* Mandated education in suicide prevention and depression recognition and treatment for health care professionals.
* Promotion of community and individual opportunities for social connection.
* Training community members and social services providers to identify older people at risk of suicide.

We request that the *Health of Older Persons Strategy* acknowledge that suicide in older people, particularly older men, is an important public health problem that can be prevented in many cases. We request that the *Health of Older Persons Strategy* acknowledges that there is good evidence  that education of community members and health care professionals, and promotion of social connections, can minimise suicide risk, and that the final Strategy document explicitly includes and endorses these approaches to address suicide prevention.

1. <http://www.health.govt.nz/publication/suicide-facts-deaths-and-intentional-self-harm-hospitalisations-2012>(accessed 28/08/2016)

Health of Older Person Strategy: Submission to consultation Draft.

Grey Power Timaru Inc

The Older Person’s Oral health Survey 2012 highlights the degree of untreated disease and unmet need in this group. This burden has been largely ignored by the Ministry of Health and successive Governments, primarily because of cost implications.

Assessment, treatment and rehabilitation processes need to include an oral health assessment as part of the overall parcel of care.

We request that the *Health of the Older Persons’ Strategy* acknowledge that regular dental check ups and treatments for older people, on fixed incomes and limited means is often not affordable, so leading to the poor level of oral health reported in the rest home residents surveyed in the 2012 survey.

We would like to see Government funding for the implementation of the recommendations under Healthy Ageing in section 5 of the consultation draft action plan.

Health of the Older Person Strategy: consultation draft submission

Grey Power Timaru Inc

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| **Submission 140** |



The New Zealand Medical Association (NZMA) wishes to provide feedback on the Health of Older People Strategy.[[1]](#footnote-1) The NZMA is New Zealand’s largest medical organisation, with more than 5,500 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders. Our submission has been informed by feedback from our Advisory Councils and Board.

1. We welcome the development of the updated strategy on the Health of Older People (the strategy). In general, we consider the strategy to be headed in the right direction. We are supportive of the draft vision for the strategy, namely, that “older people live well, age well and have a respectful end of life in age-friendly communities”. We note that the document identifies the following five outcome areas for the strategy: i) healthy ageing and resilience; ii) high quality acute and restorative care; ii) living well with long-term conditions; iii) better support for people with high and complex needs; v) respectful end-of-life care. These are all important areas that we support.

2. Despite our broad support for the strategy, we have a number of concerns with the document. These include: a lack of attention to the medical workforce; failure to acknowledge the resources required to achieve a number of proposed actions; and a discrepancy between the emphasis on the social determinants of health in the ‘Vision and Objectives’ section of the strategy and the substance of the items proposed in the subsequent action plan. We elaborate on our concerns in the following paragraphs.

3. The strategy’s lack of attention to the medical workforce is a major concern. Healthy ageing in age-friendly communities is a laudable goal, but medical, nursing and allied health staff have an important role to play in the health of older people. For example, general practitioners have a key role to play in the co-ordination of many older people’s healthcare and social needs, as well as providing healthcare in aged residential care facilities. There are regional (and in some cases national) shortages in many medical specialities that play a key role in the health of older people (eg, geriatrics, palliative care, psychiatry). We believe the strategy needs to acknowledge the important role played by the medical profession in the health of older people. We recommend the addition of a specific action point addressing current / impending workforce shortages in the medical (and other healthcare) workforce. Health Workforce New Zealand could take the lead on this item.

4. The items in the action plan are presented as though they are all new initiatives. Yet many of the actions are likely to be already happening. For example, the actions under point six to support effective rehabilitation closer to home should already be happening. Before imposing a set of ‘new’ actions on the sector, we suggest that it would be useful to conduct a stocktake of what is already been done. Where actions are already underway, the strategy should make it clear that it is recommending the continuation or improvement of existing actions.

5. The draft actions do not have funding attached. We consider the failure to acknowledge the resource allocation required to achieve a number of the actions to be a major shortcoming. For example, funding is likely to be a major barrier to actions to improve oral health in all community and service settings. Current access to dental care is frequently unaffordable for a large segment of the older population. Many hospices around the country are struggling to meet their funding needs. While we welcome the actions relating to improving the quality of palliative care, adequate resourcing is needed to successfully implement these. Additional funding will also be required to successfully implement actions relating to the provision of timely needs assessment and service co-ordination for home help, and the expansion of falls prevention schemes.

6. We welcome the emphasis the main body of the document gives to taking action on the social, environmental and economic determinants of health, and to equity. We note that the Vision and Objectives section states that: *“Together with other government sectors and communities, the health system will work to improve the social, economic and physical environment factors for healthy ageing and achieve equity, removing barriers to participation. There are many opportunities to benefit long term from investments in social and environmental factors that influence health.”*  Despite acknowledging the importance of these concepts, we are disappointed that the action plan is largely silent on tackling the wider determinants of health. As the strategy purports to adopt a life-course approach to the health of older people, we consider that the action plan should include more measures, including policy or regulatory measures where they have been shown to be effective, to “help people to avoid developing long-term health conditions or slow the development of these conditions”. Measures to address the proximal determinants of health should be given greater attention in the action plan.

7. While the preamble to the strategy acknowledges the concept of equity in its broadest sense, the action plan has a narrow interpretation of equity, which is viewed primarily as equitable access to, and benefit from, healthcare. We consider health equity to be an ethical principle concerning the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage.[[2]](#footnote-2) We suggest that this broader concept of health equity be incorporated into the whole document.

8. We note that item 13 includes the development of health apps targeting older people with long-term conditions. While we recognise the value of enabling technological tools such as smartphones, apps and wearable devices, we urge caution with respect to the assumption that new technologies will assist older people to live well. Like many countries, New Zealand has a digital divide; older people are among population groups less likely to have or use the internet.[[3]](#footnote-3) Furthermore, declining visual acuity, cognitive decline or chronic conditions such as arthritis may all affect the ability of older people to use technology. It is important that the use of technology should not exacerbate existing inequalities in health.

9. Older people have much to offer the rest of society. We suggest that the draft strategy better reflects the value of older people as taonga. This could take the form of considering what older people give to society, and ways to harness these contributions. An example might be the provision of shared community facilities at aged care facilities, with crossover visits to adjacent childcare facilities. We consider that the emphasis on the term ‘independence’ throughout the document could be unduly restrictive and interpreted as culturally insensitive for some cultures. Many cultures value interdependence as opposed to independence. As people age, they are valued as taking on different, but important, roles in the wider family (eg, as cultural leaders, caring for grandchildren). We suggest that the strategy acknowledge the value of interdependence and the changing roles played by older people.

10. We welcome the action relating to medication management. We suggest this be expanded to address polypharmacy. This will require a major cross-sectorial approach, starting with all groups of prescribers. We suggest that the strategy also include actions aimed at preventing over diagnosis.

11. Given that this document is the basis for a 10-year strategic plan, we suggest that it should acknowledge and factor in critical contextual factors in addition to projected demographic changes and financial projections. Such factors include climate change, particularly given the well-established relationship between heat waves and increased mortality in the elderly.[[4]](#footnote-4) The strategy should also give consideration to antimicrobial resistance, given the well-established relationship between residential care facilities and antibiotic resistant organisms.[[5]](#footnote-5)

12. Finally, we have concerns that multiple lead organisations/sectors are identified for certain actions in the action plan. We suggest that each action should have a single lead rather than multiple organisations, with perhaps a distinction made between primary lead and secondary supporting organisations. This step should contribute to facilitating accountability when evaluating the actions. We also suggest that PHOs could lead action item 16 (integrate funding and service delivery round the needs and aspirations of older people, to improve health outcomes of priority population groups).

We hope that our feedback has been helpful and look forward to learning the outcome of this consultation.

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| **Submission 141** |

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| This submission was completed by: (name) | Active Ageing Research Group (AARG)  |
| Organisation (if applicable): | Auckland University of Technology |

This submission *(tick one box only in this section)*:

[ ]  comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity)

[x]  is made on behalf of a group or organisation(s)

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[ ]  Asian [ ]  District health board

[ ]  Education/training provider [ ]  Local government

[ ]  Service provider [ ]  Government

[ ]  Non-governmental organisation [ ]  Union

[ ]  Primary health organisation [ ]  Professional association

[x]  Academic/researcher [x]  Other *(please specify)*:
Gerontology research group

### Healthy ageing

1a. The draft Strategy sets out a vision for the goal of healthy ageing: see page 14 in the draft document. Do you have any comments or suggestions regarding this vision?

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| The Active Ageing Research Group (AARG) at AUT University agrees, in general, with the Strategy vision that “older people live well, age well and have a respectful end of life in age-friendly communities”. To shift the focus from a personal to a population level, the AARG suggests the vision aspires explicitly to embrace the: 1) **ethnic and social diversity** of the older adult populations in NZ; 2) importance of focusing at a **population** rather than individual level; 3) centrality of older people’s **experiences** as opposed to what they “have”; and 4) importance of **inclusive**, rather than merely age-friendly, communities. The vision might then read: “diverse populations of older people live well, age well and experience respectful end of life in inclusive communities.  |

1b. The draft Strategy includes actions that are intended to achieve the goal of healthy ageing: see page 31 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| The AARG agrees: 1a\* ‘establish age-friendly communities in line with the Positive Ageing Strategy’ is the right place to start. Ageist attitudes within communities needs to be included in the strategies, as does a person-centred/person-driven approach. 2a\* ’Increase the availability of strength and balance programmes in people’s homes and community settings’ is the right place to start. Residential aged care ‘communities’ need to be included in the scope. Needs a clear definition of what age-friendly community means. 3b\* ’Participate in the cross-government Ministerial Group on Family Violence and Sexual Violence Work Programme’ is the right place to start. Ending all forms of ‘elder abuse’ matters. 3e\* ’Support initiatives that maximise healthy ageing through supported housing and age-friendly communities where this will also contribute to regional economic and social development’ is the right place to start; secure housing options are integral to building inclusive communities. Strategies need to clearly articulate how all forms of older people’s disabilities fit with such initiatives. 4e\* ’Support older people’s uptake of technology for communication with health providers and their family and whānau’ is the right place to start. Include friends and social networks, especially co-ethnic communities for older immigrants, in the strategy. The AARG disagrees: 4f\* ’Increase the accessibility of information on healthy ageing and health and social services…so that people can be more ‘health smart’’ is the place to start. The AARG proposes that 4e is a higher priority for diverse communities of older adults to build social connectedness.  |

### Acute and restorative care

2a. The draft Strategy sets out a vision for the goal of high-quality acute and restorative care: see page 17 in the draft document. Do you have any comments or suggestions regarding this vision?

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| The AARG supports the vision for acute and restorative care. Comments: Given the rapid increase in demographic diversity and underserved communities of older adults, the AARG suggests co-ethnic communities receive support, along with families and whānau.  |

2b. The draft Strategy includes actions that are intended to achieve the goal of high-quality acute and restorative care – see page 33 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| The AARG agrees: 7a\* ’Develop, implement and review prevention and treatment of injuries for ACC and health clients’ is the place to start; particularly strategies for ‘enhancing rehabilitation services for injured older people…to achieve maximum independence and recovery closer to home, and work with local health systems to integrate prevention and rehabilitation into existing service models’. Comments: It is good to see informal caregivers recognised in the Strategy. It should be enacted in partnership with informal carers. Track how well services achieve outcomes as hospitals can shuffle patients from one team to another to avoid penalties Models need to be customised for diverse communities of older adults, particularly for older immigrants and those for whom there are language and cultural barriers to accessing ‘main stream’ services.  |

### Living well with long-term conditions

3a. The draft Strategy sets out a vision for the goal of living well with long-term conditions: see page 20 in the draft document. Do you have any comments or suggestions regarding this vision?

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| The AARG supports, in general, the vision, particularly for ‘improved methods of early detection and prevention’, and for ‘health outcomes for vulnerable older populations with long-term conditions to be equitable with outcomes for the population as a whole. Comments: Promoting self-management can be interpreted as shifting the responsibility to individuals, and ‘blame the victim’ thinking. There is recent research informing critical success factors for translating self-management skills into everyday life changes. Methods must be co-designed with older people to ensure their experiences and voices are taken account of.  |

3b. The draft Strategy includes actions that are intended to achieve the goal of living well with long-term conditions: see page 34 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| The AARG agrees: 9a\* ‘Regularise and improve training of the kaiāwhina workforce in home and community support services’ is the right place to start. This workforce needs to be recognised as highly skilled, doing essential work and therefore paid a wage that recognises this. 9c\* ‘Progress training packages to enhance capability and capacity….’ is the right place to start, to enable 9a to be achieved. 9d\* ‘Develop a range of strategies to improve recruitment and retention of those working in aged care’ is the right place to start, particularly if it includes residential aged care. This strategy must include central and organisational support, customised skill mix for staff matched with people’s/residents’ needs, remuneration packages that recognise the value of this workforce, and the highly skilled nature of the work when it is done well. 9f\* ‘Enhance workforce capability and training pathways to encourage more entry and retention of the workforce among Māori and Pacific peoples’ is the place to start, given Māori and Pacific people’s need for living well with long term conditions. 11a\* ‘Strengthen the implementation of the NZ Dementia Framework, and the actions specified in “Improving the Lives of People with Dementia” is the right place to start. 11g\* ‘Provide community-based, early intervention programmes for people with musculoskeletal health conditions’ is the place to start, particularly if programmes include resistance training, balance & flexibility exercises, and cardiorespiratory training. 12a\* ‘Promote community support for older people with mental illness…’ is the place to start. 13a\* ‘Include health apps targeting older people with long-term conditions…’ is the place to start, provided the apps are developed and piloted in partnership with ethnically diverse, and underserved, hard to reach older adults; to ensure the accessibility and usability by diverse older adults. 13b\* ‘Promote use of tele-monitoring to monitor conditions and alleviate social isolation, especially among rural and remote locations’ is the place to start, particularly if the severe social isolation of ethnically diverse older adults is targeted. The AARG disagrees: 11b\* ‘Encourage health, social services and communities to become more dementia-friendly’ is the place to start. Simply ‘encouraging’ dementia-friendly services and communities is a lame strategic goal. The AARG strongly suggests the implementation in the first two years, a strategy to “**regularise education and training** for health, social services and communities to **be dementia-friendly**’ 11g\* ‘Better coordinate and integrate rehabilitation for people recovering from a stroke…’ is the place to start; unless the focus is expanded to **include other neurological insults**, particularly **traumatic brain injury** as falls and motor vehicle accidents are common causes of older adults’ TBI, and there is poor recognition of the need for rehabilitation services to be customised to older adult needs. Also, the strategy should be expanded to **include community reintegration** as the focus for rehabilitation for older adults.  |

### Support for people with high and complex needs

4a. The draft Strategy sets out a vision for the goal of better support for people with high and complex needs: see page 24 in the draft document. Do you have any comments or suggestions regarding this vision?

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| The AARG supports the vision. Comments: There is a need to value older adults as integral to achieving the vision through including them as service co-designers and educators, and include co-ethnic communities along with families and whānau. Older adults must be offered choices.  |

4b. The draft Strategy includes actions that are intended to achieve the goal of better support for people with high and complex needs: see page 37 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| The AARG agrees: 14a\* ‘Explore possibilities for a frailty identification tool to enable primary and other health professionals to identify frail older people earlier’ is the place to start, provided the strategy moves beyond the current medicalisation of frailty, and different models for defining/diagnosing frailty are closely examined, and early predictors are identified. 18a\* ‘Develop standard referral and discharge protocols between aged residential care facilities and services’ is a place to start. The AARG disagrees: That 16a and 16d have not been included for ‘implementation in the next two years’. The AARG strongly suggests that strategies to ‘ensure that some trials focus on population groups that currently…are not well catered for in current approaches’ and ‘improve the coordination of social services to vulnerable older people across the sector’ are an immediate priority. That 18b and 18d have not been included for ‘implementation in the next two years’. The AARG strongly suggests strategies to ‘explore options for providing telephone advice and triage for aged residential care facilities, especially after hours’ is an immediate priority; and ‘explore options for aged residential care facilities to become providers of a wider range of services to residents, including non-residents’ ought to be prioritised. The latter strategy could be implemented as part of the prioritised enablement of inclusive, age-friendly communities. The AARG is unclear what 21b\* ‘Examine options to reduce work-related barriers to informal care’ means. All strategy statements ought to be able to stand alone, therefore, this goal needs clearer articulation.  |

### Respectful end of life

5a. The draft Strategy sets out a vision for the goal of a respectful end of life: see page 27 in the draft document. Do you have any comments or suggestions regarding this vision?

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| The AARG supports the respectful end of life outcomes. Comments: The AARG suggests the language of “loved ones” has found its place in the popular media, however it has no place in public policy. The language needs to clearly state who is implicated by the strategy.  |

5b. The draft Strategy includes actions that are intended to achieve the goal of a respectful end of life: Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| The AARG agrees: 22a\* ‘Increase public awareness about and use of advance care planning…’, provided “public” is removed so it reads ‘increase awareness about…’, as full awareness needs to be developed across all public and service sectors. In addition, the needs of older people dying away from their country of origin ought to be identified as having particular needs for a respectful end of life. 24b\* Support the implementation of Te Ara Whakapiri: Principles and guidance for the last days of life’ is a place to start. 24c\* ‘Progress a national collection of patient.people’s and whānau carers’ experiences of the care provided at the end of life’ is a place to start, provided the language is changed from patient to **people’s**, and the experiences gathered represent the ethnic, social and gender diversity of New Zealand’s ageing population, particularly the experiences of older immigrants, and socially ‘hidden’ groups. 24d\* ‘Work with the Palliative Care Advisory Panel to implement the recommendations…’, provided diverse populations are represented on the Panel.  |

### Implementation, measurement and review

6 The draft Strategy includes proposals for implementing, measuring and reviewing the proposed actions: see page 41 in the draft document. Do you have any comments or suggestions regarding these proposals?

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| The AARG agrees that implementation, measurement, and review include: 25a\* Implementation of the Strategy ought to be done “with health and social sector partners…within the first three months of the Strategy’s release.’ 26d\* Incorporate home and community support users’ experiences’ is integral to implementation and management, provided ‘users’ include the voices of residents in aged care facilities. Qualitative research is essential to building knowledge and the translation of results into usable solutions. 26e\* Include representatives of older people in DHB regional forums’, provided ‘include’ means enabling their contribution and taking account of their opinions. 26f\* ‘Co-design a service model with consumers….’ is a critical feature in the future strategic landscape. 27a\* ‘Develop a system to evaluate progress….and support the health system to be person centred…’ 27c\* Regularly review the Strategy implementation progress and the prioritisation of actions’, provided the data are transparent. 27d\* ‘Publish indicators for each DHB on a regular basis’. 28b\* ‘Increase understanding of links between loneliness and health status, and promote research into building population resilience.’ The AARG strongly supports diverse populations of older adults’ loneliness as a pressing health concern. 28c\* ‘Ensure alignment between the NZ Health Research Strategy, key research initiatives and centres with the identified needs of the ageing population, and that the research informs policy and service development.’ Promoting translational research through intervention studies needs to be central to designing and implementing usable, relevant actions.  |

### Other comments

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| The AARG recommends a full glossary of terms is included so it is clear what is meant by the concepts referred to, such as “person-centred”, “community”, “resilience” etc. Such a glossary is essential as multiple interpretations of what is meant is a foundation for wide misinterpretation.  |

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| **Submission 142** |



**Submission on Health of Older People Strategy**

**To:** Ministry of Health

**Submitter:** Canterbury District Health Board

Attn: Jane Murray

Community and Public Health

C/- Canterbury District Health Board

PO Box 1475

Christchurch 8140

**Proposal:** This document sets out a draft strategy for the health and wellbeing of older people for the next 10 years. Its vision is that older people live well, age well, and have a respectful end of life in age-friendly communities

## SUBMISSION ON Health of Older People Strategy

## Details of submitter

1. Canterbury District Health Board (CDHB).

## Details of submission

1. The CDHB welcomes the opportunity to comment on the Health of Older People Strategy. The future health of our populations is not just reliant on hospitals, but on a responsive environment where all sectors work collaboratively.
2. The CDHB has a number of recommendations for consideration which would further improve health outcomes for the community.

## General comments

1. The use of the five key themes along with the life course approach to healthy ageing makes the document easy to read and clear. The document encourages society to recognise and value the contribution of older people.
2. The CDHB thanks the Ministry of Health for holding the recent consultation workshop in Christchurch. Participants at this forum, including consumers, geriatricians and health service providers from across the system expressed their views and suggestions.
3. This submission adds to those views expressed by CDHB clinicians at the recent forum. The CDHB looks forward to working with the Ministry of Health on consideration of the resource implications. Some initiatives may require an investment approach across government agencies. Other prioritised actions might require a funding stream if current cost barriers are to be overcome.
4. **Oral Health:** It is encouraging to see that the oral health of older people is recognised in the draft HOP strategy as an aspect of general health and in healthy ageing. An increasing proportion of older people are retaining their natural teeth and they have high oral health care needs. For some, cost is cited as a barrier to accessing dental services.
5. **Healthy environments and age – friendly communities:** The CDHB supports the Associate Minister’s direction to the Ministry to consider the National Ethics Advisory Committee (NEAC) report to the Associate Minister of Health (5 May 2016). We suggest that a decision should be made as to whether dementia initiatives are integrated into the HOP Strategy Action Plan, whether there is a defined dementia action plan (as recommended by NEAC), or a mixed model. On page 6, “HOPS in its government context” diagram, a reference to NEAC Recommendations could be added to the lowest box.
6. **Improving workforce recruitment and retention in Aged Care:** All Western countries are struggling with addressing this workforce challenge. Care work needs to be made a more attractive and credible career option[[6]](#footnote-6); this means improving the status of working in aged care. Consideration should be given to enabling trained, experienced care staff to progress through to other healthcare roles such as support workers, nursing, physiotherapy and other careers in health. This needs investment, and the Kaiāwahina Action Plan is a bridge to make it happen. Employees can see a serious, professional future that is worth working towards; employers get more applicants, and more motivated staff; and older people and patients get more committed, longer-term relationships with people who have a genuine stake in caring1.

## Specific comments

**Healthy ageing**

*1a. The draft Strategy sets out a vision for the goal of healthy ageing: see page 14 in the draft document. Do you have any comments or suggestions regarding this vision?*

The CDHB supports the points raised in pages 15 -16 regarding healthy environments and age-friendly communities, which are consistent with a ‘Health in All Policies’ approach to cross-sector initiatives.

The vision is relatively comprehensive and there are clear, measurable statements.

‘Achieving equity for Māori and vulnerable population groups’ – The CDHB has made the assumption that this covers ethnic minorities and migrant populations, as many of these populations are also vulnerable. If they are not included in the above statement, additional wording should be added to the vision to reflect their needs.

*1b. The draft Strategy includes actions that are intended to achieve the goal of healthy ageing: see page 31 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?*

Action 1a is supported. The CDHB supports initiatives to encourage implementation of the Dementia-Friendly communities model. Canterbury has local evidence of need and potential benefit in Karen Smith’s Christchurch 2015 research[[7]](#footnote-7).

Consideration should also be given to the vocational aspects of the older person. Flexible and supportive back-to-work programmes after accidents or illness allow for older people to make a timely recovery.

 Actions that the CDHB believe that also should be given ‘two year’ priority:

 Action 1c “*Work across government and with local interest groups to improve access to, and coordinate assistance to socially isolated older people and develop initiatives that better address the physical and social determinants of health.”* These people are amongst the most vulnerable people, and to delay this action will result in more people falling into this category exacerbating the issue. The CDHB advocates for this to be initiated very early in the work plan while acknowledging it might take longer to achieve.

 Action 2b “*Expand the provision of targeted health promotion initiatives, and services to increase resilience among Māori and other vulnerable older populations who have poorer health status.”* These groups, including migrant populations, are amongst our most vulnerable. It is important that there is no delay in addressing the health issues of these groups.

 Action 2c “*Review the Green Prescription programme, including the potential for other health professionals to prescribe*.” The CDHB supports this action as it has the potential to improve health outcomes for a large number of people.

 Action 3a “*Health and social sector agencies partner to share information and improve the identification of vulnerable older people, and coordinate services to better meet their needs.”* The sharing of some information is already occurring at various levels with protocols, parameters and restrictions on how information is shared to protect risks to patients and to staff. There is potential for further gains and efficiencies.

A barrier to better integration of those with mental health needs is the separate funding streams for mental and physical health. This affects rest home placement, and services such as district nursing and home supports.

 The CDHB would encourage the Ministry of Health to include local authorities as one of the lead agencies for *Action 3e “Support initiatives that maximise healthy ageing through supported housing and age-friendly communities where this will also contribute to regional economic and social development.”* The programmes, infrastructure and services that local authorities provide have a great influence on people’s ability to age in place and the quality of their lives within their communities.

 Action point 5c “*Disseminate updated information and advice on dental care to older people, family, and carers in communities, and aged care organisations*” seems to be an achievable goal that could be met quite quickly. Improved dental care improves quality of life. There are older people who are limited to a soft diet where they do not need to be as a result of a lack of dental care.

 Commentary on other Actions:

In regards to Action 4d: “*Improving the effectiveness of health literacy information”*, improving health literacy requires age-appropriate formatting of information e.g. use of larger fonts, multimedia including print format for “non-users” of electronic media.

The action point 5a to “*develop referral pathways for optimal dental care throughout ageing…*” reflects the need for early intervention and a life-course approach. This can be achieved by working with others in the aged care sector, GPs, and medical specialties to ensure oral health is identified as part of overall health, and that oral health care is considered when developing care plans. This is consistent with the requirement set out in the NZ Health Strategy for a smart system that works as one team.

The action point 5b is to “*identify and promote innovative care arrangements for oral health care of people living in aged residential care*”. First there is a need for oral health to be included in the overall care planning of the older person when they move into residential care. Without this, it would not be possible to adequately arrange for provision of that care. In addition, there needs to be improved access to oral health care for older people who live in residential facilities – in some cases this may be best achieved with domiciliary or on-site care.

**Acute and restorative care**

*2a. The draft Strategy sets out a vision for the goal of high-quality acute and restorative care: see page 17 in the draft document. Do you have any comments or suggestions regarding this vision?*

The vision for high-quality acute care for older adults is supported; older adults need accessible and affordable care in a crisis, in elective situations and in restorative phases of care.

When episodes of planned or urgent care in hospitals occur, geriatrician review and interdisciplinary team involvement can further maximise rehabilitation potential for the pre-frail and frail elderly. As older adults transfer from one care setting to another across the care continuum, timely communication between the secondary and primary health care teams is required to coordinate care effectively. We agree that family and whānau need involvement in the rehabilitation plan when a person returns to their home. Access to the appropriately trained and interdisciplinary team to apply restorative principles should continue across care settings. Timely access to equipment aids and supports the older person’s recovery.

Meeting restorative care goals is enabled in the community by sharing clinical goals and information across the healthcare team, including home based support providers. Workforce stability in the home care sector helps with the provision of continuity of care, and continuity in the care team fosters effective working relationships. (See general comment about workforce development in aged care on page 3.)

 Embedding the philosophy of restorative care models across an organisation takes managerial support as well as training. It is positive to note that Health Workforce NZ will be overseeing implementation of Kaiāwhina training.

The CDHB agree that Health Apps for those with long term conditions who are au fait with technology will help people to take responsibility for managing their own conditions.

The CDHB would also like to see the following two outcomes included “*Access to the appropriately trained interdisciplinary team to apply restorative principles to all older people as required*’ and ‘*Encourage those working with the older person to apply restorative principles in every interaction (as appropriate)”*. This needs to be an ‘all of service approach’ such as the CDHB has adopted through its CREST programme.

*2b. The draft Strategy includes actions that are intended to achieve the goal of high-quality acute and restorative care – see page 33 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?*

Working across the sector with ACC and others should ensure more consistency and reduce discrepancies between funding of services. For example, there can be significant variance between funding entitlements for the person who has a traumatic brain injury after a motor vehicle accident versus the person who has very similar symptoms after removal of a malignant brain tumour.

**Living well with long-term conditions**

*3b. The draft Strategy includes actions that are intended to achieve the goal of living well with long-term conditions: see page 34 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?*

The CDHB agrees that the asterisked action points are a priority, however also recommends that “*Work with Māori, Pacific and other population groups to develop culturally appropriate home and community support service models*” is a priority. Māori are over-represented in the group of people with long term health conditions and it is important that health services address their needs in the immediate future. The CDHB has assumed that migrant populations fit in under these population groups.

The CDHB recommends that Action 9a “*Supporting undergraduate and graduate curricula”* also includes the Competency Assessment Programme curriculum as the Aged Care sector is so reliant on overseas qualified nurses. The CDHB recommends that nurse leaders and the Nursing Council work together to ensure that the Competency Assessment Programme (CAP) is “fit for purpose” for internationally-qualified nurses entering employment in Aged Residential Care (ARC) settings in New Zealand. Forty-five per cent of Registered Nurses employed in ARC qualified overseas in widely diverse health systems. For many, the CAP they undertake before registration does not sufficiently address the way the NZ health system works for older people. Many non-Europeans will never have worked in an ARC facility in their country of registration, as no such institutions exist in their health system.

Consideration could be given to include interRAI training in the above curricula. New Zealand has an opportunity to use the interRAI data to better inform health and social services planning for such complex cases. The Comprehensive Clinical Assessment (interRAI) tool “allows the Ministry of Health to access data on how older people are doing in rest homes, and in the community, to identify any trends or gaps so that health policy can be developed which addresses healthcare needs”.

The CDHB recommends that another action point is included “*To support the carers of people with long-term conditions to minimise carer stress*”. Using tools to recognise and monitor carer stress is helpful.

The CDHB notes that dementia is mentioned in only two of the 93 actions, 11a and b, The CDHB further notes there is a risk that integration of dementia into the larger plan may not produce the level of attention to dementia that the National Ethics Advisory Committee recommended.

The CDHB also notes that little is said in this draft about the needs of those with long-term intellectual disabilities who are ageing. In particular, we recommend that further attention be paid to those for whom standard ARCs are not suitable, and whose needs may become too complex for other residential facilities, or to remain at home.

**Support for people with high and complex needs**

*4a. The draft Strategy sets out a vision for the goal of better support for people with high and complex needs: see page 24 in the draft document. Do you have any comments or suggestions regarding this vision?*

At the Ministry of Health forum on 15 August, there was discussion about a model in the report from the Productivity Commission[[8]](#footnote-8) on social services in New Zealand. This is the four quadrant model on page 53. The report notes “many clients have multiple, complex and inter-dependent needs. For these clients, a model segmenting service users according to the complexity of their needs and their own capacity to navigate the services they need”. Quadrant D service users have high needs and less capacity to navigate the system. These older adults identified in Quadrant D would need a response encompassing both health and social systems.

Joint investment approaches across government agencies and local authorities are needed. With regard to social housing, if an older adult with chest problems is in a cold damp house, health response would need to work with social services to ensure adequate housing.

There is a strong emphasis in the draft Strategy on the role of family and whānau in caring for older people with long-term conditions. While the CDHB supports this in principle, there needs to be recognition that not everyone has family/whanau. Similarly, family/whānau are not always able to support the older person, and such support even when available, can be precarious. It cannot be assumed that this support will be available in all instances.

*4b. The draft Strategy includes actions that are intended to achieve the goal of better support for people with high and complex needs: see page 37 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?*

The CDHB recommends that the wording in Action 14 “*Reduce frailty in the community”* is amended to “*Recognise frailty in the community”*. The frailty tool(s) could be used to assist this.

Action 18a: “*Better integrate services for people living in aged residential care”.* This is a very significant piece of work. It may merit further exploration as it is complicated by varying models of primary care provision for ARC residents after hours; the complexity of funding arrangements between ARC and primary care providers, how to better share care records (e.g. between ARC records, pharmacy, primary care, after hours teams etc.).

Action 21b “*Examining options to reduce work-related barriers to informal care*”: The CDHB strongly supports this action to find a way to support carers in a real way. The right investment at this stage has huge gains later on.

**Respectful end of life**

*5a. The draft Strategy sets out a vision for the goal of a respectful end of life: see page 27 in the draft document. Do you have any comments or suggestions regarding this vision?*

Refer to the South Island Alliance Palliative Care Workstream’s response.

The CDHB’s Older Persons and Rehabilitation service consider that for people who receive End of Life care in ARC, there should not be any additional charges. There is ambiguity with regard to some ARCs proposing additional charges for premium rooms at End of Life.

 *5b. The draft Strategy includes actions that are intended to achieve the goal of a respectful end of life: see page 40 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an \* are the right actions to begin with*?

Refer to the South Island Alliance Palliative Care Workstream’s response.

The CDHB advocate that all people (no matter their financial standing) should receive the same, excellent level of care at End of Life.

**Implementation, measurement and review**

*The draft Strategy includes proposals for implementing, measuring and reviewing the proposed actions: see page 41 in the draft document. Do you have any comments or suggestions regarding these proposals?*

Action 25 “*Implement the Strategy”*: Note general comments on pages 2 and 3. When it comes to implementation, the CDHB looks forward to working with the Ministry of Health on consideration of the resource implications.

Action 28 “*Improve the knowledge base”*: As well as the research agencies, explicit mention could be made of using interRAI data to improve the knowledge base and inform planning.

Thank you for the opportunity to submit on Health of Older People Strategy.

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| --- |
| **Submission 143** |

|  |  |
| --- | --- |
| Organisation (if applicable): |  Alzheimers New Zealand |
| Position (if applicable): |  Chief Executive |

This submission *(tick one box only in this section)*:

**√** is made on behalf of a group or organisation(s)

We will publish all submissions on the Ministry’s website. If you are submitting as an individual, we will automatically remove your personal details and any identifiable information.

If you do not want your submission published on the Ministry’s website, please tick this box:

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**√** Non-governmental organisation



**Health of Older People Strategy - Feedback on consultation draft**

Thank you for the opportunity to comment on the draft Update for the Health of Older People Strategy. Our feedback covers:

* our high level comment on the draft strategy;
* the significant impact dementia has in our communities;
* our comment on the specific issues raised in the Strategy with particular focus on dementia issues; and
* our recommendations for responding better to the challenge that dementia presents

**High level comment on the Health of Older People Strategy – Consultation Draft**

Overall Alzheimers NZ supports the proposed Strategy.

We agree with the draft vision: the focus on ageing well; living well with long term conditions; receiving high quality acute and restorative care; support for people living well with long-term conditions and dying well. We are delighted to see these five outcome areas set out so clearly and we look forward to seeing this strategy being implemented.

At present people with dementia often see the health system as one that consigns them to the ‘waiting room’ following their diagnosis and doing little more than support them to mark time[[9]](#footnote-9). Our view is that implementation of the five outcome areas will go a long way to supporting people living with and affected by dementia to live independently and well for as long as possible and in the way right for them. Implementing this Strategy will also provide adequate residential care when and if needed and will assist people with dementia to die well whether in the community or a residential home.

We have three general concerns about the Strategy as currently drafted. First, the five outcome areas represent a significant, and very positive, shift from the current arrangements. Achieving a shift of this magnitude requires a comprehensive change strategy and it is difficult to see what change strategy is planned.

Second, dementia is one of the greatest healthcare challenges of our lifetime. It is therefore disappointing that the draft Strategy does not seem to recognise the size and scale of the challenge that dementia represents to the New Zealand health care system, nor the opportunities presented by doing more and better for people living with and affected by dementia.

Thirdly, we are concerned that there is a risk that with more than 100 actions in the Action Plan attention focusses on achievement of those irrespective of whether they are delivering on the bold and strategic strategy.

We offer suggestions for addressing each of these issues below.

We understand that a detailed Implementation Plan will be prepared and would welcome the opportunity to contribute to that development process.

**The significant impact dementia has within our communities**

*I can think of no other disease that has such a profound effect on loss of function, loss of independence and the need for care. I can think of no other disease so deeply dreaded by anyone who wants to age gracefully and with dignity. I can think of no other disease that places such a heavy burden on families, communities and societies. I can think of no other disease where innovation, including breakthrough discoveries to develop a cure, is so badly needed.’*

*Dr Margaret Chan, Director-General of WHO:* Opening remarks at the WHO Ministerial Conference on Dementia, March 2015

***What is dementia***

Dementia is an umbrella term for a wide range of diseases that change and affect our brain. There are many forms of dementia, the most common of which is Alzheimer’s Disease, which is the diagnosis for around two thirds of people with dementia.

Dementia is a progressive disease – it spreads through the brain leading to increased and more disabling symptoms. At present it cannot be prevented, cured or slowed. However, as we outline below, there are strategies which can reduce the risk of developing dementia for some at least of the people who develop dementia.

Age is the greatest risk factor for dementia. However early-onset dementia can affect people from as young as their 30s to their early 60s. Other risk factors include a lack of physical activity, excessive alcohol consumption and eating a poor diet high in saturated fat. Pre-existing medical conditions that increase the risk of dementia include Parkinson’s Disease, stroke, type 2 diabetes and high blood pressure.

However, evidence is emerging[[10]](#footnote-10) that suggests that the risk of dementia can be reduced by changes in lifestyle. Many of these life changes are similar issues to those which reduce risks for a range of cardiovascular conditions. Estimates suggested that addressing risk factors could reduce the onset of dementia between 10 – 20%[[11]](#footnote-11).

***The prevalence and incidence of dementia***

Internationally there are 46.8 million people living with dementia. This number is predicted to double every twenty years rising to 131.5 million by 2050.

Data in the 2015 World Alzheimer Report[[12]](#footnote-12) suggests that there are currently around 60,000 New Zealanders living with dementia. Based on this report, we would expect that number to increase to around 154,000 by 2050 as the population continues to age. On this topic, we note that the Strategy used figures that were developed by Alzheimers NZ in 2012. Those figures have subsequently been updated based on the 2015 World Alzheimer Report and are publicly available.

Given the size and scale of the challenge dementia presents, it is disappointing that dementia is not included in Figure 6 (p.23) about the conditions affecting older people. We expect this relates to the paucity of data about dementia in New Zealand - the level of data on dementia compares poorly with other countries, and indeed with the level of information available on other conditions in New Zealand such as heart disease and diabetes (p.21).

***The impact on the person with dementia***

Dementia has a significant impact on people living with dementia. The evidence suggests that dementia makes a much larger contribution to disability and the need for care than other chronic conditions[[13]](#footnote-13). Dementia affects each person’s health, their sense of identity and their financial situation.

***Impact on family / whanau***

There is also a significant impact on the family/whanau supporting the person with dementia. Our experience, and the 2015 ADI report[[14]](#footnote-14) suggests that two out of every three New Zealanders know or have known someone with dementia and for people over 60 that number increases to 85%.

Dementia affects the financial situation of each of the primary supporters of a person with dementia; their employment and career opportunities and their sense of identity in their families and community.

***Impact on women***

Recent research[[15]](#footnote-15) which provided an overview of international research from 133 studies, mostly in North America and Europe showed:

* most people living with dementia are women and that women are more at risk of developing dementia than men. For example, in 2015, 62% of people with dementia in the United Kingdom[[16]](#footnote-16) were female, largely because of their greater life expectancy;
* women are more likely to be the primary caregiver in a family situation involving dementia, affecting their health, social relationships and financial security; and
* women are also most likely to be the provider of formal care in the community and in hospitals and care homes, where low job status, poor salary and inadequate training affects them, their families.

***Impact of Health Services***

The 2013 World Alzheimers Report[[17]](#footnote-17) concluded that:

1. nearly half of all older people with a need for care are likely to have dementia, and that
2. dementia (and cognitive impairment) are the leading contributors to people moving into care.

This means that long-term care is mainly about care for people with dementia. As we all know, people with dementia have particular needs – they require more personal care, more hours of care, and more supervision – and this combination brings increased pressure on family carers and higher costs to the health system.

As the numbers with Alzheimer’s Disease grows the impact on health services will increase because of the impact dementia has for people, their need for care and support for the future costs of long-term care. Given the impact dementia has for people and their need for care and support, the 2015 ADI Report[[18]](#footnote-18) suggests that the future costs of long-term care will be driven to a very large extent by the growing numbers of people living with dementia.

In addition, the growing numbers with Alzheimers will impact on prevention services, on primary and secondary care. The people who will be the ‘older old’ members of NZ’s population in 2050 were born in the 1970s. These are the years where efforts to manage hypertension, obesity, high cholesterol and so on now can have the most impact

New Zealand’s ability to influence the course of dementia across our communities and reduce these costs depends largely on the success, or otherwise, of its efforts to:

* improve public health – promoting messages about the proven protective and modifiable risk factors for dementia;
* find treatments that can alter the course of the condition – focusing New Zealand’s contribution to the research effort on finding interventions that work to support New Zealanders to live well with dementia; and
* identify strategies that reduce the impact of dementia on individuals and their families – focusing on supporting innovative approaches to care and community based services.

***The cost of Dementia***

Internationally dementia cost US$818 billion in 2015[[19]](#footnote-19). This was an increase of 35% since 2010. Costs of informal care and the direct costs of social care contribute most costs. The threshold of US$I trillion is expected to be crossed by 2018.

The *Dementia Economic Impact Report*[[20]](#footnote-20) suggested that the annual cost of dementia to New Zealand in 2011 was almost $1billion. This sum reflects the direct costs of medical care, the direct costs of social care, and the indirect costs of the care and support provided by family/whānau.

Investment in services for people affected by dementia makes good economic sense. The cost of dementia is significantly higher than for other chronic conditions. Recent estimates in the United Kingdom indicate that the annual cost of dementia to society in the UK is estimated at £26.3 billion by Alzheimer’s Society. This is higher than the cost of cancer, heart disease, or stroke[[21]](#footnote-21).

Similarly, recent American research[[22]](#footnote-22) demonstrated that the health system costs for dementia exceeded those for other common conditions for older people, largely because of the growing numbers of older people, the length of time people live with dementia and the need for ongoing support. This situation is likely to be the same in New Zealand.

Investment in research and other efforts to delay the onset of dementia, for instance through promoting actions to reduce risk factors, will help. Delaying onset by two years would reduce the prevalence of dementia by 20% - delaying onset by five years could reduce prevalence by 50%.

And initiatives that support people to remain at home for as long as is right for them will also reduce costs – a simple cost benefit analysis indicated that delaying entry to residential care by three months would create a net benefit to New Zealand in that year of $32million[[23]](#footnote-23).

***How well is New Zealand responding to dementia***

At the moment, because of the paucity of data here is NZ, we do not really *know* much about how well New Zealand is doing – and it is possible, perhaps even likely, that we are not doing very well. The OECD recently compiled material that demonstrates that the quality of services delivered to people affected by dementia in OECD countries is poor:[[24]](#footnote-24)

* More than half of all people with dementia are undiagnosed;
* One in three only leave the house only once a week;
* Family/whanāu of people with dementia are 20% more likely to have mental health problems;
* A third of people with dementia in residential facilities are on antipsychotics;
* Hospital costs are three times higher than for other people; and
* A third of people with dementia who come out of hospital have with reduced functional ability and half of these never recover.

While New Zealand did not contribute to this work, there is no reason to believe the situation is materially different here.

Closer to home, our Consumer Advisory Group advises us that people living with dementia in New Zealand communities need and want services that:

* are hopeful and support them to live every day to the fullest;
* support them to remain at home for as long as is right for them;
* recognise the respond to the unique needs of the person with dementia and the person supporting them – both together as a family unit, and separately; and
* are nationally consistent and integrated, with support offered to help people affected by dementia navigate through the myriad of individuals and organisations they interact with when accessing services.

In their view, the services and support currently available in New Zealand does not deliver on these expectations.

**Responses to specific issues raised in the draft Strategy**

This section contains our feedback on individual components of the strategy. As noted earlier we are generally in support of the overall vision and its potential impact on the health of older people. Our comments focus specifically to how the draft Strategy can be strengthened to better support people living with and affected by dementia.

***Healthy Ageing (Questions 1a and 1b on p.14 – 16)***

Alzheimers NZ is very supportive of the strong emphasis on healthy ageing in the draft Strategy. The 2014 World Alzheimer Report[[25]](#footnote-25) provided authoritative evidence about modifiable risk behaviours for dementia. One point strongly made in that report was that it was never too late to for older people to start to make the changes which reduce the risk of dementia, stroke and cardiovascular conditions.

We welcome the focus on long term conditions and improving the management of long term and chronic conditions. Most people with dementia have comorbidities, often including other long term conditions[[26]](#footnote-26), and a system that address this issue in detail will be useful.

*Age-friendly communities*

Alzheimers NZ supports the goal of age friendly communities (Action 1) and is working with the Office of Seniors in this area. We strongly support the focus on addressing social isolation which is recognised, alongside loneliness as a risk factor for dementia[[27]](#footnote-27). Successful implementation of age and dementia-friendly communities will help reduce this risk.

Our strategy for the next ten years is to focus on and be champions for a dementia-friendly New Zealand and we have a number of initiatives underway in support of this strategy including a dementia-friendly recognition programme which is currently being piloted. Given this work we think it appropriate to add Alzheimers NZ as a Lead for Action 1a (note also our comments on Who Leads Actions at the end of this feedback).

A recent publication[[28]](#footnote-28) observed “Dementia friendly communities has the power to change the way we think about living with dementia. It marks a fundamental shift from a focus on meeting the physical and health needs of the person with dementia to supporting the person to achieve the best quality of life reasonably possible.”

To achieve this goal, it is important to see that all parts of society are involved in making decisions about frail elderly including those with or affected by dementia – Government, health providers, NGOs, community groups, individuals with dementia and their family and friends and the wider community of all ages.

But this is not always the case. For example, the Transport and Industrial Relations Select Committee recently agreed to hear a mother concerned about the safety of her children if they had to cycle on the road rather than the footpath[[29]](#footnote-29). While we certainly don’t disagree with the importance of making cycling safe for children we noted that the voice of the frail elderly will not be considered also – although concern for the situation of this group is one of the reasons for the current law to which a change is proposed.

We would recommend that central and local government therefore make it a routine process to consider the impact of any proposed changes in policy or practice on the elderly and/or people with dementia before any changes are made.

*Resilience*

There is growing evidence, particularly from the United Kingdom, that encouraging physical activity such as walking is helpful for people with dementia and their informal carers[[30]](#footnote-30). This is now a successful and well established intervention.

There are other forms of activity that also valuable for people with dementia. Recent research has shown the value of visits to art galleries, choirs, attending community cafes and other opportunities to mix. This raises issues like the need for transport to community activities and the opportunities for volunteering.

*Working across the sector*

As noted the risks, and the ways of addressing them, that are important for dementia are also important for a range of other health issues, including but not limited to cardio-vascular diseases, diabetes, falls, the need for support from family and friends and relevant training for health professionals. There is therefore a great potential for developing cross section methods of working to address many of these issues, particularly in the health promotion space.

*Technology*

As noted (p.24) technology has a growing potential to assist older people in general and people with dementia and their carers. ‘Assistive Technology’ for example includes a wide range of devices from simple ‘low tech’ items such as calendar clocks to more ‘high tech’ items such as automatic lighting and telecare sensors.

It is important to recognise that many older people – both those with dementia and their informal carers - do require support learning to master the technology. A stronger focus on providing training might strengthen Action 4e.

***Acute and restorative care (Question 2 a-b pages 17-19)***

We strongly support the focus on acute and restorative care and the outcomes that are sought. Dementia is a long term condition and people with dementia have high rates of acute illness[[31]](#footnote-31) **.**

The experience of people with dementia in hospitals is often inadequate. A recent British study[[32]](#footnote-32) found (among other key points) that at least 25% of beds were occupied by people with dementia; on average people with dementia stayed more than twice as long as other patients over 65; only 2% of those surveyed felt that staff understood the needs of people with dementia and people with dementia were more likely to have falls. We would be very surprised if the New Zealand experience were substantially different and recommend adding an action to address this issue. We believe that an appropriate action would be “Each hospital should prepare an annual report on the experience with patients with dementia”. This report would be a tool for monitoring change and improvement in this area.

***Living well with long-term conditions (Question 3 a-b pages 20 - 23)***

Most people with dementia live with that condition for many years while their need for support progressively grows. We therefore support this outcome area.

*Early detection*

Research has shown that early detection is vital if people with dementia are to receive the appropriate services early, including early rehabilitation, thereby reducing their future need for more acute services. The promotion of early detection is a key and successful component of the English National Dementia Strategy and has been government’s focus to date in implementing the NZ Framework for Dementia Care.

*Support for care partners*

Informal carers are an important component of the care for many older people with long-term and complex conditions. As the draft strategy notes, it is important that the action and intent of the NZ Carers Strategy is incorporated into the Health of Older People Strategy.

Current government policy relies heavily on the extensive support being provided for people with dementia by informal care partners, usually by a spouse or child. The draft Strategy undertakes to ensure that carers receive the support they need (p.22).

However, compared with other countries, New Zealand has only a limited knowledge of the realities of the life of informal carers for people with dementia. Gaps include knowledge of the health impact on carers, the need for more and better support, recognition and recompense for the impact on their income and their financial planning for their own future in New Zealand.

This shortfall need to be addressed as a priority. We suggest an action for section 15 might be ‘‘conduct a comprehensive research on the impact on and needs of caregivers for people with dementia”. The Ministry of Health or the Office of Seniors would be the lead. There are a number of comprehensive studies which would provide models for this work[[33]](#footnote-33).

*Increasing health smartness*

It has been estimated in the United Kingdom that up to a third of Alzheimers cases might be because potentially modifiable risk factors[[34]](#footnote-34). Many of the~~se~~ risk reduction activities are similar to those for reducing the risk of strokes and cardio-vascular disease[[35]](#footnote-35). There is therefore the potential to achieve two or more outcomes with the single action.

Therefore, while we are certainly not under-estimating the value of developing resilience and healthy environments, it seems strange that the document and the Action Plan pays relatively little attention to the potential of providing (and the ability of people to subsequently respond to) health promotion information that is prepared in a method appropriate for older people

An additional action therefore might be “to increase the supply of and awareness of age specific health promotion information on reducing the risk of cardio-vascular disease, fall, diabetes and other conditions highlighting the way these might also reduce risks for dementia”. Groups who could contribute might include support for PHOs and NGOs working in this area, such as Alzheimers NZ. The Leads would be DHBs and the Health Promotion Agency.

*The Navigator role*

The first paragraph on page 24 talks about older people wanting their information to be available to all the clinicians they see and we agree with this point. People with dementia and their care partners also want help to navigate their way through the multitude of people and organisations they have to interact with. We are therefore keen to see the navigator role, which is central to the model outlined in the New Zealand Framework for Dementia Care, implemented nationwide.

A recent evaluation in the UK[[36]](#footnote-36) found that Navigators were a particularly useful component of providing access to and use of the services that are available for people with dementia. There is no reason to doubt that the navigator role would also have advantages for other population groups[[37]](#footnote-37) required to link with many different parts of the health system.

However, despite the central role for Navigators in the New Zealand Framework for Dementia Care there is no mention of this role in the Strategy. We strongly believe that the funding and development of this role should be a priority Action. We suggest that Action 12 include ‘promote the development and funding of navigator roles throughout the country for people with dementia and other older population groups’. This would be consistent with the recent NEAC advice to the Associate Minister of Health[[38]](#footnote-38). The Leads would be Alzheimers NZ, DHBs and other Non-governmental organisations.

We are concerned that there seems to some feeling that the need for a role such as navigators is seen as a reflection of a systems failure rather than a good in itself. We are certainly in favour making the health system more consumer friendly but conditions such as dementia for example are complex in themselves inevitably involving a wide range of health and social service providers, impacting on a wide range of people – not just the person with dementia - and usually accompanied by other health conditions[[39]](#footnote-39). A stand-alone navigator role with a focus on individuals for dementia and other cognitive conditions therefore seems easy to justify. Local Alzheimers organisations would be ideal employers[[40]](#footnote-40).

*Support Networks for people with dementia*

In Australia and the United Kingdom in particular the Governments have actively promoted the development of a wide range of support networks, for example Dementia Cafes. A number of evaluations[[41]](#footnote-41) have shown these to be valuable for people with dementia and their informal carers offering advantages such as providing opportunities to meet other people with dementia and for carers to interact. These provide a range of activities for people with dementia. Successful ones include walking groups, choirs, acting, visiting galleries, reading groups and coffee cafes.

We consider these services to be an important part of the suite of community and home based services and propose the following action, perhaps as part of Action 11. ‘Promote and fund the development and ongoing peer support networks for people with dementia and their carers through initial pilots in 2-3 DHBs’. The Leads would be The Ministry of Health, DHBs, Local Government Association, Alzheimers NZ and other non-governmental organisations.

***Support for people with high and complex need (Pages 24 – 26 Questions 4a-b)***

There are strong similarities between the issues raised in this section and the previous section and Living Well with long term conditions. Therefore, many of the issues we raised there are also relevant for this section. These include the need for support for the Navigator role or providing appropriate salaries and training for support workers.

We were surprised though to see Action 21a to review carers issues, particularly in light of the endorsement of the NZ Carers Strategy. Appropriate support has been one of the issues care partners have raised for many years and they have been clear about their top priority issues:

* Respite when, how and where they need it
* Good quality information
* Help to navigate through the system

What is needed now is not another review but action to implement changes to respond the needs that we know.

***Respectful end of life (Pages 27 – 28 Questions 5a-b)***

There is a common perception that many people with dementia find life unacceptable. While this is true for some, there is a wide body of anecdotal evidence and academic research on people with dementia, their family/whānau, dementia consumer groups, carers and health professionals both in New Zealand and internationally that shows this is not true for most.

It is therefore important to see that this period is well managed for people with dementia. We strongly support the outcomes and actions proposed for End of Life.

In our recent submission on Assisted Dying we considered what would assist end of life for people with dementia. We concluded these included:

* Promoting greater public awareness that dementia is a terminal condition and the importance of planning for it throughout life;
* Encouraging people with dementia themselves and their families/whānau to develop a greater awareness of the needs and preferences of people with dementia for their death while they are still mentally competent as this becomes more difficult as dementia advances – greater availability of early diagnosis would assist here;
* Providing increased support for advance planning to enable people with dementia to plan their future care specifying the types of care they would and wouldn’t wish to receive – in the event that the legislation was changed to allow medically-assisted dying a person could indicate their attitude to this;
* GPs, home care staff and other healthcare professionals and Alzheimers organisations who support people with dementia encouraging people with dementia and their family/whānau to plan for their future care – training is needed to assist them and others working with people with dementia raise the topic;
* Recognising the importance of dignity for people with dementia at the end of their lives and providing training to all staff working with people with dementia on how to promote dignity and see people as individuals;
* Significantly increasing coordinated care for people with dementia and their family/whānau and carers whenever a decision is made to withhold or withdraw care is made – factors to assist this include good access to palliative care, more research on the final days of dying with dementia and professional training for people working with people with dementia;
* Increasing research on detecting and treating pain in people with advanced dementia;
* Increasing the availability of training available for staff in hospices, dementia wards and hospital wards to deliver end of life care and ensure that where advance care plans are in place they meet the legal requirements; and
* Extending funding for the provision of, and training for, staff such as care co-ordinators to support people to die in their own homes and the availability of appropriate staff for this purpose – research suggests most people with dementia would prefer to die at home.

***Implementation, measurement and review (Pages 29-30 Question 6)***

The draft Strategy discusses the need for continuous improvement and we are very supportive of this suggestion. As p.23 notes, continuous improvement relies on having a wealth of data. However, as we have noted earlier, New Zealand has a paucity of data on dementia available. Much of what exists, and is quoted in the document, is prepared by Alzheimers NZ.

This situation needs to be remedied with urgency - to support planning, funding, monitoring and quality improvement. We suggest an Action (perhaps 22) ‘The Ministry of Health prepare and publish a comprehensive review of data on dementia in New Zealand’. The leads would be the Ministry of Health with DHBs and Alzheimers NZ. Such a publication should be updated at appropriate periods no greater than five yearly. This would be consistent with Action 28b.

We have recommended for some time that the Ministry develop a set of outcome indicators. This work will take some time and in the meantime we suggest the following as an interim measure. As noted earlier, these indicators were developed by the OECD as part of their analysis on the response to dementia by OECD countries:

* Proportion of people with dementia who have a diagnosis – OECD suggests more than half of all people living with dementia do not have a diagnosis;
* How many times people living with dementia in our communities leave their home – OECD suggests only once a week;
* Proportion of family/whanāu of people living with dementia with mental health problems – OECD suggest family/whanau are 20% more likely to experience mental health problems than other members of our communities;
* The proportion of people living in residential facilities on antipsychotics – currently OECD suggests 30% of residents are taking antipsychotics;
* The hospital costs for people with dementia – OECD suggests costs for people with dementia are three times higher than for other people; and
* The proportion of people with dementia who come out of hospital return to their homes and communities with reduced functional ability, and those that never recover – OECD suggest a third of people with dementia return from hospital with reduce functionality and half never recover.

An action might be ’The Ministry works with the sector to develop a set of quality indicators to measure the quality of dementia care in New Zealand”.

**Capacity and capability**

Successful implementation of the draft Strategy relies on a strong and sustainable sector and workforce at a time when the Health of Older People sector has significant capability and capacity issues.

***Training for the workforce***

It is not clear that health professionals are routinely actively involving people with dementia in their own assessment, diagnosis and care planning[[42]](#footnote-42). There is a substantial literature[[43]](#footnote-43) on the importance of professionals interacting well as equals with people with dementia and their families and carers in order to enable them to maximise the quality of their life and end of their life. But the feedback that we receive from our local Alzheimers organisations regional offices suggests that many health professionals are not skilled at working with people with dementia or their family and caregivers.

Consequently, we are particularly interested in improving the skill levels of all health, community and kaiāwhina staff when they deal with people with dementia in acute and restorative care. Action 9 refers to the need for training for kaiāwhina (already underway) though not specifically for dementia where many work. It does not mention health professionals though a recent British study[[44]](#footnote-44) indicates the need for this. Increasing and improving the role of primary care providers in particular is a focus of the English Dementia Strategy.

We suggest an action Point such as ‘All staff who work with people with dementia should undertake appropriate training for working with people with dementia and other neurological conditions”. This would be both during their initial training and as a part of ongoing education. The Leads for both components would be training institutions, DHBs and the Ministry of Health.

***Strengthening the Workforce***

The Health of Older People sector relies heavily on a workforce that is underpaid, undertrained and undervalued. As the demographics change and the workforce shrinks at the same time as demand grows this situation will only worsen.

While there are a number of actions to strengthen and grow the workforce within the action plan, our view is that more work is needed to confirm that together those actions are sufficient to address the value, pay and training issues in order to achieve the required significant increase in the size and quality of the workforce.

***The role of non-governmental organisations***

The draft strategy relies on a strong and sustainable NGO sector that is nimble and able to innovate, and that is providing consistently high quality care and support.

However, at present the sector is vulnerable and struggling to secure reliable and sustainable funding and therefore staff. A particular problem is the different procurement and contracting arrangements than exist now which at best cover 50% of the cost of the services contracted.

The action plan does include an action relating to the commissioning and contracting arrangements which is welcome, but our view is that a broader perspective is needed, included considering arrangements other than contracting that will support a sustainable sector delivering quality services while still allowing for new and better ways of doing things.

**Responding better to the significant challenge that dementia presents**

***International response to the challenge of dementia***

Internationally there has been considerable action in the dementia sector at governmental level over the past three years. There are now 26 countries, including most of the European Union, which have completed a National Dementia Plan and more are underway.

The World Health Organisation has urged all countries to develop and implement National Dementia Plans to transform national dementia care and support and is in the process of developing a global dementia plan for adoption in 2017.

A recent review of the English Dementia Strategy[[45]](#footnote-45) shows some of the successes. In the countries which have strategies there has been a significant rise in funding for service provision and research, a growth in public awareness and growing support for the community and voluntary workers.

The 2015 World Health Organisation meeting on dementia was attended by Ministers and/or senior government officials from most western and Asian countries as well as NGOs. Alzheimers NZ were the only attendees from New Zealand.

***How is New Zealand responding?***

New Zealand does not seem to be following this lead. Alzheimers NZ believes that achieving the goals set out in the draft Strategy requires a comprehensive National Plan for Dementia.

Recent advice to the Associate Minister of Health from NEAC[[46]](#footnote-46) recognised that much was being done in the dementia area. However, they believed this activity could be strengthened and focused through a dementia action plan with specific actions and measures of performance across central and local government, businesses and communities.

The Ministry of Health sees the strategic direction as set by *Framework for Dementia Care*[[47]](#footnote-47)*.*  To date though, implementation of the Frameworkhas been focused on supporting primary care providers to improve detection and diagnosis of dementia. Attention has not yet turned to implementing those elements of the framework that support people to navigate their way through the system or support them to live well at home for as long as is right for them. Even being generous in our interpretation, only four of the nine areas in the Framework[[48]](#footnote-48) seem to be addressed to any degree by the outcomes and actions in the draft Strategy.

A particular concern facing New Zealand, and indeed any health system, is variation in the level of services that people receive simply because of where they live, often known as the postcode lottery. The recent Interactive Dementia Atlas in England[[49]](#footnote-49) highlighted the considerable variation in services people received dependent on their residential location. Given the knowledge of variation in other services in New Zealand, and anecdotal information we receive, it would be surprising if this was not the case in dementia care in New Zealand.

We believe that a National Dementia Plan is urgently needed, and that the plan needs to have a dementia-friendly New Zealand at its heart. It needs to focus on:

* increasing awareness of dementia, its risks and ways to address them
* shifting the balance of services from residential care to the home and community, where most people with dementia live
* tackling the failures in secondary and tertiary services – where poor understanding of dementia has increased side effects and complications and results in poor recovery
* addressing the variation in services – the “postcard lottery”
* capturing quality data so we know about the people living with dementia, what we’re doing to support them and how well we’re doing
* making advances towards a cure through adequate investment in research and public health measures
* tackling the capability and capacity issues relating to the workforce and the NGO sector. Recognise the importance of the workforce, increase training and salaries and training for the informal workforce.

We suggest the following action: Develop a National Dementia Plan to respond to the challenge of dementia’. Leads would be the Ministry of Health, Office of Seniors, Local Government Association and Alzheimers NZ.

***Some issues to consider***

*Who leads actions?*

Almost all the actions proposed have a Government agency, usually the Ministry of Health and/or DHBs, as the lead agency. This is often logical. However, we believe that achieving many of the changes proposed calls for leadership, cooperation, input and action from a wide variety of groups, not just the Government.

For example, the development of dementia friendly communities requires input from a wide variety of community groups, and probably less direct input from central government. It is worth noting that this initiative is led by the national Alzheimers organisation in England, Scotland and Australia. There are examples of other actions where other community groups should be closely involved. For example, one would expect Diabetes NZ to have a lead role for Action 11c.

Therefore, we also recommend that NGOs should be identified in the leadership column where they have a significant role to play in achieving actions – appropriately supported and funded of course. In some cases, it would be appropriate to have these groups take the lead role appropriately supported by the Ministry of Health. We would certainly be keen to take a lead role in the development of age friendly communities with a particular focus on dementia-friendly communities.

Because dementia will become such a significant issue for the elderly in the future, not only for those with dementia but their families and caregivers, we recommend that the development of dementia-friendly communities is identified as an important part of Action 1.

*A name change for the strategy?*

We have some concern that a possible name change for the strategy from Health of Older People to Healthy Ageing is being considered. There is already a Positive Ageing Strategy that draws together all government, professional and community sectors to address the overall situation of the older person. There is a danger of confusion.

While we see healthy aging as a significant part of the health of older people, and of course the preferred outcome, it overlooks (seemingly even excluding) the situation of older people with disabilities and other health problems. We strongly support the continued use of the current wording.

***Achieving this bold strategy***

We certainly endorse the range of the vision as expressed on p.13. We believe that the broad objectives make good sense, and represent an overdue move away from the institution focussed system in place today. We believe that if this vision was achieved that the life and health status of older people would be increased.

As the document observes (p 8 and 9) the population of the elderly is increasing. The cost of services for the elderly will take up an increasing percentage of the health and social services budget. We have noted the increasing demands of dementia. Other demands will increase and decrease with medical and health developments.

There is a danger that with increased cost of services for the elderly the funds available for other groups, for instance the young who are rightly a focus of the New Zealand Health Strategy, will become more pinched. At a broad level the health system is for all.

So it is important that we get things right **now**, that the strategy addresses the needs of the elderly and that it recognises that continuous change will be required as an ongoing process, not just every ten years as a new strategy is developed.

It is ironically the long list of actions that accompany this vision that causes us some unease. Some of these, for example Action 6a on supporting effective rehabilitation closer to home almost call for detailed action plans on their own. Others, such as Action 5 on oral care or Action 9 on kaiāwhina workforce are already underway. How do all of these hold together for the achievement of the higher level objectives? Will achieving these individual actions deliver the broad vision?

There is a danger that a long list of actions once endorsed become unchanging priorities and circumscribe the ability of the strategy to consider and move on to other developments. We would like there to remain more flexibility to address the problems and adapt to changes as they arise.

As the document implicitly and explicitly observes, achieving the Strategy will require input from a wide range of bodies including Government agencies, health and social service professionals, provider and advocacy NGOs and representatives of the community of older people. Groups with different experiences of the health needs of the elderly.

We think that there are two steps that would make a significant contribution to achieving this vision. First, The Implementation Plan will be an important part of shaping the strategy, of “double-checking” the priorities and ensuring that these are established and achieved. It is therefore very important that all these groups or their representatives are represented at this critical stage in establishing the Plan and determining the way it is monitored and changed if necessary.

Secondly, we think that it would be valuable to establish a Reference or Review Group including Government, providers, NGOs, researchers and academics. It would be appropriately supported by analysts and statisticians. This group would meet two or three times a years and review progress to date both on objectives and on the long list of Actions. It would consider whether the actions were succeeding to achieve the objectives and whether there should be changes to the objectives and the Actions that support them. It would commission periodic wide scale evaluations of the Strategy that include recommendations.

These initiatives we think would considerably strengthen the likelihood that the Strategy will succeed, bring together the key players and ensure that the structure is relevant for the needs not only of older people but of the entire population for whom the health system is responsible.

**Conclusion**

The draft Strategy is bold and represents a positive step forward. Successful implementation requires a clear change strategy, an investment in the capability and capacity in the sector and rigorous monitoring and evaluation.

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| **Submission 144** |



**Health of the Older People Strategy Feedback**

Cancer Consumers New Zealand (CCNZ) (formally National Cancer Consumer Representative Group NCCRAG) are pleased to have the opportunity to contribute to the feedback on the draft National Strategy for the Health of the Older Person.

CCNZ is made up of eleven members representing the regional cancer network consumer groups, Maori and Pacific and non-government organizations.

Established in 2011 two of the objectives of the group are:

* To provide effective leadership for cancer consumer representation in New Zealand
* To function as a trusted advisor to the cancer control sector.

Being able to provide advice and guidance at a national level on work such as this supports our objectives.

**General comments**

We believe that this is a robust document and support the draft strategy noting the comments below.

Our caution would be around the funding and resource implications in order to deliver on the Strategy. The brightest of ideas can fall over without due consideration to human resourcing, change management and funding at national, regional and local levels.

We also note that the document lacks the inclusion of the consumer representative voice. The action points on pages 31 – 42 need to reflect that consumer representative groups would be leads along with those already stated. This would reflect the NZ Health Strategy and a one-team approach to health care. It would also allow for the sparing of resources in an already stretched Ministry.

**Specific comments**

| **Section Number** | **Page #** |  **Suggestions/Comments** |
| --- | --- | --- |
| Bullet point 2 | 4 | We acknowledge that improved discharge planning was an action point from the previous strategy. We would like to see a change of language from ‘discharge of care’ to ‘transfer of care’ which indicates that there is still health care provider involved with the patient as they move from one service to another, or back into the community. |
| New Investment approaches | 10 | We caution that ‘social investment’ approaches must proceed with a high level of transparency in order to maintain the trust of the New Zealand population. |
| Workforce development | 10 | A workforce who is adequately paid for caring for our older people is key. There needs to be a review of funding models so that the value of people working in such roles is financially recognised. |
| Smart System | 12 | We need to be aware of the potential for any data collected to be used for secondary purposes and note that the use of data will need robust governance around it. |
| Resilience | 17 | We agree that there needs to be more done to reduce the stigma of depression and anxiety and that there needs to be greater support for mental health services. |
| Acute and restorative care | 15 | We suggest that the use of health navigators may benefit the outcomes for this section (such as the Cancer Nurse Coordinators who are employed in DHBs).We support the philosophy of shifting from doing things for people to working with them. We agree with family involvement in rehabilitation as long as the person has indicated that this is what they want. |
| Supported discharge and restorative care | 18 | Restorative care sounds like the restorative justice system and has potential to be interpreted negatively. |
| Quality | 18 | Determining individual outcomes is important however the questions need to be open questions (not closed). |
| Integration in the health sector and across agencies | 18 | We agree that there is a need to reduce the amount of times a person needs to ‘tell their story’. Any standardised assessment needs to have clarity around lead clinician and who has responsibility it is to ensure the assessment is current. |
| Enabling technology | 22 | We acknowledge that the use of technology has great potential in assisting to keep people well for longer, and at home for longer. We caution that there must be governance over the use of technology in terms of policy, security and confidentiality. |
| Priority populations | 22 | There needs to be a link to prevention and early detection in order to improve health outcomes for priority populations. |
| Support for people with high and complex needs(4th bullet point) | 24 | We support this outcome but not that it must be within appropriate boundaries as sharing of social sector information is a new phenomena  |
| Knowledge and communication | 24 | We agree that IT can be an enabler to knowledge and communication but again caution around privacy and confidentiality. Nobody should avoid seeking care because of concerns and privacy and confidentiality. |
| Health and social sector coordination | 25 | We note that an enabler to individual access to personal health information is the electronic patient portal and GPs should be encouraged to adopt these. |
| Our vision for support for people with high and complex needs(last bullet point) | 26 | DHBs need to be clear and transparent about the data they collect and the purpose they will use that data for. |
| Respectful end of life | 27 | We appreciate this content. End of life care is missing from the New Zealand Health Strategy which was released in April 2016. |
| A system of continuous improvement | 30 | The Strategy indicates that the Ministry of Health will work with its major partners to develop an implementation plan but does not identify who those major partners are. CCNZ would like to indicate its desire to participate in this as a national group with a strong view on long term condition. |
| Action Plan | 31 - 42 | Consumer Representatives, should be identified as leads alongside the other agencies identified in the Action plan. It should be about working in partnership with consumer groups to ensure that services, policies etc are developed with them not for them. |
| Action Plan 2 c | 32 | Change to read “review **and promote** the Green Prescription .....” |
| Action Plan 5 a | 33 | Consider the funding model as the cost of oral health care is what prohibits many from attending dental services. |
| Action Plan 7 a (bullet two) | 33 | What is the purpose of a national hip fracture registry? It is not explicit as to the benefits of collecting this information nationally. |
| Action Plan 9 a | 34 | Consideration needs to be given to how the kaiawhina workforce is remunerated as they are an under-valued resource |
| Action 18 b | 38 | Future proof by ensuring that video conferencing is considered as an alternative to telephone calls, where the clinician could remotely view the person. |
| Action 18 d | 38 | We would like more detail around the additional range of services that aged residential care facilities could provide. |
| Action 19 d | 39 | All allied health workers should be included in this statement. |
| Action 25 a | 41 | Re-word to read “With health and social sector partners, **and consumer representation ....”** |

Again we thank you for the opportunity to provide feedback on this draft Health of the Older Person Strategy and note that we would appreciate feedback on the response provided.

We look forward to working with you in the future.

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| **Submission 145** |

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| --- | --- |
| Organisation (if applicable): | Centre for Research, Evaluation and Social Assessment (CRESA) |
| Position (if applicable): | Director |

This submission *(tick one box only in this section)*:

[ ]  is made on behalf of a group or organisation(s)

Please indicate which sector(s) your submission represents *(you may tick more than one box in this section)*:

[ ]  Academic/researcher

1. **Introduction**

This submission has been prepared by the Centre for Research, Evaluation and Social Assessment Ltd (CRESA) and Public Policy & Research Ltd. It reflects many years of research into the role of adequate and appropriate housing in empowering New Zealanders to age well. It also draws on preliminary findings from the MBIE-funded research programme, Finding the Best Fit: Housing, Downsizing and Older People in a Changing Society; and the Life when Renting research programme in the Ageing Well National Science Challenge. The latter programme is focused on enabling older people’s independence, active lives and participation in the face of structural housing tenure changes and the growing reliance of older people on rental housing.

The submission:

* Acknowledges the importance of the strategy, both as a holistic vision for ageing well and in identifying the need to establish age friendly communities that provide a range of quality, age-friendly housing for older people, including the growing number of older people dependent on the rental sector.
* Comments on ageing in place as the overwhelming preference of older people in New Zealand and the importance of accessible housing, home modifications and access to in-home care across all tenures in achieving this.
* Highlights the rising number of older renters living in precarious housing situations and the implications that increasing dependence of older people `on the rental market has in terms of inter-generational care, finance, healthcare and premature entry into aged residential care.
* Draws attention to the increasing number of adults aged 50 and over who are experiencing first time homelessness due to a shortage of appropriate, accessible and affordable housing, and the potential implications older homelessness has for healthcare.
1. **Ageing in Place**

We are encouraged to see that the strategy has a focus on promoting social connection within age friendly communities, creating integrative networks to improve access and coordination of assistance, improving the delivery of social services and promoting home and community support models of care. Of particular importance, from our perspective, is the recognition that “older people want to stay in their communities and access services closer to home,” and that housing plays a pivotal role enabling people to achieve this outcome.

Ensuring that older people have access to healthy, accessible and affordable housing is critical to enabling them to remain in their homes and communities for longer. Housing provides a base for ontological security, maintaining health, quality of life, engagement with family, community and society and facilitating activity and independence (Spillman, Biess and MacDonald 2012). Poor housing conditions and poor accessibility can result in “housing-related disability” and reduce the safety, efficacy and feasibility of older people caring for themselves, or being cared for, in their own homes (Spillman, Biess and MacDonald 2012). In this context access to in-home care and home modifications are critical factors in enabling people to age in place and, we believe, should be key interventions used to achieve the strategy.

 Australian research indicates that home modifications (such as grab rails, level access, wet area showers etc.) improve the safety, health, mobility, independence and confidence of older people (Bridge 2015). They allow older people to remain active and engaged in their communities, reduce the risk of injury for carers and can postpone or, in some cases, prevent entry into aged residential care (Bridge *et al.* 2006, Bridge *et al.* 2008, Hulse and Saugeres 2008, Spillman, Biess and MacDonald 2012). Bridge (2015) has estimated that the annual cost offset of home modifications to health and aged care services in New South Wales is $3.75 million. However, when DIY modifications were included in modelling, potential estimated savings rose as high as 15 million per year. She suggests a DIY subsidy of up to $2000 would be cost effective as well as significantly improving the quality of life of recipients, increasing the stock of accessible housing and reducing the need for institutional care.

It is important to recognise that ageing in place is the preference of the majority of older New Zealanders regardless of their tenure status, rather than a “goal specific to homeowners” (Freilich *et al.* 2014). However, older renters face substantial obstacles to ageing in place. Lack of tenure security, poor quality housing and inadequate living conditions can contribute to considerable emotional and psychological distress, illness and potential injury (Hulse and Saugeres 2008). Older tenants on low incomes are often forced to live in inappropriate and poor quality housing due to a lack of affordable and available rentals with accessible features (Hulse and Saugeres 2008).

Older tenants typically have little control over their living conditions as they are unable to make changes to their home without the consent of their landlord and often have limited financial capacity to pay for modifications. Research has repeatedly indicated that older people tend to have significant anxiety about requesting repairs or modifications, and many hesitate to do so for fear of rent increases or eviction (Morris 2009, Freilich *et al.* 2012, Fear *et al.* 2004, Izuhara and Heywood 2003). Furthermore, landlords can be reluctant to implement modifications due to the perception it will decrease the value or desirability of the dwelling. The ability of older renters to modify their dwellings so they can live comfortably and safely is an issue that needs attention, as renters typically have poorer health outcomes and higher levels of disability than owner occupiers (Spillman, Biess and MacDonald 2012). Australian research also notes that older people living in rental accommodation are often poorly covered by in-home care services, which can result in premature entry into aged residential care facilities (Bridge *et al.* 2006, Bridge *et al.* 2008).

The strategy recognises that the provision of support and care services is critical to supporting older people to age well for longer in their communities. We think it is important to reiterate that, regardless of tenure, many old people with support needs could continue to live in mainstream housing (provided it was affordable and accessible) if the necessary support services were available. Health and support services often assume that older people have family who are able to support them, however, high levels of renting among younger family members and residential mobility may mean family members may not be placed to provide the necessary support and assistance. Support services that provide help with heavy housework, gardening, lawn mowing and home repairs and maintenance are fundamental to allowing older people to continue living independently in their own homes (Saville-Smith and James 2010).

1. **Older Renters**

We are pleased to see that the strategy acknowledges the growth in the number of older renters and the need to provide a greater range and quality of housing in the rental sector. This is an issue of considerable importance and some concern as policies, income support settings and practices in health and housing are based on the assumption that the majority of older people are in mortgage-free homeownership and are poorly structured to delivering ageing well and ageing in place to a population that is increasingly dependent on the rental market. Recent policy shifts in New Zealand such as the abolition of tenure security in public rentals, under supply of smaller and accessible housing and disposal of council pensioner stock are trends that put older renters at greater risk and, should these trends continue, are likely to result in a significant number of older people living in precarious housing situations. The following discussion in this section is concerned with the challenges faced by older renters and the wider implications of the shift in tenure.

International research indicates that older renters, in both private and public rentals, have a greater risk of housing stress and poor dwelling conditions. Older people are competing for housing with younger people who may be more mobile and have more resources, so may be forced to accept inadequate housing and/or unaffordable housing due to a lack of available options. Housing options for older people may be further compromised by poor accessibility such as stairs and narrow entryways and an inadequate supply of smaller (1-3 bedroom) homes (Gonyea, Mills-Dick and Bachman 2010, Petersen 2015). As has been noted above, older renters may also experience more difficulty and expense in accessing in-home care and support services required to enable them to live well. Older tenants have an increased probability of becoming isolated and experiencing reduced capability and functioning (Morris 2012). International research has identified tenure as an independent variable in admission to aged residential care (Bridge *et al.* 2006, Bridge *et al.* 2008, Carnemolla and Bridge 2011, Connolly 2012).

High, often unaffordable rents and other housing related costs associated with poor housing performance, unhealthy conditions and poor connectivity of rental housing to services severely impacts on the quality of life and wellbeing of older renters. A recent report by The Salvation Army asserts that although rents in New Zealand have risen 4% a year over the past five years, the accommodation supplement has not been reviewed since 2007 (Johnson 2015). Renters typically have much lower levels of financial security than owner-occupiers and those in the private market who are predominantly dependent on the pension face considerable housing stress. In 2016, around 40,000 people aged 65 years and over receive the Accommodation Supplement and this figure is likely to underestimate the need.[[50]](#footnote-50)

Lack of tenure security has implications for older renters’ ability to remain engaged and active with their social networks and communities. The frequent moves entailed by renting, particularly in the private sector, can make establishing new connections and maintaining old ones difficult, especially for those with reduced mobility, and can increase loneliness and isolation (Howell 2016, Morris 2012, Colic-Peisker *et al.* 2015). Frequent moves may also result in delays seeking services, help, or medical care (Howell 2016). Moving also involves a considerable expenditure of time, energy and financial resources that can result in substantial distress and difficulty. Current regulations allow landlords to end a tenancy without grounds and with very little notice given the problems tenants often face in locating and accessing another dwelling. Inability to find a new home following a notice to vacate can lead to older people being forced to live in inappropriate and/or unsafe accommodation and place an increasing burden on health and social support services. The high rate of renting among older Māori and Pasifika renders these groups particularly vulnerable.

USA data shows that older renters have higher rates of disability than owner-occupiers and are thus more vulnerable (Spillman, Biess and MacDonald 2012). This over-representation is also apparent in New Zealand, particularly in relation to council rental stock, but it is obvious across all types of rental accommodation – see figures below based on 2013 census data (Saville-Smith 2014).

Unmet housing need, inappropriate and unaffordable housing stock, and increasing reliance on a very lightly regulated rental market are likely to increase pressure on income support and superannuation as older people are less able to meet housing costs, the costs of in home care, the costs of residential care funding and costs on families, who may themselves be unable to provide the necessary care and support required by their older relatives. The difficulties faced by older renters also raises concerns that more older people will be forced to live in marginal accommodation and may risk losing their housing altogether.

1. **Older homelessness**

Australian and other International research indicates that issues around housing affordability and availability are resulting in an increasing number of people aged 50 and above experiencing homelessness for the first time. The majority of people in this demographic have held down jobs, raised families and led conventional lives before a crisis or series of crises have resulted in the loss of housing (Petersen and Parsell 2015, Johnson 2015, Lovisi *et al.* 2007, Rota-Bartelink and Lipmann 2007, Shinn *et al.* 2007). While there is no clear picture of the extent of elder homelessness in New Zealand (Richards 2008) there is “little to stop such a trend emerging” (Johnson 2015) as NZ faces similar pressures in terms of decreasing homeownership, rising rents, lack of tenure security and inadequate income support (Johnson 2015). In this section we will present an overview of those experiencing homelessness in older age and the factors that tip them into homelessness.

Researchers agree that homelessness in later life is related to structural, economic and policy factors such as unemployment and lack of affordable housing, combined with personal vulnerabilities and inadequate welfare and support (Crane and Joly 2014, Gonyea, Mills-Dick and Bachman 2010, Warnes and Crane 2006). Factors repeatedly implicated include conflicts with partners, family or housemates, disintegration of relationships, death of a spouse, loss of a job, physical or mental illness, domestic violence/family abuse and difficulty meeting rent or mortgage payments (Lee *et al.* 2016, Kisor and Kendal-Wilson 2002). Abuse and neglect are significant factors in older women’s homelessness (Petersen 2015, Kisor and Kendal-Wilson 2002) and can “tip the balance from marginal housing to homelessness” (Kisor and Kendal-Wilson 2002). Accessibility issues can also contribute to homelessness. Some older tenants may be obliged to leave their homes because they can no longer manage stairs or design features (e.g. showers over baths) make the home unsafe, however they may then struggle to find another, more suitable rental (Petersen and Parsell 2015).

Of particular concern is the fact that studies suggest a number of older people experiencing first time homelessness have not been receiving benefits they were entitled to before losing their housing (Shinn *et al.* 2007, Rota-Bartelink and Lipmann 2007, Cohen 1999), despite the fact a number have been in contact with social or health services (Warnes and Crane 2006, Crane and Warnes 2002). Some researchers have noted cases where older tenants have been evicted due to rent arrears arising from problems in receiving benefits, either because of administrative issues or because tenants have struggled to complete the application process (Warne and Cranes 2006). A similar scenario may be emerging in New Zealand, where the Citizens Advice Bureau reports seeing an increasing number of people seeking help to access emergency accommodation (often while couch surfing or sleeping in cars), some of whom have been referred by one or more government agencies (CAB 2015:15).

The risk of homelessness in older age is greatest for those aged 50-64. This group is vulnerable to changes in employment status and income, may struggle to find new employment if laid off (due to age discrimination), and are ineligible for pensions and entitlements available to those aged 65 and over (Cohen 1999, Warnes and Crane 2006, Crane and Joly 2016). Single older women are at particular risk, as they are likely to retire with only half the savings of men (Darab and Hartman 2013, Kisor and Kendal-Wilson 2002). Māori are also over-represented in statistics that compound the risk of homelessness (Richards 2008).

Homelessness is unacceptable from a human rights and moral perspective, however it also poses significant costs to the public purse, particularly health and justice, as well as to the viability and productivity of communities and settlements. Homeless people in their 50s and 60s often present with geriatric symptoms typically associated with much older age groups, such as functional and mobility impairment, frailty, cognitive impairment, loneliness, isolation, depression and incontinence, due to their harsh living conditions and poor diets. They are also vulnerable to elder abuse (National Coalition for the Homeless 2009, Petersen and Parsell 2015, Gonyea, Mills-Dick and Bachman 2010, Crane and Joly 2006, Rota-Bartelink and Lipmann 2007, Crane and Warnes 2000, Cohen 1999). The severity of their health problems can become a barrier to accessing treatment and leaving homelessness (Petersen and Parsell 2015). The mortality rate of homeless people is 3-4 times that of the general population and usually results from acute or chronic conditions exacerbated by homeless life, rather than substance abuse or mental illness (National Coalition for Homelessness 2009).

1. **Ways forward**

It is well established that good housing is pivotal to people’s health and wellbeing in later life. There is also increasing understanding of the pivotal role of appropriate housing in the development of age friendly communities (Phillipson nd). The key policy and programme areas that will help to support and improve older people’s health and wellbeing are:

* Mandatory requirements around lifetime design in new residential dwellings.
* Home modifications.
* Retrofitting insulation.
* More flexible and more effective in-home help and support for personal care and household management.
* Assistance with home safety.
* Provision of information and advice to improve older people’s ability to identify and choose the best housing options for themselves.
* Review of the adequacy of the Accommodation Supplement and tying of the receipt of the supplement to rental accommodation to condition standards, tenancy security and affordable rents.

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| **Submission 146** |

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| --- | --- |
| Organisation (if applicable): | Lakes DHB |
| Position (if applicable): | Health of Older People Portfolio Manager |

This submission *(tick one box only in this section)*:

[ ]  comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity)

x[ ]  is made on behalf of a group or organisation(s)

We will publish all submissions on the Ministry’s website. If you are submitting as an individual, we will automatically remove your personal details and any identifiable information.

If you do not want your submission published on the Ministry’s website, please tick this box:

[ ]  Do not publish this submission

Your submission will be subject to requests made under the Official Information Act. If you want your personal details removed from your submission, please tick this box:

[ ]  Remove my personal details from responses to Official Information Act requests

Please indicate which sector(s) your submission represents *(you may tick more than one box in this section)*:

[ ]  Māori [ ]  Regulatory authority

[ ]  Pacific [ ]  Consumer

[ ]  Asian x[ ]  District health board

[ ]  Education/training provider [ ]  Local government

[ ]  Service provider [ ]  Government

[ ]  Non-governmental organisation [ ]  Union

[ ]  Primary health organisation [ ]  Professional association

[ ]  Academic/researcher [ ]  Other *(please specify)*:

### Healthy ageing

1a. The draft Strategy sets out a vision for the goal of healthy ageing: see page 14 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Document should change to Healthy Ageing Strategy - as to live well when older needs to start before getting old.. References in point 1of p16 vision should reflect People rather than Older people as it is a whole of life relevant rather than only when considered old. |

1b. The draft Strategy includes actions that are intended to achieve the goal of healthy ageing: see page 31 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| Goals should remove references to “Older” and reflect “People” so document considers ageing well is not related to being old.Good to see dental needs highlighted |

### Acute and restorative care

2a. The draft Strategy sets out a vision for the goal of high-quality acute and restorative care: see page 17 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Section puts too much emphasis on hospital admission and does not recognise the increase in primary responses to people who are acutely unwell but not admitted or present to ED and should receive access to the same planned approach to treatment and regaining independent function as well as what is needed to continue to live at home with support. Emphasis should be on reducing the risk of hospital admission and long length of stay / complications by developing alternative approaches that allow person to be treated in the community or ED and not be admitted. Not everyone goes to hospital when old or frail.Access to allied health assessment, advice, aids and equipment to maintain independence should not be only available after hospital discharge, but should be linked to NASC / interRAI assessment for people who are experiencing early decline in independent function, cognitive impairment, or who are at risk of institutional risk. Fracture liaison service - > 50% of eligible population would not be seen in hospital but primary radiology service.Injuries are not the only reason for needing allied health intervention - majority will need this because of decreasing functional decline through loss of muscle strength, balance and co-ordination not associated with acute events. Restorative or responsive support services should be the priority.Hospitalisation increases dependency – so if this is a key issue, then emphasis needs to be around admission avoidance, minimising risks of delirium, falls, pressure area wounds, long length of stay, poor nutrition / dehydration. Discharge planning should be more than planning for discharge, but actually include the support and care required to transition a person home, and through their recovery period. |

2b. The draft Strategy includes actions that are intended to achieve the goal of high-quality acute and restorative care – see page 33 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| Title should be reversed to focus on Restoration, maintaining independent function and managing acute events appropriately. Goals focus too much on hospital admission and overlook that majority of acute events do not or should not result in hospital admissionReadmission rates are not significantly high and don’t deserve separate mention. Through analysis, it can frequently be noted that a person readmits because of a different diagnosis than the one before and not because of complications from pervious conditionReference to using data should expand not just to identify falls / fractures which is current theme – but be more universal as it would be expected to include other risks - such as institutional risk, palliative care needs, pain management, pressure area wounds. NZ needs to move towards a single shared health record that is readily available / accessed by the range of health professionals involved in supporting a person to maintain their independence and ability to live longer at home. The strategy is lacking this vision or expectation that all sectors in health will develop shared clinical record connectivity between primary, secondary, tertiary, allied health, community support services, pharmacy and palliative care providers to reduce the need for multiple assessments / care plans or risks that an older persons needs / background / treatment or care / support needs are not well understood. |

### Living well with long-term conditions

3a. The draft Strategy sets out a vision for the goal of living well with long-term conditions: see page 20 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Would like to see:* early detection being linked to identifying people who are at risk earlier through primary care
* Increase use of technology to support clinical diagnosis, treatment and monitoring between clinicians and patient – eg video conferencing in rural areas
* references to home and community workforce low pay / variable training/ cultural appropriate / high staff turnover to also include residential care workforce
* priority populations such as Maori / Pacific age earlier – not just through long term conditions and therefore their age related disability needs should be considered earlier
 |

3b. The draft Strategy includes actions that are intended to achieve the goal of living well with long-term conditions: see page 34 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| Heading is Long Term Conditions but text then adds fraility which is generally seen as age relatedSuggest remove reference to “older” people as long term conditions usually relates to adult medical conditions not age related onesMost common medical condition through interRAI is cardiovascular conditions, congestive heart failure, chronic respiratory disease – before diabetes and cancer Delirium probably has the most life changing impact for an older personFrom interRAI - Most common risk factors is urinary incontinence, cardiorespiratory, institutional risk, physical activity, mood before pain, fallsKaiawhina is a term that home based support provider staff do not recognise so it is unlikely to be recognised by the general public. Suggest that an English version is added eg. support worker / Kaiawhina |

### Support for people with high and complex needs

4a. The draft Strategy sets out a vision for the goal of better support for people with high and complex needs: see page 24 in the draft document. Do you have any comments or suggestions regarding this vision?

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| It would be good to see the strategy have a focus on knowing who has high and complex needs – identifying needs, developing MDT care plans and monitoring progress … increased use of case management / navigator approach |

4b. The draft Strategy includes actions that are intended to achieve the goal of better support for people with high and complex needs: see page 37 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| 14 development of fraility identification tool is short sighted – this is a 10 year document, so principle is for there to be early identification of people who may be frail or vulnerable. Fraility is not always recognised as including dementia … perhaps this needs to be referenced separately16. last 2 bullet points could be combinedDocument is 10 year strategy so reference to a trial pilot is not long lasting and should be replaced with more generic statement. |

### Respectful end of life

5a. The draft Strategy sets out a vision for the goal of a respectful end of life: see page 27 in the draft document. Do you have any comments or suggestions regarding this vision?

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| OK section |

5b. The draft Strategy includes actions that are intended to achieve the goal of a respectful end of life: see page 40 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| Advanced care planning is term that is not well understood … perhaps changing this to future care planning may be more acceptable |

### Implementation, measurement and review

6 The draft Strategy includes proposals for implementing, measuring and reviewing the proposed actions: see page 41 in the draft document. Do you have any comments or suggestions regarding these proposals?

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| No comment |

### Other comments

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| 27e - Research is a formal process that is resource intensive and I wonder if this should be less restrictive and referred to as Review or evaluate28. Kaiawhina workforce minimum dataset - - this is a 10 year document, so what is the purpose of a minimum data set for one sector of the workforce … within this 10 year period, the number of health professionals who will be retiring will have significant impact on the ability of the health sector to maintain the standard / range of services that are currently happening.Improving the knowledge base is something that should be happening across the medical / nursing / allied health and non registered workforce – not just the current workforce of interest |

A Healthy Ageing strategy has the power of changing current management, clinical practice, processes and systems to better service people who are the centre of the strategy – just by being visionary, setting what is ideal best practice, taking a more global view and still having the capacity to change.

One of the positive aspects of the last strategy was the ability to develop a long term – over many years – plan at DHB level for service development and then to be able to review achievement and progress on an annual basis.

At this stage, although this document does have some good aspects, it doesn’t have the same ability to reflect a vision and therefore develop an action plan that would include all points that one can demonstrate progress within DHB.

If we follow the strategy until 2026, can we be confident that we will meet the needs of the older population of 2026 and the years following when we will be in an environment of greater numbers, greater vulnerability, fewer workers / health professionals, greater reliance on non paid family / friends?

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| **Submission 147** |

**Home and Community Health Association**

**Submission on Health of Older People Strategy consultation draft**

**Organisation:**

The Home and Community Health Association Inc (HCHA) is the industry association for organisations that provide or have an interest in home and community health services in New Zealand. Services provided by HCHA members include personal care and household management, community nursing, chronic injury support, palliative support, end of life care in the home, child care, respite care, mental health community support. Our members employ approximately 22,000 staff, primarily support workers, but also nurses, allied health staff, coordinators and managers. HCHA members support around 110,000 people each year in their homes, including an estimated 70,000 older people.

This submission includes viewpoints submitted by members following its circulation. It has also been agreed to by the HCHA Board.

**1. Summary Comments on the Draft Strategy**

 1.1 HCHA congratulates the Ministry of Health on the draft consultation document. Its structure and quality reflects the impressive range and depth of consultation undertaken. The result is a strong focus on the user of services and recognition of the value and independence of people. The life course approach adopted in the report reflects the range different supports and health focuses that people need to live and die well.

* 1. HCHA is pleased to see references to the Home and Community support workforce throughout the report. However the In Between Travel Time Settlement and the Director-General’s Reference Group report addressed broader issues and made recommendations on broader issues than the workforce. Its recommendation - for a strategic and more nationally consistent approach based more closely on client need - is not reflected in the HOP Strategy refresh document. Focussing only on the workforce will not be sufficient to generate the capacity of this service to manage the increasing volume and capacity of client need. Historic models will not manage increasing demand and increasing need for better outcomes. These issues were detailed in the independent report from the 2015 review of the sector by the Director-General’s Reference Group.
	2. We have had comment from members that the consultation draft has focussed on services that are already in place, and that the review process does not appear to have taken the opportunity to consider substantially innovative approaches to health services for older people.

**2. Title, Introductory pages, foreword**

* 1. HCHA supports a change of title of the Strategy, such as Healthy Ageing Strategy because the current title limits the focus to the ‘over 65s’ rather than taking a full life course approach.
	2. HCHA advocates for more use of Te Reo throughout the strategy report. It is a national language that should be supported through regular use. We suggest at the very least, the frequent use of words, phrases and concepts in sentences, more specific cross references to Te Korowai Hauora, and the use of whakataukī . As a minor example, HCHA supports the use of whānau to replace all instances of family/whānau in the report. There are few people who do not understand the concept of whānau, and it has a broad as well as specific meaning.

**3. Quality improvement since HOP Strategy 2002**

The comment is made that since the release of the Health of Older people Strategy in 2002 a number of improvements have been made. Included in these is reference to ”*a significant improvement in the quality of health care in aged residential care; and we are making improvements in home and community support service”*

HCHA proposes that this be amended to state “*significant improvements in the quality of health care in both aged residential and home and community support services”*. HCHA recognises that there is much more that needs to be achieved for home and community services, however the comment as it stands appears to suggest that improvements in home and community services have been light relative to those in aged residential care services. We challenge the fact behind that assumption. Quality changes that are particularly relevant are:

* Requirement via contract for all publicly funded service providers to be accredited to and audited against the national quality Standard.
* Complete revision of the Home and Community Support Sector standard NZS 8158
* National review (NZQA) of all qualifications relevant to the sector to make them more relevant.
* Complaints categorisation process piloted and implemented nationally
* interRAI assessments for all people seeking or receiving home support services
* Introduction of restorative and rehabilitative care and increased use of funding mechanisms to incentivise more person centred and outcomes based services (also resulting in consolidation of services)
* Significant ACC service review of HCSS services, which included increased service investment, increased training requirements, and greater consistency of service quality through use of a lead contractor model. This also generated consolidation of services.
* Increased use of early supported discharge models for post-acute care, including significant implementation in Canterbury following the 2010-2011 earthquakes
* Funding for dementia training in home support.
* Negotiated national agreement on payment of travel time and major review of home and community support services including regularisation of the workforce and sector sustainability, the aims of which are to stabilise the workforce and improve capacity of the sector.
* Development and revision of Carers Strategy and Action plan, applicable across relevant agencies. The action plan focuses on supporting respite, health and wellbeing of whānau, provision of information for whānau, and increased awareness and understanding of the carer’s role.
* Individualised funding, EIF and Enabling Good Lives have also had a significant impact on service philosophies, and although it is not clear what specific impact these will have on quality of services for older people, the general language of client choice, control and person centred services are now impacting upon service reviews.

**4. HCHA comments on the main body of the report**

* 1. Page 5 and 6. **Treaty of Waitangi references.**  HCHA considers that the paragraph acknowledging “the special relationship between Māori and the Crown through the principles of the Treaty of Waitangi in the health and disability sector” is weak. The principles of partnership and participation are just touched on, and protection does not appear to be addressed, which is problematic where equity is being considered. The strength of the assertion is also somewhat undermined by its positioning on this page and its listing absence on the following page. This raises questions about the relationship between strategies, the Treaty Principles and the Treaty itself. The relationship between the Health Strategy and the HOP Strategy, and the relationship between the NZ Disability Strategy and the HOP Strategy are both reasonably clear. That does not seem the case for the Treaty, the Treaty principles or He Korowai Oranga.
	2. Page 7 **– Life Course Approach.** HCHA supports the ‘life course approach’ of the strategy and the framework that has been adopted. It helps focus the reader on the consumer, on diversity, and on resource and support allocation.
	3. Page 9. The need to address inequities was a theme often raised during the consultation process. It is touched upon on page 9, but not addressed directly in the actions section, leaving one wondering how the general goals identified on page 9 will actually be put into action and achieved.
	4. The statements on page 9 in relation to **He Korowai Oranga** reflect a somewhat watered down interpretation of the source document. He Korowai Oranga is strong on increasing capacity and capability of Māori providers to deliver effective health and disability services for Māori. This has been weakened to ‘contribution’ and ‘participation. Similarly He Korowai Oranga also identifies inequity as a key challenge, and we think that should be more closely referenced in this section, which is about equity. Perhaps include direct quotations from that strategy document?
	5. Page 13. HCHA supports the **vision and objectives.** It is not clear, however, how addressing inequity is integrated within the vision or objectives.
	6. Page 15. **Resilienc**e. HCHA supports the comments on resilience including the positive approach to promotion of wellbeing, connectedness and enhanced physical, intellectual and emotional resilience. We think that the collective ‘we’ of health services also need to identify and address restraints on these goals. Some of these restraints are generated by our own health activity (such as institutionalisation and dependency, prioritisation of clinical interventions, limits and silos of contracted services), others are socio-political (eg colonialization, prejudice in relation to ageing, disability, sexuality).
	7. Page 15-16. HCHA supports the recognition of the importance of housing, transport and social connections and connectedness. In relation to the vision statements on page 16, HCHA suggests that the sentence “All older populations are supported to age well in ways appropriate to their needs” ought to be enhanced by the addition of “abilities, culture and sexuality” at the end. This should reflect the diversity of people.
	8. **Acute and Restorative Care** Pages 17-19. HCHA is supportive of any approach that promotes enablement and rehabilitation, though we note that ‘restoration and rehabilitation’, whilst ideal goals, need to be also viewed within the context of general decline for many. It should not necessarily be seen as a failure of the health person or of any individual for them to be experiencing failing health.
	9. HCHA does not think there is sufficient emphasis in this section on the journey of the person through acute care treatment. As an example, there is little on the training of doctors and nurses regarding honest discussions with patients and their families about support and treatment options, particularly in relation to quality of life goals.
	10. Page 19. Regarding the statement that ‘Home and community support workers and family carers are often involved in rehabilitation. Information sharing, training and other means of support could enhance the range of activities they undertake.’ We think this needs more specific attention on removing some of the current inhibitors of better service delivery. These include:
	11. Lack of flexibility via contract or needs allocation to offer support services that focus on goal setting, rehabilitation and enablement
	12. Limitations on access to skilled clinical and rehabilitation experts
	13. Limited consultation and involvement in broader care structures (such as multidisciplinary teams and health alliances)
	14. commissioning practices that do not account for the costs of training and professional development for the home and community workforce.
	15. Commissioning practice that does not match needs assessment to resource allocation, and uneven commissioning per need across New Zealand.
	16. Limited support for the training of nurse assessors in the home and community support sector.
	17. Poor access by providers of home and community support services to interRAI data on their clients
	18. For the reasons give above we suggest that the vision for acute and restorative care needs to include:
1. Better alignment between needs and resourcing by health, ACC and community services results in closer alignment between the service design goals and the service delivered; and
2. Best access to, training on and use of data is shown to better inform decisions on supports provided
	1. **Living well with Long term Conditions** HCHA is generally very supportive of the vision and rationale in this section. Our comments in relation to the need to align funding models more closely to client need apply.
	2. Page 22 **Enabling technology.** There is such rapid change in technology that health services are likely to be delivered in ways we may not imagine now. The first paragraph focuses on what is currently known and used technology. Suggest including comment that the health system needs to be robust enough to enable new technologies whilst still maintaining access, affordability and accountability.
	3. Page 22 **Health Workforce.** HCHA supports the focus on the home and community workforce. There are other critical workers as well as kaiāwhina, and development strategies are also needed for them (nurses, managers, coordinators)
	4. **Family and Whānau**. Pages 22-23. There is scant mention of respite care, and nothing on day services in the strategy. We suggest that greater focus is needed on each, drawing on feedback during the consultation. It is the experience of our members that families need a range of respite care and day service options. These can include in home respite support, residential based respite, remote enabled monitoring, resourcing for carer support groups, and support for physical or social activity programmes for people including those with dementia. HCHA also supports a change in emphasis from passive forms of respite services where the person is ‘cared for’, to the social/disability model, where the person is expected to be an active participant in decision making and where the person has opportunities to build relationships and be involved in society.
	5. HCHA considers that family caregivers should have the (resourced) option of taking part in assessments on the level of social, emotional, psychological, financial and physical strain they experience to inform further development of carer support options.
	6. Transport is often a limiting factor for people accessing respite and day service options. DHBs and local authorities, service providers, consumer support groups and volunteer groups should work together to find innovative and cost effective ways of supporting people to attend day service and respite services.
	7. Page 23. In light of our comments above, HCHA supports a change to the paragraph regarding the workforce that supports older people and their families to manage long-term conditions, to include ‘and a range of options for respite that support social inclusion and active participation’
	8. **Support for People with High and Complex Needs.** Our comments made above on respite and day services also apply to this section.
	9. As above, HCHA supports a change in emphasis from passive forms of services for people with high and complex needs where the person is ‘cared for’, to the social/disability model, where the person is expected to be an active participant in decision making as much as possible and where the person has opportunities to build relationships and be involved in society. We refer to comments made earlier in our submission about restraints that are generated by care options, such as institutionalisation and dependency, and prioritisation of clinical interventions and societal attitudes. We note these restraints can apply to home and community support services as well as residential , hospital and respite services. There also needs to be more research undertaken around factors in caring activities that generate dependency, and create isolation.
	10. In light of our comments above, we think that the vision should include a statement about supporting, as much as possible, independence and active participation for people with high and complex needs
	11. In relation to the vision statement’s inclusion of people from different ethnic groups and rural locations, we suggest that people with disabilities, and people who are LGBT also need to be included (‘…from ethnic groups, disabled people, LGBT people and those in rural locations …’
	12. **Respectful End of Life** In general HCHA fully supports the philosophy and commentary made in this section.
	13. HCHA considers that advanced care planning should occur well in advance of the last days of life.
	14. There is not a great deal of information in the body of this section on workforce development. Home Support providers and workers have identified palliative in home care as being both highly stressful and highly rewarding. But they have also expressed a strong need for the opportunity to develop their skills, and knowledge of palliative care through more training opportunities and peer mentoring.
	15. Page 28 refers to the Adult Palliative Care services review. HCHA has expressed concerns directly to the Ministry of Health about the quality of the review report, which we think shows poor understanding of the level of palliative care provided in home based services. More time and resourcing is needed to more comprehensively reflect the range of adult palliative care services. That review is not sufficiently forward looking.
	16. **Action Plan.** HCHA supports the aims of the Action plan. There are quite a lot of actions. As noted earlier in our submission there does not appear to be actions relating to reducing inequity. These should be integrated throughout the action plan.
	17. Under **Improve health literacy and communication systems** HCHA considers that all New Zealanders should have online access to their health records.
	18. Under ‘**Improve oral health in all community and service settings’**  there is an action item for identifying and promoting innovative care arrangements for oral health care of people living in aged residential care. This should also apply to community care, bearing in mind the findings of the Older persons Oral Health study. As an example, home based care providers could include checking teeth and supporting/encouraging oral health care in their tasks.
	19. **Acute and restorative care.** There is not a great deal on illness and injury prevention in this work plan, such as reducing of falls at home, which is where the majority of falls occur. HCHA suggests working with general practice and home and community providers to develop reporting triggers for people who are identified as at high risk of falls or acute admissions. This could be part of a broader community reporting and action framework (eg GPs, family/whānau). It happens in some places, but there are many gaps of unwillingness or silo’d responses.

This submission was completed by:

Home and Community Health Association Inc

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| **Submission 148** |

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| --- | --- |
| Organisation (if applicable): | Te Pou Ltd (T.A. Te Pou o te Whakaaro Nui) |
| Position (if applicable): | Chief Executive |

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[ ]  Asian [ ]  District health board

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[ ]  Service provider [ ]  Government

[x]  Non-governmental organisation [ ]  Union

[ ]  Primary health organisation [ ]  Professional association

[ ]  Academic/researcher [ ]  Other *(please specify)*:

### Healthy ageing

1a. The draft Strategy sets out a vision for the goal of healthy ageing: see page 14 in the draft document. Do you have any comments or suggestions regarding this vision?

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| The vison is well articulated and makes a lot of sense, but it is not clear what is meant by focusing on ‘equity’ in relation to older people. Does it mean, for example, more equitable access to health services? Prevention of health problems associated with getting older, including mental health problems, through encouraging social connection and physical activity, is based on good evidence. However stigma towards people with mental health problems is not only “still quite high amongst older populations”, as stated. |

1b. The draft Strategy includes actions that are intended to achieve the goal of healthy ageing: see page 31 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| The actions marked with \* appear to be appropriate to start with. However there are other actions which could also begin, such as the review (presumably with a mandate to expand to better meet the needs of older people) the GRx programme. GRx appears to have quite good uptake and results, is well-established within primary care, and might benefit from additional resource for older people.It is not clear how the oral health actions will assist older people who cannot afford dental care. Cost is a major barrier to dental health services for many older people. |

### Acute and restorative care

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| 2a. The draft Strategy sets out a vision for the goal of high-quality acute and restorative care: see page 17 in the draft document. Do you have any comments or suggestions regarding this vision?Looks good. People would prefer to be supported to live at home and retain their autonomy for as long as possible with minimum hospitalisation. Including families/whanau in decision making and support processes is a good idea where families are functional. This is not always the case.  |

2b. The draft Strategy includes actions that are intended to achieve the goal of high-quality acute and restorative care – see page 33 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| The goal identified as “the number of people readmitted to hospital following hospital treatment reduces” reads like an outcome measure and needs to be reworded, including to reflect the population identified.The actions identified with an \* are good, but it would be good to have some idea of when other actions are going to be prioritised for implementation.  |

### Living well with long-term conditions

3a. The draft Strategy sets out a vision for the goal of living well with long-term conditions: see page 20 in the draft document. Do you have any comments or suggestions regarding this vision?

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| This section provides clear definitions and vision. However again, the use of the term ‘equitable’ is not clear in the vison statement “Health outcomes for vulnerable older populations with long-term conditions are equitable with outcomes for the population as a whole”. Does this mean that older people with LTCs can have the same health outcomes as the general population – ie all ages with no LTCs? This seems a bit unrealistic, or perhaps it’s just unclear. Suggest being more specific. |

3b. The draft Strategy includes actions that are intended to achieve the goal of living well with long-term conditions: see page 34 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| It’s good to see that most of the workforce development actions have been prioritised with an \*. The term ‘dementia-friendly’ is used in 11b. It is not clear what this means (is this some kind of communications campaign?), and a definition might be helpful.11i mentions the early identification of mental illness and addiction that can mask or contribute to other LTCs. The term ‘diagnostic overshadowing’ is often used to describe this phenomenon, which is particularly important for people with mental illness who do not have their physical health problems diagnosed or treated, or treatment is delayed, with often serious implications. As well, mental illness, and particularly depression, is often ‘overshadowed’ by physical LTC diagnoses. Poor diagnosis of physical health problems amongst people with mental health problems contributes to significant inequities in health outcomes for this group, who have greatly reduced life expectancy and quality of life. Similarly, there is strong evidence that mental illness, particularly depression and psychosis, increases risk of cardiovascular disease and other LTCs.We consider this to be a priority for action, based on a large body of evidence summarised as part of Equally Well (Te Pou o te Whakaaro Nui, 2014) and request that this action has an \*.  |

### Support for people with high and complex needs

4a. The draft Strategy sets out a vision for the goal of better support for people with high and complex needs: see page 24 in the draft document. Do you have any comments or suggestions regarding this vision?

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| The vision statement reads well and is very positive. We note that barriers to high-quality health services are often financial.  |

4b. The draft Strategy includes actions that are intended to achieve the goal of better support for people with high and complex needs: see page 37 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| We support 17a being made a priority (given an \*), based on evidence of significant physical health inequities for people with mental illness and addiction. The meaning of 21b is somewhat unclear. Suggest rewording to be more specific.  |

### Respectful end of life

5a. The draft Strategy sets out a vision for the goal of a respectful end of life: see page 27 in the draft document. Do you have any comments or suggestions regarding this vision?

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| This section is sensitively and respectfully written and strikes a good balance.  |

5b. The draft Strategy includes actions that are intended to achieve the goal of a respectful end of life: see page 40 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| Increased public awareness about advance care planning and enduring powers of attorney is quite appropriately identified as a priority. This section is very good.  |

### Implementation, measurement and review

6 The draft Strategy includes proposals for implementing, measuring and reviewing the proposed actions: see page 41 in the draft document. Do you have any comments or suggestions regarding these proposals?

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| It’s good to see that a priority is to develop an implementation plan with a 3-month timeframe. Likewise, it’s good that service user perspectives will be informing future service development, via the HQSC, as a priority. We strongly support the establishment of an outcomes and measurement framework and planning and review process, led by the Ministry of Health.  |

### Other comments

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| Thank you for the opportunity to comment and provide feedback. Regarding tracking progress over the next ten years, we would like to hear about your plans to enable stakeholders be able to monitor progress as the strategy is implemented. For example:Will there be an annual report on progress against key objectives or targets?Will regional approaches be prioritised as well as individual DHB responses?Will smart systems be developed to gather and share (in a timely way) the experiences and stories of people using services and their families?In a similar vein, the value of hearing about improvements in older people’s health and their health care over the next decade will need to be considered. Exemplar services or innovations could be showcased so providers can learn from the success of others. This may require dedicated resources that could be targeted at learning how best to introduce and manage changes that deliver better service outcomes.It is positive to see that planners and funders will be responsible for monitoring the quality of care provided by the private providers of accommodation and homes for older people which are profit driven.  We would strongly encourage cross-sector and regional collaboration to achieve the outcomes of the strategy. This may require investment in dedicated roles and functions needed for service transformation. We suggest the inclusion of an overt focus on building leadership capacity and capability needed to initiate and support change at the various levels in the health care system. |

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| **Submission 149** |

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| This submission was completed by: (name) | Elder Care Canterbury Consumers c/o Valda Reveley |
| Organisation (if applicable): | Presbyterian Support USI |

This submission *(tick one box only in this section)*:

[ ]  comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity)

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* [ ] Consumer

[ ]  Asian [ ]  District health board

[ ]  Education/training provider [ ]  Local government

[ ]  Service provider [ ]  Government

* [ ] Non-governmental organisation [ ]  Union

[ ]  Primary health organisation [ ]  Professional association

* [ ]  Academic/researcher [ ]  Other *(please specify)*:
This group includes a mix of ethnicities

**General comments on the draft strategy**

**The draft vision for this Strategy is that older people live well, age well and have a respectful end of life in age-friendly communities.**

What have we got right in the strategy?

As a Consumer group we felt the Strategy was a good document and one which engendered good consideration and discussion

What could we improve on?

We were and are concerned at the implementation, the words are there but does the funding support the goals, e.g. around rural services. Involve local Communities. We are also concerned that more and more is being passed on to the GP’s but they might not have the same priority in their practices.

What would you focus on and why?

Building social connectedness and wellbeing in age friendly communities, we agree with the statement and the goals but would want to focus on the how therefore we would prioritise “C”.

Recruiting, educating and offering a career pathway for care workers: The retention would be greater, the work would be held n higher regard. Unit standard training would ensure communication skills to a respectful level and cultural matching could be better considered: The meaning of restorative could be better understood by Consumer and Care worker and implemented to achieve the agreed to goals:

Accessibility: Housing and new builds, influence these before they are built, ensure proper door widths, no steps or lips. Ensure accessible toilets with changing tables suitable for adults with a disability not just for babies in public spaces. Highlight the need for public accessibility. Hear the Consumer voice which needs to be heard intelligently so it translates to actual design improvement, not be given lip service.

**Background**

To achieve this vision, we need to ensure our policies, funding, planning and service delivery:

* prioritise healthy ageing and resilience throughout people’s older years
* enable high quality acute and restorative care, for effective rehabilitation, recovery and restoration after acute events
* ensure people can live well with long-term conditions
* better support people with high and complex needs
* provide respectful end of life care that caters to personal, cultural and spiritual needs.

These five outcome areas form the framework for this Strategy. We will set out to achieve our vision in these five areas within a system that, as the New Zealand Health Strategy requires, is people-powered, delivers services closer to home, is designed for value and high performance, and works as one team in a smart system.

**Healthy ageing**

**Healthy ageing is about maximising physical and mental health and wellbeing, independence and social connectedness as people age.**

What does healthy ageing mean to you?

We as a group support the statement above; again we feel it is in the how, the detail. How do we encourage governing bodies that very worthwhile achieving activities such as Healthy Eating Healthy Ageing.. Senior Chef should not be lost or minimized. Falls Prevention has gone through a similar process.

Health Smart- needs to start early and include eating & exercise, we see this developing, Senior Chef in Canterbury **was** a great example.

How can we maximise health and wellbeing as we get older?

Encourage older individuals and Communities to give back, become involved in their own local communities and people. Encourage and lead by example intentional connection, right down to smiles and hellos, encourage age inclusiveness. Recognise that not everyone is a joiner or a group person, find out what possibilities there are for individual thinkers. Support and encourage Neighborhood Support groups being established. How well do individuals engage with their GPs over a concern, double appointment are expensive and the “Dr is a busy person”. Are patients aware of what is available within the practices?

Dentistry should be included more when talking of health & wellbeing as should **Healthy** housing

**Background**

The key elements of the action plan for health ageing, outlined in the [Draft Strategy](http://www.health.govt.nz/publication/health-older-people-strategy-consultation-draft), are to:

* build social connectedness and wellbeing in age friendly communities
* increase resilience through local initiatives
* work across government to prevent harm, illness and disability, and improve people’s safety and independence
* improve health literacy and communication systems
* improve oral health in all community and service settings.

**Acute and restorative care**

**Older people are high users of hospital services, both planned and unplanned, and are especially vulnerable to rapid deterioration.**

How well is the health system looking after people when sudden and acute health issues affect them?

If the person is in Hospital, discharge is an area which can be the difference between success and fail. If the transition & linkage into the home situation is timely and managed well, the outcome is more successful & effective. This would include the absolute basics through to follow-up within a few days and the Consumer understanding what and why their acute episode has happened, what the ramifications may be short and long term and practicing new techniques of management. This is crucial and needs to be repeated until understood. If they have a service or services minimise the service personnel involved daily/weekly.

What are the best ways that older people can regain health and function after a sudden or serious illness or injury?

Understanding it and the ramifications, having a supportive, knowledgable connection or network they can share their worries or concerns with, being encouraged to return to their normal life or introducing them to new ideas or challenges and staying with them for the adjustment period this could be a role for an NGO Volunteer perhaps? A new service could be developed with the DHBs, this would need to include some funding for social connection i.e. coffee & transport.

**Background**

The key elements of the action plan for acute and restorative care, outlined in the [Draft Strategy](http://www.health.govt.nz/publication/health-older-people-strategy-consultation-draft), are to:

* support effective rehabilitation closer to home
* improve outcomes from injury prevention and treatment
* reduce acute admissions.

**Living well with long-term conditions**

**Long-term conditions can occur at any age, but become more prevalent as people get older.**

What do you think are the best ways to ensure that older people with long-term conditions can live healthy and independent lives?

Keep them involved with their own care, treat them as the knowledgeable people they generally are. Ensure pain relief/management is available when they need it. With their permission ensure their families/support people know what they need to know to be able to support and/or encourage. Nutrition was an area we felt important to highlight in here.

In this section we prioritised point 9b

How can we support older people to live well with long-term conditions?

As above but in addition, help them to explore new goals/interests if they are unable to continue with old ones - this needs to be done sensitively by someone who can establish a connection with the person.

We did not like the word “sharpen” under delivery of service. (perhaps refine??)

**Background**

The key elements of the action plan for living well with long-term conditions, outlined in the [Draft Strategy](http://www.health.govt.nz/publication/health-older-people-strategy-consultation-draft), are to:

* ensure that those working with older people with long-term conditions have the training and support they require to deliver high quality, person-centred care
* enhance cross sector, whole-of-system ways of working
* expand and sharpen the delivery of services to tackle long-term conditions
* inform individuals and the community so that they are better able to understand and live well with long-term conditions and get the help they need to stay well
* use new technologies to assist older people to live well with long-term conditions.

**Support for people with high and complex needs**

**Older people with high and complex needs are one of the most vulnerable groups in society. They are more likely to become ‘frail’; that is, to deteriorate markedly after an event that would otherwise have minor effect on their health.**

How can we ensure older people with complex needs are well supported?

Similar to above, involve them in the solution, spend time with them and their support network to establish ongoing interests and management. If they are to remain in their own home, provide **coordinated** care across Providers if one Provider can’t manage the range of work which is preferable. Reduce the number of different people and systems attending to the person, ensure they remain in control as much as possible. Support the carer, they should be able to maintain their lives as well whether it be health, work, social. Acknowledge family/support community; improve the financial resources for being supported at home.

**Background**

The key elements of the action plan for support for people with high and complex needs, outlined in the [Draft Strategy](http://www.health.govt.nz/publication/health-older-people-strategy-consultation-draft), are to:

* reduce frailty in the community
* with service users, their families and whānau, review the quality of home support services and residential care in supporting people with high and complex needs, and involving family and other caregivers
* integrate funding and service delivery around the needs and aspirations of older people, to improve health outcomes of priority population groups
* improve the physical and mental health outcomes of older people with long-term mental illness and addiction
* better integrate services for people living in aged residential care
* improve integration of information from assessment and care planning with acute care services, and with those responsible for advance care planning
* improve medicines management
* build the resilience and capability of family and whānau, volunteer and other community groups supporting people with high and complex needs, and those with life-limiting illnesses

**Respectful end of life**

**Our experience in the last stages of life can be profoundly important for us and for our loved ones.**

What would a respectful end of life look like for you or those close to you?

The ACP initiative is excellent but confusing to many, our group recommends having “Cafe” type events to lessen the anxiety of the subject and where middle aged/older people can come together and discuss what it means for them and where trained people could be available to help consumers work through it. The process of this information being added to their records can be explained also. (Is there a good level of buy in from GPs?)

How do we best achieve a respectful end of life, tailored to the needs of the individual and their family?

Don’t wait until we are old/old (*we range in age from late 60s to mid 80s*) do it now - Promote and demystify ACP: Offer opportunities within communities to explain it and the empowerment of making choices for ourselves, have interesting clear information available for families

**Background**

The key elements of the action plan for respectful end of life, outlined in the [Draft Strategy](http://www.health.govt.nz/publication/health-older-people-strategy-consultation-draft), are to:

* build the resilience and capability of family and whānau, volunteer and other community groups supporting people with end-of-life care needs
* ensure widespread and early participation in advance care planning
* build a greater palliative care workforce closer to home
* improve the quality and effectiveness of palliative care.

**Implementation, measurement and review**

**The success of this strategy depends not only on whether we have identified the right actions to take over the next 10 years, but on how successfully we implement the Strategy**

What would success for the health of older people look like for you?

Consumers involved in their own care: One service coordination, delivery timely, consistent, inclusive and not fragmented, limit to key regular carers. Communication has to be a priority

What needs doing to make the strategy a reality?

The Action plan words are there it will be the detail and how it is translated to and by the service deliverers. **Involve the Consumers in the decisions**

What do we need to do to measure success?

Regularly ask the consumers what is working for them and/or what is missing, ensure information is taken back to them if something has been actioned.. or not.

**Background**

The key elements of the action plan implementation, measurement and review, outlined in the [Draft Strategy](http://www.health.govt.nz/publication/health-older-people-strategy-consultation-draft), are to:

* with health and social sector partners, complete a Health of Older People Strategy Implementation Plan within the first 3 months of the Strategy’s release
* include older people in service design, development and review and other decision-making processes
* establish an outcomes and measurement framework and planning and review processes
* improve the knowledge base.

Involve the community in planning the Age Friendly Cities, there has been consultation with Consumers from time to time but the final changes didn’t reflect the conversations and there was no feed back to individuals or groups consulted. Listen to Consumer stories, do outcomes meet our expections?

We as a group support the Strategy Goals with the emphasis on ensuring the implementation is definitely person centred and **do it with us not for us.** Thank you for the opportunity to contribute.

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| **Submission 150** |

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|  |  |
| Organisation (if applicable): | NZ ASSOCIATION OF OPTOMETRISTS |
| Position (if applicable): | NATIONAL DIRECTOR |

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[ ]  Education/training provider [ ]  Local government

🗹[ ]  Service provider [ ]  Government

[ ]  Non-governmental organisation [ ]  Union

[ ]  Primary health organisation 🗹[ ]  Professional association

[ ]  Academic/researcher [ ]  Other *(please specify)*:

## Comment: WHAT THE STRATEGY IS MISSING

The strategy fails to address the urgent need to make specific reference to loss of sight rather than just mentioning it in passing.

A key point noted in respect of the need for a new strategy is that “Remaining in good health, aging well and being able and supported to live well with long term conditions is critical to enable older people to continue participating and feeling valued, which in turn is important for health and wellbeing.”

However, the strategy does not address the fact that visual impairment negatively impacts on:

* + Independent living
	+ Quality of life
	+ Self-ranking of health
	+ Depression
	+ Falls and fractures[[51]](#footnote-51)
	+ Increased need for community and/or family support, and
	+ Earlier institutionalized care[[52]](#footnote-52).

And these are the very things the strategy seeks to improve!

Research has shown the relative risk of hip fracture is 8.0 for non-correctable visual impairment and visual impairment contributes 30% to risk of hip fracture (adjusted for age, sex, history of stroke, arthritis, self-reported health, past and current use of medication)[[53]](#footnote-53) It is no accident that the ACC specifically refers to impaired vision as a contributing factor in its ‘thinksafe’ falls prevention programme and encourages people to get their eyes checked regularly.

To ensure positive ageing it **is** necessary to retain maximum visual function. For some people that will mean no more than having a proper prescription in their spectacles. For others it will mean managing or treating conditions that cause blindness.

It seems that NZ is not doing well in this respect:

 Around 168,000 New Zealanders are blind or have a sight impairment that cannot be corrected by glasses or contact lenses (2013 Disability Survey Data)

This is an increase over the 2006 data which recorded 94,700 people with a sight impairment that cannot be corrected by glasses or contact lenses

For at least 20% of the people registered with the Blind Foundation, blindness was preventable.

We need to pay particular attention to age related macular degeneration, glaucoma and cataracts. We need to consider who is at risk and whether can risks be minimized. We need to think about treatments.

**We need to think about collecting information on eye diseases and conditions – perhaps we should have a national minimum dataset for eye health information.**

We know that macular degeneration is the leading cause of blindness in Australia and the USA. Can we assume the same will be true of New Zealand? What do we know about eye health and ethnicity in New Zealand? From Australian research we know that over there ARMD is responsible for more than two thirds of new cases of blindness in people aged over 50. [[54]](#footnote-54) [[55]](#footnote-55) USA studies show that for white Americans and the population as a whole AMD is the leading cause of blindness but cataracts and glaucoma cause the most blindness among African Americans and glaucoma is the most common cause of blindness among Hispanic Americans. Here we need information on Caucasian, Maori, and Asian population groups.

There is an overwhelming need for data on the eye health status of the New Zealand population and this strategy will need to incorporate and increased emphasis on local research in both primary and secondary eyecare for older people.

## Other points in response consultation questions

### Healthy ageing

1a. The draft Strategy sets out a vision for the goal of healthy ageing: see page 14 in the draft document. Do you have any comments or suggestions regarding this vision?

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| The strategy needs to pay particular attention to age related macular degeneration, glaucoma and cataracts. We need to consider who is at risk and whether can risks be minimized. We need to think about treatments. **We need to think about collecting information on eye diseases and conditions – perhaps we should have a national minimum dataset for eye health information.**We know that macular degeneration is the leading cause of blindness in Australia and the USA. Can we assume the same will be true of New Zealand? What do we know about eye health and ethnicity in New Zealand?USA studies show that for white Americans and the population as a whole AMD is the leading cause of blindness but cataracts and glaucoma cause the most blindness among African Americans and glaucoma is the most common cause of blindness among Hispanic Americans. From Australian research we know that over there ARMD is responsible for more than two thirds of new cases of blindness in people aged over 50. [[56]](#footnote-56) [[57]](#footnote-57)Oral health is specifically noted and certainly the association between cardiovascular disease and periodontal bacteria is well recognised but the associations between positive aging and healthy eyes do not seem to have been adequately considered in this strategy.**Diabetes:**People with diabetes are at risk of developing diabetic eye disease so it is important that all areas of New Zealand have access to a really great DR screening programme. As the risk increases with age then this strategy needs to specifically address access to community based screening for older people. We probably could also make better use of the knowledge that artery narrowing in patients with diabetes coincides with the need for limb amputation. [[58]](#footnote-58) Narrowing of the arteries is relatively easy to track across successive eye examinations. Retinal artery thinning is one of the earliest signs of hypertension. Research has shown that women with the narrowest arteries in the retina had almost double the risk of developing serious heart problems -but it was not predictive for men. [[59]](#footnote-59) |

1b. The draft Strategy includes actions that are intended to achieve the goal of healthy ageing: see page 31 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| Health Promotion and Health Literacy Actions need to include specific consideration of eye health:**Nutrition:**It is common to see promotion of healthy nutrition as a means of reducing some kinds of cancer, obesity, heart disease and so on. But the idea of eating for eye health is not being addressed despite AREDS the Blue Mountains Eye Study, the Beaver Dam Eye Study and Seddon (2003)[[60]](#footnote-60) showing the importance of a diet rich in brightly coloured fruit and vegetables and a role for antioxidants and minerals in delaying or reducing the onset of dry AMD. There is also evidence of a higher AMD risk with increasing consumption of dietary fat together with significant protection from increasing dietary fish.**Smoking Cessation**The risk between smoking and macular degeneration is well established [[61]](#footnote-61) and importantly for eye health benefits it is never too late to stop smoking. Current smokers have 4 x the risk of developing AMD than never or past smokers. [[62]](#footnote-62) Over 5 years, smokers develop AMD 3 x more frequently and 10 years earlier than non-smokers [[63]](#footnote-63) |

### Acute and restorative care

2a. The draft Strategy sets out a vision for the goal of high-quality acute and restorative care: see page 17 in the draft document. Do you have any comments or suggestions regarding this vision?

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2b. The draft Strategy includes actions that are intended to achieve the goal of high-quality acute and restorative care – see page 33 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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### Living well with long-term conditions

3a. The draft Strategy sets out a vision for the goal of living well with long-term conditions: see page 20 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Eye diseases are often degenerative and fit the definition of an ongoing, long term or recurring condition that has significant impact on a person’s life. The impact of l ow vision is every bit as important as that of chronic pain or arthritis. People need to be provided with information about early detection and early intervention of sight threatening eye disease. They need to know that many eye conditions may have no warning signs or symptoms in the early stages even during a period when vision is being slowly lost.A New Zealand study of public knowledge, attitudes, and practices related to eye health an disease[[64]](#footnote-64) showed that importance of eye health was rated highly but knowledge about sight threatening conditions was low.More recent research in the USA[[65]](#footnote-65) gave similar results. Of the 2044 survey respondents, most (87.5%; 95% CI, 84.5%-90%) believed that good vision is vital to overall health while 47.4% (95% CI, 43.7%-51.1%) rated losing vision as the worst possible health outcome. Respondents ranked losing vision as equal to or worse than losing hearing, memory, speech, or a limb. When asked about various possible consequences of vision loss, quality of life ranked as the top concern followed by loss of independence. Nearly two-thirds of respondents were aware of cataracts (65.8%) or glaucoma (63.4%); only half were aware of macular degeneration; 37.3% were aware of diabetic retinopathy; and 25% were not aware of any eye conditions. Approximately 75.8% and 58.3%, respectively, identified sunlight and family heritage as risk factors for losing vision; only half were aware of smoking risks on vision loss. |

3b. The draft Strategy includes actions that are intended to achieve the goal of living well with long-term conditions: see page 34 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| Low vision is not amenable to treatment and people with low vision or vision impairment are less able to maintain independent living they have increased need for community and/or family support, and require institutionalized care earlier than their same age counterparts who have good vision.People with low vision have been shown to experience lower self-rated quality of life. They also rank their own health as lower than do their fully sighted counterparts. People with low vision have higher rates of depression and increased incidence of falls and fractures.The impacts of low vision need to be overtly acknowledged and actions within the strategy for Health of Older People need to be broadened to include older people with visual impairment and the limitations that impaired vision creates against positive ageing. |

### Support for people with high and complex needs

4a. The draft Strategy sets out a vision for the goal of better support for people with high and complex needs: see page 24 in the draft document. Do you have any comments or suggestions regarding this vision?

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4b. The draft Strategy includes actions that are intended to achieve the goal of better support for people with high and complex needs: see page 37 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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### Respectful end of life

5a. The draft Strategy sets out a vision for the goal of a respectful end of life: see page 27 in the draft document. Do you have any comments or suggestions regarding this vision?

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5b. The draft Strategy includes actions that are intended to achieve the goal of a respectful end of life: see page 40 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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### Implementation, measurement and review

6 The draft Strategy includes proposals for implementing, measuring and reviewing the proposed actions: see page 41 in the draft document. Do you have any comments or suggestions regarding these proposals?

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### Other comments

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| **Research**There is an overwhelming need for data on the eye health status of the New Zealand population (especially for older people) and this strategy will need to incorporate and increased emphasis on developing solutions for eye health service delivery which are:* Sustainable
* Equitable
* Responsive to the needs of older people
* Clinically safe
* Cost effective and
* Can be adequately funded
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| **Submission 151** |

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| This submission was completed by: (name) | Professional Nurse Leaders |
| Position (if applicable): |  Chronic and Long Term Condition Directorate |

This submission *(tick one box only in this section)*:

[ ]  comes from an individual or individuals (not on behalf of an organisation nor in their professional capacity)

X[ ]  is made on behalf of a group or organisation(s)

We will publish all submissions on the Ministry’s website. If you are submitting as an individual, we will automatically remove your personal details and any identifiable information.

If you do not want your submission published on the Ministry’s website, please tick this box:

[ ]  Do not publish this submission

Your submission will be subject to requests made under the Official Information Act. If you want your personal details removed from your submission, please tick this box:

X[ ]  Remove my personal details from responses to Official Information Act requests

Please indicate which sector(s) your submission represents *(you may tick more than one box in this section)*:

[ ]  Māori [ ]  Regulatory authority

[ ]  Pacific [ ]  Consumer

[ ]  Asian X[ ]  District health board

[ ]  Education/training provider [ ]  Local government

[ ]  Service provider [ ]  Government

[ ]  Non-governmental organisation [ ]  Union

[ ]  Primary health organisation [ ]  Professional association

[ ]  Academic/researcher [ ]  Other *(please specify)*:

### Healthy ageing

1a. The draft Strategy sets out a vision for the goal of healthy ageing: see page 14 in the draft document. Do you have any comments or suggestions regarding this vision?

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| The general statement on pg 13 “ Older people live well, age well and have a respectful end of live in age friendly communities” with objectives then discussed are applicable and understood for the general population over aged 65yrs. These include the shift from treating illness to reducing or preventing risk factors by addressing the physical, social and environmental risks to healthy ageing.The ADHB has a longstanding commitment to developing integrated services across the hospital/community interface to address the above issues and the direction provided by this strategy will support and guide further services. However the ADHB have an urban multicultural population including an escalating Asian population but alongside this, is the Central Auckland homeless population with their specific needs and risk factors, Many of this group are ageing drug addicts and alcoholics who would not fit into the normal healthy ageing pattern outlined in this strategy when they do form part of the ageing pattern and use of health servicesThere is recognition of the opportunities frorm investments in social and environmental factors influencing health (pg 15) but not direct mention of the above group, within this section, unless the term elder abuse and neglect encompasses this group (pg 16). The action plan pg 31 point could be highlighted or discussed more in the pg 14 section.The inclusion of elder abuse is great and the recommendation to work with civic providers a positive objective. |

1b. The draft Strategy includes actions that are intended to achieve the goal of healthy ageing: see page 31 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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### Acute and restorative care

2a. The draft Strategy sets out a vision for the goal of high-quality acute and restorative care: see page 17 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Acute and restorative care is an area of focus for the reablement and Older People’s Health stream within our directorate. Several current and planned streams of care for older people focus on the objectives outlined within pg 17-19 therefore the recommendations to streamline service assessments and use of shared care plans could be a national objective as opposed to a local objective. This goal or domain is current and with the direction provided and support from the Ministry could reduce hospitalisations and improve quality of life for older people especially those with risk factors or who would benefit mostly from restorative care alongside the older person’s goals.  |

2b. The draft Strategy includes actions that are intended to achieve the goal of high-quality acute and restorative care – see page 33 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| Pg 33 no.6. a. The recognition of the wider team of health professionals around the older person/family/whanau is important. For family to navigate around the circle of support and care requires knowledge and skills. Developing a really integrated multidisciplinary service was part of the previous Health of Older People’s Strategy and growth in this area should continue to reduce acute admissions thus reducing risk of iotrogenic risk factors and helping older people to remain in their own environment . |

### Living well with long-term conditions

3a. The draft Strategy sets out a vision for the goal of living well with long-term conditions: see page 20 in the draft document. Do you have any comments or suggestions regarding this vision?

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| There is appreciate reference to the workload impact to the health and social sector workforce which is currently stretched and adapting to new ways of working to achieve the goals and objectives outlined here. This included the recognition on pg 22 of the need for improved alignment of service models, funding methods and levels of training. Investment in funding models is imperative in allowing health professionals to work alongside older people to achieve strategy recommendations.. |

3b. The draft Strategy includes actions that are intended to achieve the goal of living well with long-term conditions: see page 34 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| As above pg 34 9. a.c. e. d. are important . 9.f. is equally important however for the ADHB with a growing Asian population including northern and southern Asian requires focus. |

### Support for people with high and complex needs

4a. The draft Strategy sets out a vision for the goal of better support for people with high and complex needs: see page 24 in the draft document. Do you have any comments or suggestions regarding this vision?

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| Several of the outcome areas on pg 24 are current or planned programs for the ADHB including Early support discharge, Rapid Response teams screening people either in the hospital or at home or Aged residential care, Frailty pathway for older people admitted to the emergency department and the Nurse Specialist screening and assessing older people in the emergency department with supported discharge home. These programs support the goals of the vulnerable older person and the directions given on pg 24-26 will guide further development Recommendations on pg 25 encouraging the range of health specialities to be part of one team providing services closer to home requires support and acceptance by all of Primary Care. This could certainly be achieved with the support of the Ministry and local authorities |

4b. The draft Strategy includes actions that are intended to achieve the goal of better support for people with high and complex needs: see page 37 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| Our directorate have worked together to address frailty and how to reduce risks and improve understanding. The frailty tool currently used has been taken from the NHS. However it is known that nationally there are several versions of frailty identification used. Would not further work across the country or within a strategy assist in the national development of a frailty pathway as developed by the NHS. |

### Respectful end of life

5a. The draft Strategy sets out a vision for the goal of a respectful end of life: see page 27 in the draft document. Do you have any comments or suggestions regarding this vision?

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| For this section enclosed are the comments from the Palliative Care NP for the CLTC directorate and Professional Nurse Lead.*Given my area of practice I have chosen to focus my feedback on the final section of the Strategy; “Respectful end of life”. I would like to congratulate the developers of this Strategy for being explicit about the need to integrate palliative and end of life care into the care of older people. I hope the following comments are helpful.**Planning in Advance**In the current draft there is a significant focus on the use of advance care plans and conversations related to this process to improve the provision of palliative care for older people. While this may be an important strategy to clarify patient preferences at the end of life, however not everyone wants to complete an advance care plan and there are other factors that need to be highlighted in the Strategy.**Firstly, conversations related to goals of care are an important component in planning for the future. These conversations need to be well documented by clinicians and communicated to all providers involved in the care of the older person, across the whole system of care. This is even more important for those who do not wish to document their wishes in an advance care plan. Secondly, whilst providing an opportunity to complete an ACP should be routine in practice, it should not essential in order for clinicians to provide appropriate care that is aligned with patient and family preferences.* *Planning in advance as guided by ACP requires a level of awareness that one is nearing the end of their life. This “awareness of dying” is an integral component to the Western model of achieving a good death and is a dominant discourse in palliative care. However, some cultures (and some individuals) have a preference around truth telling that may result in them being unable or unwilling to talk openly about their preferences.* *What matters most to patients?**I like that there is a focus in this section on what matters most to people at the end of life. These principles could be used to provide a framework for the “Respectful end of life” section. For example, conversations regarding goals of care and preferences at the end of life could be included in the section on “good communication” and include a reference to the role of ACP; and included in the section on “control of pain and other symptoms” could be reference to supporting the development of a well-educated gerontology workforce on the skills and knowledge required to provide good palliative care and recognizing when they need to refer to a specialist palliative care provider for support.* *I would also like to see included a reference to a more integrated model of generalist-specialist palliative care, with specialist providing support based on clinical coaching and mentoring to the generalist provider working with older people, whether this be in an aged residential care setting, the community or the hospital setting.* *Collective decision making**When referring to preferences and decision making at the end of life, it is important to include different ways that people may adopt in this process. Individual autonomy dominates the Western model of health care however other cultures take a more collective approach to decision making. This inevitably impacts on how we have conversations about goals of care and decision making at the end of life. This is particularly so for some Maori and Pacifika patients.* *Our vision for enabling a respectful end of life* *I prefer the use of terms such as “family, whanau and friends” or “significant others” rather than “loved ones”. This is just a personal preference as it assumes that those we want around us are the ones we love the most, this is not always the case. People facing the end of their life should be given the opportunity to discuss their fears and goals but equally there choice to not do so should be respected and not seen as a failure in our care.**Technology improves end of life care – not entirely sure what this means and how it relates to the following sentence about advance care plans and review of medicines. Does this mean that decisions regarding interventions should be aligned with patient’s preferences regarding end of life care, which may or may not be outlined in an advance care plan?* *Reference to the cultural needs of different groups needs to be more explicit e.g. collective decision making and truth telling are just two examples of different cultural needs in relation to conversations about death and dying. There are also issues such as the different meanings of home. For example, Maori see home as being not only their place of residence, but also their ancestral home. This needs to be included in any conversations regarding preferences for place of care and place of death.**“People talk comfortably about dying and preparing for death” is a big goal and possibly fails to acknowledge preferences for those who do not want to talk about death and dying which could be a cultural norm for them. Indeed, it could be a norm that has been adopted for many years within a family group. I wonder if it would be better to say “People are given the opportunity to talk openly about dying and preparing for death if that is their wish”. Often people are not given this opportunity because clinicians don’t feel particularly comfortable in starting the conversation rather than the other way around!* |

5b. The draft Strategy includes actions that are intended to achieve the goal of a respectful end of life: see page 40 in the draft document. Do you have any comments or suggestions regarding these actions? Do you agree that the actions with an 🟏 are the right actions to begin with?

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| All very good points. In practice as a community based gerontology NP one of the difficulties that are hopefully addressed is that of allowing funding for dying at home for older people with non malignant illnesses with an extended and unknown trajectory who are often moved to residential care due to funding and social issues. In the United Kingdom there are several programs that allow more opportunity to spend the end of life at home for this group. |

### Implementation, measurement and review

6 The draft Strategy includes proposals for implementing, measuring and reviewing the proposed actions: see page 41 in the draft document. Do you have any comments or suggestions regarding these proposals?

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| Good plan and will help with evaluation for further frameworks. |

### Other comments

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16. Public Health England (2016) *Health matters: midlife approaches to reduce dementia risk* Public Health England [↑](#footnote-ref-16)
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